Title: Does exposure to Reproductive Health Programmes lead to desired outcomes? Findings from the 2006 Uganda Demographic and Health Survey.

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Abstract

Research was conducted to determine whether exposure to family planning programmes resulted in improved Adolescent Sexual Reproductive Health behavioral outcomes among adolescents of ages 15-24 in Uganda. The essential research question was - Among female adolescent's 15-to-24-year-olds, are those who report exposure to reproductive health programmes more likely than those not exposed to such programmes to: use condoms? Have fewer sexual partners? Use modern contraceptives? And abstain from sex or delay first intercourse? Data on adolescents was selected from the UDHS, 2006 file concerning 3610 adolescents. Results of the study suggest evidence of a significant positive programme effect on sexual knowledge, attitudes, and behaviors.

Introduction

In Uganda, adolescence is regarded as the period during which the process of growth into adulthood occurs. Adolescents represent a significant (almost one-fifth) and rapidly growing segment of the population. The social economic characteristics of these young adults are quite influential in shaping their development in terms of health, sexual and child bearing experiences (UNFPA, 2007).

Traditionally, adolescents are still regarded as children and hence have been exploited in part due to the culture of silence imposed upon them as they lack a way to express their voice in family and community affairs. They are not regarded as adults because they are still under the care of their parents, most do not have property, and decisions are still made for them. Adolescents are seen as needing guidance and protection from their parents, relatives and

community members. They are also sometimes seen as unruly and stubborn. Many adolescents are still living with their parents and have little or no power to exercise their sexual and reproductive rights. Adolescent girls are particularly disadvantaged as males are accorded higher value than females.

Adolescents are confronted with life threatening health risks related to unwanted pregnancies, HIV/AIDS and sexually transmitted infections (STIs). HIV/AIDS remains the leading cause of death within the most productive age ranges of 15-49 (PEAP 2004-2008). Adolescence is a life period of experimentation and frequent risk taking. Key factors for adolescent vulnerability to sexual and reproductive health problems include: lack of awareness and lack of correct information about the risks of unwanted pregnancies and STIs, peer and other social pressures, lack of skills needed to resist such pressures and to practice safe behavior, lack of youth-friendly sexual health and counseling services, poverty, traditional cultural norms that give young women a low social position, and little power to resist persuasion or coercion into unwanted sex.

There is a diverse ethnic composition, community norms and values and traditional practices relevant to adolescent sexual and reproductive behavior are relatively similar across the country. Some of the social norms and practices are beneficial for adolescent reproductive health such as upholding virginity, while others are harmful in as far as the risks of HIV/AIDS, other STIs and unwanted pregnancy are concerned. Traditionally, virginity was upheld and there were gifts given to the paternal aunt such as a goat and other gifts if the husband found the bride a virgin at marriage. However, anecdotal information reveals that this practice has long ceased to be of cultural importance and is no longer commonplace. Those practices that increase adolescents' vulnerability to reproductive health risks include early exposure to unprotected sex, early marriage and genital cutting (female circumcision is practiced among the Sabiny while male circumcisions is practiced among the Bagisu, both of Eastern Uganda).

There are different gender socialization processes for adolescent boys and girls in Uganda. Traditionally, discussion of sex and other reproductive health matters between adolescents and adults has been restricted to certain topics and certain people. For adolescent girls among the Bantu ethnic groups of Uganda, the traditional channel of communication about sex has been the senga (i.e., the father's sister or aunt) while for adolescent boys community elders have fulfilled this role in some settings. Given the HIV/AIDS pandemic, parental guidance and communication on such issues is mentioned in many countries as an important protective factor. Yet there is little adolescent-parent communication in Uganda today and is largely a function of social and cultural norms prohibiting direct communication about sexual matters between parents and adolescents.

Uganda is experiencing a "youth bulge" in its population. More than half (56%) of the population is below the age of 18 and 34% are between the ages of 10-24 (Uganda Population and Housing Census 2002).

Prevalence is relatively low among youth. In general, young people still face many challenges to their sexual and reproductive health as well as to their overall wellbeing. The HIV prevalence among young adults (15-24 years) is 2.9% with young women nearly four times more likely than men to be infected (MOH[Uganda] and ORC Macro 2006). Mass media exposure and other aspects of modernization have reportedly relaxed social controls over sexual behaviors for many Ugandan adolescents (Bohmer and Kirumira 1997). Out of school youth, surveys show, are less informed about sexual matters, have fewer resources available to them and are more likely to engage in risky sex (Bohmer and Kirumira 1997; Ndyanabangi, Kipp and Diesfeld 2004). Older men have sexual relations with younger women and the latter are often powerless to insist on condom use (Luke 2005). Most Ugandan youth know about HIV/AIDS but many do not perceive themselves to be at personal risk of contracting the disease (Hulton, Cullen and Khalokho 2000). Even those youth with substantial knowledge about HIV and STDs report engaging sometimes in risky sex (Sekirime et al 2001).

The Government of Uganda has developed a number of policies that target adolescents. These policies focus on health and in particular, sexual and reproductive health (SRH) and HIV/AIDs; gender; and education (K2-Consult Uganda Limited 2001). Uganda's current Health Sector Strategic Plan (HSSP) includes activities that focus on "(expanding) and (consolidating) provision of adolescent friendly health services" in support of the MOH objective of reduction of neonatal, infant and maternal mortality and morbidity (Ministry of Health 2007).

Several programs and organizations specifically support the government's prioritization of youth. Eighty five HIV/AIDS organizations reported focusing on various components of youth service interventions (AMREF-Uganda and The Uganda AIDS Commission Secretariat 2001). For example, international NGOs such as AMREF, GOAL Uganda and Save the Children; United Nations agencies such as the United Nation Children's Fund, the United Nations Population Fund, the World Health Organization and the United Nations Joint Programme on HIV/AIDS; and bilateral donors such as the United States Agency for International Development, the British Department for International Development, the European Union all work in support of the government's youth focus.

Previous Studies on ASRH

Uganda is one of only two countries (the other is the US) that have managed to reverse its HIV/AIDS epidemic (Slutkin et al 2006). As such, Uganda has been intensively studied. Most of the decline, which began in the early 1990s, has been due to behavioral changes, specifically, delayed sexual debut and reduced number of partners (Asiimwe-Okiror et al 1997; Kilian et al 1999; Uganda AIDS Commission 2003, 2005).

There have been a number of significant studies in Uganda looking at ASRH programs and impact. Most recently, the Uganda HIV/AIDS Sero-Behavioral Survey 2004–2005 segmented many of its findings according to age and dedicated an entire chapter to sexual behavior indicators among youth. HIV/AIDS remains one of the most devastating epidemics worldwide. Although Uganda managed to reduce the prevalence from as high as 18% to the current 6.4%; HIV/AIDS remains a major challenge. Prevalence rates have stagnated between

6 and 7% since 2002 and recent studies indicate an upsurge if no new innovations is crafted to scale up the response. The HIV/AIDS sero- behavioural survey (MoH 2004/5) gives evidence of increased numbers of sexual partners and an increase in new infections among adults in stable unions including the married.

Data and Methodology

Data used in this study are from the Uganda Demographic and Health survey (UBOS and ORC Macro 2006). The 2006 Uganda Demographic and Health Survey (UDHS) is a nationally representative survey of 8,531 women age 15-49 and 2,503 men age 15-54. For purposes of this presentation only a total of 3610 female adolescent respondents of ages 15 to 24 were selected for this study. A binary logistic regression model was fitted to a set of variables - exposure variables on one hand and outcome variables (sexual behaviours variables) on the other (see Table 1.0). For each outcome variable a logistic model including all the six exposure variables was fitted.

Table 1.0 Variables used in the a analysis

Exposure variables	Outcome/dependent variables
Visit by a health worker who talked about Family Planning in the past 12 months. Visit by respondent or children of respondent to a health facility other than a family planning clinic. Heard of Family Planning on radio during the last month Heard of Family planning on TV during the last one month. Heard of Family Planning in News Papers during the last month Heard of Family Planning on Video or film.	Used condom at last intercourse Intend to use family planning during the next one year Ever used a modern method of contraception. Age at first marriage Had an STD in the past 12 months. Ever Tested for HIV

Results and Discussion

Use of condom at last sexual intercourse

According to the multivariate analysis results presented in Table 2a, females adolescent respondents who reported having themselves visited other clinic other than an FP clinic or their children having done so were less likely to have used condoms at last sexual encounter compared to those who or whose their children never made a visit to other health facility not FP clinic. This finding is expected given that information on condom use is usually more clearly relayed to the population by family planning trained workers in the FP clinics and not any other health facilities. This finding also points to lack of integration of family planning services into the health system in the country. Significant positive outcomes were obtained for female adolescents who got exposure to TV and Newspapers during the one month prior to

the survey. All the other exposure variables did not exhibit any impact though the direction of the coefficient was in a positive direction.

Table 2a: Results of the impact of exposure to reproductive health message on use of condom at last sexual intercourse, DHS, Uganda 2006	
Exposure variable	Result
Visit by a health worker who talked about Family Planning in the past 12 months.	
Visit by respondent or children of respondent to a health facility other than a family planning clinic.	–
Heard of Family Planning on radio during the last month	
Heard of Family planning on TV during the last one month.	+
Heard of Family Planning in News Papers during the last month	+
Heard of Family Planning on Video or film	
Note: A plus sign (+) indicates a significant impact of exposure to reproductive health message, and a negative sign (-) indicates significant negative impact. No sign indicates that the impact was not significant.	

Intension to use family planning during the next one year

The findings presented in Table 2b predict the impact of exposure variables on intention to use family planning services in the one year following the survey. These findings show that visit by respondents or respondents children to a health facility other than a family planning clinic is positive. This implies that the messages at the health facility a similar to those given at the family planning clinic. Similarly ever heard of family planning message on radio and from a newspaper are positive. Usually messages on radio and in newspapers and visit to health facility can influence one is decision to use family planning.

Table 2b: Results of the impact of exposure to reproductive health message on intension to use family planning during the next one year, DHS, Uganda 2006

Exposure variable	Result
Visit by a health worker who talked about Family Planning in the past 12 months.	
Visit by respondent or children of respondent to a health facility other than a family planning clinic.	+
Heard of Family Planning on radio during the last month	+
Heard of Family planning on TV during the last one month.	
Heard of Family Planning in News Papers during the last month	+
Heard of Family Planning on Video or film	

Note: A plus sign (+) indicates a significant impact of exposure to reproductive health message, and a negative sign (-) indicates significant negative impact. No sign indicates that the impact was not significant.

Ever used of modern contraceptive method

It was also important to discuss exposure to family planning message by ever use of modern contraception. Apart from having been visited by health worker and heard of family on video or film, the rest of the exposure variables are positive. Usually practice is preceded by knowledge. When an individual gets the knowledge, her attitude changes. This implies that one cannot be use unless exposed to messages, irrespective of the channel message. There other exposure which were not significant is mainly because little effort has been done using them in encouraging individuals to use family planning method.

Table 2c: Results of the impact of exposure to reproductive health message on ever use of modern contraceptive method, DHS, Uganda 2006	
Exposure variable	Result
Visit by a health worker who talked about Family Planning in the past 12 months.	
Visit by respondent or children of respondent to a health facility other than a family planning clinic.	+
Heard of Family Planning on radio during the last month	+
Heard of Family planning on TV during the last one month.	+
Heard of Family Planning in News Papers during the last month	+
Heard of Family Planning on Video or film	
Note: A plus sign (+) indicates a significant impact of exposure to reproductive health message, and a negative sign (-) indicates significant negative impact. No sign indicates that the impact was not significant.	

Age at first marriage

Age at first marriage was categorized into two. Those who married before age 18 were regarded as early marriage while exposure was those who were aged 18 plus. Age at first marriage was positive with heard of family planning on radio and TV during the last one month. Frequent listeners of radios or viewers of television are more likely to marry late than their counterparts who do not.

Table 2d: Results of the impact of exposure to reproductive health message on age at first marriage, DHS, Uganda 2006	
Exposure variable	Result
Visit by a health worker who talked about Family Planning in the past 12 months.	
Visit by respondent or children of respondent to a health facility other than a family planning clinic.	
Heard of Family Planning on radio during the last month	+
Heard of Family planning on TV during the last one month.	+

Heard of Family Planning in News Papers during the last month	
Heard of Family Planning on Video or film	
Note: A plus sign (+) indicates a significant impact of exposure to reproductive health message, and a negative sign (-) indicates significant negative impact. No sign indicates that the impact was not significant.	

Contracted an STD in the preceding one year

The impact of having contracted an STD in the preceding one year has showed almost positivity with all types of exposure messages to reproductive health. Usually, when people contract the STD or when they know someone who has contracted an STD, they want to learn more on how to prevent the STDs. Even the TV was almost positively significant.

Table 2e: Results of the impact of exposure to reproductive health message on having contracted an STD in the preceding one year, DHS, Uganda 2006	
Exposure variable	Result
Visit by a health worker who talked about Family Planning in the past 12 months.	+
Visit by respondent or children of respondent to a health facility other than a family planning clinic.	+
Heard of Family Planning on radio during the last month	+
Heard of Family planning on TV during the last one month.	
Heard of Family Planning in News Papers during the last month	+
Heard of Family Planning on Video or film	
Note: A plus sign (+) indicates a significant impact of exposure to reproductive health message, and a negative sign (-) indicates significant negative impact. No sign indicates that the impact was not significant.	

One of the most challenging issue has been voluntary testing and counseling (VCT). Usually people accept to VCT when they are well informed. No wonder, it is only having heard of family planning on video or film which was not significant. All other exposure variables were positive and significant. These results are summarized in table 2f below.

Table 2f: Results of the impact of exposure to reproductive health message on having ever tested for HIV, DHS, Uganda 2006	
Exposure variable	Result
Visit by a health worker who talked about Family Planning in the past 12 months.	+
Visit by respondent or children of respondent to a health facility other than a family planning clinic.	+
Heard of Family Planning on radio during the last month	+
Heard of Family planning on TV during the last one month.	+
Heard of Family Planning in News Papers during the last month	+
Heard of Family Planning on Video or film	
Note: A plus sign (+) indicates a significant impact of exposure to reproductive health message, and a negative sign (-) indicates significant negative impact. No sign indicates that the impact was not significant.	

Conclusions

This assessment proved effective as a design for examining the impact of exposure to reproductive health messages on adolescent behavioural outcomes. The findings clearly show that exposure to reproductive health messages leads to positive outcomes. However, the author believes that this methodology can be effectively used to determine program impact at the population level in cases where baseline data do not exist. Although a baseline-endline experimental design is theoretically preferable to post-test only design for many reasons, when a comparable baseline is not available, the design used in this evaluation can prove effective.

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