Abstract:

Knowledge of family planning among young people (10-24) in 15 programme districts in Uganda

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Background

According to the national Vision 2040, Uganda aspires to attain upper middle income status by the year 2040, which would see per capita income rising from USD506 in 2011 to USD9,500 by 2040. Modelling of the demographic dividend has shown that this is possible, if the country benefits from the demographic dividend. This would, however, require a drastic reduction in total fertility rate from 6.2 in 2011 to about 2.2 children per woman by 2040. Among other key investments, increasing contraceptive prevalence rate (all women modern methods) from 20.7% in 2011 to 67% by 2040 is critical for the required fertility reduction and change in the age structure necessary for the demographic dividend. Given the current youthful nature of Uganda's population with 70% aged 24 years and below, and a high teenage pregnancy rate of 24% , investing in young people, especially their access to sexual and reproductive health information and services, holds the key to Uganda's prospects of benefitting from the demographic dividend and attaining the economic growth targets of Vision 2040. Use of family planning by young people is dependent on their knowledge of sexual and reproductive health including knowledge of the different methods of family planning and where to get them.

In 2011 the Government of Uganda and the United nations launched the 4-year Joint Programme on Population with the goal of accelerating the onset of a demographic transition in Uganda and pave way for the country to benefit from the demographic dividend. One of the key interventions was to increase young people's access to sexual and reproductive health information and services including family planning. Whilst the programme had a national scope, downstream service delivery interventions, including provision of youth friendly sexual and reproductive health information and services focused on 15 selected districts. Provision of youth friendly services, supported by establishment of youth friendly corners at health facilities, and involvement of schools and communities was a key strategy of the adolescent sexual and reproductive health programme.

This paper is based on a household based sample of 2,747 young males and females aged 10-24 years interviewed in 15 programme districts as part of the mid-term evaluation of the Joint Programme on Population which was commissioned by UNFPA in 2013. The paper assesses the level of knowledge of family planning methods among young people aged 10-24 years and variations by age group (10-14 and 15-24) and sex in the programme districts. The analysis also examines variations in sources of information including preferred sources and access to ASRH services. Based on the experience in programme districts, the paper provides recommendations for scaling up adolescent sexual and reproductive health to accelerate the demographic transition in Uganda.

Methods

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The mid-term evaluation sampled a total of 1119 households in the 15 districts, and all eligible members, including 2,747 young people aged 10-24 years were interviewed. In addition to descriptive analysis, multivariate techniques will be utilized to analyse factors associated with variations in levels of accurate knowledge of family planning and where appropriate, comparisons will be made to the baseline and findings from the currently on-going end of programme evaluation.

Results

Comprehensive knowledge of family planning is very limited among the young people, especially the very young adolescents. Only six (6) per cent of young people (10-24 years) had accurate knowledge of three methods of contraception (male condom, oral contraceptive pill and emergency contraceptive pill). This, however, represented a substantial improvement compared to 1.3 per cent in 2012 (baseline). There was a clear sex and age dimension to young people's knowledge of family planning with higher proportions of young males having accurate knowledge of all three methods (9.6%) compared to their female counterparts (3.5%). This is attributed largely to the much higher levels of accurate knowledge of male condoms among males than females. The proportion with accurate knowledge of all three methods of contraception was lower among younger females (10 to 14 years old) at 2.3% compared to those aged 15 to 24 years (6.2%). Level of accurate knowledge of the three methods varied by district, being highest in Oyam (28.2%) and Kitgum (20.2%) and lowest in Abim (none), Gulu (0.63%), Yumbe (0.76%), Kanungu (1.06%) and Katakwi (1.36%).

The main source of information on sexual and reproductive health for young males aged 10 to 24 years was the radio, followed by peers. For young females (15 to 24 years) the main source of information was a health facility. Young males preferred to receive sexual and reproductive health information from peers (28.5%), health workers (24.1%), parent/guardian (14.6%), school teacher (12.3%) and relatives (11.8%), while for girls aged 10 to 14 years, the most preferred person to discuss issues of sexual and reproductive health with was a parent/guardian (36.8%), followed by a school teacher (21.3%), health workers (15.7%) and peers (14.3%). Only 2.4 per cent of young males and less than one per cent of girls aged 10 to 14 mentioned staff at a Youth Friendly Corner (YFC). It should be noted that only 25% of the young people had ever been to a Youth Friendly Corner, which may partly reflect the distribution of the Youth Friendly Corners, as they were only established at selected schools and health facilities and yet the sampling for the evaluation did not consider this. Religious leaders were not seen as people to go to for such information by all respondents regardless of age and gender.

Negative community attitudes, mainly due to myths and misconceptions about condoms and contraception deter young people from accessing sexual and reproductive health information and services. For example, it was noted that in Abim district, negative attitudes of district officials towards the distribution of condoms amongst young people affected their access to condoms. As a consequence, young males improvised and were reported to be using pieces of white polythene as a barrier, lubricated with Shea nut oil "moo ya".

The evaluation also noted concern about lack of age appropriate and culturally acceptable information, education and communication materials on adolescent sexual and reproductive health. Whilst the joint programme produced a wide range of information, education communication (IEC) materials for young people on family planning, which have been translated into local languages, with culturally accepted images, these had not yet reached all districts at the time of the mid-term evaluation.

Conclusions

There is need to address myths and misconceptions about adolescent sexual and reproductive health on the part of parents, school and health facility staff, district and local level officials, community gate keepers and political, religious and cultural leaders to increase young people, especially the very young female adolescents' access to reproductive health information and services.

It is important to consider the age and gender specific needs of young people in interventions to increase their access to sexual and reproductive health information and services. Customised age and sex appropriate packages of youth friendly services for communities, health facilities and schools to address the needs of both male and female , and younger and older adolescents and youth will increase access to information and levels of knowledge of family planning.