HIV/DISEASE AND ADOLESCENT REPRODUCTIVE HEALTH PROGRAMS IN RUBAGA DIVISION (CASE STUDY MUVUBUKA AGUNJUSE)

BY

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DECLARATION

I ABE, hereby declare that this dissertation is my original work and it has never been presented before to any high institution of learning for an award of a degree in any other University.

Signed: ..... Date 17/08/2012

ABE JULIUS PETER (student)

This thesis has been submitted for examination with my authority as a University supervisor

PR. SEMPEBWA GODWIN B.

Signed: ..... Date 17/08/2012

DEDICATION

This dissertation is dedicated to my supervisor Pr. Sempebwa Godwin B, Ms. Gladys Namata and all my family members for being there for me for all these years of my study. I therefore appeal to all adolescents to try as much as possible to put into practice all that has been the subject matter, the discussion, and recommendation of this report which could be the only way young adolescents would use to avoid pre-marital sexual behaviors.

ACRONYMS

A.R.H:- Adolescent Reproductive Health Programs

AFHS - Adolescent Friendly Health Services

AIDS - Acquired Immune Deficiency Syndrome

EC- Emergency contraception

FP - Family Planning

HIV - Human Immune Deficiency Virus

ICPD - International Conference on Population and Development

MOH - Ministry of Health

NGO - Non- Governmental Organization

PIDC - Pediatric infectious Disease clinic

PMTCT- Prevention of mother to child transmission

R.H:- Reproductive Health

SGRV- Sexual and gender based violence

SRH: - Sexual Reproductive Health

STI: - Sexually Transmitted Infections

TASO:- The AIDS Support Organization

UDHS:- Uganda Demographic and Health Survey

UN - United Nations

UNFPA: - United Nations Population Fund

UNICEF - United Nations Children Emergency Fund

UNICEF: - United Nations Children's Education Fund

UNPIN - United Nations Population Information Network

VCT - Voluntary Counseling and Testing

WHO - World Health Organization

WHR - World Health Report

ABSTRACT

There is an increasing worldwide concern about adolescent's health and development problems. These health problems relate more particularly to the reproductive health. This is an area where adolescents are fast growing physically, emotionally and morally. The adolescents at this stage are always curious to find out different things including sexual practices, relationships, socializing and modeling behaviours.
The researcher's aim was to assess the ARH programs available, percentage of those adolescents that are HIV positive, barriers to the accessibility of the programs and lastly to check whether HIV/Disease infection rate depends on the ARH programs available at the health centre.

There are quite a number of services that were found to be provided by Muvubuka Agunjuse as a teenage centre and these include STD/STI management and treatment , HIV counseling and testing , Guidance and counseling on sexually related issues , Family planning (e.g. issuing condoms and contraceptives) , Outreach of the youth and sensitization, Antenatal care ,Post abortion care and General Medical services.

An analysis of variance was done and the result shows that there is a relationship between HIV prevalence and the ARH programs provided by the health provider. Hence HIV/Disease depends on the services delivered.

A number of factors have affected the ARH service delivery, these include: in adequate funding, lack of Parents and community support, inadequate ARH trained health workers, lack of support supervision and inadequate drugs and equipment. In spite of all these inadequacies, majority of health providers are friendly when serving adolescents.

DEFINITION OF TERMS

Youth/adolescents

The world Health Organization (WHO, 1999) defines adolescents as persons in the 10-19 years age group while youths are defined as those between 15-24 years. The World Health Organization combines these two overlapping groups into one entity of "Younger people" covering the age range of 10-24 years. In this study, teen age (10-24 age group) was considered.

Adolescence

This is a period of biological and psychosocial turmoil. Adolescents have to make decisions pertaining to their teenage life and their future life. The biological change concern for appearance, sexuality, and search for identity, sex roles and the whole question of their future status are quite overwhelming. They have no prior experience of such pronounced change, which makes the whole situation difficult to understand.

Health

This is the complete physical, mental, and social well being and not merely the absence of disease or infirmity. This underpins the need for a holistic approach, concerned with a broad range of health problems and social conditions affecting young people and with issues related to attitudes and behaviors as well as illness and injury.

Adolescent sexual and Reproductive Health

Adolescent Sexual and reproductive health include safe motherhood (prenatal care, safe delivery, and management of problem pregnancy, postnatal care) access to family planning. Prevention and management of STDs including AIDS, prevention and management of complications of abortion, elimination of harmful practices such as FGC, premature marriage, domestic and sexual violence.

Adolescent Sexual risks

Adolescent sexual risks are sexual behaviors that put adolescents at risk for unplanned pregnancy, STIs, HIV infection, health problems related to pregnancy and child bearing. They include too early initiation into sexual activity, sexual intercourse without the use

of contraceptives and/or condoms, sexual intercourse with more than one partner and sexual intercourse with a partner infected with an STI or HIV.

Youth/Adolescent Friendly Services

A youth Friendly Health service is a setting that is welcoming, pleasing and comfortable to young people and even relaxing and enjoyable (UNICEF, 1996). Others have described it, as one that offers many services, is open in the afternoon and evening has empathetic, knowledgeable and trustworthy counselors. These services have to be private, confidential, affordable, accessible and staffed with sensitive service providers.

Abortion

The termination of a pregnancy. This may happen on its own (spontaneous abortion or 'miscarriage') or it can be the result of a medical procedure (induced abortion). In countries where abortion is illegal, like Uganda, abortion services can be dangerous. If it is not performed by a medical doctor or gynecologist, it is often done in a rushed and unhygienic manner that puts women's health at great risk. An abortion is safe when it is performed by professional, trained and well-equipped service providers in a hygienic setting.

AIDS

Acquired Immuno-Deficiency Syndrome, a fatal disease in which the human immune system is weakened by the HIV virus and cannot guard the individual against any disease-causing organisms, even those that can be treated with drugs. AIDS is the final stage of an infection with the HIV virus (Human Immuno-deficiency Virus), which is transmitted through blood and bodily fluids (semen and vaginal fluids). AIDS in itself is not the cause of death. People who die of AIDS actually die of other infections to which the body does not have any resistance as a result of its weakened immune system.

Antenatal

The period before birth. For example, antenatal care is the care needed by a woman throughout her pregnancy.

Behavior

The manner of conducting yourself; the response of individuals or groups to their environment.

Contraceptives

Methods used to prevent pregnancy (also known as birth control or family planning methods).

Family planning

Family planning means planning how to improve the quality of family life. It includes:

1.taking decisions on regulating and spacing childbirth;

2. choosing suitable contraceptive methods;

3. helping childless couples to have children;

4. counselling of both parents and would-be parents;

5. developing the necessary parental, social and family budgeting skills.

HIV

The Human Immunodeficiency Virus that causes AIDS (Acquired Immuno Deficiency Syndrome). The virus weakens a person's immune system so that the body cannot fight off common infections. HIV is transmitted after exposure to an infected person's blood, semen, vaginal fluids or breast milk.

HIV test

A blood sample is taken from the arm with a sterile disposable needle. Then the blood sample will be examined on the presence of antibodies towards the HIV virus. If this test is done directly after unsafe sex, it has to be repeated three months after the unprotected sexual intercourse, as you can be infected for up to three months without yet having enough antibodies to show up in the blood test. These three months are referred to as the window period.

HIV/AIDS

HIV is the virus that causes AIDS. The term 'HIV/AIDS' is often used because infection with HIV eventually leads to AIDS. A person has AIDS (in contrast to just being infected with HIV) when his/her immune system gets so weak it can no longer fight off common infections and illness and he/she gets ill.

Prenatal Care

Medical services a woman receives during her pregnancy. The purpose of prenatal care is to monitor the health of the pregnant mother and foetus to ensure proper growth and

development for both. Prenatal care can also detect birth defects at an early stage of pregnancy.

Sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.

Values

Beliefs held by one person or a group of people. Values shape people's opinions, attitudes and actions, as well as their ways of thinking and are often influenced by a person's family, religion, culture and life experiences.

Virginity

The state of being a virgin: a social concept in which refraining from sexual intercourse till marriage is greatly valued. The concept of virginity is loaded with double standards against women: women are often expected to preserve their virginity till marriage though men can be implicitly encouraged to lose their virginity, mostly without blame or prejudice.

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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Adolescence is a life phase in which young people are particularly vulnerable to health risks, especially those related to sexuality and reproduction: HIV/AIDS, unwanted pregnancy, unsafe abortion, too early marriages and child bearing, sexually transmitted infections, substance abuse, and poor nutrition. Uganda has a high proportion of young people less than 25 years. This is about 68.9% of the total population. About 47.3% are below the age of 15 years. One in every four people in Uganda is an adolescent (23.3%) and one third (33.5%) of all Ugandans are young people. (MoH Adolescent draft Policy, 2000). In Uganda adolescents are known to be poor users of contraceptives. According to UDHS 1995 their contraceptive prevalence rate was reported to be 7.2% using any method in the age group 15-19. The status of adolescent health in Uganda is poor. They suffer from specific conditions that have more devastating effects such as reproductive health problems: early/unwanted pregnancy, unsafe abortion and STI/HIV/AIDS; psychosocial problems such as substance abuse, delinquency, truancy, sexual abuse, etc. For instance adolescent pregnancy rates stand at 43%. There are high rates of STDs and HIV infection in the adolescents than the general population (MOH, 1999).

There is an increasing worldwide concern about adolescent's health and development problems. These health problems relate more particularly to the reproductive health. Worldwide, young women and men suffer a disproportionate share of unplanned pregnancies, sexually transmitted diseases, including HIV, and other serious reproductive health problems. About one half of all HIV infections worldwide occur among people age 25 and under, according to the World Health Organization (WHO). In industrialized countries, two of every three STD infections occur among people under 24 years of age, and the proportion of infected youth in developing countries is believed to be even higher.

Young people are particularly vulnerable to the adverse consequences of early sexual behavior and as such are widely recognized to be one of the most important groups for reproductive health interventions. This increased vulnerability is caused by a number of

biological, behavioral, and psychological factors including hormonal changes at puberty, cervical anatomy, immunological naivety, inability to recognize symptoms of infection, sexual experimentation including experimentation with same sex partners, non-consensual sex, imperceptions of risk, immaturity of

Communication skills, contraception choice, poor health seeking behavior, and alcohol or illicit substance use. In addition, structural (societal) factors that facilitate HIV and STI spread are also well documented. Economic deprivation, sex inequalities and mobility, including social disruption, are all important determinants of HIV /STI spread.

The consequences of sexually transmitted infection (STI) and unplanned pregnancy can be devastating. Young women are at the start of their reproductive life and risk compromising their future fertility through tubal occlusion or ectopic pregnancy. In many areas, young women who get pregnant are withdrawn from school, further disadvantaging them. In countries where access to abortion is limited, the gynaecological consequences of "back street" abortion can be dire. While young men suffer fewer direct health consequences of early sex, infection or pregnancy can still have adverse consequences for them—for example, with respect to further education and training opportunities.

Numerically, young people between the ages of 10 and 24 make up one third of the world's population. Eighty per cent of these young people live in developing countries where the burden of infection with both STIs and HIV is greatest. Half of all people infected with HIV globally are infected before age 25.

Developing, implementing, and evaluating interventions that not only minimise the risk of sexual intercourse in young people but also facilitate development of healthy sexual behaviour patterns and relationships are therefore a priority. There is evidence that initiating prevention interventions when teenagers are still sexually naive, before patterns of risky sexual behaviour are firmly established, is likely to be more effective than trying to change established behaviour in older adults. Interventions started in early adolescence will therefore have the greatest chance of minimising the risk from early sexual intercourse.

However, adult discomfort with adolescent sexuality is common and there is concern among some, often highly influential groups, that sex education promotes experimentation and increases sexual activity. There is disagreement about how explicit educational material should be, how much there should be, how often it should be given, and when it should be initiated.

Given the importance of this topic there has been relatively little rigorous evaluation of the effectiveness and cost effectiveness of reproductive health interventions targeting adolescents, which means that policy makers with concerns about public reaction have few data to support widespread and comprehensive implementation.

More than 10 percent of all births each year are to women ages 15 to 19, according to the Washington-based Population Reference Bureau (PRB). Even when pregnancy among young married women is planned, the health risks for teenage mothers and their babies can be serious. Because their bodies are not fully mature, the risk of maternal mortality is two to four times higher for pregnant adolescents than for pregnant women over 20. Infant mortality also is greater among adolescent mothers typically 30 percent higher for infants born to women ages 15 to 19 than for those born to women 20 or older.

Approximately 2 million adolescent women in developing countries undergo unsafe abortions each year,3 and a third of all women seeking hospital care for abortion complications are under age 20. For young women who undergo unsafe abortion, short-term health problems can include infection or injuries from the procedure itself, such as a perforated uterus, cervical lacerations or hemorrhage. Long-term complications include increased risk of ectopic pregnancy, chronic pelvic infection and possible infertility.

In Uganda adolescents account for 30% of pregnancy related deaths and 30% of these are caused by post abortion complications (Stembile, 2002) maternal mortality is 506 live births (MOH HSSP 1 Uganda report, 2004) According to Williams, in 18 African countries, at least a third of today"s 15 year olds are expected to become infected with HIV during their adult lives and will die from this terrible disease (Williams, 2004). For developing countries, adolescents to avoid unplanned pregnancies, diseases and other

serious reproductive health problems, they need accurate information and services. We need a variety of carefully designed school based programmes, community efforts and responsible Mass Media messages to help educate the youth.

That is basically the major reason as to why many programs in the past and present have been set up to address their reproductive health (RH). Many of these programs basically focus on achieving goals such as, Family Planning, post abortion care, counseling and guidance, health and breast feeding education (UDHS, 2002) rather than the real well being of the adolescents and this urge of attaining goals by the program managers has left most adolescents and their "burning" issues ignored.
In Africa today, young people aged 15-24 represent more than half of all new HIV infections on the continent (Hisel, 2000).

Uganda is not an exception since Ugandan adolescents become sexually active at an early age of 14years hence increasing the high risks of, sexually transmitted infections (STIs) and HIV/AIDS. In addition Africa has about 72,000 maternal deaths occurring among adolescents due to unsafe abortions and the like making up almost 44-48% of the total maternal deaths annually.

In 1995, it was noted in Uganda that teenage pregnancies lay at 43 percent and at 31 percent by the year 2001. These alarming figures basically spearheaded the urgency for the need for the initiation of ARH programs at all levels of the society in order to offer contraception services, antenatal services and counseling and guidance. (UDHS, 2000/2001)

According to UDHS (2000 / 2001), the number of adolescents in Uganda will increase from 4.2 million to 7.3 million by 2015. In the same way, it also states that, 200,000 adolescent girls are married off against their will each day and that 16% of the girls and 6% of the adolescent boys are reported to have contracted different STI's. By this, it's estimated that 6000 adolescents make up a portion of the total reported cases of new HIV infections. This is basically what led to the interest in setting up ARH programs.

Addressing the concerns of adolescents in Uganda, particularly those related to reproductive health is vital due to the fact that like in many other developing countries in Sub-Saharan Africa, a large population is very young. Today's young adults are our future. Their energy, leadership and wisdom will shape the world during this new century. They will care for our own generation as we grow older and they will nurture the next generation. "Consequently, protecting their good health is a vital concern for all of us. Effective strategies and programmes to protect the reproductive health of young adults are needed in every country, but are especially urgent for the youth in developing countries" (Williams, 2004).

1.1.2 Background to Study Area

The case study is Muvubuka Agunjuse which is a health program for Adolescents within the Buganda Kingdom; it is located in Kisenyi-Mengo parish and is directly under the Ministry of Health Buganda Kingdom. This Ministry is responsible for the promotion of health education, the provision of adequate, accessible health services.

The area surrounding the clinic is a densely populated slum, with market places, bars, and small industries, particularly for metal recycling. It has a substantial immigrant population, such as Somalis and Ethiopians, and intermarriages are common. Many youths have come from villages to live with relatives or to look for employment; very few live with both parents. The Ministry of Health of Buganda Kingdom runs the Muvubuka Agunjuse centre, where services are provided to young people aged 10–24 years, to improve their reproductive health standards. Medical treatment, counselling and contraception advice are offered by a nurse/midwife and a social worker. At the centre, peer communicators organize youth clubs offering a variety of activities, such as music, games, drama and discussion groups. Youths from the Muvubuka Agunjuse centre are referred to the AIDS Information Centre (AIC), also in Kisenyi, for VCT for HIV, where clients are offered pre- and post-test counseling. The AIC has a special 'youth corner' with specially trained youth counselors and a low service fee (less than US$1). However, the youth corner has only two counseling rooms (where only two counselors can work at the same time) although the number of youth clients can reach 30 in a day; this means long waiting hours for clients. Life for a young person in Kisenyi is characterized by tending to personal and family responsibilities. Most young people

struggle to receive an education or to find work; many have been sent away from their rural homes because their parents could not afford to pay school fees. These young people tend to hold the belief that education is a way out of poverty. Some already have children of their own to support. Many young people in Kisenyi have had personal experience with HIV or AIDS through friends and family members.They receive information on HIV and AIDS from friends, teachers and the media. Many read Straight Talk, a newspaper supplement with information about sexual and reproductive health matters for young people, or they listen to Capital Doctor, a radio programme to which young people may call in or write with questions about bodily changes, sexuality, menstruation and pregnancy.

1.2 Problem statement

In Uganda and many other sub-Saharan countries, many A.R.H programs have been set up to improve Adolescent reproductive health and they have actually achieved a number of commendable goals as per their stated goals. It has been noticed that mainly the people in urban centres are aware of these Adolescent reproductive health programs and most of the illiterate ones are still not aware of the existence of these services.

Though, most of these ARH services are free of charge, most adolescents fear to access them thinking that they have some costs.

Services such as Voluntary Counseling and Testing have not been adequately utilized, hence deterring the fight against HIV/AIDS at all levels of the society. There are very many other problems that the youth are facing that either directly or indirectly lead to poverty and disease and these are:- Lack of change agents (due to rural-urban migration) to serve as role models and facilitating community development, Inability to mobilize local resources, Geographical isolation and neglect (lake Victoria islands),Ignorance of opportunities, Lack of goals and targets in life, Polygamy and large family size, Laziness among the youth and gambling,Inability to meet scholastic material due to income, alcohol and attitude among parents,

Poor career-guidance, high rate of girl-child drop out due to early pregnancy, peer influence, and parents neglect ,Poor information management, Limited capacity of the existing facilities (medical and counselling staff, medicines, modern equipment),Inadequate knowledge and practices on causes and preventive measures, Chronic diseases and high medical cost (on AIDS, T.B, Malaria etc),Inadequate and/or un-even distribution of health facilities resulting into long distance to health facilities

Many agreements have been signed by the government of Uganda and educational institutions in the fight against HIV/AIDS infections among the adolescents forgetting that, early sexuality among the adolescents does not only lead to HIV/AIDS but also raises critical problems such as early pregnancies, unsafe abortions and social rebuke ,hence the data has to be checked

1.3.0 Objectives of the study

1.3.1 General objective

The main objective of the study is to evaluate the impact of the ARH programs in Rubaga Division

1.3.2 Specific objectives

i. To review existing HIV/AIDS treatment, care and support programs available to adolescents at Muvubuka Agunjuse in Kisenyi-Mengo parish.

ii. To determine the percent of adolescents accessing the different ARH programs/ Services

iii. Evaluate the effectiveness of these A.R.H programs on HIV/Disease

iv. To assess and spell out the barriers that are hindering the adolescents from accessing these services.

1.4 Scope and Importance of the study

The research is going to be carried out at Muvubuka Agunjuse (kisenyi health

Centre) .

As a major problem, the data provided by the Ministry of Health pertaining to A.R.H is still to be checked

1.5 Hypothesis of the study

H_0: There is a relationship between HIV/Disease and ARH programs.

Ha: There isn't a relationship between HIV/Disease and ARH programs.

1.6 Significance of the study

This research will serve as a reference base for Demographers, researchers and students; on the extent to which the HIV/Disease infection rate is affected by ARH programs and its positive or negative impact in Uganda.

To policy and decision makers, it will help in the formulation of policies within the country as well as help in determining the impact of these programs. Policies remain sensitive to economic, social and cultural realities of Uganda without giving in to the aspects of these realities that are dangerous to the health of adolescent. Formulation of policies that seek to strengthen and to provide an enabling social and legal environment for the provision of high quality accessible adolescent health interventions can be a country's strength (MOH, 2004).

1.7 Limitation of the study

This study was conducted using data from the secondary source. Uganda just like any other developing country is faced with the problem of reliable data because of the inadequacy of resources for data collection, limited trained personnel which in most cases subject the data collected to errors. Therefore, the findings may to a small extent deviate from what is on the ground.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction:

This chapter brings about relevant literature that has been written down in relation to the topic of study. It shows literature on factors that influence the accessing and average use of ARH programs by adolescents at Muvubuka Agunjuse. It also offers an overview of the available ARH programs and factors that constrain or influence adolescent's access to these programs plus adequate ways on how to improve the available programs.

2.1.1 Reproductive health

Reproductive health is the state of complete physical, mental and social well-being and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive process functions and systems at all stages of life. (UNFPA/POPIN, 1995) The international conference on population and development (ICPD) programme of action states that "reproductive health implies that people are able to have capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other choice of regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women go safely through pregnancy and childbirth and provide couples with best chances of having a healthy infant" (POPIN/UNFPA, 1995)

2.1.2 Adolescents

According to the Uganda National Adolescent Health Policy (MOH, 2004) and (WHO,1996) the term "adolescent" refers to those aged between 10 and 19, "Youth" as those between 15 and 24, "Young People" as a term that covers both age groups, that is to say those between the ages of 10 and 24. Adolescence is a period of physical psychological and social transition from childhood to adulthood and may fall within either age range. In the researchers view, adolescence is a term commonly not understood. Most people generalize all young people as youth even to the age of 35; some people still categorize them as youth. However, the Uganda National Adolescent

Reproductive Health policy defines youth as all young people, female and male from the age of 10-24 years, it is however flexible and accommodative to other young people depending on their social and economic circumstances. The policy recognizes that many times, the words "adolescent, "Youth" and Young people are used interchangeably. Whenever specificity is desired, the policy is made clear. As far as the above terms are concerned, in this research the 10-24 age group is used.

2.1.3 Policy

The Uganda National Adolescent Health Policy 2004 is an integral part of the National Development process and reinforces the commitment of government to integration of young people in development process.

The policy complements all sectoral policies and programmes and defines structures and key target areas for ensuring that adolescent health concerns are mainstreamed in all planning activities. The policy recognizes the critical roles adolescents themselves can play in promoting their own health and development and emphasizes the need for their participation in planning, implementation, monitoring and evaluation of programmes. The policy remains sensitive to economic, the social and cultural realities of Uganda without giving in to the aspects of these realities that are manifest/ dangerous to the health of adolescent.

The policy further seeks to strengthen and to provide an enabling social and legal environment for the provision of high quality accessible adolescent health interventions. (MOH, 2004). Although the policy sounds good and has well defined guidelines, it has been in a draft form since 2001 and only published in 2004. The policy is little known to the stakeholders. There is a need to publicize and implement the policy in order to achieve its objectives. Awareness of the policy is a key to planning and implementation of adolescent reproductive health interventions. This is generally the case around the world where commitment to meeting adolescent health needs has never been higher. The 1994 international conference on population and development and the 2001 UN special session on AIDS affirmed the rights of younger people to high quality sexual and reproductive health information and services (World Bank, 2002).

2.1.4 Supportive environments

Include rules and policies that promote sexual and reproductive health such as policies that facilitate preventive and corrective health behaviours and rule or regulations that govern adolescent sexual reproductive health related behaviours.

2.1.5 Adolescent Reproductive Health services

Adolescent Friendly Reproductive health services that are defined as a setting that is welcoming, pleasing and comfortable to adolescents and even relaxing and enjoyable (UNICEF, 1996). Other studies have described AFRHS as services that are user friendly such that they are private, confidential; affordable accessible and staffed with sensitive service providers. The typical AFRH services as described by WHO include the following range of services:

i. Quality family planning

ii. STD and HIV prevention services, such as VCT

iii. Antenatal services

iv. Maternity services

v. Counseling services.

The above can be achieved if the health facilities are able to attract adolescents in a friendly manner by integrating AFRH services into these facilities, and be able to monitor behavior changes in AFRH services by providers and track the use of AFRH services by adolescents.

According to Path Finder report of 1997, health services for the youth have remained on the periphery of mainstream family planning programmes for most of the last twenty – five years, and support among donor, policy makers and programme managers has been largely uneven. Adolescent needs have not received universal recognition, and the services that are designed to meet their needs do not receive adequate funding or technical support. This is because Adolescents have often not been treated essentially as

a separate population. Adolescents are a group that requires special youth appropriate messages, alternatives such as job training, fairs and youth centres that offer attractive activities that include entertainment or leisure incentives.

While reproductive health information, counseling and service delivery, have been identified as a necessary programme for adults for decades, availability of such programs has been more recently endorsed for adolescents. The international conference on population and development (ICPD) which met in Cairo in 1994 and the fourth International Conference on women, in Beijing in 1995, endorsed the rights of young people to reproductive health and development.

AFRH in Uganda has not been fully integrated in the health care system. The health care system is already over burdened with a number of factors, such as inadequate trained health workers and ill-equipped facilities. Serving young people with reproductive health information, education, counseling and services therefore remains a challenge.

Many societies customarily withhold information from young people until felt necessary to impart it; this typically occurs at puberty or marriage which historically has occurred close together (Scunderowitz, 2000). In Uganda discussion of sexuality matters is still a taboo especially to young people.

2.1.7 Planning and development of Adolescent reproductive health programmes.

Adolescent's Health and Development affect economic prosperity. Therefore investing in health and development of adolescents is the right thing to do; it"s the smart thing for countries that want their economies to grow faster. (World Bank, 2002) According to Senderowitz, 2000, Involving young people in reproductive health programs means identifying ways for them to participate in a meaningful way in some aspect of a project's planning, implementation, and evaluation.

Several issues that influence the quality of reproductive health services for this vulnerable age group includes the following:

i. Gender perspectives, which are largely defined by social and cultural conditions, shape the way adolescents view sexuality and play an important role in gaining access to information and services. A survey in the USA was Conducted to examined the relationship between sex education and use of contraception at first intercourse Women who received formal instruction on contraceptive use before their first sexual intercourse were more likely to use a method. Women were less likely to use a method if they received information on contraception the same year they began sexual activity.

ii. Sexual health education typically delays the initiation of sexual activity among youth, and helps them to avoid risky behaviors when activity begins. For teenagers already sexually active, including those who are married, sex education can encourage correct and consistent use of contraception or STD protection. Fears that sex education programs encourage or increase sexual activity appear to be unfounded, research suggests.

iii. Youth programs that succeed tend to share certain traits, such as involving young adults, parents and community leaders during planning. involving community members, especially parents and teachers, is critical to implementation of a sex education program.

iv. Parents' acceptance of or resistance to programs can determine whether children will participate "Involving parents and community leaders and asking them to provide input into the curriculum regarding community norms and needs may reduce opposition to sex education programs, may calm parents' unrealistic fears, and may even enlist adults as partners in their children's education," says Dr. Waszak.

v. Psychological and social pressures that youth often face are important considerations when providing reproductive health services. Sociocultural factors that influence adolescents' views on sexuality, their access to information, and their access to health services affect reproductive health and well-being, including teenagers' ability to protect themselves from unplanned pregnancy or STDs.

vi. Media, including posters, drama, broadcasting and publications, can inform young people about important reproductive health concerns and where to obtain services. Radio and television messages can be aimed at getting young people to delay first intercourse and to use condoms when they do become sexually active. After providing information on AIDS and STDs, the messages end by saying: "Go talk to your dad about AIDS," or "Go talk to your mother about ST

2.1.8 Family and community support

In Uganda, social support systems such as family and community support many times respond in a non-supportive way because they are not aware of adolescent reproductive health needs and how the changing environment is continuously affecting them (Nahabwe, 2000). Conditions threatening minors' confidentiality for contraceptive services might also deter some teenagers from accessing STD testing and treatment. (Jones et al. 2004). Many providers adopt types of activities to encourage parent-child communication. They provide information to clients, their families and the larger community by distributing pamphlets with tips on how to talk to adolescents or how to host open houses. According to Nahabwe, 2004, most service delivery centers are not adolescent friendly, this leads to low levels of use of health services for prevention and management of pregnancies and STD"s including HIV/AIDS among adolescents. Even where health services are available, they are still inaccessible to adolescents due to the negative parents, community, and health worker"s beliefs and attitudes towards unmarried adolescents who seek reproductive health services. Most of the existing health services predominantly target adult women (Nahabwe, 2004). In the view of the researcher, in most cases, parents do not respond to adolescent reproductive health needs not because they do not want but because they do not have information regarding reproductive health issues.

This has not only happened in Uganda. (Kahuthi, 1995) reported that in Kenya, about half of school – age youth are out of school and difficult to reach. In addition, the government does not allow open discussion of human sexuality, reproductive health, sexually reproductive health, or sexually transmitted infections (STI"s) and HIV/AIDS

prevention on Television and Radio. As a result, most out of school youth do not have access to information or discussion about these topics. According to World Bank, investing in Health and Development of adolescents, build on the benefits of past government expenditures on child survival and education, and enhance future economic and social development. By contrast, risky or unwanted sex and other unhealthy behaviours are tied; to individual, family and community factors that influence adolescent behaviour and that are closely related to economic and educational prospects. Too many youth who lack opportunities to make positive contribution to society turn to crime and violence and feed existing civil unrest. (World Bank, 2002). In the opinion of the researcher, improving adolescent health also requires changing the social norms that promote negative health outcomes, for example, gender discrimination, norms that promote early sexual activities or that stigmatize using condoms, cultural expectations to marry and bear children early in adolescence.

Today, it is no longer valued and necessary for a bride to be a virgin as it used to be in Ugandan tradition. Pre-marital sex (Gender Issues Research Report Series, no. 14) has become much more common. Traditionally, adolescent girls received sex education from a female family member, mostly an adult auntie or a grandmother. The event that led to this sex educational conversation was often the first menstruation. Girls would then get instructed on female hygiene, abstinence during menstruation, on how to please a man sexually and finally on the sexual act itself. Any sexual activity was only allowed after the girl got married. Tradition obliged women to keep their virginity until marital vows had been taken.

Therefore girls had their first sexual experience at a much later age than nowadays. The general breakdown of society's moral values brought about by social strife since independence, coupled with the breakdown of the social infrastructure, including schools and health services, rural-urban migration, have changed adolescent sexual behavior considerably.

In the past two decades, the importance of implementing A.R.H programs has been a vital importance in the reconstruction of the health sector in Uganda. After the diagnosis of the first HIV/AIDS patient in 1982 in Uganda, the government made a drastic campaign to find ways on how to combat this mysterious disease though, during this time, Uganda was faced with the guerilla war that was going on in the Luwero triangle

and by this, the government that was in power was scared to make the AIDS scourge public fearing international pressure since it was facing its downfall. The campaign was halted, though medical attention was still being rendered to the victims of the scourge (Berk, L.E 1997).

When the NRM government came into power in 1986, the fight against HIV/AIDS became one of their priority goals in the health sector and among the entire population (MOH, 2002: 12). By 1989, the HIV prevalence rate stood at 30%, and by this, the NRM government was forced to device other appropriate ways on how to fight this deadly disease, approaches such as, provision of free condoms, mass sensitization campaigns involving the mass media and the most fruitful of all these approaches was the creation of The AIDS Support Organization (TASO) which offered free counseling and testing of HIV/AIDS.

After the takeover by the NRM government, massive education campaigns were initiated and they basically focused on the school going adolescents. Sex education which was thought of as a taboo before became part of the school curriculum. And by so initiating, the government apportioned a 50% fee in order to boost these campaigns in areas such as mass media publicity and the printing of the relevant ministry of health literature that was meant to sensitize the general public about their health. The government's policy aimed at the control of HIV/STD and sexual reproductive health through sex education in 60%of primary schools and life skills training in 10% of secondary schools brought about desired results in the fight against HIV/STDs.

Adolescents should be able to attain adequate knowledge both formally and socially so that, they get to be involved in the decision making process of their health and lives. This will clearly help in spelling out to them (add) their responsibilities and also show them how effectively they are expected to carry them out.

(Phillip R, 1998) emphasized that school programs were the best means through which reproductive health programs would be implemented effectively.
It has been noted that AIDS awareness programs have gotten a lot of attention from the youth (adolescents) than the A.R.H programs (Kirby, 1999) because they basically focus

on helping the adolescents in setting realistic goals and avoiding peer pressure through allowing peers to discuss together and also entertain them, hence proving at least a short term impact on the population of interest.

In Uganda today, 30-40 percent of all adolescent females get pregnant before the age of 18 years. This shows that the A.R.H programs have to device a mechanism to sort out this high problem (Kimbi Izehak, 1999). The number of African children living with HIV continues to escalate despite the advances made in prevention of mother to child transmission (PMTCT). Ninety percent of the estimated three million children living with HIV live in sub-Saharan Africa (RCQHC 2003). In Uganda, HIV prevalence among children whose mothers are HIV positive is still very high (10 percent). Whereas previously it was never anticipated that infants born with HIV would have the opportunity to live on to adulthood and sexual development, the roll out of treatment programs has made this possible, albeit for a small but growing proportion.

True numbers of living children and adolescents born HIV positive are almost impossible to find, but some indications are available. For instance, the oldest surviving HIV perinatally infected client of the AIDS Support Organization (TASO) in Uganda turned 25 years this year. TASO has also registered 4,696 adolescents living with HIV since infancy. The Pediatric Infectious Disease Clinic (PIDC) in Mulago hospital, Kampala, serves over 500 adolescents living with HIV, of whom 95 percent were perinatally infected. Given the rapidly improving access to ART for infants and children and the slow expansion of effective PMTCT services, the population of perinatally infected adolescents is expected to grow rapidly over the next few years.

As with all adolescents, many of those that are HIV positive are beginning to explore their Sexuality – they are dating and some of them are beginning to have sex. During 2006 alone, TASO and PIDC reported 184 and 7 pregnancies respectively among young HIV positive people receiving services. It is unclear whether these pregnancies were intended or unintended. This notwithstanding, HIV infection seems not to have significantly changed attitudes towards childbearing in Uganda (Kirumira 1996).

Moreover, the desire to have children early in adult life remains strong, including for people living with HIV and AIDS (PLHA), and a romantic relationship is commonly not considered legitimate unless it produces a baby.

Generally, Ugandans have their first sexual experience early in life. According to the 2004-2005 HIV/AIDS Sero-Behavioral Survey (MOH and ORC Macro 2006), 14 percent of young women and men have sex before they turn age 15, and 63 percent of women and 47 percent of young men have sex before age 18. Thus in this context, adolescents living with HIV may desire and/or succumb to familial/social pressure to have children early so that they do not die without an offspring.

However, existing HIV care and support programs do not seem to address the fertility aspirations or desires of this small but rapidly growing population of adolescents. The difficulties of working with adolescents in general on issues of sexual and reproductive health are made even more complex for adolescents living with HIV.

Key interventions to alter disease transmission and prevention of pregnancy among adolescents have tended to emphasize delaying sexual debut, reducing the number of sexual partners, and increasing correct and consistent condom use. A major limitation however, is that these interventions have tended to focus on the general population, which is assumed to be either HIV negative or unaware of their HIV status. The absence of targeted research on the fertility intentions and/or sexual and reproductive health needs of adolescents living with HIV has rendered this impossible. While some existing HIV/AIDS treatment centers in Uganda are now beginning to offer family planning, these services tend to target HIV positive adults.

Guidelines and Service Standards for Sexual and Reproductive Health and Rights (MoH, 2006), for instance, defines adolescent SRH as one of the components of reproductive health and considers sexuality as a central aspect of being human. It provides for family planning and contraceptive service delivery as a component of reproductive health, with the objective to increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs them.

The document explicitly emphasizes adolescents and individuals or couples infected with HIV among the priority groups. Moreover, no verbal or written consent is required from parent, Guardian or spouse before an adolescent client can be given family planning services. It further Stipulates that in order to promote informed choice, all clients seeking contraceptives should be given adequate information about all methods available in the country. It recommends the use of dual protection -- use of a condom and another family planning method-- to protect against

It also provides for the use of emergency contraception (EC) or other methods of contraception to prevent unintended pregnancies following unprotected sexual intercourse or rape. Adolescents are also recognized as a priority group with respect to ante-natal and post-natal care services as well as issues regarding sexual and gender-based violence (SGBV). Wide-ranging information is supposed to be given during ante-natal/post-natal visits, including prevention of STI/HIV, warning signs of pregnancy complications, responsible parenthood, care of the new born, nutrition, and immunization.

In order to achieve the desired goals in these programs (ARH), many Non Governmental Organizations (NGO's) were introduced in order to reach out to those areas where the government had not put enough emphasis. These NGOs helped in funding the construction of many health centers which have availed free Voluntary Counseling and Treatment (VCT) services not only to the adolescents but also to the general public this fact has been appreciated by the government like in the PPA, 2002 report where it was noted that, there was a 77 percent increment in the overall utilization of health centers by the overall population.

The health of adolescents has practically gained a lot of attention and issues pertaining to their health have been of great concern in both developed and developing countries (WHO, UNICEF/UNFPA, 1989).

In addition, if sexual and reproductive health is discussed during counseling of young HIV positive clients it tends to focus on delaying sexual initiation. Service providers seem neither interested, nor motivated or prepared to find out whether these clients are

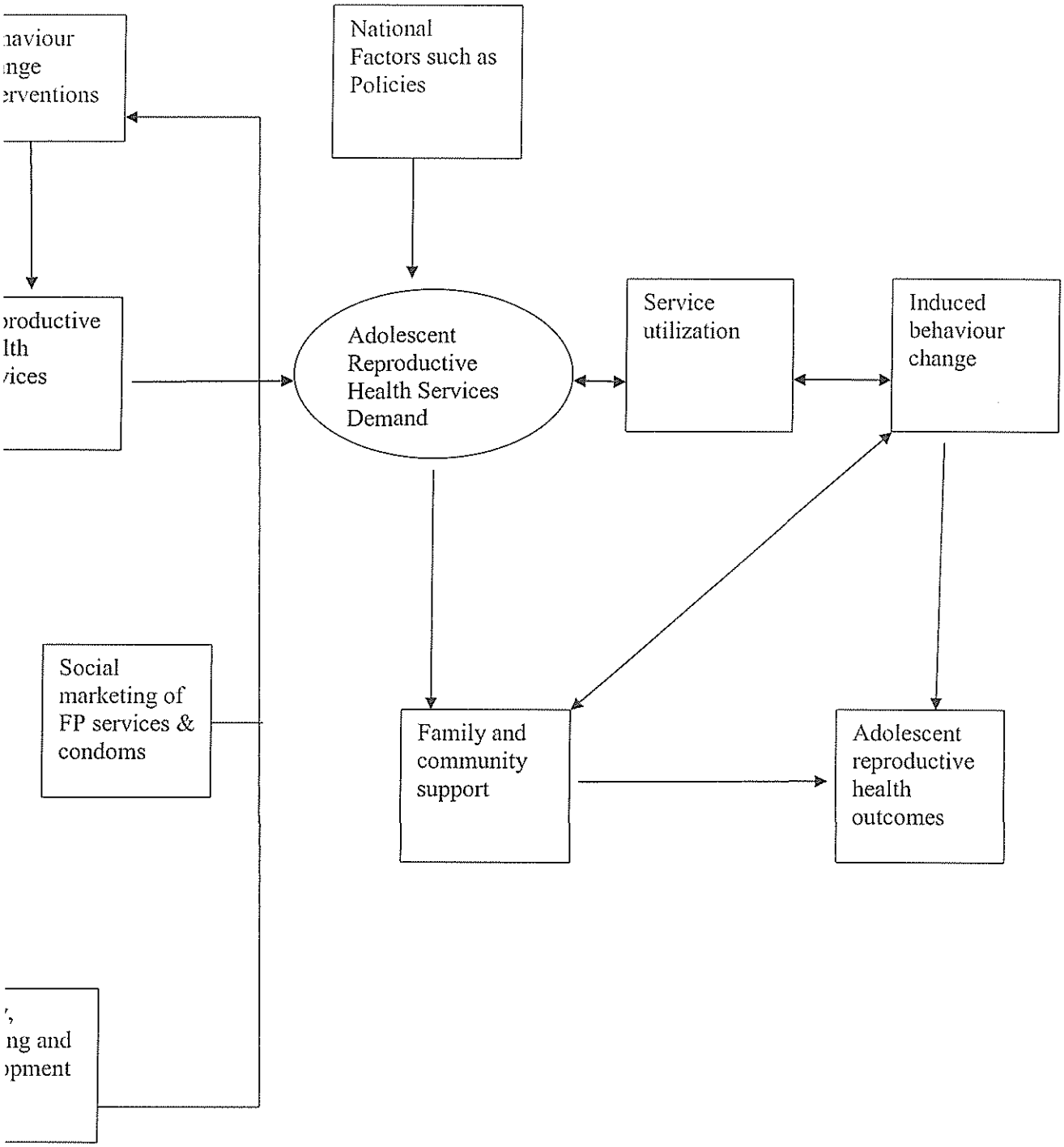
sexually active. Thus, issues related, for instance, to fertility intentions, are not given due attention, often leaving sexually active adolescents living with HIV un-prepared and unable to negotiate contraceptive use or even to access contraceptive methods.

Most of the programs that are being conducted mainly aim at only offering services and not checking the effectiveness of these services to the adolescents. This is basically why there is need to check and evaluate the effectiveness of these A.R.H programs on adolescents.

(Hughes and McCauley, 1998) say that lack of youth friendly services is the major reason as to why most A.R.H programs are not succeeding in what they pursue. Basically adolescents are not being given the right information to help them. Possible remedies to help implement and deliver ARH program

2.1.7 Conceptual Frame work

(*Source: P. Russell Brown, Youth Now, November 18.2003*)



The above conceptual framework explains the process that lead to the creation of individual demand of ARH through the improvement of ARH knowledge, skills and service that are accessible, available, appropriate and friendly. This should be facilitated by a policy environment that supports ARH services, information and skills development. This helps to create the social and cultural environment at community and family levels. These support positive sexual and reproductive health development for adolescents. This could therefore increase service utilization leading to individual behaviors change hence positive reproductive health outcomes.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

This chapter includes a descriptive analysis of the data, the methodology or the analytical methods, employed in carrying out the research work. This research adopted an empirical research method. The researcher relied mainly on secondary source of data from Muvubuka Agunjuse located in Kisenyi-Mengo parish.

3.1 Research Design

The research design employed the use of quantitative and qualitative techniques to analyze the secondary data scientifically to critically conclude the research. This also employed a descriptive analysis of the variables under study to know their nature and behavior over the period.

Also inferences were drawn by fitting the regression model and testing for its significance using the t-statistics.

3.2 Target Population and Sampling Methods

The target population under study was the Adolescents who accessed the ARH programs at Muvubuka Agunjuse over a period of four years. That is from 2008 to 2011 respectively.

3.3 Data collection instrument and source

The data was be collected from Muvubuka Agunjuse, Ministry of health, including internet and other books that have literature on Adolescent reproductive health. The sample is restricted to the annual time series data over a four year period from 2008 to 2011 of HIV/Disease and the Adolescent reproductive health programs available. These have been included, based on the research question and also after critically assessing the literature on the issues of HIV/Disease in the Area.

3.4 Validity and reliability

The research is threatened by the fact that, the data is from a secondary source and therefore any error from the data collection process definitely affects the outcome but the source is the official document about Muvubuka Agunjuse in Kisenyi-Mengo parish.

3.5 Data analysis methods

Simple analysis of variance (ANOVA) is conducted using STATA statistical data analysis software package to determine the exact nature and strength of the relationship that exist between HIV/Disease and the ARH programs over the period under study.

Prior to the regression analysis and analysis of variance (ANOVA), descriptive analysis was conducted to describe the behavior of the individual variables over the duration of the study by plotting a Bar graph .

The regression model:

$$Y = \propto + \beta X$$

By stating the hypothesis as below, a test for the significance of regression coefficient is made.

H_o: $\beta=0$

H_a: $\beta\neq0$

$$t = \beta \sqrt{\sum x^2} / S$$

t_α is obtained from the t-tables.

If $t \leq t\alpha$; then the H_0 is rejected, otherwise it is accepted.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

4.0 Introduction

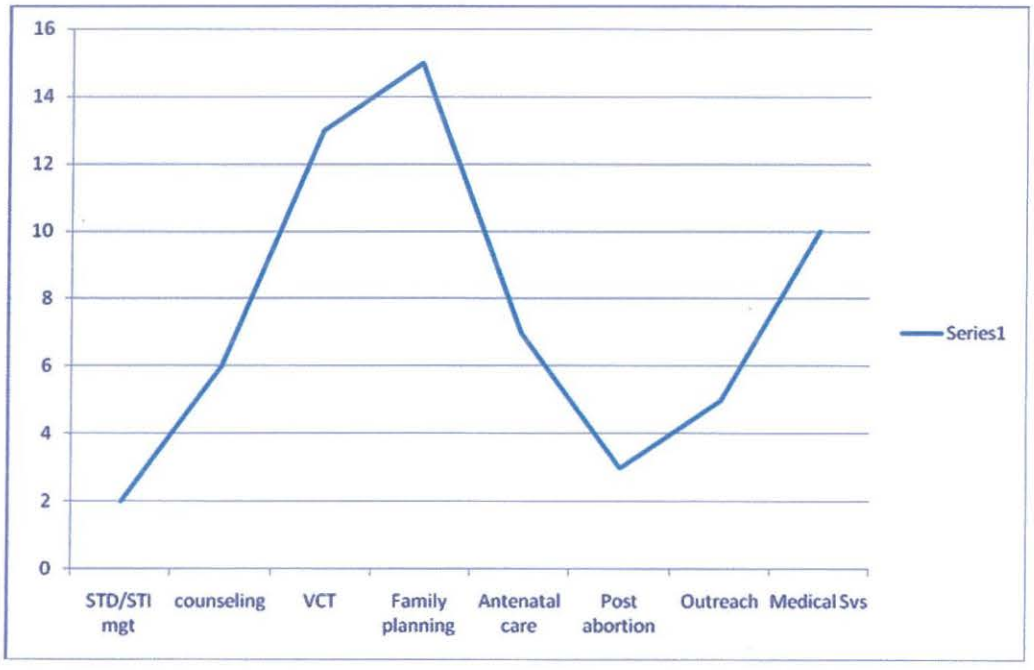
This chapter is a presentation of data, analysis and interpretation of results which are organized in figures, tables and graphs based on the research objectives and corresponding research questions .The chapter also entails testing of the stated null hypotheses and discussions of meaning and implication of the findings.

4.1 Services Rendered

Muvubuka Agunjuse has quite a number of services rendered to the adolescents who endeavor to reach the health centre for help and these services include:-

STD/STI management and treatment , HIV counseling and testing , Guidance and counseling on sexually related issues , Family planning (e.g. issuing condoms and contraceptives) , Outreach of the youth and sensitization, Antenatal care ,Post abortion care and General Medical services.

Figure 1. A simple line graph showing usage of services at the health unit in kisenyi-mengo parish



The most frequently used service is contraception use this arises from the fact that the ABC strategy is the main profound factor that is being passed onto adolescents as a way of reducing the spread of illness among the adolescents.

Voluntary Counseling and Testing

Counseling people at various centers has become a major pillar of the fight against various illnesses such as HIV/AIDS, STDs, complications that may result from abortion among others. The counseling services start with the client reporting to the register at health unit, followed by an interaction with the counselor and eventually begin to entrust each other for further help from the health practitioner.

Abortion

The termination of a pregnancy. This may happen on its own (spontaneous abortion or 'miscarriage') or it can be the result of a medical procedure (induced abortion). In countries where abortion is illegal, like Uganda, abortion services are dangerous since some are not performed by a medical doctor or gynaecologist, or is often done in a rushed and unhygienic manner that puts women's health at great risk. An abortion is safe when it is performed by professional, trained and well-equipped service providers in a hygienic setting.But because of some expenses, some adolescents seek help from unqualified personnel hence not much care is given leading to death and other complications.

Antenatal care

The period before birth. Antenatal care is the care needed by a woman throughout her pregnancy but due to the limited resources, many adolescents do not get this care yet costly at the same time.

Family planning

Family planning means planning how to improve the quality of family life. It includes: taking decisions on regulating and spacing childbirth, choosing suitable contraceptive methods, helping childless couples to have children, counseling of both parents and would-be parents, developing the necessary parental, social and family budgeting skills. Due to limited resources some

adolescents don not access these services yet as mention before limited funds still affects them. The overall reason for low usage of services like post abortion care and antenatal services, medical services is that around the adolescent stage people tend to hide or carry out abortion without consulting qualified health workers and besides these services are slightly expensive for adolescents to accommodate this explains the variation in services attained in health reproductive programs.

4.2 The Analysis of variance (ANOVA) on the relationship between HIV/Disease and the Adolescent reproductive health (ARH) programs

Ho: HIV/Disease depends on the ARH programs

Ha: HIV/Disease does not depend on the ARH programs

i.e. $\mathbf{H_o: \beta=0}$

$\mathbf{H_a: \beta\neq0}$

The level of significance is 0.05

Table 1. Represents ANOVA

Source	Degree of freedom	Sum of squares	Mean sum of squares	F- ratio = 0.36
Between	1008.33333	1	1008.3333	
Within	5672.6667	2	2836.33333	
Total	6681	3	2227	

Since the F-ratio is 0.36 which is less than 1, we accept the null and conclude that HIV/Disease depends on the ARH programs

4.3 The regression analysis on HIV/Disease and ARH programs

Regression analysis was performed on the two variables under study and the results of the regression analysis are presented in table below.

Given the simple linear regression model;

$Y= \alpha + \beta X_i$

Y is the HIV/disease as the dependent variable

α represents other factors contributing to HIV/Disease infection

β represents the ARH programs

From table below α=567, β= -18.33333 so the fitted model becomes;

$Y= 567-18.33333X_i$

The computed value of t-test is given as

$$t = \beta \sqrt{\sum x^2} / S$$

Which leads to $t_{calculated}$ as below

t = -0.06

The critical value of t , which is $t_{tabulated}$ is given as

$t_\alpha = 3.182$

The decision rule is that if $|t| \leq t_\alpha$ accept H_0

From the findings above, $t_{calculated}$ is less than $t_{tabulated}$ therefore the null hypothesis is accepted and concluded that HIV/Disease depends on the ARH programs available

Table 2. Regression analysis on HIV/Disease and ARH programs

Variables regressed	Coefficient	Std. Err	t	P> |t|
Programs and HIV/Disease	-18.33333	30.74808	-0.60	0.612
Constants	567	232.1429	2.44	0.135

Source: secondary data (2008-2011) **level of significance 0.05**

Interpretation

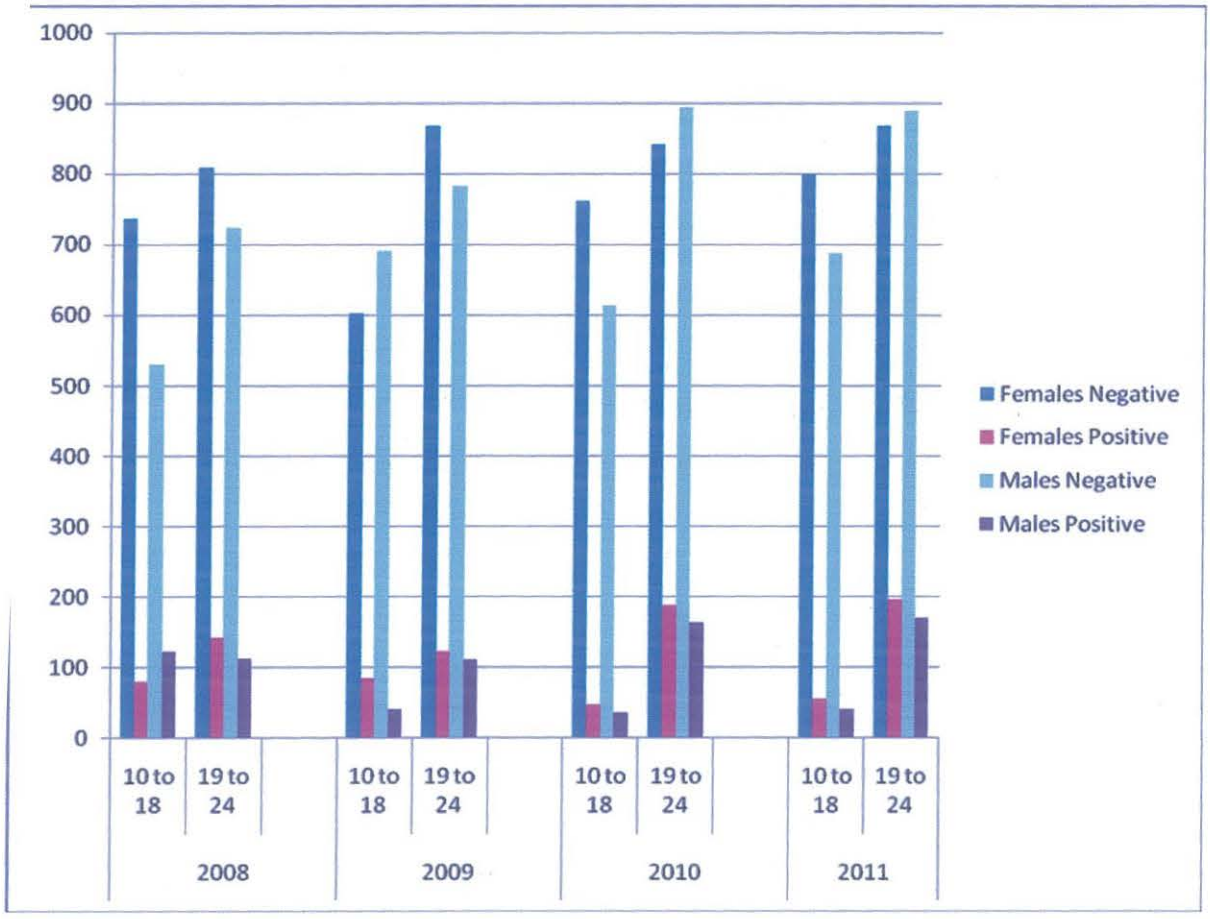
From the findings above, $t_{calculated}$ is less than $t_{tabulated}$ therefore the null hypothesis is accepted and concluded that HIV/Disease depends on the ARH programs available

Table 3. the percentage of Adolescents accessing the VCT and STI management programs

Year	Age Group	VCT	Ad %	STI Mgt	Ad %
	10 to 18	1468	45.11371	96	13.50211
2008	19 to 24	1786	54.88629	615	86.49789
	10 to 18	1419	42.96094	42	10.34483
2009	19 to 24	1884	57.03906	364	89.65517
	10 to 18	1459	41.15656	180	27.86378
2010	19 to 24	2086	58.84344	466	72.13622
	10 to 18	1583	42.71452	127	21.09635
2011	19 to 24	2123	57.28548	475	78.90365

According to the table above, the age group 10-18 has a lower rate of infection than the age group 19-24, and this is why the research did not only take on the first age group but also the second in the analysis of the adolescent health programs.

igure 2. A Bar Graph showing the different age groups with the HIV/Disease status



According to the graph above, the age group 10-18 has a lower rate of infection than the age group 19-24, with more female patients than the males in the given period of study. This is because at the age of 19-24 the youth are more sexually active and start to indulge in sexual acts yet with little or no guidance on such behaviors and the results or effects of their acts.

4.4 Hindrances/Barriers towards accessibility of A.R.H programs by the youth

i. **Lack of money to acquire services.**

Most adolescents accounting to 60 percent (UDHS, 2006) have been noted as saying that most A.R.H programs are not cost friendly hence forcing them away and this has made a lot of adolescents to seek Reproductive Health services thinking that they are so expensive.

ii. **Distance to health centers**

Most adolescents mainly in the rural areas face a huge burden of accessing health centre's since many adolescents live far away from the health centers where these services are mainly offered and this is the reason as to why the ARH programs should be taken to the grass roots(UDHS, 2006)

iii. **Inadequate knowledge**

Many non-school going adolescents have practically failed to realize that there are health services that are being offered to help them with their entire social and health problems since most of the programs are being offered in only schools and not at the grass roots and this is really a major problem. (Child and Adolescent Health and Development Progress Report 2002/2003)

iv. **Linkage of health outcomes to youth development**

Many programs are increasingly concerned with linking health outcomes to youth development, it is basically impossible to assume that development factors have the same influence on health in different settings as outcomes are embedded in specific and local contexts each with their own social and cultural values. Measuring the social and cultural context of youth development is difficult and many require time and resources that many programs do not have.

v. Lack of Family and Community support

Adolescents face problems, of sexually transmitted diseases, including HIV/AIDS, abortions, defilement, rape, drug abuse such as fuel and glue sniffing but much as they would like to get support from their parents in accessing AFRH services, there is still lack of openness in discussing sexual matters at home. Yet in some cultures it is still a taboo to discuss sexual matters with parents.

vi. Some predisposing factors to adverse adolescent reproductive health

Some adolescents identify predisposing factors to ARH problems as; un employment which lead to idleness, forced marriages and lack of school fees to complete school.

CHAPTER FIVE
DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter focuses on the discussion of the results in relation to the purpose, objective and stated hypotheses of the study, adolescent risky sexual behaviors and includes conclusions and recommendations based on the study.

5.1 Discussions

Meeting the health needs of youth is critical to both ensuring the health of future generations and to improving the quality of life of today's young people. The POLICY Project's Adolescent Reproductive Health (ARH) Working Group seeks to create a shared understanding of critical issues in ARH, both globally and regionally, and to explore ARH issues in the context of reproductive health policy.

The ARH Working Group promotes the integration of ARH issues and approaches into Policy's country programs. The working group creates and disseminates relevant information, resources, and tools for POLICY staff and partners to use in efforts to raise awareness concerning the importance and magnitude of ARH issues.

Some of these tools include country briefs, case studies, and computer models. Members of the ARH Working Group and the FOCUS Project recently updated the NewGen software package. NewGen is a computer model that helps youth advocates and policymakers understand the effects of different policies and programs on youth behavior and characteristics, such as levels of school enrollment or number of HIV infections.

5.2 conclusions

There was low level of knowledge in the ARH issues namely; Guidance and counseling on sexually related issues, Antenatal care, and Post abortion care . Adolescents had positive attitudes towards condoms. This was indicated in their willingness to collect condoms.

Adolescents begin sexual activities at an early age i.e. the average age at first sexual encounter between 12 years in both males and females and the HIV infection rate is high among females of 19-24 than in the males

Adolescents talk to health workers and friends when affected by STDs more than they talk to partners and teachers.

Adolescents out of school are more vulnerable to the exposure to STDs infection than the ones in school. Idleness was stated to be key and the possible reason for the vulnerability to STI infections. However, evaluations that have been done among young adults in both developing and industrialized countries show that formal sex education programs can increase knowledge of reproductive health and can improve the use of methods to protect against pregnancy and STDs.

In the view of researcher therefore, there has been some attempt to address adolescent reproductive health issues in Uganda. With the policy to address ARH in place, there is a clear indication that, at some point, ARH problems will be addressed in future. However, there is need for total commitment from both the planners from the ministry of health, education and sports with that of gender, labour and community development.

5.3 Recommendation

a. More sensitization programs, campaigns and literature regarding dangers of risky sexual behavior like AIDS, pregnancies and STDs should be made available to adolescents to avoid risky sexual behaviors.

b. People around adolescents should help them to build their confidence towards behavior change and also support them to put into practice all the knowledge they acquired to avoid risky sexual behaviors. Such people include parents, guardians, teachers, and the knowledge they should put into practice is that of assertiveness on risky sexual behavior.

c. Provision of counselors to help adolescents who fail to make a constructive decision concerning with sexual behaviors should be at every school.

d. Services should be extended to far areas since some people cannot move towards the services; hence the regular use of mobile clinics can help solve the issue of distance.

e. Advocacy for more funding in order to drugs that will be delivered in time and most of all to hire more personnel for better service delivery.

f. Programmes of adolescents should be established to address, poverty, idleness, information, education and communication.

5.4 Further findings

a. The FOCUS on Young Adults program recently analyzed reproductive health programs in developing countries and found few studies that demonstrate sex education results in behavioral change. A study to find out the impact of sex education on behavioral change needs to be conducted.

b. A study to find out the relationship between alcohol consumption and HIV/AIDS infection rate , domestic violence and Child Sexual Abuse and Exploitation should be done

c. A research to find out the Sexual and reproductive health needs of adolescents prenatally infected with HIV in Uganda should be conducted

d. Eastern Uganda is said to be having the highest prevalence of HIV/Aids, hence study to find out the infection rate and the existence of ARH programs should be conducted in the region.

e. A research to find out the relationship between HIV/Aids and mother to child infection should be carried out in the country in order to find a better solution to the problem.

REFERENCES

Alfred A. Knopf. (1985). Human Development, (3rd ED) New York

Berk, L.E (1997). Child Development through life span, (5th ED) Boston/London: Ally & Bacon

Breason Simon et al (2001): School education and HIV control In Sub-Shaan Africa: From discord of Hanoi Biomedical Research and training Institute, Harare Zimbabwe Journal of International reproductive health Mark 2001.

Cates W, McPheeters M. Adolescents and sexually transmitted diseases, current risks and future consequences. Presented at the *Workshop on Adolescent Sexuality and Reproductive Health*

Child and Adolescent Health and Development Progress Report (2002/ 2003)

Developing Countries: *Trends and Innovations,* National Research Council, March 25, 1997, Washington.

Gender Issues Research Report Series, no.14

Hisel 2000 (An Unmet Public Health Problem)

Hughes. And **Mc McCauley**, 1998(Improving the Fit Adolescents needs and Future Programs for Sexual and Reproductive Health in Developing Countries)

Kirby D. School-based programs to reduce sexual risk-taking behaviors. *J Sch Health* 1992;62(1):280-87

Ministry of health. (2000). National Adolescent Health Policy. Kampala Ministry of Health.

Ministry of health. (2001). National Training Curriculum for health workers on adolescent health and development

Nahabwe .P, 2004: Uganda Country experience on adolescent sexual and reproductive health. A Paper presented at the International forum on population and Development held on 8th Sept 2004 at WUHAN CHINA.

Nakkazi Damalie , Communication between Mothers and their daughters on the subject of sexuality and HIV/AIDS in Uganda

Path Finder / ITERTH: Dish Project, 1995: Reproductive health skills, Nurses and Midwives handbook

Reproductive Health on Young Adults in Uganda
(UDHS 2000-2001)

Risks and Realities of Early Childbearing Worldwide: *Issues in Brief.* New York: The Alan Guttmacher Institute, 1997.

Sexual and reproductive health needs of adolescents perinatally infected with HIV in Uganda, Harriet Birungi

Sempala Fred and **Muhimbise Moses** (2008),Mission Uganda

Uganda youth Development Link (UYDEL), Website; www.UYDEL.com

World Bank, 2002: "Adolescent health at a glance" *www.wbln0018. worldbank.org/ HDNet/ hddoc* (reviewed on 30th July 2005).

APPENDICES

APPENDIX I: Budget Proposal

Budget item	Quantity	Unit price	Total
Data costs		15,000	75,000
Flash disk	1	15,000	15,000
Spiral Binding	3	15,000	45,000
Travelling costs			300,000
Miscellaneous			50,000
Total			485,000

APPENDIX II: Time Frame

Task Name	Duration (2012)
Proposal Writing	April 25th
First Review of Proposal by Supervisor	April 30th
Final Review of Proposal by Supervisor	May 20th
Handing in the Proposal	May 30th
Start of Project Report	June 24th
Finishing of the research report and review by the Supervisor	July 30th
Handing in the project	Aug 26th

Appendix III : Data collected

Year	Age Group	Females		Males					
		Negative	Positive	Negative	Positive	VCT	Ad %	STI Mgt	Ad %
2008	10 to 18	736	80	530	122	1468	45.11371	96	13.50211
	19 to 24	808	142	723	113	1786	54.88629	615	86.49789
Total		**1544**	**222**	**1253**	**235**	**3254**	**100**	**711**	**100**
2009	10 to 18	602	85	691	41	1419	42.96094	42	10.34483
	19 to 24	867	123	782	112	1884	57.03906	364	89.65517
Total		**1469**	**208**	**1473**	**153**	**3303**	**100**	**406**	**100**
2010	10 to 18	761	48	614	36	1459	41.15656	180	27.86378
	19 to 24	841	188	893	164	2086	58.84344	466	72.13622
Total		**1602**	**236**	**1507**	**200**	**3545**	**100**	**646**	**100**
2011	10 to 18	798	56	688	41	1583	42.71452	127	21.09635
	19 to 24	868	196	888	171	2123	57.28548	475	78.90365
Total		**1666**	**252**	**1576**	**212**	**3706**	**100**	**602**	**100**