The use of contraceptive in Uganda: An analysis of access and rights amongst adolescents

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Abstract
The main objective of this article is to assess aspects of access and rights influencing contraceptive use amongst adolescents in Uganda from a social justice perspective. Specifically, the article addresses current practices and policies related to contraceptive use amongst young people according to socio-demographic characteristics. Additionally, the article addresses the awareness of young peoples' rights to access contraceptive services. A review of reproductive health programs and policies in Uganda based on an applied psychology framework were reviewed. Data collection methods used in this study included Focus-Group Discussions (FGDs), in-depth interviews and observations as well as key informant interviews. Findings indicated that the policy regimes in place appear to be more restrictive than promoting access to contraceptives by adolescents. Contraceptive use amongst adolescents was high at 46% for urban adolescents as opposed to 27 percent of adolescents residing in rural areas. Likewise, there was a significant relationship in age, marital status and contraceptive use. Adolescents who were enrolled in school faced restrictions in accessing contraceptive services as compared to their counterparts not enrolled in school. Last but not least, almost all adolescents were aware of their rights to access contraceptives and reproductive health services.

We conclude that the policy regimes on reproductive health for adolescents imposed by the government seem to be detrimental to the otherwise good intentions of the government of promoting health in this age group. Instead, the adolescents have found themselves not accessing contraceptive services because of such policies in place. Socio-demographic characteristics play a significant role as far as access to and use of contraceptives is concerned. Age and marital status, had a significant influence on access to and use of contraceptives. Likewise, being enrolled in school or not being enrolled in school also determined access to contraception services. There seems to be a concerted effort to ensure that all adolescents access the correct information about their sexual and reproductive health services.

Declaration: This manuscript has not been published and is not under consideration for publication by another journal.

Background
Contraceptive use as a preventive measure for promoting sexual and reproductive health and well-being of individuals is a social justice issue which calls for equity of opportunity between members of society, including men, women, boys and girls. However, contraceptive use in Sub-Saharan Africa is still very low, contributing to high fertility rates, including unwanted pregnancies. This can, in turn, spur high rates of abortion. Moreover, current evidence shows slow progress in expanding the use of contraceptives amongst adolescents, particularly of low socioeconomic status (Boerma et al., 2008).

While there are policies to guide and regulate contraceptive services, some tend to pose a negative influence on utilization of these services. Unwanted pregnancies, unsafe abortions, and significant challenges in accessing contraceptives endanger the health and reproductive rights of adolescents. According to Hubacher et al (2008), poor patterns of contraceptive use such as high discontinuation rates and incorrect use contribute significantly to the problem of unintended and unwanted pregnancies. This can partly be explained by restrictive policies and practices regarding contraceptive use enforced by some governments. Health advocates, however, are using human rights mechanisms to ensure that governments honor their legal commitments
to ensure access to services essential for reproductive health.

Inequity in health exists when people are unfairly deprived of the resources they need to maintain good health or protect themselves from unwanted or undesirable conditions. Shah and Chandra-Mouli (2007) argue that it is only through the equity lens that we can observe whether certain strata of the population such as the poor, young, single, rural residents and under-educated women are being deprived of the family planning resources needed to avoid unwanted pregnancies. Khalaf et al (2010) found that many young women in Jordan were not aware of the reproductive health services available to them, and there was a strong consensus about the need for information about reproductive health services. In fact, young people have a right to accurate information about sexual and reproductive health, but such is lacking in many developing countries.

In Uganda, there is a strong consensus that young people face significant challenges in accessing contraception partly due to the current policy and practice regarding contraceptive use. According to the Population Reference Bureau (2009), 49 percent of the Ugandan population was below 15 years and 20 percent was between the age of 15 and 24. Hubacher et al (2008) report that a large number of young people in Uganda are in or are soon reaching their reproductive age and thus have a potential risk of unplanned and unwanted risky sexual behaviour. They add that by 15 years of age, 11 percent of adolescents in Uganda had initiated sex and by age 19, 64 percent of young people had had their first sexual encounter.

Sexual Activity among Adolescents

Uganda has a predominantly young population with 47.3 percent being under 15 years of age (Ministry of Health 2012). According to the Uganda Bureau of Statistics (2012) young people are now starting sexual activity at a later age than in the past, though the age at sexual initiation is still early. Recent studies indicate that adolescents start having sex at an early age; the median age being 16.7 years and marriage at 17.8 years. It would appear that most of the sexual encounters in this age group are unprotected, exposing young people to unwanted pregnancies and sexually transmitted infections (STIs), including HIV/AIDS.

Sexual activity among adolescents can be either voluntary or involuntary. Young women may have sex for romance, sexual desire, economic gain, or because of coercion. The extent of autonomy young women have in relationships is difficult to ascertain. Adolescent females account for a significant proportion of maternal deaths, which are largely due to preventable causes (WHO, 2011). Unsafe abortions contribute significantly to maternal morbidity and mortality amongst adolescents. In fact, adolescents account for an estimated 2.5 million of the approximately 19 million unsafe abortions that occur annually in the developing world.

In Sub-Saharan Africa, the proportion of unintended pregnancies is approximately 25 percent or 900,000 (Guttmacher Institute, 2010). These would significantly decrease if adolescents had access to modern contraceptive methods, but many adolescents in developing countries face barriers to obtaining and using contraceptive services correctly and consistently (Chandra-Mouli et al., 2014). It is for this reason that adolescent health practitioners are lobbying for more adolescent access to contraceptives, and that this should take a rights-based approach as opposed to the current practice that espouses contraceptive access by adolescents while effectively denying them their rights.

This paper therefore examines the current practices and policies influencing contraceptive use
amongst young people; assesses variances in contraceptive use amongst young people according to socio-demographic characteristics as well as examines the awareness of young people about their rights to access contraceptive services. A case is made for the equity and rights-based access to contraceptives by adolescents who need the services. Access to contraceptive use is an aspect of social justice, where adolescents are presented with equal opportunities to access contraceptives freely without any restrictions, sanctions, or discrimination.

Data Collection Methods

The data collection methods used in this study included Focus-Group Discussions (FGDs), in-depth interviews and observations. Three FGDs of male and female adolescents aged 13-15 years old, 16-17 years old, and 18-19 years old were used. All participants aged 18 years and above signed a consent form while those below had the consent forms signed by their parents or guardians on their behalf.

Key informant interviews were conducted with policy officials in the Ministry of Education and Sports (MoES), and the Ministry of Health (MoH), as well as with other key stakeholders working with young people in the area of sexual reproductive health and rights, including Straight Talk Foundation, a non-governmental organization in Uganda. Additionally, sexual and reproductive health programs and policies in Uganda were reviewed based on an applied psychology framework. Furthermore, the study utilized reports from the National Strategic Plan on Reproductive Health, government, and the United Nations.

The inclusion criteria for participants were Ugandan adolescents within the age group of 13-19 years. Participation was voluntary, whereas exclusion criteria applied to those outside the age group, non-Ugandans and involuntary participants.

The study sample included 315 respondents as indicated in Table 1 below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Marital Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;16</td>
<td>55</td>
<td>Not-married</td>
<td>285</td>
</tr>
<tr>
<td>16-17</td>
<td>109</td>
<td>Married</td>
<td>30</td>
</tr>
<tr>
<td>18-19</td>
<td>151</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>315</td>
<td>Total</td>
<td>315</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residence</th>
<th>Number</th>
<th>School Status</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
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<td>289</td>
<td>In-school</td>
<td>236</td>
</tr>
<tr>
<td>Rural</td>
<td>26</td>
<td>Out-of-school</td>
<td>79</td>
</tr>
<tr>
<td>Total</td>
<td>315</td>
<td>Total</td>
<td>315</td>
</tr>
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Results

The following three categories according to the study objectives were used to present study findings:

1. Current policies and practices influencing contraceptive use amongst young people. The government of Uganda has well-intentioned policies in place but seems to be prohibitive where access and use of contraception by young people is concerned. It is obvious that policies and practices about adolescent sexuality are influenced by our culture, which prohibits sexual relationships let alone talking about them in certain age groups. However, as Batwala et al. (2006) point out, Ugandan adolescents are living in a time of socio-cultural transition where traditional practices that formerly limited adolescents' sexual experiences are breaking down. Mass media and globalization have been far-reaching into the lifestyles of adolescents, where information about sexuality is widely available.

Gone are the days when adolescents used to get sex information from aunts, uncles or community members.

The government of Uganda recognizes the importance of addressing the sexual behavior of adolescents, not only in relation to their reproductive outcomes but, more importantly, to high-risk sexual behaviors. Survey results in
Uganda have consistently indicated that young people initiate sexual activity at a relatively early age. Faced with such a reality, it is prudent that policies and practices aim at enabling adolescents’ access to contraception, instead of appearing to be prohibitive (Shaw et al., 2012). Health advocates are using human rights mechanisms to ensure that governments honor their legal commitments aimed at access to services essential to their sexual and reproductive health.


The Government of Uganda has put in place policies aimed at improving the sexual and reproductive health of adolescents. Through the relevant policies and laws the government recognizes and emphasizes the salience of addressing adolescent sexual and reproductive health by keeping children and adolescents in school, and increasing contraceptive use and levels of supervised delivery by trained health personnel.

National policies that have beneficial implications for adolescent sexual and reproductive health include the National Youth Policy, the National Policy on Young People and HIV/AIDS, the Affirmative Action Policy, the National Population Policy, the National Health Policy, the National Gender Policy, the draft Reproductive Health Policy, the National Reproductive Health Service Delivery Guidelines, Sexual and Reproductive Health Minimum Package for Uganda, and the National AIDS Control Policy proposals. Although some of the policies are not fully implemented yet, they could provide the basis for a supportive and conducive environment for adolescent sexual and reproductive health.

However, throughout these documents, there appears to be a systematic plan to cut out mention of access to contraceptives by adolescents, particularly those in school. Instead, emphasis appears to be on abstinence, which is good for young people, but not sufficient, especially if not all information is provided to those who cannot abstain.

We strongly argue that secondary school students be provided with information about access to and utilization of contraceptive services. Faced with the reality that many adolescents in Uganda are sexually active starting at age 13, should we continue denying those still in school the opportunity to access information and services on contraception? Are we working within their rights and hence promoting social justice for adolescents as far as accessing information and services about their reproductive health?

We should, however, not forget how lack access to and information about contraceptive use can cause adolescents to drop out of school. As one of the adolescents in one of the FGDs told us, “I dropped out of school because I became pregnant and my parents sent me away from home. I now live with my grandmother. Much as I knew a little about contraceptives when still in school, I never even knew how or where I could access the services. I could not go to the pharmacy because no pharmacists would sell any contraceptives to adolescents in my area. (FGD [18-19], August 2013)

Clearly, the existing government policies about young people accessing contraceptives in some way or another influences how private operators like pharmacists approach access to contraceptives by adolescents. Pharmacists or other private operators risk being closed by the government if they are deemed to be operating outside the “law”. Some adolescents are said to ask their older sisters or brothers to buy contraceptives on their behalf, meaning adolescents have learnt to skirt around the restrictions to access contraceptives at any cost.
3. Variances in contraceptive use according to social demographic characteristics. Study findings showed significant variances in contraceptive use amongst adolescents with some social demographic characteristics and no variance in contraceptive use with other social demographic characteristics.

Age

93% of surveyed adolescents below 16 years old were not using any form of contraception. Most stated that this was because they were not sexually active – but not before adding that even if they wanted, no service provider in their “right mind” will allow them to access any form of contraceptives because they are too young to engage in sexual activities. One adolescent said,

Out of curiosity we went with a friend to a pharmacy and we requested to buy condoms. The pharmacist looked at us and his response was that we should get out of his sight before he calls the police to have us arrested (FGD, 2013).

Denying adolescents contraceptives or even the correct reproductive health information will not necessarily prevent adolescents from engaging in sexual activities, but the outcome will be increased risks associated with adolescent sexual practices. For example, the MoES does not allow mention of any form of contraception when teaching sex education in secondary schools, directing that emphasis be on abstinence during this period. The MoES guidelines on sex education in schools are very clear: “do not teach aspects of contraceptive use at any level before post-secondary.” Their argument has always been that introducing contraceptives to this age group will promote indiscipline and recklessness. The reality, however, is that adolescent will go ahead to engage in risky sexual behavior even without the use of contraceptives. The outcomes have always not been good, as evidenced from the high teenage pregnancies and subsequently high incidences of unsafe abortion within this age group.

Like their counterparts below 16 years old, older adolescents also go through the same ordeal when trying to access contraceptive services, where they are always reminded that they are minors. On the contrary, married adolescents indicated they access all information about contraception and the contraceptives. Some, however, indicated they do not need use of contraceptives because they have just started families and they need to have children. It should, however, be noted that the married adolescents were those in the age bracket of 18-19 years. None of the adolescents under 17 years were married in this study.

We also noted that the adolescents’ accessibility to contraceptive services could be influenced by age (Yakong et al., 2010). Much as the adolescents indicated their need to access and use contraceptives, the policy guidelines undercut their desires rather than promoting them. We see this as a social justice issue, which calls for critical examination of these policies in order to make them in consistent with WHO guidelines about adolescent reproductive health.

Residence and Contraceptive use

Findings indicate that adolescents in urban areas were likely to access and consequently use contraceptive services compared with their rural counterparts. This is consistent with UBOS (2012) and Yakong et al. (2010) findings, which indicated that amongst the reproductive age group contraceptive use in urban areas was higher at 46 percent compared to 27 percent in rural areas. This study revealed a stark contrast between the availability of adolescent contraceptive services in rural and urban areas. In urban areas, there was a visible presence of adolescent friendly facilities compared to rural areas. Moreover, facilities in rural
areas were seen as dilapidated and poorly stocked. Adolescents added that personnel were unfriendly when it comes to providing adolescent services. Besides, both the provider and adolescents pointed out the limited choices of contraceptives and general lack of personnel to adequately and promptly attend to adolescent reproductive health needs as being some of the challenges they encounter.

Pillai and Gupta (2011) argue that an expansion of choices that people enjoy to improve their own welfare requires vast social institutional development over and above mere economic development. The National Adolescent Health Policy has made it very clear that success of adolescent health programs will depend on the extent to which service providers are willing adopt new skills and attitudes towards adolescent-inclusive health. Another health care provider had this to say:

“As a mother, I would feel really bad if I discover my adolescent daughter is using contraceptives, but as a service provider, the regulations are clear. We should serve them equally” (Key Informant Interview, August 2013).

The quality of services and their utilization by adolescents depends a great deal on both the technical competence and attitudes of providers. This assertion is supported by the Ministry of Health (2008), who add that providers play critical roles in efforts to improve access to adolescent health care. One adolescent had this say in an FGD:

“One time I visited the health facility in the rural area to enquire how to use condoms, but the nurse asked a lot of questions and some were embarrassing. Instead of serving me, I was being questioned about my moral behavior. I vowed never to go back to those health facilities” (FGD 18-19, August, 2013).

When asked what they do then in case they need contraceptives, their response was that those with money can buy them from private drug stores, while a good number do not use any. This cannot be celebrated as good news because according to UBCS (2012), about 5.4% of adolescent males aged 15-19 years have had more than one sexual partner in the last twelve months. The results can include increased cases of unsafe abortions and worse, death. Again, adolescents in rural areas indicated they cannot spend their meager income on a ‘luxury’ such as contraceptives at the expense of other basic needs like clothing (Hall et al., 2012). It has been argued that adolescents’ low social status will leave them with limited choices about the decisions they make regarding their sexual and reproductive health rights. Creanga et al (2011) and Da’souza et al (2011) emphasize that as much as global health rights have improved considerably over the last four decades, the health status and rights of the poor everywhere compares unfavorably with more affluent sectors of society.

A dominant argument made in regional literature is that rural residents tend to lag behind as far as access to sexual and reproductive health services is concerned. This, it is argued, is attributed to the fact that the distribution of such services tend to be limited in rural areas, but this does not necessarily imply that services are well distributed in urban areas, especially in developing countries. In rural areas, most adolescents can only afford to get reproductive health services from government-aided health facilities, which are largely free. The problem is that the health care practitioners may chase adolescents away if practitioners deem them not ready to utilize contraceptives.
This is not helped by the fact that in rural areas, culture dictates it a taboo for an adolescent to walk into a health care facility and ask for contraceptive services. However, both rural and urban adolescents faced similar challenges in accessing contraceptive services. Both pointed out that in most cases when they seek services, they are judged and feel intimidated by some providers, and this tends to deter them from going back if they require the services. Other challenges pointed out included lack of privacy and receiving the silent treatment. One adolescent had this to say about privacy:

“When you visit the health facility, there is no private place where you could feel comfortable sharing your problems with the health care provider. Faced with such a situation, you end up leaving without getting the services needed” (FGD, August 2013).

Another from urban area said,

“When you arrive at the health facility, the look the health care provider gives you indicates that you are doing something wrong. This makes you feel shy and intimidated to say exactly what you are there for” (FGD, August 2013).

Marital Status and Contraceptive use

Ninety percent of the adolescents surveyed were not married. As with previous variables, the majority of the unmarried adolescents were not using any form of contraception due to being denied the services because they were considered too young. The married adolescents, on the other hand, could access contraceptive services if they wanted, but they indicated that they had just started families, hence their non-utilization of contraceptives. A health care provider pointed out that government policy is that all married couples should freely access contraceptive services without being discriminated against. This was supported by married adolescents or those who have been pregnant before, who noted that once the health care providers know that you are a married adolescent, they will provide you with all the support you need as far as accessing contraceptive services is concerned. The only exception, one adolescent added is “when the adolescent is not known to be married.” To prove his/her marital status, the adolescent has to show up with his/her spouse or with a baby; this will accelerate access to contraception services from the health care providers.

In- versus out-of-school contraceptive use

Findings indicated that 19 percent of adolescents enrolled in school were using contraception while 56 percent of out-of-school adolescents were using or had access to contraceptives. This also depended on age. For example, 74 percent of adolescents enrolled in school aged 18-19 years used contraception compared to those below 18 years. In short, more out-of-school adolescents were using contraception as compared to their counterparts still enrolled in school. These findings are congruent with a related study conducted in rural southwestern Uganda by Batwala et al (2006). Adolescents enrolled in school pointed out that no one talks to them about contraceptives in schools, because of what they understand is a gag order by the Ministry of Education guidelines. When asked how they came to know about contraceptives, they said they read about them in magazines, from peers, and on television, amongst other sources.

Findings indicated that an adolescent who was out of school and married was likely to use contraceptives compared to adolescent enrolled in school and those who were unmarried. According to related studies, contraceptive use among sexually active adolescents is low in rural areas as compared to their counterparts in urban areas.
This study never examined contraceptive use by adolescents in rural areas who are enrolled in school versus those out-of-schools.

**Awareness of adolescents about their rights to access contraceptive services**

Almost all adolescents exhibited knowledge about contraception and almost all adolescents were able to list at least one method of contraception, condom use being prominent. These findings are consistent with UBOS (2011). Batwala et al (2006) report a near universal awareness about family planning amongst young people. In contrast, even adolescents who indicated they were sexually active had not used any kind of contraception and this cut across the socio-demographic characteristics. Again, a significant number of adolescents were not very conversant about their rights to access contraceptives, let alone knowing that contraceptive use is a key element in adolescent reproductive rights.

Many indicated the need for awareness activities to enable them to understand their rights as far as accessing contraceptives is concerned. At present, they argued, most adolescents will either be cowed away or not demand for such services when they actually do not know the extent of their rights. A few adolescents pointed out that the community does not approve of them using contraception, much as they would wish to. This kind of belief by community members is much more predominant in rural areas, but not lacking in urban areas, either. This, according to the adolescents can be interpreted as trampling on their rights to access contraception. One adolescent in the FGD said,

"I was forced to marry my current partner because he made me pregnant. I am currently using contraception because the health care providers told me to do so and I want to go back to school" (female respondent, FGD, August 2013).

This is emphasized by a report on reproductive health, which states that adolescent pregnancy is most often not the result of deliberate choice, but rather the absence of choices and circumstances beyond the control of adolescents (UNFPA, 2013). This adolescent actually never asked for the contraception herself but the health care providers advised her, and this was after she reportedly confided to one of the service providers that she wished to go back to school. Someone else had to vouch for her rights to access and utilize contraceptives. UNFPA (2013), reports that 70,000 girls aged 10 to 19 die each year from complications during pregnancy and childbirth, this being attributed amongst other things to a lack of contraceptive advice. It is safe to say that the 7.3 million under-18 adolescents who get pregnant every year in developing countries can only be addressed by changing the social attitudes of various players.

By contrast, a small number of respondents in the FGDs were of the view that as much as adolescents had a right to access information about contraceptives, they should wait until they get married for them to start advocating for the rights to access the services. When we put it to them that it is their right to access the services, some seemed to be resigned to the fact that government regulations – especially those adolescents enrolled in school – tend to be restrictive and prohibitive rather than enabling towards adolescents accessing information about contraception.

Still, adolescents were able to criticize the services and facilities, labeling them inadequate to poor in some instances. They particularly pointed out that privacy in most of the health facilities is lacking, especially in rural areas. An adolescent would practically be expected to share her/his
concerns with the health care provider in the vicinity of other clients. This, to them, is a deterrent in itself, and many adolescents would actually walk away without saying a word. Talking to adolescents under conditions where they cannot be heard by others promotes privacy and improves communication. To them, this indicates better quality of services, which they can embrace.

Policymakers have persistently argued that letting adolescents enrolled in school access information about contraception will make them become sexually active, thus the need to deny them such information. Instead, this seems to be counterproductive, as many studies have consistently indicated that many adolescents are getting the information about contraception from other sources, which may have incorrect information. The policymakers in Uganda are resistant to this and continue to insist that no such information should be given in any primary or secondary schools.

There was no significant difference in awareness about reproductive health rights between adolescents out of school and those enrolled in school in urban areas. This is apparently attributed to the fact that urban adolescents would access such information from various sources, including social and mass media, peers, family, and teachers. Social and mass media is more easily accessible in urban areas than rural areas. In Ghana, mass media is a key site for disseminating information on health related aspects including adolescent sexual and reproductive health (Alkins et al., 2010). This is not any different from the Ugandan situation. Newspaper articles and pullouts appear regularly in magazines, and their content specifically targets the adolescents both enrolled in and out of school. These pullouts are provided free of charge to schools. Again, the content is regulated to ensure that information on contraceptive use is not so pronounced. On the other hand, the out-of-school adolescents who are married would get such information readily from the health care facilities in addition to other sources such as social and mass media, just like their counterparts in school.

Conclusion

The need to increase contraceptive access and use in the developing world, including Uganda, cannot be overemphasized. There is a need to define how much information on contraceptives adolescents should be exposed to. These decisions should be made bearing in mind the rights of adolescents to access and use contraception, which is necessary in the promotion of their sexual and reproductive health.

Uganda has policies and regulations in place to enable adolescents' access to sexual and reproductive health services and information; however, when analyzed, these policies appear to be more prohibitive than promotive of adolescents' rights and access to contraceptive use. We argue that such policies should aim at enabling rather than restricting and prohibiting access to contraception by adolescents, especially those still enrolled in schools.

Socio-demographic characteristics play a significant role as far as access to and use of contraceptives is concerned. Age and marital status have a significant influence on access and use of contraceptives. Likewise, being in or out of school also determines access to contraception, with adolescents enrolled in school reporting restrictions to access the services, let alone receiving information in school. As much as the adolescent sexual and reproductive health policy advocates for mainstreaming of adolescent reproductive health information into the school curriculum, information on contraceptive use has been carefully avoided until post-secondary level. Anyone who
contravenes these guidelines stands to face punitive measures, and risks having their activities within the country suspended or terminated altogether.

Adolescents in rural areas are more disadvantaged than their urban counterparts as far as contraceptive access and use. It is in the rural areas where cultural prohibition is still entrenched within the community; therefore, adolescents in rural areas face hurdles to access contraceptives. This may be because they are considered to be too young to demand for such services. The outcome has not been good, either; as such, adolescents have abandoned the services but not the risky sexual activities.

There was almost universal awareness of knowledge about contraception amongst the adolescents, although significantly fewer adolescents were aware of their access to and use of contraceptives. Knowledge about rights also depended on the socio-demographic factors, which included marital status, enrollment in or drop out of school, and residence in rural or urban areas.

We argue that access to and use of contraceptives by adolescents in Uganda must take a rights-based approach using a social justice lens. This is contrary to the current regime of policies that seem to promote the access when their actual intentions are to effectively prohibit or stop adolescents’ access to sexual and reproductive health services.

References


