

**FACTORS AFFECTING UTILISATION OF REPRODUCTIVE
HEALTH SERVICES BY THE YOUTH IN INTERNALLY
DISPLACED PEOPLES CAMPS IN KITGUM DISTRICT**

BY

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DECLARATION

I, Fred Owot, declare that this is my own original work and has never been presented to any university for the award of a degree.

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Date.....

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Sign.....

Date.....

2. Dr. Natal Ayiga

Sign.....

Date.....

DEDICATION

I dedicate this work to my Dad Mr. Stanley Mwaka and Mum Mrs. Alphonzina Mwaka who nurtured me and were a model for me. And to my brothers, sisters; Anna Atim, Stephen Akena, Rose Alal, Robert Ocen, Beatrice Apiyo, William Okello and Francis Odong.

This work is also dedicated to my children; Raymond Owot, Randy Owot, Ryan Owot, Owot Rose and my wife Betty Owot.

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Research work is not only tedious but also difficult and requires the effort of more than one person. In view of this, I would like to acknowledge a number of persons without whom this research would not have been accomplished.

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Secondly, I wish to thank my dear parents, Mr. Stanley Mwaka and Mrs. Alphonzina Mwaka who showed me the way and continually encouraged me to study hard and progressively. I thank you for the love and kindness you always offered me.

I also extend my sincere gratitude to all my lecturers at the Institute of Statistics and Applied Economics. Thank you for the enormous job you did and you continue to do to others like me. May the good Lord reward you abundantly.

I am deeply indebted to Kitgum Town College for the financial support without which I would not have completed this course. I must say I am grateful for this.

To all the respondents, I thank you so much for the willingness you exhibited by answering the questions put to you. This provided the answers to the theme of this study. I am grateful.

To all that have contributed and/ or supported me either directly or indirectly, I thank you.

ABSTRACT

This study basically looked at the factors affecting the utilisation of reproductive health services by the youth in IDP camps. The study was designed on the basis of the following objectives: - to identify reproductive health problems faced by the youth in the IDP camps, to examine the manner in which reproductive health services are utilised by the youth in IDP camps, to assess the attitudes of the youth towards reproductive health services and to determine the proportion of the youth in IDP camps that utilises reproductive health services.

The study used a cross-sectional survey design. Sampling of the youth was done by first of all clustering them into the four parishes of Palabek Kal. This method was preferred because it was believed that each cluster was representative of the entire youth population of the camp. Secondly, this method was considered cost-effective since the population of camp was big. A simple random sample of youth in the two selected clusters was undertaken using a table of random numbers.

The study found out that factors such as sex, age, marital status, level of education attained and employment status were the main determinants of the level of utilisation of reproductive health services in IDP camp. It was found that male youth in Palabek Kal IDP camp utilised reproductive health services as much as their female counterparts did. On the other hand, the higher the level of education attained by an IDP youth, the more possibilities that he or she will utilise reproductive health services. It is therefore imperative that, in order to make utilisation of reproductive services more effective in IDP camps, policies have to be geared towards promoting education. The study also found out that disparities in marital status did not significantly affect the level of utilisation of reproductive health services by the youth in IDP camp. Employment status also affected utilisation of reproductive health services in a way that those who are employed are more likely to utilise RHS than those who are not employed.

The study recommended that both formal and informal sex education programs should be increased. IDP youth need to be provided with basic information on sexuality and reproductive health. In an IDP setting, formal education was found to be limited and so information about reproductive health must be communicated in creative ways such as sports, video shows and drama. Vocational training should be encouraged to increase the productivity of IDP youth and enable them earn some income. This will in turn make them engaged in doing something more productive than getting involved in early sexual activities.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organisation
HIV	Human Immunodeficiency Virus
IRC	International Rescue Committee
IDP	Internally Displaced Person
IUD	Intra Uterine Device
LRA	Lord's Resistance Army
LC	Local Council
MCH	Mother and Child Health
NGO	Non Governmental Organisation
RHS	Reproductive Health Services
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UPDF	Uganda Peoples Defence Force
WHO	World Health Organisation

DEFINITIONS

Internally Displaced Persons (IDPs)

While there are no comparable definitions of IDPs, the working definition of IDPs formulated by Francis Deng may serve as an interim definition, especially as it is quite respected by the UN: Persons or group of persons who have been forced to flee or leave their homes or places of habitual residence as a result of, or in order to avoid, in particular, the effects of armed conflict situations or generalized violence, violation of human rights or natural or man-made disasters, and who have not crossed internationally recognized state border.

In this study IDPs will be taken as those people whose political, economic and social set-up has been disrupted by insecurity such that they leave their homes for safety in another place within the same locality. This can be the same district, county or sub county.

HEALTH

Health is defined in the constitution of the World Health Organization as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1992). In the context of this positive definition, reproductive health is not merely the absence of disease or disorders of the reproductive process, rather it is a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well being. This implies that people are able to have satisfactory and safe sex life and that they have the ability to reproduce and the freedom to decide if and, when and how often to do so. Implicit to this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law.

YOUTH

The new National Youth Policy of Uganda defines youth as “all young persons, female and male, aged 12 to 34 years.”

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

The ongoing conflict in northern Uganda, between the government and the Lord's Resistance Army, has led to displacement of over 1,200,000 people into IDP camps across the districts of Kitgum, Gulu, Lira, Apac, Katakwi and Pader. The fear of repeated attacks, abduction, murder and insecurity in the region, which started in 1990, has confined internally displaced persons (IDPs) to camp life up to now. This has led to a lot of suffering of the displaced people, as living conditions are very unfavourable.

Social conditions are a matter of universal concern: parents feel, in particular, that they are losing control over their children's behaviour. Promiscuity is perceived to be unacceptably high, with correspondingly high rates of sexually transmitted diseases, including HIV. Girls and women turn to prostitution in the absence of other economic outlets, boys to brawling, to petty crime, to rape, and in some cases to banditry. A whole generation of the youth has come of age in the alienating environment of the IDP camps, with a distorted cultural and moral reference point.

The children are abducted, trained as soldiers, and forced to commit brutal crimes and murders. Abducted girls are held as sex slaves and forced to marry. Those children who manage to escape need special psychological and medical interventions during their re-integration back into normal life (Omona G, 1998).

Several thousand children have been forced into the LRA, through a process of brutalisation in which they are socialized to violence. According to UNICEF (2002), about 29,000 people have been abducted by the LRA, including 11,000 children. Displacement has totally disrupted the livelihoods of formerly self-reliant and prosperous people. Youth suffer because their reproductive health needs are not met and insecurity exposes them to rape and other forms of sexual and physical assault.

1.2 STATEMENT OF THE PROBLEM

Over 11,000 children have been abducted in northern Uganda during the last 15 years of military confrontation between the Uganda People's Defence Forces (UPDF) and the LRA (Women's Commission 2001). Female youth have suffered sexual exploitation and abuse. The spread of diseases, including HIV/AIDS, lack of reproductive health services and education, malnutrition and sexual and gender-based violence are some of the problems faced by youth in IDP camps. Thousands of girls abducted by the LRA have become sex slaves and "wives" of the commanders and fighters.

As the number of formerly abducted young people arriving in Uganda increases due to improved cooperation with the government of Sudan to secure the safe passage of those who have escaped inside Sudan, more girls and women are arriving pregnant or with their children born in captivity. They and their children require emergency and on-going medical attention, psychological support, community acceptance and opportunities for education and livelihoods for their reintegration, as well as protection from re-abduction. Whereas most of the above mentioned emergency services are being provided by both the government and NGOs, reproductive health services targeting the youth is still lacking.

Doctors and health workers have vacated the camps due to prevailing insecurity, leaving behind desperate people in need of reproductive health services. In addition, several health units have been either destroyed or damaged in the course of the war, which exacerbates the problems related to utilization of reproductive health services by the youth in IDP camps.

This condition has resulted into a number of problems including among others: early and unwanted pregnancies, complications of pregnancies and delivery, increased maternal mortality and high prevalence of sexually transmitted infections (STIs) including HIV. Other related problems include unsafe abortions, rape, forced marriage, sexual enslavement and other forms of sexual violence.

According to Women's Commission, young people face high sexual and reproductive health risk in IDP camps, including: early sexual debut (as early as eight years) with the mean age between 15 and 16 years, with more than one third of girls having experienced their first sexual debut as a result of rape and more than half of boys and girls reporting multiple partners; higher HIV prevalence than in the South; and low acceptance of condoms and contraceptives.⁷⁵ Both male and female adult focus group participants reported that young men and women have sex before they are married. Some said that teenage girls provide sex to men in exchange for food and protection. Many male and female focus group participants said girls have unwanted pregnancies, are forced to leave school and are abandoned by the men. Young girls also attempt unsafe abortions and some have died.

The Problems that have been informally identified include inconvenient times during which RHS are provided, cost, embarrassment with the RHS provider, concerns about confidentiality and difficulty seeing a doctor or nurse. Other issues that youth identify include judgmental attitudes of staff, whether a service is

youth oriented, cultural appropriateness and the atmosphere of a health center. It was then found out that the youth in Palabek IDP camp were not utilizing RHS effectively and as a result, a number of problems were being faced by them. However this kind of research has not yet been carried out in the past and in my opinion, the factors that affect utilisation of reproductive health services by the youth in the IDP camps need to be investigated.

1.3 OBJECTIVES

The general objective of this study was to identify factors affecting utilization of reproductive health services by youth in the IDP camps.

The specific objectives of study are to:

1. Identify reproductive health problems faced by the youth in the IDP camps.
2. Determine the level of use of reproductive health services by the youth in IDP camps.
3. Examine the manner in which reproductive health services are accessed by the youth in IDP camps.
4. Assess the factors affecting use of reproductive health services by youth.

1.4 HYPOTHESES

This study tested the following hypotheses:

- 1) Lack of finances hindered youth from accessing and utilizing reproductive health services.
- 2) Age, sex, marital status, employment status and education level attained were some of the key factors determining utilisation of RHS

1.5 SCOPE OF THE STUDY

This study was conducted in Kitgum district, which is one of the northern districts of Uganda that have suffered greatly as a result of war between the government and LRA. The district comprises of Chua and Lamwo counties and it borders Pader district to the south, Sudan to the north, Gulu district to the west and Kotido district to the east. The IDP camps are found in the sub counties of Palabek Kal, Palabek Gem and Padibe, all located in Lamwo County. This study covered only Palabek Kal IDP camp.

1.6 JUSTIFICATION OF THE STUDY

This study explored reproductive health situation of IDPs. This information is useful to the government and NGO in addressing the reproductive health needs of IDPs.

Secondly, the youth could, through this study, understand the benefits of reproductive health awareness and develop positive attitudes towards reproductive health services.

Lastly, this study sought to provide additional knowledge and create challenges for further research with an ultimate aim of building an ever-greater pool of data that can be accessed by other researchers in future relating to the problems of the IDPs.

1.7 PROBLEMS FACED

The prevailing insecurity limited frequent access to the camp, as it is located in a remote area. Another problem was that the interviewees expected some reward after giving information. Lastly, the bureaucracy involved in getting clearances from the relevant authorities in order to organize interview or group discussions was tedious.

CHAPTER TWO

REVIEW OF LITERATURE

In this part, endeavours were made to examine studies that have been done on reproductive health problems of the youth and how youth access and utilize reproductive health services in IDP camps.

In Colombia, many rural civilians moved into urban areas due to political and civil violence that continued in the country for decades. This internal migration put enormous pressure on an already overstretched health infrastructure, which in turn, resulted to the internally displaced persons (IDPs) having no access to health-care of any kind. It was noted that in the country, 58% of people forced to flee were women whose husbands, sons, brothers or fathers had been kidnapped or murdered. Those women, particularly adolescent girls, were at greater risk of sexual violence and exploitation as a consequence of the impact of political violence on social and family structures. Another impact of violence and desolation among IDPs were increased number of unwanted pregnancies and abortions, and the spread of sexually transmitted infections. In response, PROFAMILIA was working in collaboration with Marie Stopes International and the Reproductive Health for Refugees Consortium to provide an integrated package of services tailored to the needs of these displaced communities. That integrated package helped to meet the needs for reproductive health care of internally displaced women and men, young and old, living under difficult circumstances (Plata and Guy, 2000).

Salama (2001) noted that, unlike refugees, IDPs could not invoke the same legal protections as refugees. Additionally, no specific international humanitarian agency is responsible for providing them with protection and humanitarian assistance. To address the shortfalls in the protection of the rights of IDPs, non-binding legal principles on internal displacement, which draw on existing humanitarian and human rights as well as on analogous refugee law, have been developed and disseminated. These principles list the important essential services that IDPs are entitled to, including food, potable water, sanitation, shelter, and medical services. However, responsibility for the protection of and provision of basic services to IDPs still rests with national governments. There is an urgent need for a specific international humanitarian agency to be given the mandate for providing such services so that tangible improvements in the health and welfare of IDPs are attained.

Most health infrastructures were damaged if not destroyed by the conflict and many health units have closed due to lack of safety. A shortage of qualified doctors and health care staff in IDP camps is particularly acute and has put additional pressure on outreach services and over-stretched health facilities.

Reproductive health services, already rare due to cultural restraints, are even more limited by the conflict. Acholi cultural practices, norms and attitudes prohibit normal discussion about sex, leaving many youth, especially girls, uninformed about the consequences of sex and other reproductive health issues. Nevertheless many young people are engaging in sex, including by force, from ages as young as 12 or 13. A research carried out by Women's Commission in northern Uganda indicates that a large number of girls said they could not say "no" to unprotected sex, and some boys said that they did not like condoms and would not wear them during sex. Others reportedly had no access to condoms, especially in IDP camps. Girls also reported that they lacked sanitary supplies during their periods.

The majority of youth viewed many of the reproductive health problems facing them as resulting from "a decline in moral values" due to the conflict. This morality gap, they say, has led to early sexual activity among youth, prostitution and an increase in domestic and community violence involving rape and sexual assault. LRA rebels, UPDF soldiers and other males are raping girls, especially those who live in IDP camps or who are formerly abducted.

In addition to spreading disease, including HIV, youth said that prostitution, rape, sexual slavery and decreased social control on youth sexuality have increased the number of unwanted pregnancies, unwanted children and child mothers, who sometimes die in childbirth. Some youth cited child mothers as the biggest problem facing girls, and pointed out that it is especially common among abducted girls, who are also frequently treated as outcasts by the community if they managed to escape captivity. Girls also cited lack of pre-natal care for pregnant girls and related health care as a major problem.

Youth do not use contraceptives despite the high levels of information available to them. They noted that low levels of contraception use is attributed to a number of factors including unavailability, inaccessibility, unaffordable user charges at health facilities, negative attitude towards contraceptive use by the youth, misinformation and myths surrounding their use.

Existing studies indicate that there are attitudinal, socio-economic costs and cultural barriers constraining youth reproductive health seeking behaviour. Even where reproductive health services are available, they are still inaccessible to the youth due to, the negative parental, community, religious and health workers attitudes towards unmarried youth who seek reproductive health services.

Currently, more than 26 million refugees, asylum-seekers and IDPs are registered worldwide with the United Nations Agencies, while millions still remain uncounted. In addition, girls and women make up about 50% of refugees and internally displaced populations, although the gender composition of displaced persons

varies between regions and countries. These women and girls are at risk of rape, unwanted pregnancies, unsafe abortions or delivery and sexually transmitted diseases. While international law requires countries that have ratified the relevant treaties to provide refugees and internally displaced persons with reproductive health services, in practice UN agencies and non governmental organisations usually have to help provide these services.

In a world where most people have less optimal access to quality reproductive health services, IDPs and refugees often live in circumstances of extraordinary instability that further hinder their access. Factors that define the IDP experience compound the challenge of attaining reproductive health. Such challenges include violence, displacement and disruption of family and community, dislocation to unfamiliar and often overcrowded surroundings, lack of infrastructure and access to basic survival needs, escalations in conflict resulting in new refugee influxes and intermittent evacuation of UN and NGO personnel.

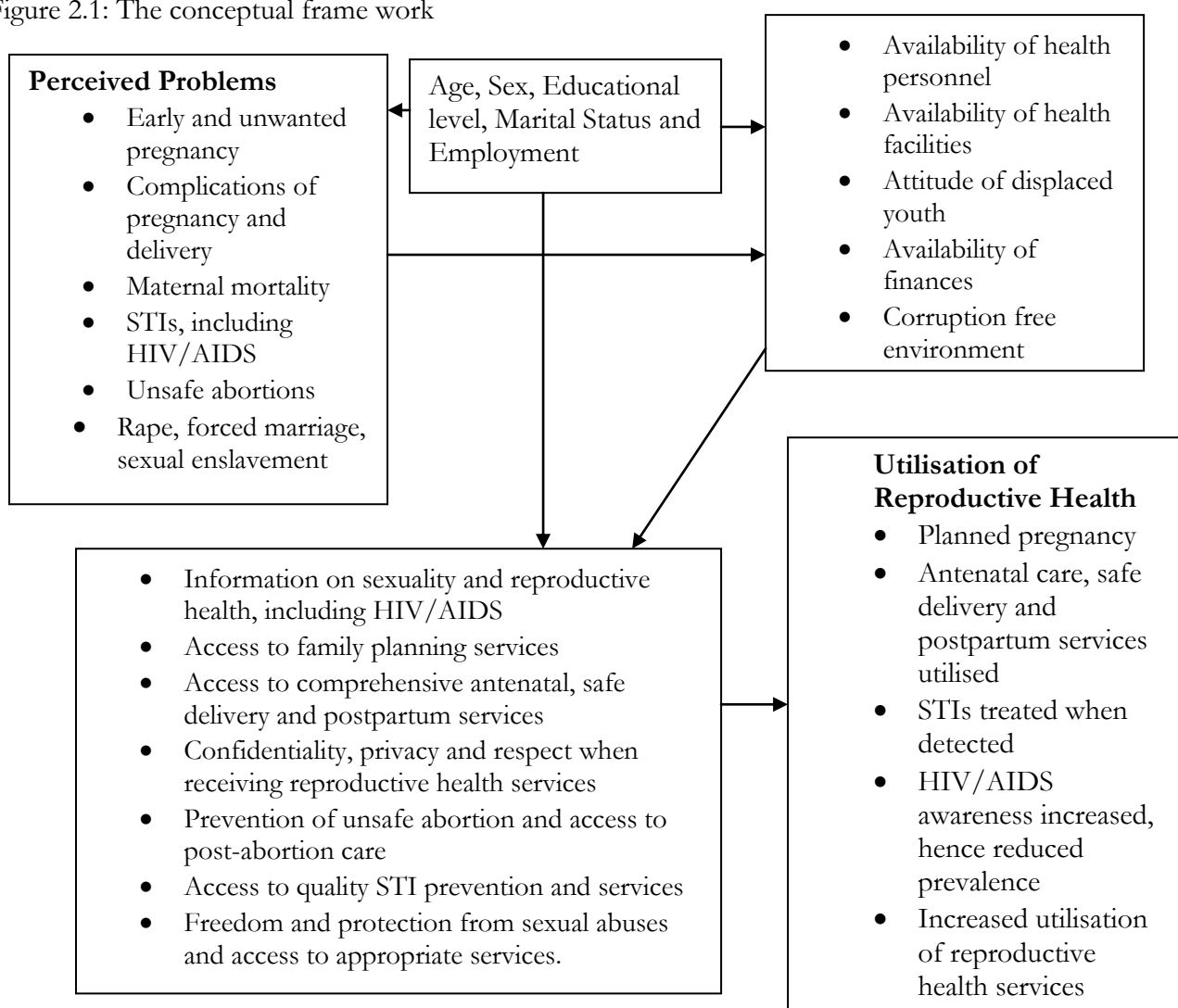
During flight and early settlement, childbirth may take place in a ditch alongside a road, in the forest or in a makeshift shelter. A study conducted among Burundian refugees in Tanzania, one of the first studies to examine the impact of pregnancy-related morbidity and mortality, found that neonatal and maternal deaths accounted for 16% of all deaths.

2.1 THE CONCEPTUAL FRAMEWORK

The diagram below illustrates, in a single comprehensive framework, the mechanism through which independent variables of the study affected the dependent variable.

Accordingly, the factors that affect the type and nature of reproductive health services, do determine their utilization by the youth in IDP camps. This framework was developed by first identifying the main determinants of reproductive health and the main components of reproductive health. The developed framework provides valuable insights in how to organise the complexity involved in studying the factors that affect accessibility and utilisation of reproductive health by youth arising from displacement. It could therefore, give a meaningful contribution to further empirical research by serving as a ‘think-model’ and provides a basis for the development of future scenarios on reproductive health of displaced youth.

Figure 2.1: The conceptual frame work



The conceptual framework above guides in the analysis of the factors that generally influence the utilisation of reproductive health services. It shows the inter-linked multidimensional aspects of reproductive health services such as planned pregnancy, family planning, STI treatment and HIV/AIDS awareness. It also shows that for IDP youth to effectively utilise reproductive health services, the following conditions must inter play; health personnel must be available to provide correct RHS information. Secondly, health facilities should be available and accessible through which RHS can be accessed. It also clearly illustrates the importance of intermediary factors such as availability of finances by the youth and their attitudes towards utilisation of reproductive health services. Underlying these are the primary factors such as age, sex, marital status, education level attained and employment status.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This Chapter primarily provides the tools and techniques used in carrying out this study. It involves both quantitative and qualitative approaches to analyzing the associations between the independent and dependent variables.

3.2 Research Design

The study was conducted in Kitgum district because it is one of the districts affected by the war between government and the LRA. It was hoped that the choice of this design would not only help to understand the situations of IDPs in Kitgum district, but also other places affected by war.

3.3 Sampling Method

Palabek Kal was picked from among the three sub counties for the study area, since resources were not adequate for all the three sub counties to be covered. The researcher listed all the households in the camp. This list was then used to select the respondents from the internally displaced youth. This method was deemed realistic since every youth had a chance of being included in the study.

3.4 Sample Size

One hundred eighty two respondents were selected from among the youth in Palabek Kal sub county IDP camp. Sample size was computed using the formula below:

$$n = \frac{Z^2 \alpha/2 pq}{d^2}$$

Where: n = sample size

d = permissible error

p = proportion of the youth in the IDP camps who utilise reproductive health services

q = 1-p

α = level of significance

Z = standardised variable of a normal distribution

Determining the sample size of the population was arrived at when the following key unknowns were defined.

1. The desired level of confidence that determined the value of Z
2. The permissible sample error d
3. The true proportion of “successes” p

The desired level of confidence was first determined from which the appropriate Z value was obtained from the standardised normal distribution. The permissible sample error d , which is the amount of error that is acceptable or tolerated in estimating the population proportion, was also determined. The third quantity, p , was estimated in such a way that the sample size needed was not underestimated observing that pq appears in the numerator. Since past information or records were not available to provide an educated estimate of p , its value was provided in such a way that the sample size could not be underestimated. In this case, the sample size was estimated using $p=0.5$. The researcher wanted to be 95% confident of estimating the proportion to within ± 0.07 of its true value. A sample of 182 youth was then obtained.

3.5 Data Collection Instruments

The researcher employed a number of instruments in carrying out this research. Firstly, to establish respondents' knowledge on how reproductive health services are utilized by the youth in IDPs camps, the researcher used oral interviews based on a structured questionnaire. Secondary data was got from already documented record on the situation in IDP camp where by high precautions and care was taken in documenting it.

3.6 Variables in the Study

The study comprised of the following demographic and socio-economic characteristics of the youth in Palabek Kal IDP camp. They are: age, sex, marital status, employment status and educational level attained by the respondents. Those are the ones referred to as independent variables. The dependent variable in this study is the utilisation of reproductive health services by the youth in the IDP camp.

3.7 Data Analysis

The Statistical Package for Social Sciences (SPSS) was used in the analysis of data. The dependent variable in this study was utilization of reproductive health services (RHS) which was a combination of antenatal, delivery and postnatal services; STD prevention and treatment and HIV prevention; and family planning information, counselling services, while the independent variables were: availability of health personnel, health facilities, age, youth' attitudes toward reproductive health services, corruption and financial availability on the part of the youth. These independent variables were then analysed to find out their effect on utilization of reproductive health services.

Univariate analysis was used to show frequencies on background information and the different factors that affect the utilisation of RHS. Bivariate analysis was used to show the relationship between the independent variables; namely: sex, religion, age, lack of money, corruption, availability of health personnel and health facilities, and the dependent variable (utilisation of RHS) by the use of the Pearson chi square which was computed using this equation below.

$$\chi^2 = \sum_{i=1}^r \sum_{j=1}^c \frac{(O_{ij} - E_{ij})^2}{E_{ij}}$$

Where: $i = 1, \dots, r$

$j = 1, \dots, c$

O_{ij} is the observed frequency

E_{ij} is the expected frequency assuming independence

Multivariate analysis was also used to carry out further statistical investigations and to establish which variables were more important in explaining factors affecting utilization of RHS by the youth in IDP camps by the use of the logistic regression model that takes the form of the equation below. This model was considered a good model to use in the analysis because the dependent variable was made dichotomous; coded as '1' for those utilizing reproductive health services and '0' for those not utilising reproductive health services and relationships were tested between the utilisation of reproductive health services and the different factors affecting it.

$$\ln \left[\frac{p}{q} \right] = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n$$

$$\text{Thus } p = \frac{e^{\beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n}}{1 + e^{\beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n}} \quad \text{Or } p = \frac{1}{1 + e^{-(\beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n)}}$$

Where P is the proportion of the youth that utilised reproductive health services (RHS)

$q = 1 - p$

$x_1, x_2, x_3, \dots, x_n$ are the factors affecting RHS

$\beta_0, \beta_1, \beta_2, \beta_3 \dots \beta_n$ are constants/coefficients of the factors

e = the mathematical constant approximated by 2.71828

CHAPTER FOUR

BACKGROUND CHARACTERISTICS OF THE YOUTH INTERVIEWED

4.1 Introduction

This Chapter presents the demographic and social characteristics of the youth in Palabek Kal IDP camp that participated in the study.

Information was collected on personal characteristics of the youth who were interviewed. The data collected included basic demographic characteristics such as age, sex and marital status. Social characteristics such as education background, occupation and religious affiliation were also collected.

4.1.2 Percentage distribution of respondents by sex

Of all the respondents who participated in the study, 63.7 percent of them were male and 36.3 percent were female as shown in Table 3.1.

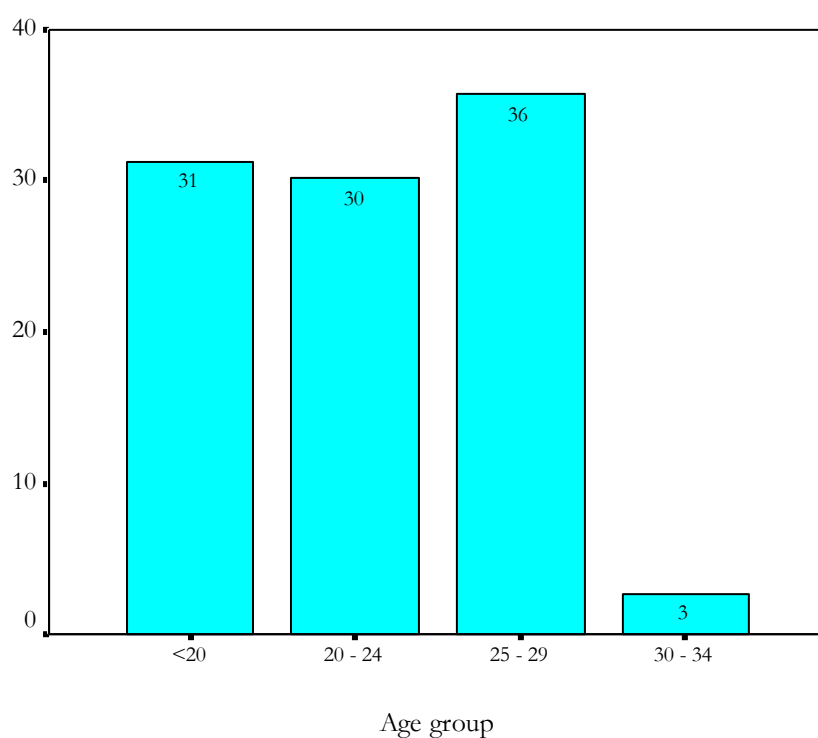
Table 3.1: Percentage distribution by sex

<i>Sex</i>	<i>Frequency</i>	<i>Percent</i>
Male	116	63.7
Female	66	36.3
Total	182	100.0

4.1.3 Percentage distribution of respondents by age

As shown in figure 2, about 31 percent of the respondents are less than 18 years and 30.2 percent are in the age bracket 19-23 years. Thirty five point seven percent of the respondents are in the age bracket 24-28 while 2.7 percent are between 29 and 33 years.

Figure 4.1: Percentage distributions of the youth by age



4.1.4 Percentage distribution of respondents by marital status

Table 3.3 shows the percentage distribution of the respondents by marital status. Sixty eight point one percent of the displaced youth who participated in the study were single and 26.9 percent were married. Those in consensual union comprised 2.8 percent while 1.1 percent and 0.5 percent were separated and widowed respectively.

Table 3.3: Percentage distribution of respondents by marital status

<i>Marital Status</i>	<i>Frequency</i>	<i>Percent</i>
Single	124	68.5
Married	49	27.1
Consensual union	5	2.8
Separated / Divorced	2	1.1
Widowed	1	0.5
Total	181	100.0

4.1.5 Highest level of education attained by respondents

Table 3.4 shows the highest level of education attained by the respondents. 4.4 percent of them did not attend any formal education while 30.2 percent attended up to primary level of education. Eleven percent and 4.4 percent of them attended up to tertiary education and university education respectively.

Table 3.4 Percentage distribution of respondents by highest level of education attained

<i>Level of education</i>	<i>Frequency</i>	<i>Percent</i>	<i>Comm. Percent</i>
No Education	8	4.4	4.4
Primary	55	30.2	34.6
Secondary	91	50	84.6
Tertiary	20	11	95.6
University	8	4.4	100.0
Total	182	100.0	

4.1.6 Main occupation of the respondents

Data was collected on the occupation each respondent was engaged in. Table 3.5 shows the distribution of the responses. One point one percent of the respondents were not engaged in any economic activity while 23.1 percent of them were peasant farmers. 5.5 percent of the respondents were commercial farmers, 6.0 percent were businesspersons, another 6.0 percent were public officers and 3.3 percent were casual labourers. Housewives, domestic servants and students represented 4.9 percent, 1.1 percent and 48.4 percent respectively. Those respondents who were engaged in other occupations represented 0.5 percent.

Table 3.5: Percentage distribution of respondents by main occupation

<i>Occupation</i>	<i>Frequency</i>	<i>Percent</i>
Peasant	42	23.1
Commercial farmer	10	5.5
Business person	11	6.0
Public officer	11	6.0
Casual labourer	6	3.3
House wife	9	4.9
Domestic servant	2	1.1
Student	88	48.4
Others	1	0.5
Total	182	100.0

4.1.7 Religious affiliation of respondents

Table 3.6 shows the distribution of respondents by religious affiliation. Majority of them were Catholic, represented by 57.1 percent. Those who confessed Protestant faith were second highest with 39.6 percent of the respondents. Muslims and the Baptist Church followers represented 1.6 percent each.

Table 3.6 Percentage distributions of respondents by religious affiliations

<i>Religion</i>	<i>Frequency</i>	<i>Percent</i>
Catholic	104	57.1
Protestant	72	39.6
Muslim	3	1.6
Baptist church	3	1.6
Total	182	100.0

4.2 Reproductive health problems faced by the youth in IDP camps

Reproductive health problems faced by the youth in IDP camps were identified. These included; risky, unwanted pregnancies and unsafe abortions, early sexual relations and pregnancies, lack of appropriate information on reproductive health, increased exposure to sexually transmitted infections (STIs) and limited reproductive health services.

4.2.1 Early Sexual activity

Early sexual activity was identified as one of the major problems experienced by the youth in IDP camps. Table 3.7 shows the age at which adolescent girls had their first sexual intercourse.

Table 3.7: Percentage distribution of respondents by age at which adolescents had their first sexual intercourse

<i>Age</i>	<i>Males</i>		<i>Females</i>		<i>Total</i>	
	<i>Freq</i>	<i>%age</i>	<i>Freq</i>	<i>%age</i>	<i>Freq</i>	<i>%age</i>
8-12	3	4.4	2	2.8	5	3.6
13-17	38	55.9	43	59.7	81	57.8
18-22	24	35.3	24	33.3	48	34.3
23-27	3	4.4	3	4.2	6	4.3
Total	68	100.0	72	100.0	140	100

From Table 3.7, the majority (57.8%) of the youth indicated that they had their first sexual intercourse between 13-17 years of age. According to the Ugandan constitution (1995), this is purely underage for sexual activities as they were below 18 years. 43.3% of the respondents reported to have had their first sexual intercourse at the age of about 20, while 5 and 6 of them had their first sexual activities at about the age of 10 and 25 respectively.

In an attempt to assess the level of sexual activities in the IDPs, respondents were asked whether they ever had sexual intercourse and the majority of them, (78.6%) reported that they had ever had sexual intercourse. Only 21.4% reported to have never had sexual intercourse.

The researcher went further to find out the circumstances under which the youth had their first sexual intercourse, and these circumstances are laid out in Table 3.8.

Table 3.8: Percentage distribution of respondents by circumstances under which they had their first sexual intercourse

<i>Circumstances</i>	<i>Males</i>		<i>Females</i>		<i>Total</i>	
	Freq	%age	Freq	%age	Freq	%age
Reward	8	21.6	72	67.3	80	55.5
Peer pressure	29	78.4	27	25.2	56	38.8
Defilement	0	0.0	6	5.6	6	4.2
Rape	0	0.0	2	1.9	2	1.5
Total	37	100.0	107	100.0	144	100

From Table 3.8, 55.5% of those who ever had sexual intercourse indicated that they had sex as a reward. About 39% had sexual intercourse due to peer pressure, while defilement and rape were also mentioned as some of the conditions under which the youth got into sexual relationships.

4.2.3 Early pregnancies

Early pregnancy is one of the most common problems among the adolescents world over. It has been found to be one of the problems prevailing among the youth in Kitgum district. Details of the results by age are presented in Table 3.9.

Table 3.9: Percentage distribution of respondents by age at which they got their first pregnancies or impregnated girls for the first time

<i>Age</i>	<i>Males</i>		<i>Females</i>		<i>Total</i>	
	Freq	%age	Freq	%age	Freq	%age
13-17	3	9.1	4	10.8	7	10

18-22	24	72.7	26	70.3	50	71.4
23-27	6	18.2	7	18.9	13	18.6
Total	33	100.0	37	100.0	70	100

It was found out that, the majority of the youth (71.4%) who became pregnant or impregnated a girl did so at the age of 18-22, which is actually a school-going age. This further means that the level of school drop-out is high due to this factor. This was followed by those within the age bracket of 23-27 with a response of 18.6%, while only 10% of the respondents got pregnant or impregnated a girl when they were within the age bracket of 13-17 years.

The researcher went further to find out the nature of pregnancy the respondents got and the results of the findings are given in Table 3.10.

Table 3.10: Percentage distribution of respondents by nature of pregnancy

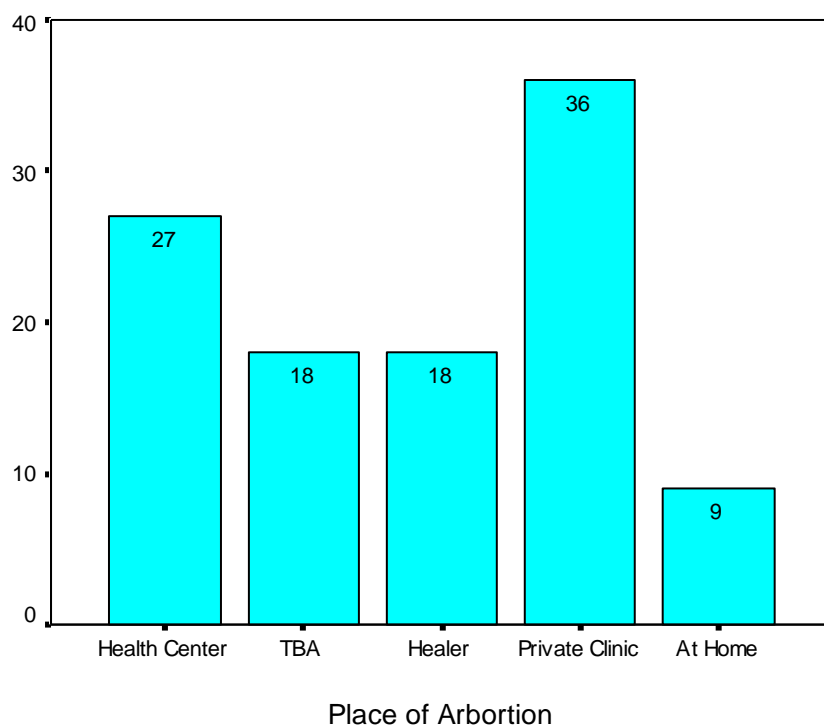
Response	<i>Ever been pregnant/impregnated</i>				<i>Planned Pregnancy</i>			
	Frequency	Males	Females	%age	Frequency	Males	Females	%age
Yes	71	19	52	39	32	11	21	45
No	111	68	43	61	39	36	19	55
Total	182	87	95	100	71	47	40	100

Results in Table 3.10 indicate that 39% of the respondents had ever got pregnant or impregnated a girl, while 61% of them had never. Of the 39% who had ever been pregnant or impregnated a girl, 45% of them had planned to get pregnant, while only 55% of them had unplanned pregnancies.

4.2.4 Abortion

The problem of abortion was also found to exist in the IDP camps. Of all the interviewed people, 6% of them were found to have carried out an abortion. When asked where they went for abortion services, the majority of them sought professional services as shown in figure 3.

Figure 4.2: Percentage distribution of respondents by where they went for Abortions



Results from figure 2 indicate that the majority (36%) of the respondents visited private clinics for abortion. Those who visited health centres for abortion comprised 27% of the respondents. Traditional birth attendants and traditional healers were each mentioned with a response of 18%, while only 2 people reported that they locally performed their abortion at home.

4.2.3 Access to Information on reproductive Health

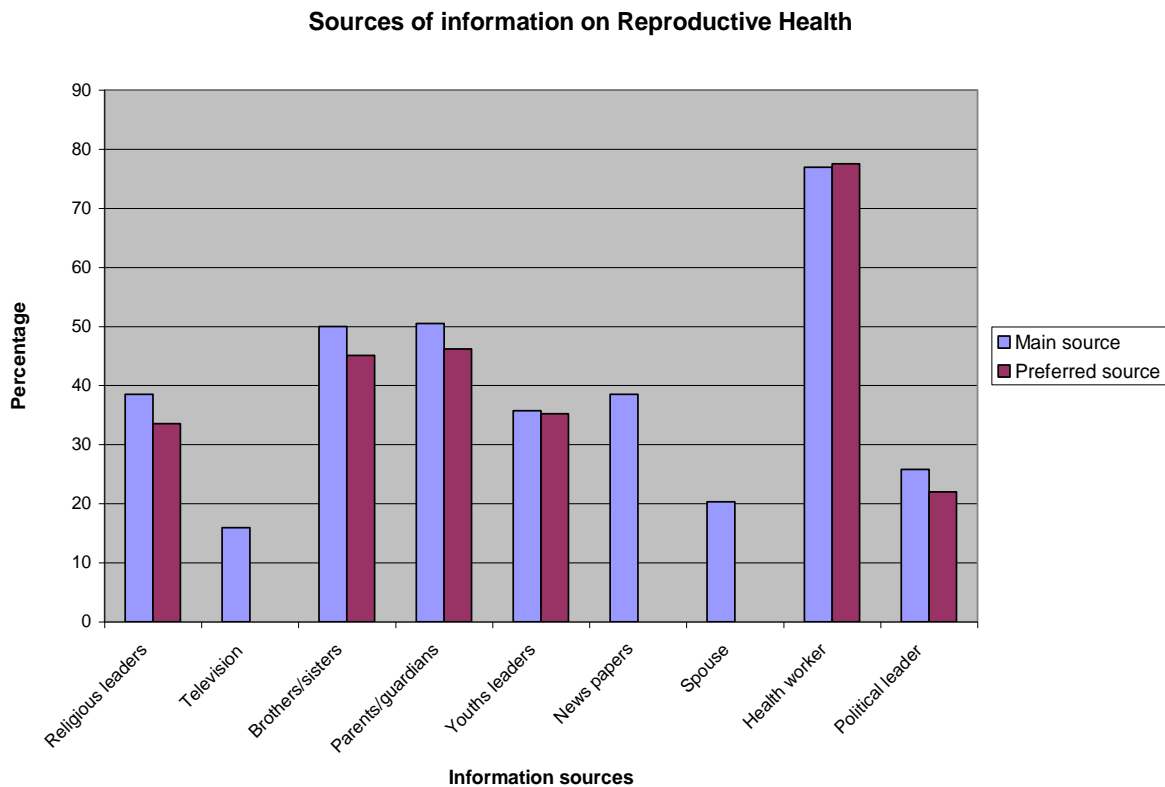
The study further sought to ascertain the awareness levels of adolescents on reproductive health services. Awareness of reproductive health services influences the accessibility of these services. The results on access to information, which leads to health services accessibility, are shown in Table 3.12.

Table 3.12: Percentage distribution of respondents by source of information on reproductive health

<i>Source of Information</i>	<i>Main source</i>		<i>Preferred source</i>	
	Frequency	Percentage	Frequency	Percentage
Radio	101	55.5	88	48.4
Peers	74	40.7	48	26.4
Teachers	72	39.6	62	34.1
Religious leaders	70	38.5	61	33.5
Television	29	15.9	-	-
Brothers/sisters	91	50	82	45.1
Parents/guardians	92	50.5	84	46.2

Youth leaders	65	35.7	64	35.2
News papers	70	38.5	-	-
Spouse	37	20.3	-	-
Health worker	140	76.9	141	77.5
Political leader	47	25.8	40	22

Figure 4.3: Source of information on reproductive health



It was found that the level of awareness about reproductive health services from various sources of information was generally low as the majority response was below average as indicated in Table 5.6. The major sources of information that indicated a positive response towards access to information by respondents were health workers with 76.9% and at the same time the preferred source with a response of 77.5%. However, when the researcher tried to probe further on how much the respondents interacted with the health workers to get information, it was found that due to high numbers of patients handled by health workers, the respondents were never given enough time to get adequate information from health workers. The radio was ranked as the second source of information about reproductive health services with 55.5% and at the same time, it was said to be the second most preferred source of information by 48.4% of the respondents.

Parents/guardians were also found to be a fairly good source of information about adolescents' health services with a response of 50.5% and most preferred by 42.6% as an information provider. Other sources

mentioned include; peers, teachers, religious leaders, television, siblings, youth leaders, newspapers, spouse, and political leaders.

4.3 Access to Reproductive Health Services

Adolescents' access to reproductive health services is influenced by the availability of such health services. The availability of health services also directly or indirectly influences other variables like awareness, utilisation and affordability.

4.3.1 Condom accessibility

An attempt was made to find out how sources of condoms influence their accessibility. Table 3.13 presents the findings of the sources of condoms in IDP camp.

Table 3.13: Percentage distribution of source of getting condoms

<i>Source of condoms</i>	<i>Frequency</i>	<i>Percentage</i>
Health centre	75	39.89
Shops	38	20.2
Private clinics	29	15.43
Partner	4	2.13
Friends	4	2.13
CBO	8	4.26
No where	30	15.96

The findings in Table 3.13 further show that most respondents (39.89%) got condoms from health centres, 20.2% got them from shops and 15.43% from private clinics. Other sources of condoms mentioned were friends and partner each with a response of 2.13%, while 4.26% indicated that they got condoms from Community Based Organisations (CBO). About 15.96% indicated that they did not get condoms from anywhere.

4.3.2 Condom awareness and use

Respondents were asked whether they had ever used a condom during their sexual encounter and the results from their responses are given in Table 3.14.

Table 3.14: Percentage distribution of respondents by ever heard of, ever seen and ever used condoms

<i>Responses</i>	<i>Ever heard of a condom</i>		<i>Ever seen a condom</i>		<i>Ever used a condom</i>		<i>Used condom in last sexual encounter</i>	
	Freq	%age	Freq	%age	Freq	%age	Freq	%age
Yes	171	94	169	92.9	105	57.7	51	28
No	11	6	13	7.1	77	42.3	161	72
Total	182	100	182	100	182	100	182	100

The findings from Table 3.14 indicate that the majority (94%) of the respondents had ever heard of a condom, while 92.9% of them had ever seen it. However, only 57.7% of them indicated that they had ever used condom while 28% of them had also used it during their last sexual encounter.

4.4 Attitudes of the Youth towards Reproductive Health Services

The study further sought to assess the attitudes of the youth towards the use of reproductive health services. The attitudes of the youth towards the use of reproductive health services influence utilisation of these services. It was found out that, the attitude of the youth towards the use of reproductive health services was generally negative.

4.4.1 Condom use During Sexual Intercourse

The level of condom use during sexual intercourse among the youth was assessed. It was found out that, the majority (66.7%) of the respondents were not always using condoms while only 33.3% of them used condoms during sexual intercourse. When the respondents were asked to tell the reasons why they never used condoms, some of the reasons given are shown in the Table 3.15.

Table 3.15: Percentage distribution of respondents by reasons for not using condom always

<i>Reasons</i>	<i>Frequency</i>	<i>Percentage</i>
Partner refused	7	5.83
Does not fit him	5	4.17
Expensive	9	7.5
Trust partner	47	39.17
Do not enjoy sex with it	5	4.17
Not available	30	25
Do not think about it	17	14.17

From Table 3.15, 39.17% of the respondents indicated that they did not use a condom because they trusted their partners that they didn't have HIV/AIDS. 25% of them reported that condoms were not available because they needed to be bought and they didn't have the money to buy the condoms. Other reasons mentioned are: the partner refused, condoms were expensive, did not think about the condoms, condom could not fit him and lastly, the respondents could not enjoy sex with the condom.

The respondents were further asked whether they had used a condom during their last sexual encounter and only 28% of the respondents indicated that they had used a condom during their last sexual encounter, while 72% of them had not. The reasons given as to why they did not use condom during their last sexual encounter are presented in Table 3.16.

Table 3.16: Percentage distribution of respondents by reasons for not using condom in the last sexual encounter

<i>Reasons</i>	<i>Frequency</i>	<i>Percentage</i>
Don't enjoy sex with a condom	6	7.60
Condoms are unnatural	3	3.80
Partner refused	7	8.86
Religion forbids it	7	8.86
Wanted to get pregnant	4	5.06
Condom not available	16	20.25
Cost of condom high	2	2.53
Trust my partner	32	40.51
Interference with performance	2	2.53

Results in Table 3.16 show that, 40.51% of the respondents reported that trusting their partners of not having the HIV/AIDS virus was the reason for not using a condom.

The respondents were further asked whether their partners had ever refused to use a condom during sexual intercourse and (38.5%) out of the 78.6% who had ever had sexual intercourse, indicated that their partners had refused to use a condom. Some of the reasons indicating why the partners refused to use a condom are given in Table 3.17.

Table 3.17: Percentage distribution of respondents by reasons for partner refusing to use a condom

<i>Reasons</i>	<i>Frequency</i>	<i>Percentage</i>
Wanted to get pregnant	15	23.44
Trusted partner	42	65.62
Fear that it might remain in them	7	10.94

Results in Table 3.17 indicate that 65.62% of the respondents indicated that they refused to use a condom because they trusted that their partners never had HIV/AIDS and other related Sexual Transmitted Diseases (STDs). 23.44% indicated that they wanted to get pregnant, while 10.94% feared that the condom might remain in them.

4.4.2 Plans for using a condom in future

The study sought to further investigate whether the respondents had any plan to use a condom in future and still the majority (50.5%) indicated that they had no plan to use a condom in future during sexual intercourse. Only 49.5% indicated that they planned to use a condom during their sexual relationship. Some of the reasons given by those who planned to use a condom are presented in Table 3.18.

Table 3.18: Percentage distribution of respondents by reasons for planning to use condom in future

<i>Reasons</i>	<i>Frequency</i>	<i>Percentage</i>
Protect against HIV/AIDS	91	48.66
Protect against STI	25	13.37
Protect against pregnancy	71	37.97

Results from Table 3.18 indicate that 48.66% of the respondents planned to use condom in order to protect themselves against HIV/AIDS. 13.37% of them wanted to protect themselves against other STDs, while 37.97% wanted to protect themselves against pregnancy.

4.5 Utilisation of Reproductive Health Services by the Youth

In light of the levels of utilisation of reproductive health services, respondents were asked about whether they had ever utilised the existing services. It was established that utilisation of health services is affected by the awareness levels of the youth on reproductive health services, availability of these services and other socio-economic factors.

4.5.1 Levels of utilisation of reproductive health services.

The level of utilisation of reproductive health services was generally found to be low. Results of the investigation are presented in Table 3.19.

Table 3.19: Percentage distribution of respondents by level of receiving health care services

<i>Response</i>	<i>Pregnant now</i>		<i>Receive ante-natal care</i>		<i>Given injection for tetanus</i>	
	Freq	%age	Freq	%age	Freq	%age
Yes	27	14.8	24	13.2	24	13.2
No	155	85.2	158	86.8	149	81.9
Total	182	100	182	100	182	100

The findings in Table 3.19 indicate that 13.2% of the female youth, who were pregnant, received antenatal care services and at the same time were given a tetanus injection. When asked to tell where they were getting the reproductive health services from, 18.7% indicated that, they got them from health centre, while 2.2% indicated that they got them from a private clinic and 1 person indicated that she got the services from a Traditional Birth Attendant (TBA); Table 3.20.

Table 3.20: Percentage distribution of respondents by where antenatal care is obtained

<i>Source of ante-natal care</i>	<i>Frequency</i>	<i>Percentage</i>
Health centre	34	18.7
Private clinic	4	2.2
TBA	1	0.5

4.5.2 Awareness and utilisation of reproductive health services

The study further sought to ascertain the awareness levels of the youth of the of the reproductive health services in relation to their utilisation. It was generally found out that much as the awareness levels were generally low, they were far higher than the levels of utilisation. Also identified was that there is a significant relationship between the levels of awareness and the levels of utilisation of reproductive health services as indicated in Table 3.21.

Table 3.21: Relationships between Family planning methods ever heard of and used by the respondents

Family planning methods	Never heard of the method		Ever heard of the method		Ever used the method	
	Freq	%age	Freq	%age	Freq	%age
Pills	69	37.9	113	62.1	98	53.8
Intra Uterine Device (IUD)	158	86.8	24	13.2	10	5.5
Injectables	127	69.8	55	30.2	30	16.5
Diaphragms	148	81.3	34	18.7	2	1.1
Condoms	50	27.5	132	72.5	102	56.0
Foam and Jelly	174	95.6	8	4.4	0	0.0
Male sterilization	163	89.6	19	10.4	1	0.5
Female sterilization	159	87.4	23	12.6	0	0.0
Withdrawal	154	84.6	28	15.4	15	8.2
Abstinence	141	77.5	41	22.5	18	9.9
Breast-feeding	129	70.9	53	29.1	20	11.0

The results in Table 3.21 indicate that the level of awareness was high especially on condom use at 72.5% and pills (62%). It is only 4% that have ever had of form and jelly as a form of family planning method and no one ever used it. Other methods of family planning that were highly known in the IDPs were injectables, diaphragm, withdrawal, breastfeeding and abstinence methods.

4.5.3 Effect of socio-demographic factors to utilisation of reproductive health services

The study further analysed the effect of socio-demographic variables to the utilisation of reproductive health services. A cross-tabulation of socio-demographic variables and the family planning methods was performed using the chi-square and it was found that there was a significant association between some of these factors and the use of reproductive health services.

Table 3.22: Relationships between socio-demographic variables and Condom use

	Socio-demographic variable	Condom use				
		Ever Used	Never Used			
1.	Sex	Frequency (Row %)	Frequency (Row %)	d.f	X ²	P-value
	Male	72 (88.9)%	9 (11.1%)	1	16.11	0.000
	Female	30 (58.8%)	21 (41.2%)			
2.	Age					
	<20	21 (52.5%)	19 (47.5%)	2	20.802	0.000
	20 – 29	51 (91.1%)	5 (8.9%)			
	30+	30 (83.3%)	6 (6.7%)			
3.	Level of Education					
	Primary	7 (31.8%)	15 (68.2%)	2	43.863	0.000
	Secondary	15 (60%)	10 (40%)			
	Higher Education	80 (94.1%)	5 (5.9%)			
4.	Marital Status					
	Never Married	42 (41.2%)	60 (58.8%)	1	0.286	0.593
	Married or ever married	14 (46.7%)	16 (53.3%)			
5.	Occupation					
	Not employed (Student)			2		

The results of the study revealed that marital status highly affect condom usage as seen in table 3.22 above. Sex, age group and level of education were found to be significantly affecting condom usage at 5 percent level of significance while occupation had no significant affect on condom use.

Table 3.23: Relationships between socio-demographic variables and pills

	Socio-demographic variable	Pills usage		Chi square results		
		Ever Used	Never Used			
1.	Age	Frequency (Row %)	Freq (Row %)	d.f	X ²	P-value
	<20	6 (60%)	4 (40%)	2	8.124	0.017
	20 – 29	67 (91.8%)	6 (8.2%)			
	30+	25 (83.3%)	5 (16.7%)			
2.	Source of Income					
	Dependant	28 (77.8%)	8 (22.2%)	1	4.585	0.032
	Non dependant	70 (92.1%)	6 (7.9%)			
3.	Marital status					
	Never married	17 (65.4%)	9 (34.6%)	1	13.360	0.000
	Ever married	81 (93.1%)	6 (6.9%)			
4.	Occupation					
	Student	6 (54.5%)	5 (45.5%)	2	11.726	0.003
	Private employed	40 (87%)	6 (13%)			
	Public officer	52 (92.9%)	4 (7.1%)			

Both age groups, source of income, marital status and occupation were found to be significantly affecting pills usage, though marital status was highly significant as shown above.

Table 3.24: Relationships between socio-demographic variables and Breast feeding

	Socio-demographic variable	Breast Feeding Method of Family Planning		Chi square results		
		Ever Used	Never Used			
1.	Source of income	Freq	Freq	d.f	X ²	P-value
	Dependant	7 (21.9%)	25 (78.1%)	1	8.647	0.003
	Non dependant	13 (61.9%)	8 (38.1%)			
3.	Marital status					
	Never married	14 (40%)	21 (60%)	1	0.225	0.635
	Ever married	6 (33.3%)	12 (66.7%)			
4.	Occupation			1	4.523	0.033
	Employed	8 (25.8%)	23 (74.2%)			
	Not employed	12 (54.5%)	10 (45.5%)			

Marital status of the people was found to be high significant factor affecting breastfeeding method of family planning. Source of income and age however, were also found to be significantly affecting the breastfeeding method at 5% level of significance.

Table 3.25: Relationships between education levels and withdrawal

Socio-demographic variable	Withdrawal method of Family Planning		d.f	X ²	P-value
	Ever Used	Never Used			
Education level	Frequency (Row %)	Frequency (Row %)	1	0.619	0.431
Secondary and below	8 (61.5%)	5 (38.5%)			
Above Secondary	7 (46.7%)	8 (53.3%)			

The level of education was found to be a significant factor in the withdrawal method at 5% level of significance.

4.5.4 Logistic regression model description

In this logistic regression model, the dependent variable considered was the utilisation of reproductive health services. The researcher considered these characteristics to define the utilisation of RHS;

- *If any one was found using any of the specified birth control methods or*
- *Going for counselling or*
- *Uses any of the antenatal, delivery, postnatal services*

Then that respondent was considered to be utilising the RHS and was given a score “1”. On the other hand anyone who never had any of the characteristics mentioned above was assigned a score “0” which denotes non-utilisation of reproductive health services. The variable for the utilisation of RHS was then regressed on the different selected factors that affected it to check the strength they had on RHS. All the different factors were considered and they are;

- *Age (this was a numerical variable); this is represented by X_1*
- *Sex (where “0” represented females and “1” represented male); this is represented by X_2*
- *Education level (This was taken as a 1=At least Primary Education and 0=No education at all); this is represented by X_3*
- *Marital status (Married or ever married =1, Never married = 0); this is represented by X_4*
- *Employment status (Employed =1, unemployed =0); this is represented by X_5*

Table 3.26: Significance of some selected factors affecting utilisation of reproductive health services (RHS) by the youth in IDP camps in Kitgum district.

Utilisation of RHS	Coefficient	Std. Err.	z	P>z	95% Confidence Interval	
Age (yrs)	0.0534976	0.0493801	1.08	0.279	-0.0432856	0.1502807
Sex	-0.0377357	0.3551294	-0.10	0.918	-0.7327765	0.659305
Education level	0.6629776	0.1834982	3.61	0.000	1.022627	0.3033277
Marital Status (Singles)	0.3362988	0.3817296	0.88	0.378	-0.4118774	1.084475
Employment status	0.0756421	0.3591228	0.21	0.833	-0.6282257	0.77951
Constant	0.4806612	1.097659	0.44	0.661	-1.670712	2.632034

The resulting logistic regression model becomes;

$$\ln \left[\frac{p}{q} \right] = 0.481 + 0.053 x_1 - 0.038 x_2 + 0.663 x_3 + 0.336 x_4 + 0.0756 x_5$$

$$\text{This becomes; } P = \frac{1}{1 + e^{-(0.481 + 0.053 x_1 - 0.038 x_2 + 0.663 x_3 + 0.336 x_4 + 0.0756 x_5)}}$$

Computations and Interpretation of each factor

The researcher computed and interpreted the results using p-value approach to hypothesis testing and logistic regression. The decision for rejecting null hypothesis in the p-value approach follows that: if the p-value is greater or equal to $\alpha=0.05$, the null hypothesis is not rejected but if the p-value is less than α , the null hypothesis is rejected. A combination of different factors was compiled, which included age, sex, marital status, employment status and educational level attained.

4.5.4.1 Sex- Hypothesis Testing

H_0 : *Utilisation of Reproductive Health Services doesn't depend on gender type of the displaced youth.*

H_a : *Gender of the displaced youth determines the utilisation trends of Reproduction Health Services*

The p-value obtained for this variable is 0.9204, which is greater than α . The null hypothesis is therefore not rejected. This therefore means that utilisation of reproductive health services doesn't depend on the sex of the displaced youth.

4.5.4.2 Education level - Hypothesis Testing

H_0 : *Utilisation of Reproductive Health Service is not determined by the levels of Education of displaced youth.*

H_a : *Utilisation of Reproductive Health Services is determined by the Education levels of displaced youth.*

A p-value for educational level attained was found to be 0.0003 which is less than α . With these computations thus the null hypothesis that summarily states that the education level doesn't affect utilisation of RHS in IDP camp was rejected and H_a which states that Utilisation of Reproductive Health Services is determined by the Education levels of youth in IDP camp was accepted.

4.5.4.3 Marital status Hypothesis Testing

H_0 : *Utilisation of Reproductive Health Service is not dependent on the marital status of IDP youth.*

H_a : *Utilisation of Reproductive Health Services is dependent on marital status of the IDP youth.*

As illustrated in table 3.26, the corresponding p-value was found to be 0.378 which was greater than α . Therefore the null hypothesis is not rejected. The implication is that utilisation of reproductive health services is not dependent on marital status of the displaced youth.

4.5.4.4 Employment Status Hypothesis Testing

H_0 : *Utilisation of Reproductive Health Service is not determined by the employment status of IDP youth.*

H_a : *Utilisation of Reproductive Health Services is determined by employment status of IDP youth.*

The p-value for this factor was found to be 0.833 which is greater than $\alpha=0.05$. The null hypothesis is therefore not rejected. This implies that those who are employed utilise RHS as much as those who are not employed. Having rejected H_a and accepted H_o , we conclude that employment status has no significant effect on how the IDP youth utilise reproduction health services.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Summary of findings

5.1.1 Sex

Gender is an important factor in understanding youth reproductive health behaviour and attitudes. Generally, males are more likely to initiate sexual intercourse and more permissive on sex than females. From the research findings and computations we can conclude that male IDP youth in Palabek Kal so often will utilise Reproductive Health Services as much as female IDP youth would. This means therefore that gender does not actually determine the utilization of RHS in an IDP setting.

5.1.2 Education

The level of education attained by an individual in relation to utilisation of reproductive health services remains unquestionable even in an IDP setting. The higher the level of education an IDP youth has obtained, the more possibilities that he or she will utilise Reproductive Health Services. Critical analysis illustrates that the IDP youth that have attained primary, tertiary or secondary education often approach and use reproductive health facilities. From these establishments it is evident and imperative that in order to make utilisation of Reproductive Health Services very effective, policies have to be geared towards promoting education in the IDP camps.

5.1.3 Marital Status

Following the standard hypothetical rule of not rejecting H_0 once the P-Value is greater than α , with a high level of precision we could conclude that disparities in the marital status are not the determinants of Utilisation of Reproduction Health Services. Indications for such a finding could be attributed to the fact that the partners have always encouraged each other to embrace reproductive health services whether married or not.

5.1.4 Employment Status

Displaced youth are frequently idle and may be more willing to engage in non-productive activities like drinking, gambling, theft and others. During this study, data was collected on occupation each respondent was engaged in. Most of them, 23.1% and 48.4% represented peasant farmers and students respectively. The little income that is got by those who are engaged in some kind of activities is normally spent on basic commodities such as food. Since most of the reproductive health services are sought from private clinics

and government hospitals at some cost, the youth normally find these services unaffordable leading to low utilisation.

5.2 Conclusions

The study was carried out to assess the utilisation of reproductive health services by youth in internally displaced people's camps in Kitgum district. The study represents an important contribution in the field of reproductive health in conflict situations where the issue is the gap between availability of quality reproductive health services and utilisation. It also goes further in identifying the factors that hinder effective utilisation of reproductive health services by the youth in IDP camps. From the findings of this study, the following conclusions can be drawn:

- 1) The study concluded that factors such as gender, age distribution, education levels, marital status, and employment status were significant determinants of the level of utilisation of reproductive health services by the youth in Palabek IDP camp.
- 2) The majority of the youth (57.8%) were found to have engaged in early sexual activities at an average age of 15 years old as shown in table 3.7 above. It was further found out that most of them had been lured into sex as a result of expecting a reward (55.5%) from men as shown in table 3.8. Early pregnancy was found to be one of the problems faced by the youth in the area of study. The highest age category faced by this problem was 18-23 years, which is a high school-going age. Abortions were also found to be a common problem with some of them performed by traditional healers and at their homes without qualified medical personnel. The other problem was lack of access to adequate information on reproductive health services. Apart from health worker and Radio, which were mentioned as having been the most used sources of information, there were also problems associated with the lack of ample time for the health workers to interact with the respondents. Furthermore, radio use also had a problem of respondents having ability to buy dry cells.
- 3) The manner in which reproductive health services are accessed by the youth was also assessed. Condom accessibility and the level of awareness about reproductive health services were high. At least 94% indicated that they had ever heard of a condom, 92.9% had ever seen it, while 57.7% had ever used it as shown in table 3.14 above.
- 4) The attitudes of the youth towards the use of reproductive health services were generally found to be negative. About sixty seven percent were found not to be using a condom during sexual intercourse and the main reason being that, they trusted their partners. However, they indicated that they would use a condom in future to protect themselves from HIV/AIDS infection.

5) The utilisation of reproductive health services was found to be generally low. This was due to the fact that the youth generally had negative attitudes towards the use of reproductive health services like the use of condoms during sexual intercourse. The utilisation of reproductive health services was also found to be affected by the level of awareness, mainly on the family planning methods as shown in Table 15 above. Also important to note is that the level of utilisation of reproductive health services was significantly influenced by some of the socio-economic factors like sex, age, level of education attained, marital status and one's employment status as presented in Table 3.26 above.

5.3 Recommendations

The conclusions above lead to the following recommendations for future consideration:

1. Both formal and informal sex education programs should be increased. IDP youth need to be provided with basic information on sexuality and reproductive health. In an IDP setting, formal education was found to be limited and so information about reproductive health must be communicated in creative ways such as sports, video shows and drama. Since sex education has been proven to lead to safe behaviour and does not encourage early or increased sexual activity, IDP youth should be informed about STDs and HIV/AIDS. Appropriate advice and supplies should be made available to them so that they develop skills that enable them make informed, responsible decisions about their sexual behaviour. For those IDP youth who do not attend school and are destined to marry very early in life, social workers should be allowed to make frequent visits to their homes and discuss matters relating to reproductive health.
2. Displaced young people should have access to a variety of commercial, private, NGO and public health services, where they can receive respectful and confidential treatment for their reproductive health needs. A careful balance should be made in using recreational activities to attract displaced youth for reproductive health services to prevent diversion from, and under utilisation of, the reproductive health services.
 - a. Condoms should be encouraged as the social norm for sexually active displaced youth;
 - b. Emergency contraception should be publicised and made available to displaced youth;
 - c. Because some health facilities exist and because some displaced youth use them, efforts should be made to make those clinics and health centers youth friendly.
3. Community development workers should train the youth on various reproductive health services and family planning methods, how to access them and the effective ways of using these reproductive

health services. This can take a trend of training peer educators who can eventually train others in order to realise adequate coverage among the youth. The displaced youth should be viewed as assets within reproductive health programs, which should be responsive to their needs and seek their active involvement. Involvement of youth in program design helps assure program relevance, ownership and participation.

4. Gender equity and fairness should be promoted in accessing and utilising reproductive health services in IDP camps. This can be achieved by integrating reproductive health services for males into female primary health care. This is hoped to increase the number of both male and female clients and reduce the cost per client.

5. Vocational training should be encouraged to increase the productivity of IDP youth and enable them earn some income. This will in turn make them engaged in doing something more productive than getting involved in early sexual activities.

6. The government of Uganda through its service delivery agencies should put in place programmes aimed at providing reproductive health services to the youth in Kitgum district. This implies the integration of reproductive health and reproductive rights into all related development priorities and programmes.

7. The government of Uganda together with other Agencies working with displaced people should help in the identification of reproductive health needs of youth in IDP camps and select areas of priority for immediate intervention. There is also need to evaluate the current programmatic responses to the needs identified and assess the potential for improvement and avoid overlap.

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MAKERERE UNIVERSITY - KAMPALA
INSTITUTE OF STATISTICS AND APPLIED ECONOMICS

**ACCESSIBILITY AND UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY THE
 YOUTH IN PALABEK KAL DISPLACED PEOPLES CAMP.**

Questionnaires

ID Number

Interviewer's Name _____ Date _____

Confidentiality and Consent

I am from Makerere University Kampala. I am conducting a study on accessibility and utilisation of reproductive health services by the youths in Palabek Kal Displaced people's camp. I am going to ask you some questions some of which may be personal and some people may find difficulties in answering. Your answers will be treated confidential. I am not going to write your name on the form and neither shall I use your name in connection with the information you will provide. You do not need to answer any questions that you do not want to and you may end this interview any time you may wish to. Your refusal to answer any questions will not be held against you. However your participation and provision of honest answers to these questions will help me better understand what people think and know about some reproductive health problems affecting displaced youths. I would highly appreciate your help in responding to these questions.

SECTION A: BACKGROUND INFORMATION

101. Sex of respondent.

Male 1

Female 2

102. What is your religious affiliation?

Catholic 1

Protestant 2

Muslim 3

Others (specify)..... 4

103 How old were you at your last birthday? (Age in completed years.....)

104 In what month and year were you born?

Month

Year

104 Have you ever attended school?

Yes 1

No 2 (Go to question 106)

105. What is the highest level of education you have attained?

Primary 1

Secondary 2

Tertiary 3

University 4

106. What is your marital status?

Single 1

Married 2

Consensual union 3

Separated/Divorce 4

Widowed 5

107. What is your main occupation?

Peasant 1

Commercial Farmer 2

Business person 3

Public Officer 4

Casual Labourer 5

Housewife 6

Domestic servant 7

Student 8

Others (specify)..... 9

None 10

108. What is your main source of income?

- Agriculture 1
- Civil servant 2
- Commerce 3
- Service industry 4
- None (dependent) 5
- Other (specify).....6



SECTION B: SOURCES OF INFORMATION ON REPRODUCTIVE HEALTH

201. What are your main sources of reproductive health information? *(Tick the appropriate responses)*

- (a) Radio (e) Television (i) Newspapers
- (b) Peers (f) Brothers/sisters (j) Spouse
- (c) Teachers (g) Parents/Guardians (k) Health workers
- (d) Religious leaders (h) Youth leaders (l) Political leaders
- (m) Others (specify).....

202. From which source would you prefer to get information on reproductive health issues? *(Tick the appropriate responses).*

- (a) Radio
- (b) Peers
- (c) Teachers
- (d) Religious leaders
- (e) Brothers/Sisters
- (f) Parents/Guardians
- (g) Youth leaders
- (h) Health workers
- (i) Political leaders
- (j) Others (specify).....

203. Whom do you talk to about your problem when you have reproductive health problems?

.....

SECTION C: SEXUAL BEHAVIOUR

301. Have you ever had sexual intercourse?

Yes 1

No 2 (Go to 304)

302. How old were you when you first had sexual intercourse?

(Age in completed years).....

303. Under what circumstances did you have sex the first time?

Rape 1

Peer pressure 2

Reward 3

Defilement 4

Mutual consent 5

Drunk 6

Other (specify)..... 7

304. Have you ever heard of a condom?

Yes 1

No 2 (Go to Section D)

305. Have you ever seen a condom?

Yes 1

No 2 (Go to Section D)

306. Have you ever used a condom?

Yes 1

No 2 (Go to 309)

307. Did you use a condom in your last sexual encounter?

Yes 1 (Go to 309)

No 2

308. Why did you refuse to use a condom on that occasion?

Don't enjoy sex with condoms 1

Condoms are unnatural 2

Partner refused 3

Religion forbids 4

I wanted to get pregnant 5

Condom not available 6

Cost of condoms high	7	<input type="checkbox"/>
Trust my partner	8	<input type="checkbox"/>
Other (specify).....	9	

309. Are condoms always accessible when you need them?

Yes	1	
No	2	

310. Do you always use a condom?

Yes	1	(Go to question 313)
No	2	

311. Why don't you always use a condom when having sex?

Partner refuses	1	
Does not fit me	2	
Expensive	3	
Trust partner	4	
Do not enjoy sex with it	5	
Not available	6	
Do not think about it	7	<input type="checkbox"/>
Others (specify).....	8	

312. Has a partner of yours ever refused to use a condom?

Yes	1	
No	2	(Go to question 315)

313. Why did that partner of yours refuse to use a condom?

Wanted to get pregnant	1	
Condom not available	2	
Cost of condom high	3	<input type="checkbox"/>
Trusted me	4	
Other (specify).....	5	

314. Would you use a condom in future?

Yes	1	
No	2	(Go to Section D)
Don't know	3	

315. Why would you use a condom in future?

Protect against HIV/AIDS	1	
Protect against STI	2	<input type="checkbox"/>

- Protect against pregnancy 3
- Others (specify)..... 4

316. Where in this area can you get a condom?

- Health center 1
- Shops 2
- Private clinic 3
- Partner 4
- Friends 5
- Community-based organisation 6
- No where 7
- Other (specify)..... 8

SECTION D: PREGNANCY

401. Have you ever been pregnant/made someone pregnant?

- Yes 1
- No 2 (Go to Section E)

402. How old were you at the first pregnancy/when when you made someone pregnant for the first time?

403. Was the pregnancy planned?

- Yes 1
- No 2

404. Have you ever had an abortion?

- Yes 1
- No 2 (Go to 407)

405. Where did you go to have this abortion?

- Health Center 1
- Traditional Birth Attendant 2
- Traditional Healer 3
- Private clinic 4
- Remained at home 5
- Others (specify).....6

406. Who performed the abortion?

- A trained health worker 1
- Traditional birth attendant 2
- Traditional healer 3
- Nursing Aids 4
- No body assisted 5
- Parents/relatives 6
- Partner 7
- Other (specify).....8

407. Are you pregnant now/Do you have someone you have made pregnant currently?

- Yes 1
- No 2 (Go to Section E)

408. If yes, are you/ is she receiving antenatal care?

- Yes 1
- No 2

409. Where do you/ does she go for antenatal care?

- Health center 1
- Private clinic 2
- TBA (Traditional Birth Attendant) 3
- Others (specify)4

410. During these visits are you/is she given an injection in the arm to prevent the baby from getting tetanus?

- Yes 1
- No 2

SECTION E: CONTRACEPTION

501. Have you ever heard about Family Planning?

- Yes 1
- No 2 (End the interview)

502. What methods have you heard of? (*Circle the appropriate responses*)

- (a) Pill
- (b) IUD (Intra Uterine Device)
- (c) Injectables
- (d) Implants
- (e) Diaphragm
- (f) Condoms

- (g) Form and Jelly
- (h) Male sterilisation
- (i) Female sterilisation
- (j) Withdrawal
- (k) Abstinence
- (l) Breast-feeding
- (m) Others (specify).....

503. Have you ever used any of these methods?

Yes 1

No 2 (End the interview)

504. Which of these methods (the ones you have just mentioned) have you ever used?

(Circle the appropriate responses)

- (a) Pill
- (b) IUD (Intra Uterine Device)
- (c) Injectables
- (d) Implants
- (e) Diaphragm
- (f) Condoms
- (g) Form and Jelly
- (h) Male sterilisation
- (i) Female sterilisation
- (j) Withdrawal
- (k) Abstinence
- (l) Breast-feeding
- (m) Others (specify).....
- (n) None

THANK YOU FOR ACCEPTING TO ANSWER THESE QUESTIONS