MAKERERE UNIVERSITY

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY TEENAGE MOTHERS AT NAGURU TEENAGE INFORMATION AND HEALTH CENTRE

BY

KANDOLE DAISY

15/U/5711/PS

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SEPTEMBER 2018
DECLARATION

I, Kandole Daisy declare that this research proposal has not been presented anywhere or to any university for similar or any other degree award.

Signature:........................................ Date:02/10/2018

Kandole Daisy

15/U/5711/PS

B/SWSA
APPROVAL

This approval is to certify that this dissertation has been submitted to Makerere University as partial fulfilment for the award of the degree of Bachelors of Social Work and Social Administration of Makerere University.

Signature: _______________________________ Date: 9/28/2018

David Kaawa-Mafgiri, PhD, MPH
Supervisor
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ABSTRACT

Despite the efforts that have been made to improve the access to sexual and reproductive health services, teenage mothers still have an unmet need for these services and access still remains limited. This study therefore analysed the access to sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre. The centre was chosen because it offers sexual and reproductive health services to young people and has over the years registered an increase in teenagers who test positive for pregnancy. The specific objectives of the study were to find out the level of knowledge and awareness of sexual and reproductive health services of teenage mothers at NTHIC, to examine the factors influencing the access to sexual and reproductive health services by teenage mothers at NTHIC, and suggest ways of improving the access to sexual and reproductive health services from the teenage mothers point of view. The study had a sample of 25 teenage mothers who were between 14-19 years, selected using purposive sampling and from whom data was collected using in depth face to face interviews guided by unstructured questionnaires.

After data was qualitatively analysed, it was found that the access to sexual and reproductive health services by teenage mothers still left a lot to be desired. The results showed that there is a still a knowledge gap when it comes to the level of knowledge and awareness of sexual and reproductive health services, which is exposed due the fact that teenage mothers are misinformed and have so many misconceptions about SRHS. Despite the little they know about the services, there are factors that can negatively influence their access to sexual and reproductive health services. However, it was noted that these teenage mothers recognise the need for improvement in access to these services, given they could point out a few credible suggestions in order to achieve this. The study was concluded by making recommendations that can improve the access to sexual and reproductive health services by teenage mothers.
CHAPTER ONE: INTRODUCTION

1.0: Introduction

This chapter provides a general introduction to the topic under research which is ‘Access to sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre.’

1.1: Background of the Study

Teenage motherhood has become one of the pressing issues in the World today. It occurs as a result of teenage pregnancies which are caused due to different factors like for example poverty, ignorance, child marriage, sexual abuse, and so on. About 16 million girls aged 15 to 19 and some 1 million girls under 15 give birth every year- most in low and middle income countries (World Health Organisation, 2014). Among the 21 countries with complete statistics, the pregnancies rate was highest in the United States and the lowest rate in Switzerland. Rates were higher in some soviet countries with incomplete statistics; they were highest in Mexico and Sub-Saharan African countries. (Sedgh.G, 2015). Today, however, countries in Africa have the highest teenage pregnancy rate in the world. By 2016, there were over 21 million pregnancies among adolescent girls aged 10-19 in developing countries, with Africa having an estimate 45% of unintended ones. (World Health Organisation, 2017) In Uganda, teenage pregnancy has been persistent with a light decline from 43% in 1995 to 31% in 2001, to 25% in 2006 and to 24% in 2011 (Uganda Bureau of Statistics, 2006; Uganda Bureau of Statistics, 2011). According to the UDHS 2011, teenage pregnancies were highest in the east, central and Karamoja regions (30%) compared to other regions with the southwest region having the lowest (15%) and central the second lowest to 19% (Uganda Bureau of Statistics, 2011). However, the UDHS 2016 states that the rate of teenage pregnancy in the country has gradually increased from 24% to 25% where adolescents between the age of 15-19 have began child bearing (Uganda Bureau of Statistics, 2016). teenage bearing is more common in rural than urban areas, the survey that was carried out also indicated that the teenage pregnancies reduced with increase in level of education and income status.

Young people in Uganda face various sexual and reproductive health risks, especially those living in urban slums and teenage pregnancies are one of them. Due to the negative consequences that come along with teenage pregnancies, it is therefore important for these
young mothers to have complete access to sexual and reproductive health services. These services may include sexual education, access to contraceptive services, prevention of STDS, sexual consent as a right, gender based violence, HIV testing, counselling disclosure and support, safe abortion, and so on (Renzaho.AMN, 2017). Despite the fact that Uganda has a national adolescent policy which aims at linking national development process to improve young people’s quality of life and standard of living (Atuyambe.L, 2009). Its impact on sexual and reproductive health needs of young people including teenage mothers has been quite inadequate. Studies in Uganda and sub-Saharan Africa have shown young people as having limited access to contraception, legal abortion as it is legally restricted and a lack of staff trained to address the sexual needs and education gaps of young people (Atuyambe.L, 2009). Submittal sexual and reproductive health does not only increase morbidity, mortality, and gender inequality but it also slows development (Crossland.N, 2015). It is very important to address adolescent sexual and reproductive health needs in Uganda because a growing number of young people are sexually active. (Atuyambe.L, 2009). A human rights approach emphasizes access to information to empower individual freedom of choice with respect to deciding whether to be sexual active or not, pursuit of a pleasurable sex life, choosing a partner, consensual sexual relations and consensual marriage, protection from sexually transmitted diseases and family planning. The availability and the access of health and information services to women and girls (including teenage mothers) that facilitate healthy pregnancies, births, mothers and babies is therefore key and very essential to good sexual and reproductive health. This research topic therefore intended to analyse the access of sexual and reproductive health services by teenage mothers by emphasizing the key areas cited out by the objectives of the study.

1.2: Statement of the problem
According to the World Health Organisation, one in every five people worldwide is an adolescent (10-19 years). An estimate of 1.7 million youth around the world lose their lives due to accidents, pregnancy related complications and violence. (Blum.R, 2005). Globally, rates of adolescent mortality now exceed those of early childhood mortality, with the exception of some very low income countries; complications related to child birth are the second leading cause of death among adolescents ages 15-19; and despite steady declines in the global number of HIV related deaths, among adolescents the number of HIV related deaths has increased by 50%. (Marston.C, 2006). In Uganda the rate of teenage pregnancy
has gradually increased from 24% to 25% where adolescents of 15-19 have begun child bearing (Uganda Bureau of Statistics, 2016). The field of adolescent sexual and reproductive health has continued to evolve, and now it is understood that young people’s health behaviour is largely influenced by a set of factors outside their control. (Blum.R M., 2005; Marston.C, 2006; Blum.R B. F., 2012). It is therefore important to consider a new paradigm shift which must take into account the broader social and structural factors that influence health behaviours and be grounded into the principles of positive youth development in order to enhance the sexual and reproductive health and over-all wellbeing of adolescents. (Plourde.K.F, 2016). This research therefore intended to give an in depth analysis of the access of sexual and reproductive health services by teenage mothers.

1.3: Purpose and specific objectives of the study

1.3.1: General objective of the study

The general objective of the study was entirely linked its title. It was to analyse the access of sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre.

1.3.2: Specific objectives of the study

- To find out the level of knowledge and awareness of sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre.
- To examine the factors influencing the access of sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre.
- To suggest ways of improving access of sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre (suggestions given by teenage mothers).

1.4: Research questions of the study

The research questions of the study are highlighted below;

- Do teenage mothers at Naguru Teenage Health centre know what the components Sexual and Reproductive Health Services are?
- What sexual and reproductive health services do teenage others at Naguru teenage information and health centre have access to?
What are the different experiences that teenage mothers at Naguru Teenage information and health centre have been through between period of conception and child birth?

What are the various demographic factors affecting the access to sexual and reproductive health services by teenage mothers Naguru teenage information and health centre?

What are the challenges/ barriers faced by teenage mothers at Naguru Teenage Information and Health Centre in accessing sexual and reproductive health services?

What can be done mitigate these challenges and improve access to sexual and reproductive health services by teenage mothers?

1.5: Conceptual Framework

The conceptual framework consists of the main independent variable, which are the sexual and reproductive health services at Naguru Teenage Information and Health Centre (NTIHC) under which there is the range of services, availability of services and the delivery system which can all influence the dependent variable which can all influence the dependent variable which is the access to sexual and reproductive services. These include the characteristics of the teenage mothers, social influence and the level of motivation and willingness to seek sexual and reproductive health services. An example can be seen below:-
The access to sexual and reproductive services, which can be other good, limited or no access can be influenced by the range of services/ nature of the delivery system. However, social influence like peer pressure and religious factors can come in between the above and the influence the level of motivation and willingness to seek sexual and reproductive health hence impacting on the access of sexual and reproductive health services.

1.6: Scope of the study
The scope area of the study was urban in nature. The study was conducted at Naguru Teenage Information and Health Centre located in Bugolobi, Nakawa division, at Kiswa Health Centre. It focused entirely on teenage mothers between the ages of 14-19 (years). The centre is the pioneer program in providing youth friendly adolescent sexual and reproductive health services in Uganda, and it has over the years registered an increasing number of young teenage girls who are testing positive for teenage pregnancy. This therefore made the scope area a credible and rich ground to provide the necessary study population to investigate the main objective of the study, which was to analyse the access of sexual and reproductive health services by teenage mothers.

1.7: Justification of the study
The issues of teenage pregnancy and limited access to sexual and reproductive health services by teenage mothers have been areas of major concern for quite a long time both globally and nationally. Many of the studies conducted, especially at national level have been largely quantitative and have not given an in depth analysis of both areas. More to that, despite the various studies that have been done, teenage pregnancy and limited access to sexual and reproductive health services by young people has gradually increased. This study, on the other hand, intended to offer an in depth qualitative analysis of the access to sexual and reproductive health services by focusing on teenage mothers at the defined scope area and the data acquired will be of significant value.

The findings from this study are expected to have educational value- in a way that they will enable the participants/ target population to acquire extra knowledge on the topic under investigation, they can as well be used by other researchers to conduct their own research and in different learning institutions to broaden their knowledge on the issue at hand. They are expected to also have practical and developmental value- where they are benefit policy
makers and concerned organisations to inform decision making in forming/ implementing sexual and reproductive health policies targeting teenage mothers in the country.

1.8: Key Terms and Concepts

During the course of this research, a few key terms will be used and these are defined below:-

Access;

Refers to the right or opportunity to make use or benefit from something.

Teenager;

There is no specific definition of a teenager. However, it can be related to the definition of an adolescent given the fact that the two terms are synonymous.

Adolescent;

The World Health Organisation defines adolescents as those people, male and female, between 10 and 19 years of age (World Health Organisation, 2014).

Teenage mother;

From the above definition, the teenage mother is a person between 10-19 who is pregnant/ has given birth.

Teenage pregnancy;

Teenage pregnancy on the other hand is defined as a teenage girl becoming pregnant. The term in everyday speech usually refers to girls who have not reached legal adulthood, which varies across the world, who become pregnant (United Natons Children’s Fund, 2008).

Youth;

This is a person between the ages of 15 and 24 years without prejudice to other definitions by member states (United Nations Educational, Scientific and Cultural Organisation, n.d).

On the other hand, in Uganda, youth are defined as all young persons, male and female between the ages of 18 and 30 years (Ministry of Gender Labour and Social Development, 2016).
**Young People;**

These are people, male and female, between the ages of 10 and 24 (World Health Organisation, 2014).

**Sexual and Reproductive Health;**

Good sexual and reproductive health is a state of complete physical, mental and social wellbeing in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to produce, and the freedom to decide if, when, and how often to do so (United Nations Population Fund, 2016).

Sexual and Reproductive health is an essential component of the universal right to the highest attainable standard of physical and mental health enshrined in the Universal declaration of human rights and in other international human rights conventions, declarations and consensus agreements.

**Sexual and Reproductive Health Rights**

Sexual and reproductive health rights encompass the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence. Specifically access to sexual and reproductive health services ensures individuals are able to choose from whether and when to have children, and to access the information and means to do so (Universal Access Project, 2014).

**Sexual and Reproductive Health Services;**

These are the services offered that encompass healthy sexual and reproductive health provided with the intent to maintain complete physical, mental, and emotional wellbeing when it comes to matters of the reproductive system (United Nations Population Fund, 2016). They include HIV testing and counselling, family planning services and contraception, safe abortion and post abortion care, antenatal/ prenatal/ postnatal care, STI treatment, gender based violence.
CHAPTER TWO: LITERATURE REVIEW

2.0: Introduction

This literature review intends to describe the key themes underlying the study and what research has been carried out on them in order to get an in-depth understanding of the issue at hand. However, it is important to note that the literature analysed considers teenage mothers as part of two broad categories, that is to say young people (10-24 years), and adolescents (10-19 years) given they lie within the same age brackets. While these terms are sometimes used interchangeably, and may be defined differently by different countries, with adolescence starting at 10 years, and young people continuing to mid-20’s, and the youth to mid 30’s (World Health Organisation, 2014) as conceptualised earlier, this study focuses on primarily the second decade of life of young girls who are either pregnant or have given birth. Where data on adolescents, young people, or youth are included, this is usually because available data have been integrated in ways that do not distinguish teenage mothers specifically.

2.1: Sexual and reproductive health services for teenage mothers at global and national level

Many people all over the world, and particularly adolescents among who teenage mothers are inclusive, face particular health risks, especially with regards to sexuality. By the age of 19 years old, half of the adolescent girls in developing countries are sexually active, about 40% married and close to 20% have children. An estimated 23 million girls have an unmet need for modern contraception and are at risk of unintended pregnancy (World Health Organisation, 2017). In Uganda, statistics have shown that teenage pregnancy has gradually increased over the years, and in the light of such issues, addressing adolescents sexual and reproductive health needs is an important and urgent policy and programmatic concern. (Neema.S, 2004). These adolescents and young people require a wide range of safe, affordable and scientifically accurate sexual and reproductive information and services that are deemed acceptable by them themselves and provided in an environment that respects their rights too confidentiality, privacy and informed consent (International Women’s Health Coalition, 2015). The provision of sexual and reproductive health services to young people across Sub Saharan Africa is commonly via public Ministry of Health, Non-governmental Organisations or faith based organisations. There are two significant approaches commonly used to deliver SRH services to young people; the targeted youth only, and the integrated approach. The targeted youth only is where services are designed and planned specifically for
the use of youth alone and these can either be facility based, school based or community based. On the other hand, the integrated approach has to do with provision of services to youth alongside the general public in health facilities but special arrangements are put to make the services more acceptable to young people (Godia.P.M, 2014). In Uganda, the targeted approach is quite rare given the limited existence of youth centres, and the later is very deficient given most general health facilities lack the provision of youth friendly services.

The Ministry of Health in Uganda adopted a package from the 1994 ICPD in Cairo and this package encompasses the different components of sexual and reproductive health and these include; safe motherhood, including post abortion care, family planning, adolescent health, STI’s including HIV and AIDS, reproductive organ cancer, gender based violence, menopause and andropause, infertility prevention and treatment, obstetric fistulae (Ministry of Health, 2006). Uganda also has the Adolescent Health Policy Guidelines and Service Standards, and the National Millennium Healthcare Package which includes Sexual and reproductive health and the rights for adolescents. However, despite the existence of all these, it is important to note that the acquisition of such services by adolescents is still lacking, and the major limiting factor is the translation of polices that exist into practice (Atuyambe.L, 2009). A significant proportion of Ugandan Adolescents have limited access to sexual and reproductive health services, and where they exist they do not address their needs (Byarugaba, 2018). Many institutions offering these services have not met the criteria of providing youth friendly services to these young people, a factor that limits the access to these sexual and reproductive health services for most of them, including teenage mothers (Nakkazi.E, 2016). According to World Health Organisation, in order for services to be considered youth/ adolescent friendly, health services should be accessible, acceptable, equitable, appropriate and effective (World Health Organisation, 2012). Youth friendly services characteristics include; service providers that are well trained and value privacy and confidentiality, youth friendly health facilities situated in a convenient place with adequate space, provision of programs that consider participation of young people and adolescents, wide range of services provided at affordable fees and within flexible hours. Studies carried out in Sub-Saharan Africa have shown that the services offered in many of the countries, including Uganda do not encompass all these characteristics (Bukenya.J.N, 2017). As seen earlier, they are usually centred in traditional adult health facility settings and are often viewed as inappropriate sources of care by adolescents and youth. Many of these teenage
mothers are also unaware of their sexual and reproductive health rights, an issue that needs to be addressed with much concern to hype and improve access to sexual and reproductive health services by teenage mothers.

2.2: Sexual and reproductive health rights for teenage mothers at global and national level
Sexual and Reproductive Health Rights refers to the concept of human rights applied to sexuality and reproduction. It is important to note that when looking at sexual and reproductive health services, it is impossible not to consider sexual and reproductive health rights for young people like teenage mothers. This is because once these young people are aware of their rights concerning reproductive health; they are empowered to demand for services that meet their needs. Amnesty International describes sexual and reproductive health rights as including the access to sexual and reproductive health care and information, as well as autonomy in sexual and reproductive decision making. They are universal, indivisible, and undeniable, and are grounded in other human rights, including the right to health, right to freedom from discrimination, the right to privacy, the right not to be subjected to torture or ill-treatment and the right to be free from sexual violence (Amnesty International, n.d). These rights encompass efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality sexual and reproductive health services, and to address sexually transmitted infections and diseases, and cervical cancer, violence against women and girls, and sexual and reproductive health needs of adolescents (World Health Organisation, 2014). In Uganda, sexual and reproductive health rights are seen relatively in the same light. The Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights also state that reproductive health rights embrace human rights that are already recognised in international human rights documents and national laws (Ministry of Health, 2006). However, the adherence to these sexual and reproductive health rights has been rather low in Uganda and many sub-Saharan counties as compared to developed countries, and they have posed a major challenge to many young people. A third of Uganda’s population is aged 10-24 years, and teenagers contribute more births than older women. Despite this being true, young people, teenagers inclusive in the country are not in position to influence their reproductive health since they do not often possess information, skills, services and means to do so. (African Youth Alliance, n.d) . This can be based on the fact there is a huge discrepancy between universally formulated sexual
and reproductive health rights and the local political, economic and community contexts in which young people live. In order to remedy this discrepancy, a comprehensive, rights based sex education that acknowledges this local reality should be put into consideration (Renzaho.AMN, 2017). Many adolescents are making uninformed decisions due to low levels of detailed knowledge about HIV/AIDS, unwanted pregnancies and clear information on the best contraceptives to use. It is important for these young people to be made fully aware of their sexual and reproductive health rights, and the responsibilities that these rights come along with. In an article by Ibrahim Batambuze in the ‘Health Digest’, he gives an example of every consenting youth having the right to have sex, but the responsibility to see to it that the necessary measures are taken to see to it that it is protected in order to safeguard against sexually transmitted diseases and infections, as well as unwanted pregnancies. He continues to add that, substantial comprehensive sexual education as seen earlier, regarding adolescents and sexuality must be widened and provided especially for young women both in and out of school (Batambuze, 2016). This in turn improves access to sexual and reproductive health services for young people including teenage mothers.

2.3: Level of knowledge of sexual and reproductive health by teenage mothers

According to a report released in 2015 by the Guttmacher Institute, there still exist gaps in the knowledge and awareness about some sexual and reproductive health services in most developing countries globally (Woog.V, 2015). Knowledge about source of contraceptives is moderate among many adolescent women in Africa and Asia, with 71% in Uganda knowing where to access contraceptives from. However, it is difficult to measure adolescent women’s source for condoms due to cultures that may not condone education on use of contraceptives especially among young women (Woog.V, 2015). A study conducted in the slums of Kampala showed that almost 77% of the sexually active respondents in upper secondary schools used condoms compared to 50% and 39% in lower primary schools which showed that young people in upper secondary school obtain critical knowledge that influences their sexual decisions. The findings showed that majority of the young people (76.6%) knew where and how to access condoms, pills, intrauterine devices or birth control purposes, but the proportion was lower among 13-17 year old participants which age bracket encompasses teenagers who are already experiencing motherhood (Renzaho.AMN, 2017).

In Africa, the proportion of adolescent women who know where to get an HIV test from is higher in East and Southern Sub regions (Woog.V, 2015). In Uganda, 40.7% of young
people between 15 and 19 years of age have comprehensive knowledge on HIV prevention, which includes limiting condom use to one uninfected partner, and rejecting misconceptions about HIV (Uganda Bureau of Statistics, 2016). Between 2003 and 2004, three quarters of the youth could name benefits of HIV testing and also knew where to get tested from. These numbers increased in 2012 to 90%. This is in line with studies that showed that knowledge of HIV/AIDS is improving in Uganda including the Uganda aids indicator survey which showed that there was increase in HIV testing among adults aged 15+ years between 2004 and 2011 (Crossland.N, 2015).

The UDHS, also states that 97.3 % of young women between 15-19 years have received care from a skilled provider for antenatal care (Uganda Bureau of Statistics, 2016), which shows that there is a high level of knowledge about the necessity for antenatal care. However, for those that decide to terminate their pregnancies, there are a number of difficulties and complications experienced due to poor knowledge of sources of safe abortion and appropriate treatments when it comes to post abortion care (Prada.E, 2005; Woog.V, 2015). The level of knowledge of STIs, especially their signs and symptoms in sub-Saharan Africa is still lacking. In Uganda, a study conducted showed that the knowledge of STI’s increased from 2003-2004 to 2012 but despite this increase, sexually transmitted infections knowledge remained low with only half of the youths able to correctly identify these symptoms (Crossland.N, 2015). In comparison, a study conducted in Ethiopia showed seemingly similar results, with only a percentage of 17.9% adolescents having knowledge on at least two symptoms of STI’s (Cherie.A, 2012). It is also important to note that there seems to be a low level of powerlessness to prevent sexual abuse especially among adolescent girls. This calls for more education on sexual and gender based violence as well as empowerment in order to prevent and avoid unwanted sexual attention, as well as to help identify potential sexual abusers (Renzaho.AMN, 2017) given that little knowledge about sexual and reproductive health rights is known. There also exists low levels awareness and knowledge of the importance postnatal and postpartum care basically in rural areas. This lack of knowledge about some sexual and reproductive health services leaves youths vulnerable to the effects of untreated sexually transmitted diseases increased risk of HIV/AIDS infection and certain cancers, infertility and risk of neonatal morbidity and mortality on pregnancy (United Nations Population Fund, 2014).
2.4: Factors influencing access to sexual and reproductive health services by teenage mothers

There are various factors that influence access to sexual and reproductive health services by the youth like for example health system factors, knowledge factors, social and economic factors. All over the world, young women face many barriers in accessing sexual and reproductive health services most especially when it comes to accessing safe abortion services. They are stigmatised for being sexually active and seeking abortion, and yet they are also stigmatised if they keep their pregnancy (Manot.L, 2015). In Uganda, for example, abortion is an act that is considered illegal, and is only permitted to save the life of the woman, to preserve physical health, and mental health. Despite the fact that the Ugandan law allows abortion to save a woman’s life, safe and legal abortion is very hard to find because services are limited, and even still, young women lack information about them. As a result, many resort to unsafe abortion which accounts for more than 10% of all maternal deaths in the country (Guttmacher Institute, 2018). Young people in Uganda are reported not to take any action when faced with reproductive health problems. It is only later when these problems persist when they visit a health facility. In the majority of African countries, Nonetheless, some of them prefer to seek out services like abortions, and treatment for sexually transmitted diseases from traditional healers, who they consider as able to uphold, the principle of confidentiality, which according to them does not exist within medical health facilities (Atuyambe.L, 2009; Woog.V, 2015) This can also be accorded to the fact that Uganda is a very cultural country and tradition is always held in high regard, which creates a trustworthy environment for anything that has to do with tradition. Most family planning and reproductive health services designed to serve young people have neglected the needs of married adolescents. Contraceptive use among young women in Uganda is largely influenced by history of pregnancy where by those that had previously given birth been more likely to access the service. This could be attributed to the existence of cultural factors where in Uganda, many cultures attach great importance to the birth of many children, as it is a sign of source of wealth, and would bring about birth of an heir. (Kabagenyi.A, 2016). It is because of this that it is safe to say that in Uganda the use of family planning services including contraceptives is relatively low because of the presence of cultural beliefs and norms like those related to attachment of importance of having a big number of children.

It is also seen that the utilisation of SRHS like antenatal care can be limited due to various reasons including the fact that young women like teenage mothers lack social support. A
study carried out in Mbarara revealed that most girls between 13 and 17 years get pregnant unwillingly and sometimes are infected with HIV/AIDS and STIs which complicates antenatal care seeking even more because of rejection from men, hence limited social and financial support (Rukundo.Z, 2015). The lack of political will has led to a corresponding lack of financial commitment to sexual and reproductive health to both the international donors and national governments which in turn makes it difficult for the young people who may not have funds for the services (Manot.L, 2015).

Another study carried out in Kabarole district in Uganda, participants agreed that reproductive health in the district is not adolescent friendly. Most often, lack of privacy and confidentiality for the adolescents attending health units was cited as one important reason. Other factors contributing to a less adolescent friendly service environment were inconvenience of other services including the fragmentation of different service components and lack of specific training of health workers on how to relate appropriately to adolescents. Also noted was that many of the respondents had a negative attitude toward the sexual activity of adolescents (Kipp W, 2007). Research carried out in the south of Africa, revealed relatively similar results, where by young people stated that reproductive health services are important but were not youth friendly (Jana.M, 2012). Common factors causing poor health seeking behaviour also include costs of services, long distance to health centres, long queues due to limited health workers serving large populations, not being comfortable with health workers of the opposite sex, stigma by health workers especially when they seek out services alone, being asked to bring their partners first before acquiring services, and the fact that some consider medical health workers a bit too ‘nosy’ for their taste (Godia.P.M, 2014; Woog.V, 2015; Jana.M, 2012). In general, a number of factors influence the access of sexual and reproductive health services by the young people- teenage mothers being inclusive in this category. Based on the literature reviewed, many of these factors are quite limiting.

2.5: Ways of improving the access of sexual and reproductive health services by teenage mothers

According to the United Nations Population Fund (UNFPA), adolescents, sexual and reproductive health must be supported, which means providing access to comprehensive sexuality education; services to prevent, diagnose and treat sexually transmitted diseases and counselling on family planning. It also requires empowering young people to know and access their rights- including the right to delay marriage and the right to refuse sexual
advances. Sexual and reproductive health education, counselling, and contraceptive provision are effective in increasing sexual knowledge, contraceptive use, and decreasing adolescent pregnancy because adolescents have special sexual and reproductive needs (whether or not they are sexually active or married). (Renzaho.AMN, 2017).

According to the World Health Organisation, actions to make health services adolescent friendly and appealing leads to increase- sometimes substantial- in the use of health services by adolescents. Adolescents need services that are offered to them in a way that they are accessible- where they are able to obtain health services that are available, acceptable- where they are willing to obtain services that are available, equitable- where all adolescents, not just selected groups, are able to obtain the available health services, appropriate- where they can access the right health services (the ones they need), and effective- where the right health services are provided in the right way, and make a positive contribution to their health (World Health Organisation, 2012).

In Uganda, young peoples’ sexual and reproductive health remains a challenge and to address these barriers, a comprehensive and harmonised sexual and reproductive health system that is youth friendly and takes into account local socio- cultural contexts is needed (Renzaho.AMN, 2017) It is important to note that young people have specific sexual and reproductive health needs that they prefer to be delivered through specified modalities. Some of these needs as sighted out by these young people include; a need for a dedicated health centre equipped with youth friendly workers and stocked medicines, provision of counselling services and health education, community outreaches to extend services to out of school young people who cannot access medical facilities, provision of free services, the need for privacy- given most young people prefer not to receive services in the presence of adults in order not to reveal their sexual activity. In comparison, a study carried out in Kenya also revealed relatively similar results, but added that adolescents expressed the need for the increase in awareness of sexual and reproductive health services because they are not familiar with some of them, which shows lack information, and also exposes the existent knowledge gap (Godia.P.M, 2014). It is also important to note that they need this information even before they become sexually active in order to be adequately prepared to make choices concerning their health. This can be done through sexuality education, offered by parents or guardians, in schools, youth centres and outreaches in order to target those young girls that are out of school (Denno.D, 2014). Sexuality education, as part of health education, is vital for young people’s development, learning and overall wellbeing.
2.6: Emerging gaps

Extensive research has been carried out on the access to Sexual and Reproductive Health services but most studies have largely concentrated on analysis of adolescents, young people and the youth as broader categories. Despite the fact that teenage mothers are also part of these groups of people, it was noted that limited studies concentrated on the access to sexual and reproductive health services by teenage mothers specifically yet they can also be considered a sensitive and vulnerable group of people of their own who need special attention in terms of reproductive health. Few studies have also been conducted on the knowledge and awareness of sexual and reproductive health services, and some factors that could possibly influence the access to these services have not been tackled. This study therefore intended to bridge this gap.
CHAPTER THREE: METHODOLOGY

3.0: Introduction
This chapter entails the methodology description of the study highlighting and describing the research design, population of the study, the sample size selection, data collection methods, data analysis, ethical considerations, and the challenges and limitations faced during the study.

3.1: Research Design
A cross sectional qualitative study using a descriptive and explanatory approach was used to conduct the study. The study took on a descriptive approach because it portrayed the characteristics of persons being studied, situations and the frequency with which certain phenomena occurred, and it was also explanatory in nature because it sought to bring out the factors responsible for influencing the access to sexual and reproductive health services by teenage mothers and also answer the question "why" in the research.

3.2: Population of the study
The population of the study refers to those people from whom the required information to find answers to research questions is obtained (Kumar.R, 2011). This study focused on teenage mothers who are receiving health care services from Naguru Teenage Information and Health Centre between the age bracket of 14 and 19 years. Data was collected from a total number of 25 teenage mothers whose selection basis can be seen in the section below concerning sample size and selection.

3.3: Sample Size Selection
The sample size used in qualitative studies is smaller than that used in quantitative research methods. This is because qualitative research methods are often concerned with garnering an in depth understanding of a phenomenon, and not necessarily make a generalisation to a larger population of interest (Dworkin.S, 2012). It is based against this that the researcher chose a sample size of 25 teenage mothers with whom in depth quality interviews were conducted. In order to acquire the 25 respondents, purposive sampling was used. Purposive sampling is a non-probability method of data collection where there is deliberate selection of a participant due to the qualities the participants possesses. (Etikan.I, 2015). This number of
respondents was seen as enough to be interviewed in the time frame in which the research is to be completed. Naguru Teenage Information and Health Centre is a health facility that offers medical care to only young people between the ages of 10 and 24 years. However, this study was narrowed down to focus on teenage mothers who are 14 to 19 years of age. This age bracket was selected based on the fact that the age registered at the centre for onset of teenage pregnancy is 14 years and also that the period of being a teenager comes to an end at 19 years as conceptualised earlier. This therefore makes purposive sampling relevant in a way that the medical team helped identify those teenagers that were pregnant or had given just birth given they take records of everyone who visits the institute hence those selected will fit the criteria/qualities of either being pregnant, or having just given birth, and in the stipulated age bracket of 14-19 years of age, qualifying them to be teenage mothers of particular interest in the study. The sample that is selected is expected to be able to provide the relevant and sufficient data for the study.

3.4: Data Collection Methods
A number of data collection methods will be used to collect primary and secondary data for the study. Based on the fact that the study is qualitative, face to face interviews will be conducted which are semi structured in nature, in order to have several key questions that are open ended, to not only help define the areas to be explored, but also allow the interviewer to diverge in order to pursue an idea or response in more detail for example through probing hence acquiring in depth quality data (P. Gill, 2008). During the interviews, an audio recorder may be used for easy data collection and storage. Observation may also be used to collect data by observing the participants during the course of the interview and as they acquire health care services at the centre.

In order to attain secondary data, document review was done to find out what has been documented about the topic of interest in the past and generate a relevant statement of the problem.

3.5: Data analysis
The data was analysed using qualitative analysis based on the relevant thematic areas and the findings of the study. A voice recorder was used to record the interviews after which verbatim were used to transcribe the data. In cases where local language, that is to say, ‘Luganda’ was used, translation was done carefully not to alter meaning. All the responses
for each respondent were typed in the computer software, Microsoft word processor, and saved as an individual word document. The typed transcripts were then read carefully after which the data was properly coded, reviewed and narrated. Presentation of the findings and their discussion were done simultaneously, and some of the responses were quoted in order to illustrate meaning of some of the data. Nevertheless, confidentiality was maintained where by identities of all respondents were kept private.

3.6: Ethical considerations
Ethics refer to norms for conduct that distinguish between acceptable and unacceptable behaviour. Ethics in research is important to promote the aims of research, such as knowledge, truth and avoidance of error, promote the values that are essential to collaborative work, to hold researchers accountable to the public / people involved in the study (Resnik, 2015).

Confidentiality and anonymity were observed where by the names of the participants in the study were not revealed and the information gathered was kept as private as possible. More to the above, informed consent was sought where by the respondents that took part had to agree to participate by signing consent forms which contained information informing them about the research and its requirements. It is important to note that participation was free, voluntary and fully informed.

All respondents were protected from legal, psychological, and physical harm during the study, and the interviewer was as objective, honest and trustworthy as possible during the interviews to minimize bias and ensure a non judgmental attitude.

3.7: Challenges and limitations
The process of obtaining consent from the Naguru Teenage Information and Health Centre to carry out research from there was quite lengthy. This is because the head of research had travelled during this time and when he returned, a research proposal had to be presented to him which had to first be reviewed alongside other members of the administration. Despite the fact that data collection started late, the researcher managed to collect all the data required to achieve the main objective of the study.
CHAPTER FOUR: FINDINGS OF THE STUDY AND DISCUSSION

4.0: Introduction
This chapter demonstrates and qualitatively analyses the findings from the study which were gathered based on the specific objectives and what the researcher deemed as important in order to achieve the main objective of the study, which was to analyse the access to sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre. The findings from the study are presented, analysed and discussed.

4.1: Socio-demographic Characteristics
The study involved a total number of 25 teenage mothers, who were receiving health care at Naguru Teenage Information and Health Centre. All the 25 participants were taking up residence in fundamentally two districts that is to say, (20) in Kampala, and (5) in Wakiso. Many of these were residing in areas that were relatively close to the centre for example, Naguru, Mbuya, Mutungo, Bugolobi, Kiswa, Butabika, Kasokosoko, and Luzira to mention but a few, for those in Kampala. Those staying in Wakiso district were able to identify areas like Najeera, Bweyogerere, Banda, Mpererwe, Kireka and Namboole as places where they stay. Twenty four participants were found to be of Ugandan descent, and one of Sudanese, with a large number religiously affiliated to Christianity [(10) catholic, (5) protestant, (6) born again], and a few to Islam [(4) Muslims]. The tribes of the different participants were also recorded, and the results showed the number of participants from different regions. From the central region (10) -who were Baganda, Northern region (2) -who were Karamojong, (6) Eastern region- among who were Itesot, Basoga, Kumam, and Balamogi, and the Western region (6)- where there were those that were Banyakole, Batoro, and Bakiga.

Distinctly, all 25 participants were young females who were either pregnant or had given birth (teenage mothers), and who were from the ages of 14 to 19 years, whereby 3 were 14 years old, (1) 15 years old, (5) 16 years, (5) 17 years, (6) 18 years and (5) 19 years old. It was also noted that majority (23) of the people interviewed had ever acquired formal education, whereby (13) last attended primary school, (9) had stopped in O’level and (1) in A’level.
Despite the high number that was recorded to have acquired education, it is important to note that none of the participants had entirely finished secondary school, as it was seen that the one with the highest level of education had stopped in senior five. Additionally, (11) participants stated that they were married and the rest (14), said they were not, with (10) living with their partners, (2) with both their parents, (5) with a single parent, and (8) with a relative, that is to say an aunt, uncle, sister or grandparent. Last but not least, participants were asked about their employment status in order to determine some of the factors that could have influenced their access to SRHS at the centre. It was revealed that the largest number (18) was unemployed, and those that were employed (7) were either doing domestic work, working as cooks in a market or selling groceries at small stalls near their places of residence alongside relative or two.

4.2: Participants’ Birth History and Experiences

The participants of the study were asked about their birth history and to share their personal experiences during or after their pregnancies. It is important to note that this was not a specific objective of the study. However, it was found necessary to collect data under this section in order to acquire more background data about the participants’ history of pregnancy and child delivery so as to determine if there was in any way a relationship with their access to sexual and reproductive health services.

In order for the interviewer to acquire the data needed for the study in this particular section, they were asked questions like if they had ever given birth, at what age they got pregnant if they had one or more children, if there were any difficulties they faced during their pregnancies and from who they got support specifically during that period of time.

According to the results obtained, the study revealed that most of the participants interviewed (16) had ever given birth and the rest (9) had never. It was noted that 13 were having their first pregnancy and 8 their second. None of the participants had experienced more than two pregnancies throughout their life spans, and out of those that had got pregnant at most twice, the average age at which they had their first pregnancy was 17 years old whereby (2) had gotten pregnant at 14, (2) at age 15, (2) at age 16, (4) at age 17, and (1) at age 18. It was also noted that the age gap between when those that had had their first and second pregnancy was quite small. Hardly had their first children made a year old when they had already given birth to the second. This substantiates the fact that there is little or no use of reliable family
planning methods for example condoms and hormonal contraceptives, given majority had their second pregnancy not so long after giving birth to their first child. Unfortunately, many studies have not considered the fact that the birth history can have an influence on the access to SRHS. The one study found to establish this particular influence in Uganda showed that young women who had given birth to their first child in the stated aged bracket of the participants in this study, 14-19 years, were less likely to use contraception (Kabagenyi.A, 2016), which results are in line with the ones from this study, showing contraception use is low particularly among those that had their first pregnancy within this age bracket, and who are in fact the majority.

When asked about their support system during/after pregnancy, all participants had at least one person giving them support. Two (2) mentioned that they had the support of both parents, 6 by a single parent, 6 by a relative (uncle, aunt, grandmother, sibling) and 12 by the fathers of their babies. Despite the fact that a large number was supported by their partners, it is important to note most family planning and reproductive health programs designed to serve young people have neglected the needs of married adolescents, a particularly disadvantaged group (Manot.L, 2015).

During the interviews, the participants were also asked if they had experienced any difficulties during or after any of their pregnancies. It is important to note that to the best of the researcher’s knowledge, there has not been a study that has tried to establish a relationship between past experiences of teenage mothers and their access to SRHS, yet the former seems to significantly influence the later. Many of the teenage mothers stated that they had financial problems due to the fact that having a child came with extra costs, for example, buying clothing for the child, acquiring medical attention and ensuring that they have healthy diet. Other participants mentioned that after carrying their children to full term, they ended up having still births due to lack of antenatal care, and one in particular said that she got pregnant the first time through rape, and was forced to carry out an abortion which was not a good experience for her. Some of these responses are quoted below respectively;

“.....for my first pregnancy, I would experience pains. Things were tough back then and I was not aware of the necessity of receiving services like antenatal so I did not go for it. I was also not eating right and taking care of myself and my baby in the right way. It was later on after speaking to the doctors that I realised that this could have been the cause of my baby's
death...for my second pregnancy, I made sure to come for antenatal." (Teenage mother, 19 years old)

“...after my first pregnancy, after carrying out the abortion, I used to experience pains and bleeding for some good time until I went to the hospital where they treated me. The doctor told me that some of the remains from the pregnancy had stayed in my womb, so they had to ‘clean’ me again.”(Teenage mother, 16 years old)

Prior having a still birth or carrying out an unsafe abortion, these teenage mothers lacked information about the importance of services like receiving antenatal care, and also post abortion care. Therefore, having gone through such experiences not only enabled them acquire knowledge on the existence and significance of these services, but also prompted them to seek them out and utilise them.

4.3: Knowledge/ Awareness of sexual and reproductive health services

One of the objectives of the study was to find out the level of knowledge/ awareness about sexual and reproductive health services. Participants were asked a variety of questions in order to know their familiarity with the services, what they entail, and where they can access them. Almost all the participants mentioned that they had ever heard about sexual and reproductive health services but none could clearly define the concept, regardless of their educational background. This shows that the demographic characteristic of educational background was not a variable in the level of knowledge and awareness of SRHS among the teenage mothers. The different definitions that were given showed that the ideas that they have on what these services are true, but still show a dearth of information. Many of the participants defined the concept as services that are concerned with issues to do with sex, regardless of their different demographic characteristics, which is true but is still quite peripheral. Sexual and reproductive health services are services provided with the intent of ensuring complete mental, physical and emotional well being when it comes to matters of the reproductive system (United Nations Population Fund, 2016), which shows that the concept has a lot more to it that just ‘sex’.

“.....are those services offered to people having anything to do with sex” (Teenage mother, 17 years old)
The quotation above is an example of how majority of the respondents defined sexual and reproductive health services. One of the respondents could not define the concept saying she did not know much about it:

“I do not know much about them. What I know is that my mother said I have to come for antenatal care and also test HIV…” (Teenage mother, 14 years old)

In addition to being asked if they have heard about SRHS, and defining the concept, participants were also asked to point up some of the sexual and reproductive health services that they know. Each of those that said they had heard about the service could mention at most three services out of HIV testing and counselling, STI treatment, antenatal care and family planning. Only (4) of the participants specifically pointed out condom use and (1) mentioned cervical cancer testing as a sexual and reproductive health service. These results are correspondent with findings from other studies that show that young people know where to access these services from (Renzaho.AMN, 2017; Crossland.N, 2015; Woog.V, 2015), indicating that they are aware that these services actually do exist. However, it is important to note that there are SRHS asides from those mentioned by the respondents. Sexual and reproductive health services also include post abortion care, post natal services, gender based violence (Ministry of Health, 2006). Be that as it may, according to the findings the knowledge about these services remains rather low given none of the services was mentioned. Other researchers have also pointed out the fact that young women have poor knowledge about sources of safe and post abortion care, post partum and postnatal care, as well as awareness about sexual and gender based violence (Prada.E, 2005; Renzaho.AMN, 2017).

It was discovered that large number (11) of the teenage mothers interviewed got to know about these services from a medical service provider during their first antenatal visits, which proves to say that there was lack of information about these services prior their pregnancies. Five (6) got to know about them from friends, (2) from school, (6) from a relative (mother, sisters, aunt) and (6) from friends. These statistics show that a number of platforms, for example mass media, have not been utilised as providers of information concerning sexual and reproductive health services. They also show that the level of involvement of parents and guardians as sources of information is flat yet it would be expected that parent would be the direct source of information and guidance when it comes to such issues. These results are also quite deviant from a study carried out in slum areas of Wakiso, where the main source of sex education was were school teachers (73.9%) (Renzaho.AMN, 2017). The study also
investigated if the participants knew any centres, asides from NTIHC that provide sexual and reproductive health services. A number of them knew at least a clinic, or hospital that provided the services, but had not received SRHS from there despite them being much more in their proximity compared to NTIHC. Some of the reasons given for this are quoted below;

“....I have never because at least this place has people of my age and this makes me comfortable. Sometimes you go to those other hospitals and you find that there are ‘big’ people who can look at you and wonder why you would even be seeking a service that has to do with sex when you are still young.”(Teenage mother, 19 years old)

“....I went there once but then I couldn’t afford going there to pay for services. So after speaking to that doctor who I told you is my friend, she is the one who showed me here and told me the services are for free...”(Teenage mother, 18 years old)

“...I have never because I never had the need to.” (Teenage mother, 18 years old)

The small number of respondents who had received services from the centres they had mentioned had only received antenatal services as well as HIV testing, which could be accorded to the fact that these are among the SRHS that teenage mother are most familiar with. There were also a proportion of those who did not know any other health centres asides from NTIHC, hence not having utilised services from any other health facility. All these reasons for not receiving care from other health centres can greatly limit the access to sexual and reproductive health services.

Remarkably, most participants did not know about sexual and reproductive health rights, and the few who knew about them could barely mention any. Sexual and reproductive health rights are a very important aspect of SRH, because without knowing these rights, these young people do not get the chance to demand for these services, and protect their best interests when it comes to reproductive health. These rights provide the access to sexual and reproductive health care, as well as the autonomy in sexual and reproductive health decision making (Amnesty International, n.d), therefore lack of knowledge about them can limit access to SRHS.

All these results show that the level of knowledge about sexual and reproductive health services is relatively low, and the amount of information that these teenage mothers have about the different services and rights leaves a lot to be desired. It is evident that even with
the little information known about for example places where to access these services, other factors can limit access to SRHS.

4.4: Factors Influencing Access to Sexual and Reproductive Health Services

The teenage mothers that took part in the study were then interviewed to find out the different factors that influence their access to sexual and reproductive health services. Data was gathered based on a number of factors which will be seen and explained in this section.

Based on the findings from the study, it is clear that more than half of the respondents believed that sexual and reproductive health services are essential for their health, a positive factor which is very instrumental in prompting these teenage mothers to access sexual and reproductive health services. This shows that because they believe that the services are important, they would definitely go ahead to seek them out. Many of them were stating reasons like these services are important because they enable one monitor the growth of their unborn child for the case of antenatal care, they ensure that you are protected from diseases by going for STI treatment, allow for one to plan when to have your next child in the case of family planning and also allow for one to be made aware HIV status for the case of HIV testing. However, despite agreeing to the significance of these services, some of the respondents questioned the authenticity of some of them which showed that they were not entirely comfortable with accessing some as can be seen in the responses below;

“.....I do not think family planning is that good because I have heard from my friends that if you use them for a long time, you do not give birth. I am also not sure about cervical cancer testing because they say they cut you inside in order to test which I do not think is healthy.” (Teenage mother, 16 years old)

“.....and they say family planning is not good especially if you have not given birth yet because they say it can ‘burn your eggs’. I know even of some friends and doctors who also say that it has side effects like either putting on weight or losing it, and also giving birth to children with disabilities...”

“It is okay if you have given birth before. I can use it after I have had my children because if not, it can make you barren”

...I heard that ‘water’ contained in condoms is not good because it can cause your eggs to burn.” (Teenage mother, 17 years old)
“...what if it (the condom) bursts and part of it stays inside you? Don’t you see that just brings more problems?” (Teenage mother, 18 years old)

From the responses given, the common services that the teenage mothers did not consider important include modern family planning methods, including condom use. The findings also showed that there is a belief in the use of modern family planning methods only if one has given birth before, or has had as many children as she wishes to have, because according to them, using these methods can make one lose their fertility in the long run. Similarly, in Nairobi Kenya, among young pregnant girls who were receiving antenatal care, none had used hormonal contraception before the conception of their first child. They also believed that making use of these modern methods like hormonal contraception would prevent them from conceiving in future (Godia.P.M, 2014). It is clear to see that many of the reasons they gave for not giving these services much importance are merely ‘hear say’ and myths, which shows that there is lack of accurate information concerning these services.

As seen earlier in the socio demographic characteristics, many of the participants of the study reside in areas that are within a close proximity of NTIHC, which was given as one of the underlying reasons as to why they chose to acquire health care from there. This was coupled with the fact that the centre deals with only young people, a factor which makes them feel comfortable, and it offers free services to its clients. Reports by agencies like World Health Organisation and Rutgers International state that there is a need to have a separate space for provision of SRHS to young people, as this helps ensure confidentiality and privacy- two important aspects that make SRHS acceptable to young people and adolescents (World Health Organisation, 2012; Rutgers International, 2016). Adolescents also need access to services at affordable rates (Desidero, 2014) just as the findings of this study show that teenage mothers have a need for free services, which are effective.

It was also renowned that some chose NTIHC because it was suggested to them by their peers, a close relative or a doctor, all whom whose advise they took on because they trusted them, hence acquiring services from the centre.

A considerate number of teenage mothers stated that they knew that the centre offers a variety of sexual and reproductive health services, including antenatal care, family planning, HIV testing and counselling and STD/STI treatment. Only (4) mentioned condom distribution. None mentioned other services offered by the centre like post abortion care, and post natal care, which could mean they are not aware that the centre offers these services or
they that are not aware of the services at all given none mentioned any of these services when being examined about their knowledge and awareness. Teenage mothers may also be aware but are not sure about what some services are called. This is because based on observation, it was noticed that one of the teenage mothers that was interviewed came with her 2 week old baby in order to have a postnatal check up. Postnatal care has been the most neglected period for the provision of quality care yet it is a critical phase in the lives of mothers and newborns (World Health Organisation, 2015). This could also explain why most teenage mothers did not mention it as a SRHS. Regardless, as much as they were aware of these services, many had only received antenatal care, HIV testing, which results are consistent with a study carried out in Wakiso, where it was found that these same services were commonly utilised. (Bukenya.J.N, 2017). This is backed by the fact many of them didn’t consider some services important as seen earlier, that is to say family planning and use of condoms for the various reasons that were stated above. One of the respondents had this to say about STI/ STD treatment;

“....it is quite embarrassing to say when you have a problem ‘down there’. So you rather just buy local herbs that can help cure your problem.”(Teenage mother, 18 years old)

The response shows that there is a belief in using traditional medicine to cure sexually transmitted diseases and infections hence limiting access to this service in particular from the centre. This synonymous with other studies, one in Uganda and another in Zimbabwe, where it was noted that young people tend to find it easier seek help from traditional healers where particular health problems persisted instead of seeking medical attention from health facilities, especially when it comes to STI treatment (Atuyambe.L, 2009; Jana.M, 2012). It is also important to not all the respondents that had utilised SRHS from the centre said they get these services in time, but added that there is a need to come early so that you do not find many people, and end up waiting for a long time;

“Sometimes when you come late, you find many people and you give up, and you are like I will come another day, and sometimes end up not coming at all.”(Teenage mother, 17 years old)

This was one of the responses given by one of the teenage mothers. This shows that when the centre receives a large number of clients, those teenage mothers that arrive late end up not receiving services because they loath waiting for long periods of time.
Spouse support is another important mediating factor that can influence the access to sexual and reproductive health services by teenage mothers. Based on the findings from the study, it is clear that spouse support does exist for some of the respondents, but is deficient because some of these teenage mothers do not receive services because their partners are not comfortable with them doing so. The results from the study showed that (15) of the respondents had the support of the fathers of their children, that is including some (4) who were already separated from them. The remaining proportion (10) did not have any support from their partners. Nonetheless, those whose partners were in favour of them receiving these services did not have their full support given their negative attitude towards some of the services;

“Yes my spouse supports me. What he doesn’t want is family planning. He said that he still wants children so I should not use family planning.” (Teenage mother, 17 years old)

“...he supports me to receive these services. But there are things he does not like now like using condoms. He says that since we both know each other’s status, then there is no use of using them.” (Teenage mother, 19 years old)

The responses above were given by teenage mothers when asked if their partners are okay with them accessing services. For the case of condom use, some added that their partners said that they did not ‘feel anything’ during sexual intercourse, which indicates towards men’s supposed reduced sexual pleasure that results from using condoms. Evidently, some teenage mothers decide not to use condoms because they would rather see that their partners are sexually satisfied. Another indicator of limited spouse support is the fact that majority of the teenage mothers, even those that have their partners support, have not received these services, for example, antenatal services, and HIV testing with them. When asked why, they said that their partners either stayed far away, or were always too busy to comply. It should be noted that it is important to receive some of these services as a couple because making healthy life decisions involves both partners in a relationship. It is because of this kind of negative reasoning given by their partners that many of the teenage mothers do not access some of these services. According to a report published by the Guttmacher Institute in New York, one of the barriers of accessing sexual and reproductive health services by adolescent women is the fact that they do not want to go alone, or without their partners to health centres to access these services. (Woog.V, 2015)
Moving forward, the study revealed that a significant number of the teenage mothers had the support of their family (parent, guardian, close relative) to receive sexual and reproductive health services, but at the same time, a few were discouraged from using family planning methods, hence not having the interest to acquire it.

Almost all respondents agreed that their religions are in favour of sexual and reproductive health services, with the exception of a few Catholics and Moslems who said that their religions do not encourage family planning and use of contraceptives such as condoms. According to them, it is said that having children should only occur after a couple is bound together as a unit by marriage, of which after doing so, reproduction should be left to occur naturally without the interference of anything.

Culture, on the other hand, turned out to be of great influence on the access of SRHS, categorically family planning services. It is important to note that in Uganda, culture and tradition are two synonymous aspects that are held high regard. When examined about cultural support, majority of the participants gave the following responses;

“...I have heard some people back where I come from say that delayed family planning is bad because it can even cause you not to menstruate and that is something very bad. In fact, it can even cause sicknesses and then you will not be able to get pregnant.” (16 years old)

“...in my village some people say that it is not good to do family planning because it can affect your chances of getting a child and also cause bleeding to death.” (17 years old)

One of the respondents, who also explained that her culture does not support the service, even went ahead to describe what would deem the use of methods like oral contraceptives safe;

“I don’t think my culture supports the use of family planning because as I told you earlier, into family planning when you are already pregnant you can give birth to a child who is deformed. Maybe that thing about the ‘panadol’ you swallow, in order to be sure that it does not burn your eggs, you can get it and put it on a banana leaf. If it burns the leaf then you know that it is unsafe to swallow it because it will burn your eggs as well. But if it doesn’t then you can swallow the medicine.” (18 years old)
The teenage mothers belonged to a diversity of tribes, and almost all pointed out that where they come from (their homelands), family planning is discouraged, with the exception of a few who showed that they were open minded to using it especially after birth of at least one child. Based on this, the impression is that cultural and traditional beliefs have an impact on the access to sexual and reproductive health services like modern family planning. According to a book chapter written by Grace Kyomuhendo, it is stated that issues to do with reproductive health for example pregnancy, conception, with and postpartum are greatly influenced by, among others, social and cultural beliefs (Kyomudendo, 2009). This study validates this statement. It is coherent that many teenage mothers do not access services like modern family planning because of their different traditional beliefs that state that there are negative consequences that are attached to its utilisation. It is also indisputable that many of these cultural beliefs are quite misleading because they do not provide accurate information and are misconceptions. This can be seen by the last response quoted where oral contraceptives are referred to as ‘panadol’, and also by the method stated which can allegedly be used to determine whether one should make use of the drug or not, hence the exposure of a knowledge gap among teenage mothers concerning modern family planning like contraceptives.

The teenage mothers all stated that they were comfortable with receiving services from NTIHC, which positively influences them to acquire services from the centre. They backed this up by a number of reasons including the fact that the centre deals with only young people, offers free services that are of relatively good quality, and has hospitable service providers, which all relates to the fact that youth friendly services increase the utilisation of sexual and reproductive health services by teenage mothers. However, in spite of these various driving/ motivational factors, majority of these young mothers rarely access these services. When asked how often they tend visit the centre to acquire services, a prevalent number said that they only access these services when they have an appointment scheduled with the doctors, like for antenatal care, and went ahead to explain why they do not deem it necessary to often seek out some of these services saying, for example, that it is not necessary to have routine HIV testing:

“As long as I know am faithful to my partner, why would I test all the time?” (Teenage mother, 17 years old)
It never really crosses my mind to test. Maybe when am pregnant or if the doctor insists that I have to” (Teenage mother, 18 years old)

Some also said that they do not get to visit the centre often because they do not get the time to do so, and money for transport, so in case they do not feel well, they self medicate with local remedies, which still shows the preference of traditional medicine to the scientific medicine that is provided in medical facilities as stated earlier. It is important to note that it is important to test for HIV, especially if one is sexually active because you can never know the status of your partner, and it also get proper medical diagnosis, in case of any signs and symptoms of a STI, hence proper medication. There were also a number of challenges faced by these teenage mothers in acquiring sexual and reproductive health services. Some of these included; lack of moral support from partners to access some services, lack of knowledge about services especially prior first pregnancies, and also financial constraints.

4.5: Ways of Improving Access to Sexual and Reproductive Health Services
Teenage mothers were also asked to suggest ways in which they think the access to sexual and reproductive health services can be improved. Many of the suggestions that were given were relatively the same, with the most common being that more centres like NTIHC should be built in order to offer services to only young people. A consensus was reached that these teenage mothers feel more comfortable receiving services with in health centres that deal with only young people, other than general medical health facilities. The World Health Organisation also recognises this by saying that making services adolescent friendly increases utilisation (World Health Organisation, 2012). This is based on the fact that when they go to other health facilities, the services offered to them do not meet their health needs and expectations, or are not what we would term as youth friendly;

“I think they need to build more centres like this one. At least this place is not like other places where you go and find ‘old’ people, and also the doctors who are very old. They look at you and wonder why you are pregnant and yet you are still young.” (Teenage mother, 19 years old)

This therefore calls for the need of youth friendly services, hence being a motivational factor for teenage mothers to seek out sexual and reproductive health services hence improving their access.
Another suggestion put forward is that more information should be given to these teenage mothers concerning these services. Based on the data analysed earlier concerning the history of pregnancy of the participants, it is clear that some of the teenage mothers got to know about these services only after going through certain difficulties, for example, having still births due to lack of antenatal, which resulted from lack of information about the service. Some of the responses given concerning the issue are quoted below:

“I think they can give us more information on these services now like for example those things they say about family planning, I would like to know if they are true or not, and also what side effects they have, and what the best methods to use are.” (Teenage mother 19 years old)

“They need to tell young people about these services. Now in my case, if I had known about antenatal earlier, my baby would have not died.” (Teenage mother, 18 years old)

This therefore shows that teenage mothers also see the need for getting more information concerning these services in order to keep healthy in different circumstances, for example during periods of pregnancy.

One of the respondents expressed the need for male education, focusing on the importance of their involvement in matters concerning the access to sexual and reproductive health services. As seen earlier, there is the existence of limited spousal support which is exhibited by the fact that some of the partners of these teenage mothers are not comfortable with them receiving some of these services, and others do not actually receive these services with them, which greatly limits their access to these services;

“These men do not know these things. For them they just tell you they want kids so do not use family planning. But they do not even understand anything about them. So I think they should educate them about some of these services.”

“Men need to know that it is important to come with us to the hospital because even when we come here the doctors ask where your husband is. So they need to know that they have to come give support and also test for things like HIV.”

A qualitative study carried out in seven countries in the south of Africa reported that young women found it difficult seeking treatment from clinics because they are asked to bring their
partners first, just as the respondent quoted above stated, which may not be easy, hence becoming a barrier to accessing these services (Jana.M, 2012). Therefore, teenage mothers need their partners to know about the significance of some of these sexual and reproductive health services before dictating that they should not utilise them. In addition, they also need their partners to support them, not only financially, but also morally by trying to be there as much as they can when they go to health facilities like NTIH to acquire reproductive health care, given even when they get there; they are asked about the whereabouts of their partners.

Primarily, these teenage mothers live a low standard of living; given the biggest number is unemployed, and those that are employed have low income jobs like domestic work. The issue of setting up centres that offer free services was suggested by one of the teenage mothers. In light of the same matter, in a study carried out in the slums of Kampala, young people including young women stated services that were highly available to them were not necessarily affordable especially post exposure prophylaxis STIs testing and counselling, HIV treatment, pregnancy testing, modern family planning methods and antenatal and postnatal services (Renzaho.AMN, 2017). Both studies revealed that primarily these young women including teenage mothers have a low standard of living given they have a low level of income, resulting from the fact that most do not work, and those that do are self employed in low income jobs. Many rely on their partners or guardians for financial support, depending mostly on who they live with, yet even still those they are dependent on do not earn much either. This is one of the reasons as to why teenage mothers in this study chose NTIH to receive health care given the centre offers free services to young people. They explained that other centres that offer good sexual and reproductive health services offer them at a fee, and quite often they cannot afford them which, limits their access to these services.

Ultimately, majority of the teenage mothers brought up the need for more doctors with in the centre, in order to reduce the waiting time for services especially on days when people are many and some end up coming late due to various reasons. It was noted that many said that they receive services in time mostly if they come early, and if they arrive and find many people, they prefer to leave without being attended to by a medical service provider. This in turn can improve access to sexual and reproductive health services.
CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0: Introduction
The main purpose of this study was to analyse the access to sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre. In the preceding chapter, effort was made to further discuss and report the findings of the study. It is presented by tree sections namely, discussion and summary of findings, recommendations and suggestions for areas of further research.

5.1: Summary of findings and discussion

5.1.1: Participants Birth History and Past Pregnancy Experiences
It is important to note that this was not an independent objective of the study. However, the researcher deemed it necessary to investigate these two aspects in a section of their own in order to acquire more background data about the teenage mothers, and determine if in any way, the birth history as well as different past experiences related to pregnancy have a relationship with the access to sexual and reproductive health services by teenage mothers. Limited studies have carried out research on birth history, and no study has tried to establish a relationship between past birth experiences and the access to SRHS by teenage mothers. Based on the findings, it is evident that birth history does have a significant effect on the utilisation of some sexual and reproductive health services, particularly the use of modern family panning methods, whereby teenage mothers with a history of at least one birth are more open minded to using family planning methods compared to those that were just pregnant with their first child. This is because of the misconceptions about family planning that teenage mothers have, stating that it can cause infertility. The fact that some teenage mothers have had a history of difficult experiences, including complications resulting from unsafe abortion, and, still births resulting from lack of antenatal care, enables them to not only acquire more information about services like the importance post abortion care and antenatal care, but also to ensure that they seek out these services and utilise them. Evidently, based on these findings, birth history and past experiences influence the access to sexual and reproductive health services, both in positive and negative ways.
5.1.2: Knowledge and awareness about sexual and reproductive health services by teenage mothers

The study revealed that teenage mothers have limited knowledge about sexual and reproductive health services. First and foremost, it is evident that some teenage mothers seek out these services only after they have gone through certain difficulties, which shows that they lacked information about them prior. Surprisingly, level of education did not have an effect on the level of knowledge and awareness of SRHS. Almost all teenage mothers regardless of their educational background were aware, but not knowledgeable about the concept, given all had relatively the same idea on the concept, but none could clearly define it. All teenage mothers stated that they were aware of at most three sexual and reproductive health services, of which majority got to know about them after getting pregnant from medical service providers. It would be expected that parents would be a major source of information concerning SRHS, as well as other key platforms. That is to say, mass media for example radios. Despite the fact that teenage mothers knew about some sexual and reproductive health services, some of the information they had about them especially concerning modern family planning methods (condoms and hormonal contraceptives) were misconceptions based on myths, ‘here say’ and traditional beliefs. On the hand, the concept of sexual and reproductive health rights seemed almost alien to the teenage mothers, given almost all did not know about them, and the few that had heard about them could not point out any. All these findings expose the fact that there is a knowledge gap amongst teenage mothers.

5.1.3: Factors influencing the access to sexual and reproductive health services by teenage health services

The fact teenage mothers believe in the importance of sexual and reproductive health services prompts them to seek them out, however, their beliefs that some of these services, for example hormonal contraceptives and condoms, can be harmful to their health also stops them from utilising them. The demographic characteristic ‘place of residence’ seemed to influence access to SRHS given almost all teenage mothers resided in the same vicinity with NTIHC, which they said is a motivational factor for them to acquire services from the centre. Other factors that motivated teenage mothers to acquire services from NTHIC include; the centre offers free services and deals with only young people, two factors that also stop them to going to other health centres, despite some being much more in their proximity than NTIHC. They stated that other health centres offer unaffordable services that are not youth
friendly. It was discovered that teenage mothers not aware of some services, including post abortion care and gender based violence, a factor, which could limit their access to these services. Most teenage mothers made no indication that their religion can influence their access to SRHS, which was not the case with culture. Relatively all the teenage mothers indicated that their traditional beliefs do not advise the utilisation of modern family planning methods, which is unfortunate because most of these beliefs are misconceptions. Teenage mothers also pointed out the preference for traditional medicines rather than getting treatment from the health centres. Asides from culture, lack of spouse support in terms of utilisation of services is considered to be another great limiting factor, given teenage mothers do not access services because their partners do not allow them, or refuse to go with them to the health centre. Many of these factors influence the access to SRHS in a way that they limit teenage mothers from accessing some of these services.

5.1.4: Ways of improving access to sexual and reproductive health services by teenage mothers.

Teenage mothers had a variety of viable suggestions to improving the access to sexual and reproductive health services. They expressed the need for health centres that offer these services to only young people, in a way that they are affordable, and accessible such that they are more comfortable utilising any services that they may need. Some teenage mothers also expressed their need for more information regarding some services, and also the need for educating males on the importance of some services. Though pointed out by a very small number of teenage mothers, the suggestion to educate males on the relevance of services like family planning was brought up, including the fact that they should be advised to provide moral support by going to the health centre to acquire these services with their respective partners.

5.2: Conclusion

Based on the results from the study, it is evident that the access to sexual and reproductive health services by teenage mothers is still lacking. Their knowledge about sexual and reproductive health is dominated by misinformation and misconceptions, majority of which are sources from their traditions and peers. Even with the little credible knowledge that they have, there are number of factors that limit their access to sexual and reproductive health
services. However, teenage mothers also recognise the fact they have unmet need for these services, given they can express what needs to be done in order to improve their access to sexual and reproductive health services.

5.3: Recommendations
The study findings revealed a number of gaps in the access to sexual and reproductive health services. Some of these gaps can be bridged by the different suggestions that were given by teenage mothers to improve the access to SRHS. Nevertheless, other recommendations to improve the access to sexual and reproductive health services include;

There is a need to increase the level of knowledge and awareness of sexual and reproductive health services amongst teenage mothers. First and foremost, parents should be the first to educated so that in turn they become the most credible and potential source of information for the teenage mothers. These young women should not have to first experience various sexual and reproductive health problems, or get pregnant first before getting to know about sexual and reproductive health services and their importance. Knowing about the importance of these services, will potentially safe guard them from any sexual and reproductive health problems.

In addition to sources of information, mass media, including radio and television should be used to convey messages concerning sexual and reproductive health, not only to adults, but to also young women who are below the age of 20 given some of them are already mothers, and are exposed to so many sexual and reproductive health issues.

Community awareness and sensitisation programmes and outreachs on sexual and reproductive health services should be held not just in urban areas, but also in the rural areas. This can be used as a strategy for cultural acceptance for SRHS, by tackling the problem of cultural influence right from the source, which in most cases are the rural areas which teenage mothers consider their homelands.

The aspect of sexual and reproductive health rights should not be ignored. In a bid to increase knowledge and awareness of sexual and reproductive health services, teenage mothers should also be educated on the existence of their sexual and reproductive health services. These young mothers need to know the rights they hold as regards to their
reproductive health, as this informs their decision making when it comes SRH, and enables them demand for services that meet their needs.

Last but not least, the government should revise its policies concerning sexual and reproductive health services for example, abortion. The participation of teenage mothers in formulation of policies should also be aforethought not only for their needs to be put into consideration, but also for them not feel stigmatised.

5.1.5: Suggested areas for further research
More studies should be conducted considering the influence of birth history and past pregnancy experiences given these are potential factors that can influence the access to SRHS.

More research should be carried out the socio-cultural influence on the access to sexual and reproductive health services by teenage mothers given the area remains a very controversial issue in Uganda because the country is conservative in nature.
REFERENCES


APPENDIX I
INFORMED CONSENT FORM FOR TEENAGE MOTHERS

Study investigator: Kandole Daisy

E-mail: dkhandhole@yahoo.co.uk

Tel: +256702111515

STUDY TOPIC: ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY TEENAGE MOTHERS AT NAGURU TEENAGE INFORMATION AND HEALTH CENTRE.

Introduction

Hello, I am Kandole Daisy, a third year student at Makerere University pursuing a bachelors’ degree in social work and social administration. As a requirement for the fulfilment of my degree, the university requires me to carry out research on a selected topic. My study topic is "Access to Sexual and Reproductive Health Services by Teenage Mothers at Naguru Teenage Information and Health Centre ". You have been randomly selected to take part as a respondent in this research and this document will provide you with further information about it, so that you can decide whether you would like to take part. Please take time to read the information carefully.

Background

The purpose of this study is to analyse the availability and accessibility to sexual and reproductive health services by teenage mothers at Naguru Teenage Information and Health Centre. Your participation in this study will greatly help in this analysis.

Risks and benefits

This research will not inflict any harm whatsoever to anyone who takes part in it and all the rights of the participants will be held in high regard.

There is no direct benefit for you in this study. However, the findings from this research could help in the facilitation of better sexual and reproductive services in the area especially
for the teenage mothers. It may also help in the formulation of better policies concerning sexual reproductive health. Participants may also be able to attain extra knowledge on the above topic.

**What do you want the participant to do?**

This study considers teenage mothers as the main participants. If you chose to take part in this study, you will be required to participate in interviews that will not go beyond 30 minutes. A voice recorder may be used to record the interviews for easy data collection and storage. You may also be required to answer a number of open ended research questions that are related to sexual and reproductive health.

**Confidentiality**

All the information gathered from you will be kept completely CONFIDENTIAL. Study codes will be used in place of the names of the participants in order to ensure anonymity and all findings gathered will be kept under lock and key after the research has been completed and used for study purposes. The information gathered shall not be shared with anyone else in order not to defy the right to privacy.

**Voluntariness**

Participation in this study is completely VOLUNTARY. You are entitled to making your own decision concerning participation in this research and you will be completely free from any form of coercion or persuasion. You are also free to withdraw from the study or stop participating at anytime without any effect on your care here at the centre. You can choose not to answer any questions which you do not like to answer. Please feel free to inform the researcher or interviewer in case any of the questions asked may seem uncomfortable or unclear to you. However, the entire process will be made as comfortable as possible.

**Contacts and questions**

In case of any questions or inquiries, please go ahead and ask now, or you may contact the researcher(s) carrying out this study at the contact below;

Kandole Daisy

E-mail: dkhandhole@yahoo.co.uk

Tel: +256702111515
If you would like to talk to someone other than the researcher(s) about (1) concerns regarding this study, (2) research participant rights, (3) research related injuries, or (4) other human subjects’ issues, please contact;

Dr. Stella Neema

The Chair

Makerere University School of Social Sciences

Research Ethics Committee

Tel: +256772457576

Email: sheisim@yahoo.com

STATEMENT OF CONSENT

I have read the above information or had the above information read to me. I have answers to the questions I have asked. I consent to participate in this research. I am at least........years of age.

Name of participant..........................................................................................

Signature or thumbprint/mark of participant................................. Date............................

Signature of person obtaining consent ........................................ Date............................

Witness of person in case person is illiterate;

Name of witness: ..........................................................................................

Signature or thumbprint/mark of participant ..............................Date............................
APPENDIX II
DATA COLLECTION TOOL

STUDY TITLE: ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY TEENAGE MOTHERS AT NAGURU TEENAGE INFORMATION AND HEALTH CENTRE (NTIHC).

Hello, my name is Kandole Daisy, a third year student at Makerere University pursuing a bachelor's degree in Social Work and Social Administration. You have agreed to take part in a research study under the above title, and this document contains a few questions that you will be required to answer. Please feel free to ask for clarification during the interview.

DATE:

TIME OF INTERVIEW:

PLACE OF INTERVIEW: NAGURU TEENAGE INFORMATION AND HEALTH CENTRE

SECTION 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1) Where do you reside?

2) What is your religion?

3) What is your nationality?

4) Which tribe are you?

5) How old are you?

6) Have you ever attended school?

7) Which level of education did you last attend?
8) Are you married?

9) Do you currently live with your spouse? If not, with whom do you currently reside?

10) What do you do to earn money?

SECTION 2: BIRTH HISTORY AND PAST PREGNANCY EXPERIENCE

11) Have you ever given birth?

12) How many children do you have?

13) At what age did you get pregnant?

14) Where there any difficulties during /after your pregnancy? Please talk about them.

15) Who gave you/ is giving you support through your pregnancy?

SECTION 3: KNOWLEDGE/ AWARENESS ABOUT THE SERVICE

16) Have you heard about sexual and reproductive health services? What are sexual and reproductive health services? What are some of the sexual and reproductive health services that you know of?

17) How did you know about sexual and reproductive health services?

18) Have heard of Sexual and Reproductive Health Rights? What are they? What are some of the sexual and reproductive health rights that you know?
19) Apart from Naguru Teenage Information Health Centre, which other health centres do you know that offer sexual reproductive health services?

20) Have you received sexual and reproductive health services from any of the centres you have mentioned above? Please explain.

SECTION 4: FACTORS INFLUENCING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES AT NAGURU TEENAGE INFORMATION AND HEALTH CENTRE.

21) Do you believe that sexual and reproductive health services are essential for your health? Please explain.

22) How did you know about Naguru Teenage Information Health Centre and why did you choose to acquire health care from here?

23) What is the proximity of your place of residence to the health centre?

24) How often do you come to receive sexual and reproductive health services? Please explain answer.

25) What sexual and reproductive health services are you aware of that are offered at Naguru Teenage Information and Health Centre? Which of these services have you received?

26) Do you receive these services in time?

27) Is your spouse in support of you receiving these sexual and reproductive health services? Please explain.
28) Have you come to receive any sexual and reproductive health service with your spouse? Please explain.

29) Is your family (parents/ guardians) in support of you acquiring sexual and reproductive health services? Please explain.

30) Does your religion support the use of sexual and reproductive health services? Please explain.

31) Do your cultural values and norms support the use of sexual and reproductive health services? Please explain.

32) Are you comfortable with coming to receive sexual and reproductive health services from Naguru Teenage Information and Health Centre? Please explain.

33) Are there any challenges you have faced in acquiring sexual and reproductive health services at Naguru Teenage Information and Health Centre? (At personal level and within the centre). Please sight out these challenges.

SECTION 5: WAYS OF IMPROVING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES.

34) In what ways do you think access to sexual and reproductive health services can be improved? (at personal level and within the centre)

THANK YOU FOR YOUR COOPERATION.

END.