

Factors influencing Utilization of Reproductive Health Service among Adolescents aged 12-19 Years in Mbarara Municipality Schools.

Musinguzi Dickson

Faculty of Nursing Sciences Kampala International University, Uganda.

ABSTRACT

Complications of unwanted pregnancies and unsafe abortion are the leading causes of disability and death among adolescents especially girls between ages 15-19 years. The study focused on assessing the factors influencing the utilization of Reproductive Health Services among adolescents aged (12-19 years) in Mbarara Municipality schools. A sample of 100 respondents was enrolled in the study using systematic random sampling. A cross sectional descriptive study design was used in two Government Aided Secondary Schools that is; Nyakayojo secondary school and Mbarara secondary and a simple random sampling technique was used to select schools and class for the study. The study indicated mass media (31.8%) as a major source of information about RHS. Most adolescents indicated that they faced huge barriers including long distances to travel to health facilities while incurring high transport costs, harsh service providers, spending long hours in lines and lack of confidentiality also inclined them from accessing RHS thus causing them to miss some of these reproductive health services, Therefore service providers extend operational time beyond official working hours, have good attitude towards adolescents who are seeking RHS and should provide privacy. The Government should also increase the number of health units offering RHS to adolescents which can reduce on congestion, long queues and travelling long distances thus attracting more adolescents.

Keywords: unwanted pregnancies, Unsafe abortion, Adolescents, Girls, Health facilities.

INTRODUCTION

Within the framework of the World Health Organization's definitions, Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life [1]. Reproductive Health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so [2-12]. Globally, the adolescent population is estimated to be 1.25 billion, among these, 515 million are between 15-19 years old and 85% of the total adolescents are living in developing world [1]. The WHO assessed in 2008 that "Reproductive and sexual ill-health accounts for 20% of the Global burden of ill-health for women, and 14% for men. Issues affecting Adolescent Reproductive and sexual health are similar to those of adults, but may include additional concerns about teenage pregnancy and lack of adequate access to information and health services. According to WHO [13] existing health services often fail the World's adolescents (10-19-year-olds) and will suffer from mental health disorders, substance use, poor nutrition, intentional injuries, chronic illness and do not have access to critical prevention and care services. According to UNFPA [14], reproductive health at any age profoundly affects health later in life and many behaviors that have a life impact on health begin in adolescence. The utilization of Reproductive Health Services is an important component in preventing adolescents from different sexual and reproductive health problems where it plays a vital role in safeguarding adolescents in Sub-Saharan African (SSA) countries including Ethiopia, which accounts for a high proportion of the region's new HIV infections as well as maternal and infant mortality ratios (Feleke et.al, 2013). According to the World Health Organization [13] more than 2.6 million young people aged 10 to 24 die each year in the world, mostly due to preventable causes, about 16 million girls aged 15 to 19 years give

birth every year, young people, 15 to 24 years old, account for 40% of all new HIV infections among adults. In any given year, about 20% of adolescents will experience a mental health problem, most commonly depression or anxiety and approximately 430 young people aged 10 to 24 die every day through interpersonal violence. According to the UNAIDS Report [15], of the 35 million people living with HIV in the world, 19 million do not know their HIV-positive status, adolescent girls and young women account for one in four new HIV infections in SSA. In developing countries, there are about 12.8 million births by adolescents aged between 15–19 years, and a large proportion of these pregnancies are unplanned [16]. Among married women who are 15–19 years old, only 17% practice Family Planning methods currently, and among unmarried sexually active adolescents, the use of contraception is believed to be even lower [17]. A WHO report in Algeria, Bangladesh, Ethiopia, Indonesia and Nigeria showed that the risk of dying from complications related to pregnancy or childbirth is two times higher for those aged 15–19 years than for women in their mid-twenties [1]. Uganda has one of the highest teenage pregnancy rates in Sub-Saharan Africa [18]. Among sexually active youth aged 15–19 years, women and men who were tested for HIV test were only 24% and 27% respectively [19]. There is need to decide on strategic choices to mitigate HIV prevalence among adolescents to mitigate their vulnerability and risks of acquiring HIV.

METHODOLOGY

Research Design

The study employed a cross sectional descriptive study design and quantitative methods for data collection.

Study Setting

Mbarara municipality is located along the highway to Rwanda about 290 kilometers from Kampala in the south western region of Uganda.

Study Population

The study population enrolled HAT adolescents aged 12-19 years found in the selected Government aided mixed secondary schools in Mbarara Municipality. These were used because majority of students join senior one (S.1) when they are 12 years and complete senior six (S.6) by 19 years. These adolescents were presumed sexually active and usually experience their first sexual encounter during these ages thus required Adolescents Reproductive Health Services since they are more vulnerable to a wide range of SRH problems.

Sample Size Determination

The sample size was determined using Fisher's formula developed in 1990.

$$n = \frac{z^2(pq)}{d^2}$$

Where n= sample size

z= standard deviation at confidence level of 95% which is 1.96

p= proportion of population with the desired characteristics

q= proportion of population without desired characteristics q=1-p

d= level of significance or measure of anticipated error taken as 0.05

Therefore, for this study:

n=desired sample size of adolescents between 12-19 years

z= standard deviation at confidence level of 95% = 1.96

p= proportion of the population who are adolescents of 12-19 estimated at 50%= 0.5

q= 1-p i.e. 1-0.5=0.5

d= level of anticipated error of 5%= 0.05

Substituting the values into the formula

$$n = \frac{z^2(pq)}{d^2}$$

$$n = \frac{1.96^2(0.5 \times 0.5)}{(0.05)^2}$$

$$n = 384$$

Therefore 384 adolescents were needed for the study.

However due to limited time and resources for the study, a sample size of 100 adolescents of 12-19 years was used.

Sampling Procedure

Simple random sampling was used to select two government aided mixed secondary schools using a list of mixed public schools in Mbarara Municipality. The four schools were given numbers from 1 up to 4. Then these numbers were written on papers and were well folded. They were later put in a box and shaken properly. One paper was picked randomly from the box, opened and name of the school recorded down which happened to be Nyakayojo secondary school. Again the paper was folded again and placed back in the box. The box was shaken properly and

Musinguzi

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another paper picked and the name of school selected was recorded down which was Mbarara secondary School. The selected schools had classes from senior one up to senior six and one class was selected for the study in both schools. The class was chosen randomly. Here six papers written on 1-6 were put in a box, shaken well and one paper was picked which represented a class, this happened to be S.5. Systematic random sampling technique was used to pick the respondents in the selected class, followed by every 2nd person from the list to ensure randomness until 50 respondents were picked from each school since a sample of 100 was used. The researcher distributed 50 questionnaires for each school.

Inclusion Criteria

- The study included only participants in the age bracket of 12-19 years. One class in both schools was targeted for the study.
- Those that consented to participate in the study.

Exclusion Criteria

- Those who were not in the age bracket of 12-19 years.
- Those that did not consent to participate in the study.

Research Instruments

The self-administered questionnaires with close-ended questions were used for data collection. The questions were prepared in a logical sequence in order to address the research objectives. The questionnaire was pre-tested for validity in one of the Government mixed secondary school in Mbarara Municipality that was not chosen for the study.

Data Collection Procedure

An introductory letter from Kampala International University School of Nursing Sciences seeking approval to undertake the study was got and taken to the office of the Principal Education Officer Mbarara Municipality granting permission to go to the selected Government mixed secondary schools. A pre-test self-administered questionnaire was given to respondents until the sample size was reached and adolescents aged 12-19 years participated in the study. Informed consent was obtained from all participants before enrollment into the study. Privacy and confidentiality was maintained throughout the process of data collection.

Data Analysis

Data was exported to SPSS windows version 16.0 for analysis and Microsoft excel program and presented in form of graphs, tables and pie-charts for easy interpretation.

Ethical Consideration

An introductory letter was obtained from Kampala International University School of Nursing Sciences and the Principal Education Officer Mbarara Municipality. Prior to administering the questionnaires, the objectives of the study were clearly explained to the participants and oral informed consent was sought from the respondents. Participants were informed about the procedure and the voluntary nature of participation in the study. Confidentiality and anonymity was ensured throughout the execution of the study and informed that no adverse consequences would arise if they refused to participate and that data collected would remain private and used only for research study purpose. This helped to eliminate bias and doubts about the aim of the study.

RESULTS

Table 1: Shows gender of respondents (n=100)

Gender	Frequency	Percentage (%)
Male	44	44
Female	56	56
Total	100	100

Majority 56% of the respondents were female participants while 44% of the respondents were males.

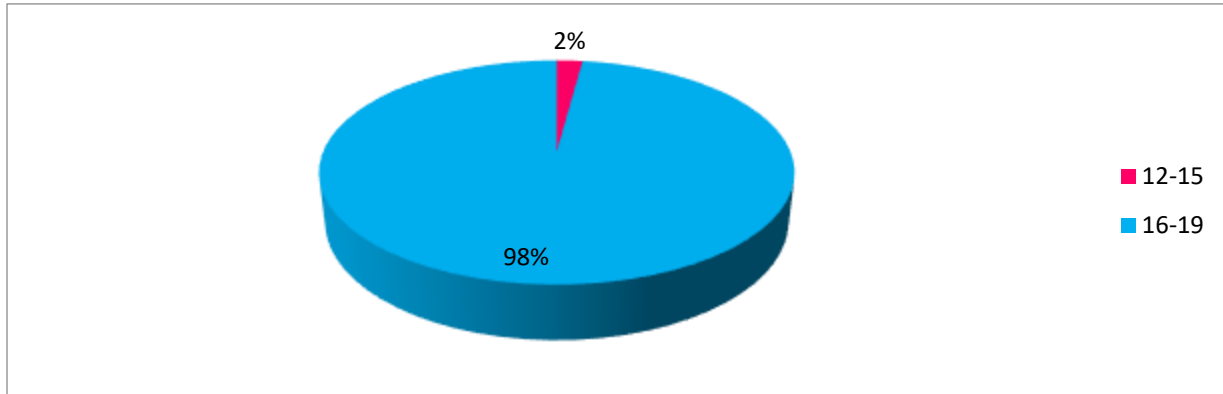


Figure 1: Showing the Age Range of Respondents (n=100)

Majority 98% of respondents were in the age range of 16-19 and the minority 2% were in the age bracket of 12-15 years.

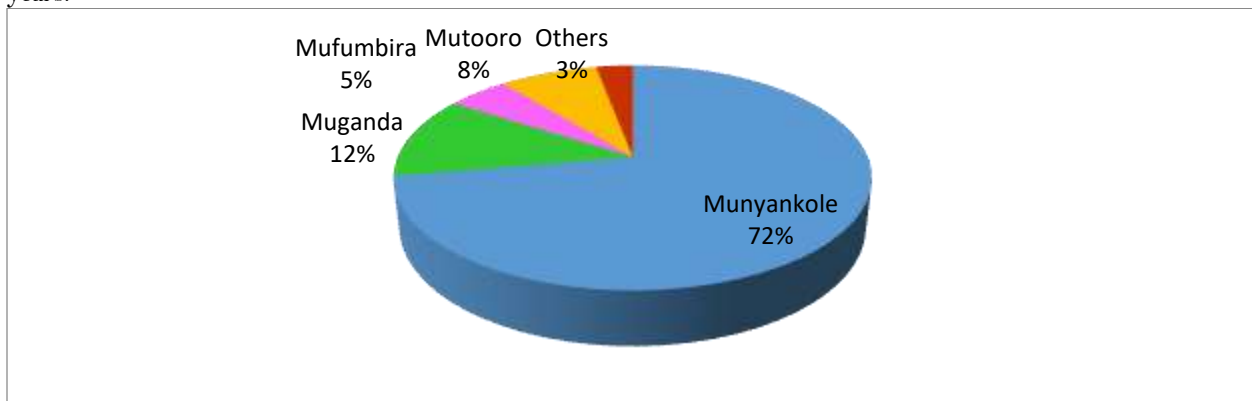


Figure 2: Showing the Tribe of the Respondents (n=100)

Majority of the participants in the study were Banyankole 72% and the least was 3% representing other tribes.

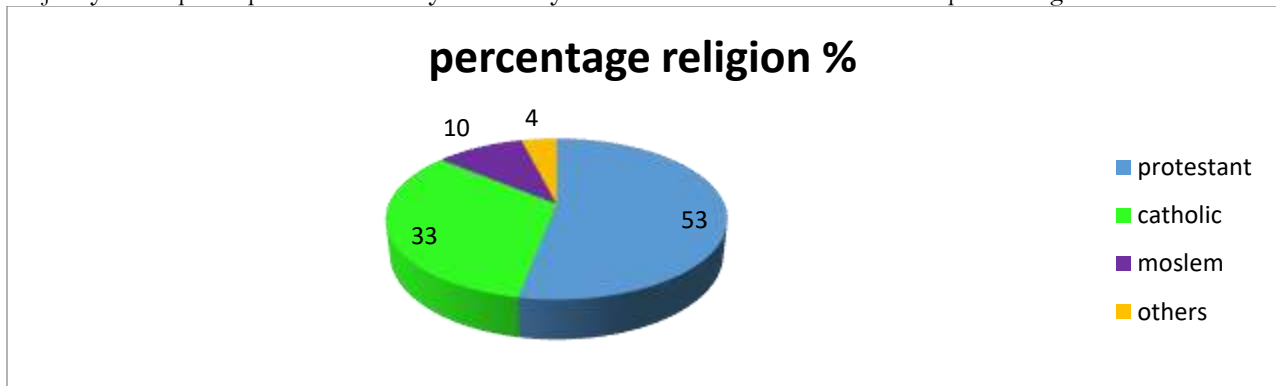


Figure 3: Showing the Religion of the Respondents (n=100)

From the study findings, majority of the respondents were Protestants 53% and the least was other religions with only 4%.

Adolescent's Knowledge about Reproductive Health Services.

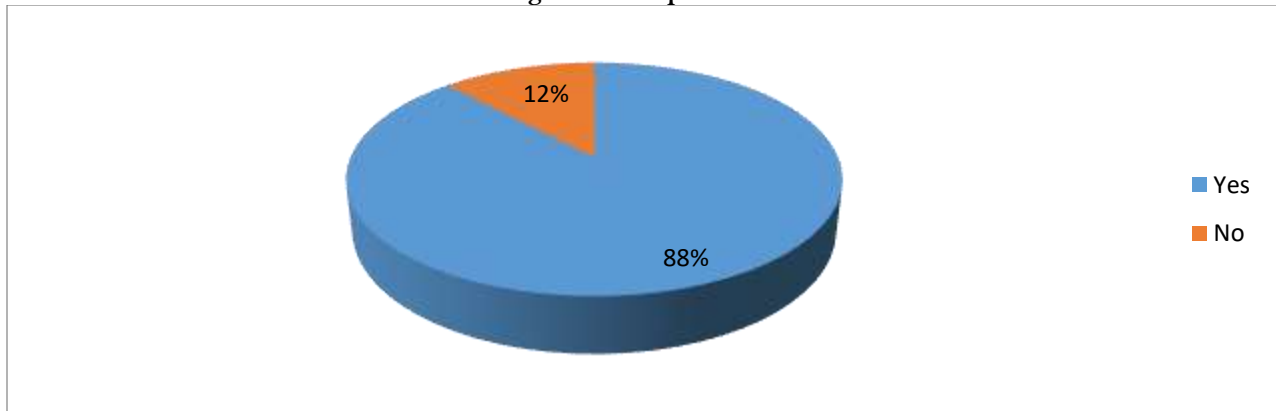


Figure 4: Shows Adolescent's Knowledge about RHS (n=100)

Majority of respondents 88% knew about Reproductive Health Services while 12% had no knowledge about Reproductive Health Services.

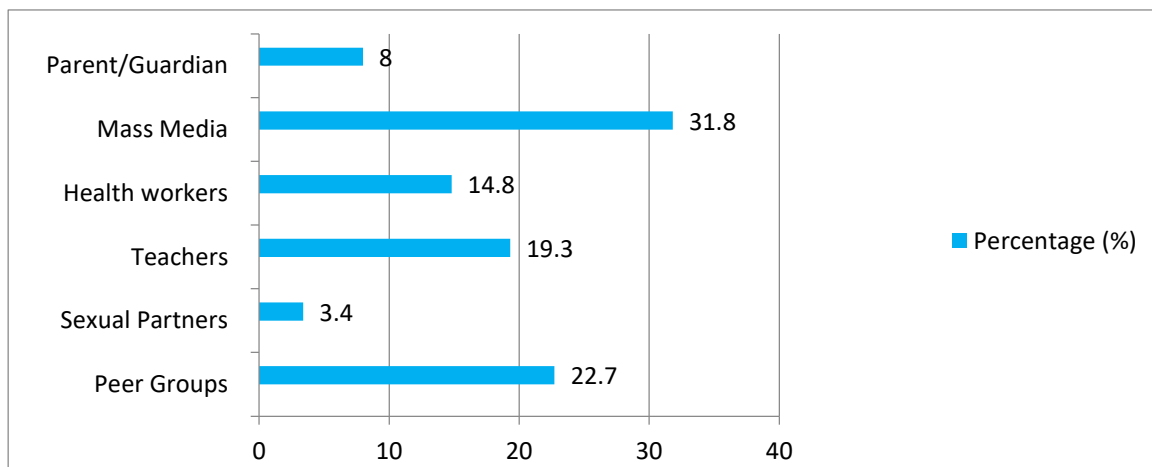


Figure 5: Showing where adolescents' got information about Reproductive Health Services (n=88).

Majority of respondents 31.8% got information about Reproductive Health Services on mass media and the minority 3.4% got information from their sexual partners.

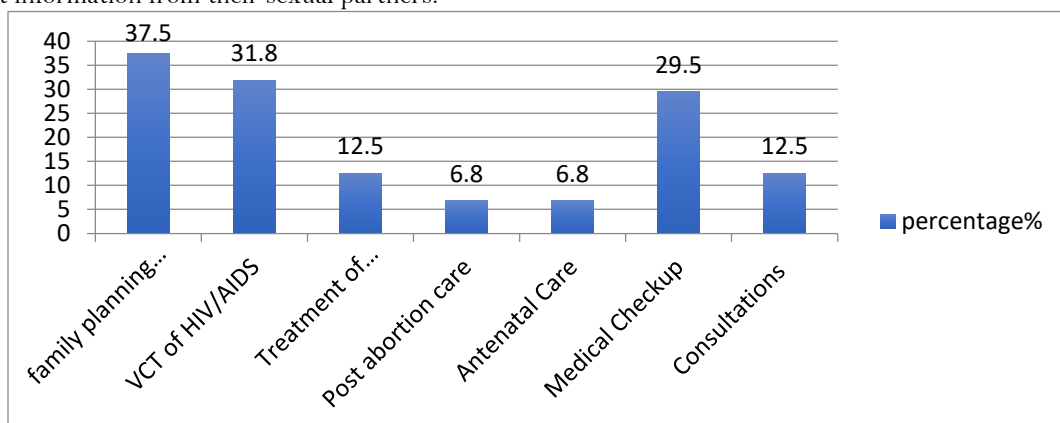


Figure 6: Shows Reproductive Health Services known by Adolescents (n=88)

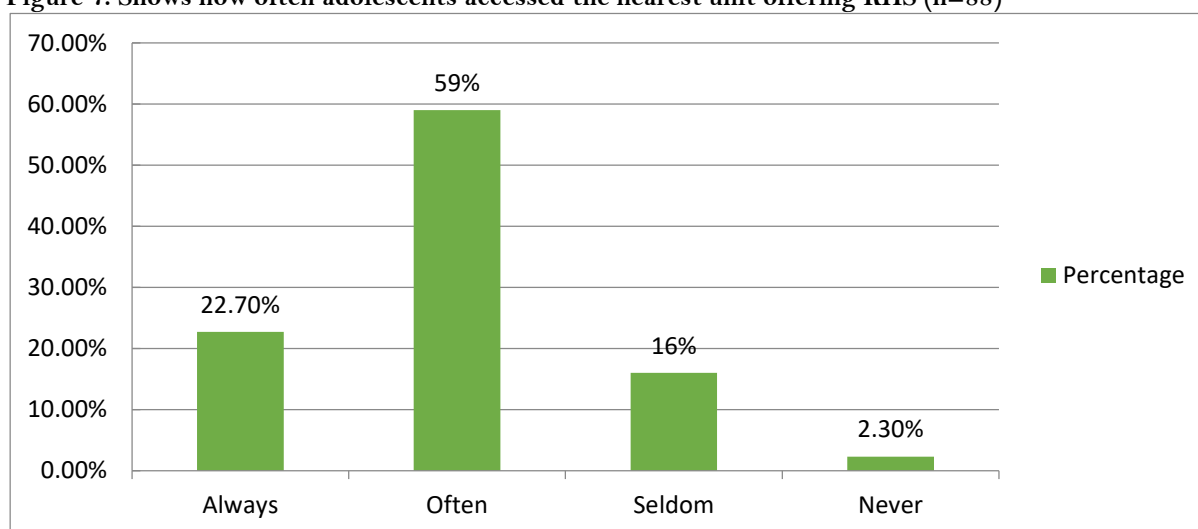
Majority of the respondents 37.5% knew Family Planning Services since it had the highest percentage and the minority knew Antenatal care and post abortion care since both had the lowest percentage of respondents 6.8%.

Table 2: Showing the Distance of the nearest Health Unit from the Adolescent's Place of Residence (n=88)

Distance	Frequency	Percentage (%)
Near, a short walking distance	18	20.5
Near but requires about Shs.1000/= for transport	26	29.5
Far, requires > 2000/= for transport	44	50
Total	88	100

Majority of participants 50% revealed that the distance of their nearest Health Unit from their place of residence was far and required more than 2000/= to cater for transport.

Figure 7: Shows how often adolescents accessed the nearest unit offering RHS (n=88)



Majority of the respondents 59% often accessed their nearest health unit offering Reproductive Health Services while 2.3% never accessed these services.

Table 3: Showing how adolescents were handled in while at Reproductive Health Units (n=86).

Care at Reproductive Health Units	Frequency	Percentage (%)
Good-friendly, welcome	33	38.4
Moderate-welcome	43	50
Bad, Harsh and rude.	10	11.6
Total	86	100

Most participants (50%) received moderate-welcome; this implies that adolescents could easily interact with the health workers on issues pertaining their reproductive health problems.

Table 4: Shows whether adolescents had ever visited a RHS Unit and missed the services required (n=86).

Response	Frequency	Percentage (%)
Yes	40	46.5
No	46	53.5
Total	86	100

Minority 46.5% of the participants revealed that they had ever visited the Reproductive Health unit and missed the services they required.

Table 5: Showing Reasons Why Adolescents missed RHS in the Health Units they visited (n=40).

Reason	Frequency	Percentage (%)
The queue was long	19	47.5
I found neighbors and felt ashamed	8	20
The service provider refused to give the service	11	27.5
The health unit was closed	2	5
Total	40	100

Majority of participants (47.5%) argued that they missed access to RHS in the Health Units they visited because the queue was long (patients were very many) and the minority 5% found the health units closed.

Table 6: Shows whether Adolescents were happy with the services they received (n=86)

Response	Frequency	Percentage (%)
Yes	40	46.5
No	46	53.5
Total	86	100

Majority 53.5% of the participants in the study were not happy with the services they received from their health units.

DISCUSSIONS

The majority of the respondents (56%) were female participants while 44% of the respondents were males. This showed that female adolescents are dominating in higher advanced classes in Mbarara Municipality schools than male adolescents. The age range of 12-19 years was considered because these are adolescents who are sexually active and need to know about RH rights since they are prone to getting unwanted pregnancies which would end up in unsafe abortions. Majority (98%) of the respondents was in the age range of 16-19 years. This was because students join senior one by the age of 12 years and are expected to have completed senior six by the age of 19 years. Since senior 5 class was chosen, these students were expected to be in the age range of 16-19 years. The least (2%) were in the age bracket of 12-15 years, this could indicate that they started schooling at an early age or skipped some classes that is why they were in senior five. The majority of the participants in the study were Banyankole (72%). This was because the study was carried out in Ankole region where the Banyankole tribes are dominating. Baganda followed with 12%, Batooro 8%, Bafumbira 5% and least were from other tribes 3%. From the study findings, majority of the respondents were Protestants (53%). This was evident because one of the schools where research was conducted (Nyakayojo Secondary School) is founded by Church of Uganda which had many protestant students. It was followed by Catholics with 33%, Moslems (10%) and 4% representing respondents from other religions.

From the study findings, 88% of the respondents knew about Reproductive Health Services [25-35]. This showed that adolescents are aware of RHS hence can prevent themselves from getting unwanted pregnancies which could end up in unsafe abortions. This differs from findings by Abajobir and Assefa [20] who revealed that Reproductive health knowledge and services utilization amongst adolescents is still low. However, 12% of the respondents showed that they had no knowledge about RHS. This meant that they had no idea about these RH services and may end up getting unwanted pregnancies which may end up in unsafe abortions. When asked where they got information about RHS, of the 88 participants, 31.8% revealed that they accessed information about Reproductive Health Services on mass media, which included television, radio, internet, film/cinema, music and magazines. This is in line with [21] who contended that mass media and social marketing campaigns provided young people with RH information and are modestly effective in persuading both female and male adolescents to change healthy behaviors. Again 19.3% of the respondents indicated to have accessed information and knowledge about RHS from their teachers. This implied that the teachers and schools are playing a fairly great job to impart knowledge about RHS to adolescents. Therefore, it is expected that all students in schools are likely to use RHS thereby preventing unwanted pregnancies which may lead to unsafe abortions.

Most participants (50%) revealed that the distance of their nearest Health Unit offering RHS from their place of residence was far and that it required more than Shs.2000/= to cater for transport.

Most adolescents (50%) and (38.4%) cited that they received moderate welcome and good friendly welcome whenever they visited their nearest Health Units. This implied that adolescents could easily and openly interact

with the health workers on issues concerning their reproductive health problems such that they can get services freely thus preventing themselves from becoming pregnant. Only 11.6% found harsh and rude health workers who denied them the services. This implied that these adolescents did not get the services they needed and ended up going back home without being assisted and this may lead them to get unwanted pregnancies that may end up in unsafe abortions. Of the 86 respondents who had ever visited the RHS unit, only 46.5% reported to have ever visited and missed the services they required. When asked why they missed these RHS, most participants (47.5%) argued that they missed access to RHS in the Health Units they visited because the queue was long implying that there were many clients in the line which inclined adolescents from accessing Reproductive Health Services from their nearest Reproductive Health Units [25-35]. The long lines could have been due to very few health workers at the health units hence not getting services. In addition, 27.5% of the respondents cited that the service providers were harsh and refused to give them the service. This indicated that some health care providers had an unsupportive attitude towards providing SRHS to adolescents characterized by judgmental attitude and lack of competence coupled with lack of knowledge in handling adolescents friendly. The results are in relation to Tilahun *et al.* [23] and Godia [24] who urged that negative provider's attitudes have been identified as a major barrier that discourages young people from seeking or returning for health care hence missing services that would prevent them from getting unwanted pregnancies that would end up in unsafe abortions. More so, 20% of the participants revealed that they found their neighbors at the health units and felt ashamed. The findings indicated that the environment in which the adolescents were expected to seek service was not conducive. The results are consistent with Kennedy *et al.* [25] who asserted that adolescent's access and utilization of sexual and reproductive health services was limited due to fear and shame, lack of confidentiality and privacy towards health seeking behaviors of adolescents. This is also in line with James *et al.* [26]'s assertions that placing barriers on teens' access to confidential health services directly endangers their health and welfare because it deters them from seeking the reproductive and sexual health care services and information they need [27]. Lastly, 5% of the respondents mentioned that they found their health units closed. This implied that adolescents were limited by inconvenient health facility operating hours that prevented them from accessing health care facilities. This is in consistency with Abebe [28] who asserted that inconvenient health facility operating hours could prevent adolescents' access to health care facilities and their proper use of the offered services.

CONCLUSION

It is concluded that most adolescents knew about RHS and got information about RHS from mass media and less from teachers and health workers. The least 12% of adolescents never knew about RHS thus are likely to get unwanted pregnancies which would end up in unsafe abortions hence increasing on maternal mortality. Most respondents were aware of family planning services thus could easily utilize them and protect themselves not to get unwanted pregnancies which may end up in unsafe abortions. All these inclined adolescents from utilizing RHS thus prefer privacy and confidentiality when accessing these services.

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