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Original Article

PREDICTORS AND PRACTICES OF SEXUAL AND REPRODUCTIVE HEALTH AMONG ADOLESCENT GIRLS IN LIRA CITY, NORTHERN UGANDA. A CROSS-SECTIONAL STUDY.

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Abstract

Background

Sexual and Reproductive health among adolescents is an increasing public health concern worldwide. Practices of Sexual and Reproductive Health among Adolescent Girls in Lira City, are reinforced and perpetuated by factors that occur at individual, social, and community, and many others. Therefore, this study aimed to assess the predictors and practices of sexual and reproductive health among adolescent girls in Lira City.

Methodology

This was a cross-sectional study using quantitative methods, participants were randomly selected by stratified and simple random sampling to have equal representation from all classes. Data was collected using a structured self-administered questionnaire. Data was analyzed using SPSS version 23 and descriptive and inferential statics were generated at univariate, bivariate, and multivariate levels.

Results

170 respondents participated in this study with a 100% response rate, the majority of the respondents were aged 18 years. 80(54.8%) senior five, 49(31.5%) Anglican, 70(47.9%) Langi tribe, 123(84.2%) resided in urban areas. The descriptive results showed that 67.1% had poor SRH practices. Logistic regression showed that Class attendance and knowledge of SRH were the predictors of SRH practices among adolescent girls. Being in senior four, five, and six would increase the likelihood of having good practices by 16.4%, 20.0%, and 18.9% respectively compared to lower classes.

Conclusion

The study findings showed that 60.3% of the adolescent girls aged 18 and 19 years in Lira City 67.1% of them had poor SRH practices. Additionally, the study revealed that attending higher classes and having good knowledge of SRH were predictors of good SRH practices among adolescent girls aged 18 and 19 years in Lira City.

Recommendations

The schools should collaborate with public health facilities in the region to provide outreach of health education and basic SRH services to adolescent girls in schools to enhance proper SRH practices.

Key Words; *Lira city, predictors and sexual and reproductive practices, Adolescent girls.*
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Background of the study

Sexual and Reproductive health among adolescents is an increasing public health concern worldwide. Sexual health refers to a state of physical, emotional, mental, and social well-being about sexuality and sexual relations and not merely the absence of disease, dysfunction, or infirmity well as Reproductive health encompasses all aspects of an individual's physical, mental, and social well-being, rather than merely the absence of illness or infirmity, about the reproductive system and all its functions and processes (World Health Organisation, 2023). Adolescents are among the most vulnerable groups to adverse SRH outcomes worldwide, for example, according to UNICEF (2023), over 140, 000 adolescents were newly infected with HIV worldwide in 2022 alone well as many sexually active young people do not know their HIV status and their partners. Furthermore, More than 333 million new cases of curable STIs i.e. syphilis, gonorrhea, chlamydia, and Trichomoniasis among others are registered worldwide each year with adolescents 15-19 years ranking second highest after young people of 20-24 years age group (Mayaud, McCartney, Ong, & Mabey, 2023).

In Sub-Saharan Africa, adolescent girls are four times more likely to be infected with HIV than adolescent boys due to the desperate cross-generational sexual relationships for economic and material benefits since older men are more likely to be HIV positive, and these relationships often are characterized by coercive unprotected sex (Maulide Cane et al., 2021). The

vulnerability is worsened by a lack of access to HIV information and prevention services. According to UNFPA-Uganda (2021), Uganda has one of the highest teenage pregnancy rates in Sub-Saharan Africa with over 25% of Ugandan women becoming pregnant by the age of 18 years. In 2020, over 19% of all pregnant women in Uganda were teenagers (UNFPA-Uganda, 2021).

Recent studies in developing countries show that these poor SRH outcomes among adolescent girls are a result of poor knowledge of SRH that fuels the indulgence in SRH behaviors and practices such as poor menstrual hygiene management, unprotected sexual activities with multiple sexual partners and underutilization of SRH services (Mabuza & Mabuza, 2020; Trant et al., 2022). These bad SRH practices are reinforced and perpetuated by factors that occur at individual, social and community, institutional, and health care systems as well as macro levels such as; age, socioeconomic factors, cultural and religious beliefs and norms, level of education, family and peer support, knowledge of SRH issues, availability and access to sanitary facilities, attitudes of SRH service providers, convenient location of health facility, access to essential SRHR information and services, adolescent health policies of among others (Mbizvo et al., 2023). The Ugandan government has since 2017 committed to implementing the "National Adolescent Health Policy" and the "National Sexuality Education Framework" with the intent to improve access to SRHR information and basic services delivered to adolescents and young people such as contraception, STIs testing, and treatment, HIV counseling, and testing services, Post-abortion care, and menstrual health education among others (Dlamini, Tagoola, Mutalya, Odaga, & Christiansen, 2019). Despite the efforts, many studies have demonstrated evidence of low knowledge levels of SRH, low levels of utilization of SRH services, and continuing practice of risky SRH practices and gender disparities among adolescents (Murungi, Benyumiza, Apio, Nekesa, Misuk, et al., 2023). Lira City in Northern Uganda has continued to report the highest rates of teenage pregnancies, and HIV prevalence among adolescent girls and boys in Uganda with girls being more affected than boys (Murungi, Benyumiza, Apio, Nekesa, Misuk, et al., 2023). For example, 1,851 new cases of HIV infections were reported in Lira City between September 2022 and October 2023 particularly prevalent among adolescents with the majority of the affected individuals being girls. The district also records over 5000 teenage pregnancies each year (Napyo et al., 2020). Additionally, over 60% of adolescent girls in the region do not know basic menstrual hygiene practices, and have little knowledge of their menstrual cycle and the consequences of unprotected sexual intercourse (Napyo et al., 2020). This signifies poor SRH practices and an unmet need for SRH information and services in the area.

However, it remains unclear the factors associated with the disproportionately low levels of knowledge and poor practices of SRH among adolescent girls in the area due to a paucity of literature conducted on the subject. Furthermore, there is limited literature on the subject among school-going adolescent girls who are also inherently affected by resulting school dropouts and other related disputes. Thus, to bridge these gaps, this study intended to Assess Predictors and Practices of Sexual and Reproductive Health among Adolescent Girls in Lira City, Northern Uganda.

Methodology

Study Design

This study used a cross-sectional study design employing quantitative research methods to Assess Knowledge and Practices of Sexual and Reproductive Health among Adolescent Girls in Lira City, Northern Uganda at one particular point in time.

Study Site and Setting

This study was conducted among adolescent girls (18 to 19 years of age) in Lira City, Northern Uganda. Lira City is among the 9 newly elevated cities in Uganda, it's located in Lango Sub-region in Northern Uganda. The city has over 20 secondary schools and a secondary school was randomly selected using a simple random sampling technique.

Study Population (Target and Study Populations)

This study targeted all adolescent girls in Uganda well as the accessible population will be adolescent girls of ages 18 and 19 years in a selected secondary school in Lira City, Northern Uganda. All adolescent girls in all classes from senior one to senior six in the age bracket of 18 and 19 years were included in the study and the anticipated accessible population was approximately 250 adolescent girls.

Eligibility Criteria

Inclusion Criteria

All adolescent girls ages 18 and 19 years who were students in the selected secondary school present during the period of data collection were included in the study.

Exclusion Criteria

The adolescent girls ages 18 and 19 years in the selected secondary school who were critically ill and thus unable to participate in the study were excluded from this study.

Sampling technique

This study employed stratified random sampling followed by simple random sampling to randomly select the study sample from the accessible population. The stratified random sampling technique involved splitting the population into different groups called strata (Different Classes in the school) and then randomly selecting participants from each subgroup.

Sample Size Determination

The sample size was determined using the Yamane (1967) formula. This formula makes the following assumptions to suit the design effect for this study as follows;

n = N / (1 + Ne^2)

Where. n= required sample size, N = Population size, and e = Margin of error (e) = 0.05 based on 95% level of significance. The researcher anticipated approximately 250 adolescent girls ages 18 and 19 years in the selected Secondary School. Substituting this as "**N**" in the formula.

n =250 / (1+250*0.052)

n=154

Thus, the total sample size of this study was **170** adolescent girls aged 18 and 19 years after adding 16 participants accounting for the estimated 10% non-response rate.

Data Collection.

Independent variables

In this study, the independent variables included; social demographic characteristics of participants such as age, socioeconomic status, physical disabilities, cultural background, education status of family members and parents, religion, and Knowledge of SRH including knowledge of STIs and HIV/AIDs and STI/HIV testing and counseling services and menstrual symptoms, hygiene, and management.

Dependent variables

The dependent variable in this study was SRH practices. The study focused on SRH Practices related to STIs and Menstrual health. These included behaviors related to seeking/utilizing STI testing and counseling services, prevention of STIs, menstrual hygiene, and management of menstrual symptoms like menstrual flow, cramps, and overall discomfort related to menstruation.

Data Collection Techniques and Instruments/Tools.

This study employed self-administered questionnaires and data was collected using structured questionnaires. The questionnaire was adopted from 3 previous research studies conducted in Uganda in line with the different objectives of the study (Murungi et al., 2023). The questionnaire constituted structured questions adapted based on the study objectives of this study. The questionnaire, therefore, had 3 sections including social demographic factors like; age, address of residence (Urban/Rural), and the schooling section (Boarding/day), among others: Knowledge of Sexual and Reproductive Health and Rights with questions; menstrual cycle and hygiene and sexually transmitted infections: sexual and reproductive practices like; management of menstrual symptoms and menstrual hygiene practices, of the adolescent girl, behaviors related to seeking/ utilization of STIs testing and counseling services, prevention of STIs. All the questions on knowledge and practices of SRH were on were positive statements on a 5-point Likert scale with Strongly agree (5), agree (4), Neutral (3), Disagree (2), and strongly disagree (1). Mechanism to Ensure a Scientifically Rigorous Study

Validity.

A measuring tool's validity is determined by how well it performs its intended function, which is related to whether the tool measures the behavior or quality that it is intended to measure (Sürücü & Maslakci, 2020). The researcher was trained and mentored in research ethics, data collection, and overall research methods and the researcher worked closely with the supervisor (Research mentor) in the development of the questionnaire to ensure that it covers all the constructs intended to be measured and a high content validity.

Reliability.

The term reliability refers to the degree of stability and consistency of the study tool over time (Sürücü & Maslakci, 2020). That is to say, when a researcher applies the same study tool in the same study setting should get consistent results. The study tool was pretested among 24 adolescent girls in Lira Secondary School Amuca, in Lira City to ensure the clarity, suitability, and reliability of the questions used and make appropriate adjustments. The Cronbach alpha was applied to determine and ensure the reliability in terms of internal consistency of the questionnaire and was well above 0.7 on the Cronbach's alpha scale thus, the study tool was considered reliable (Taber, 2018).

Data Collection Procedure.

Upon ethical approval from the Lira University Research and Ethics Committee (**LUREC-2024-216**), the researcher sought and gained administrative approval from the administration of the school. The researcher then coordinated with the class coordinators of each class to recruit participants by stratified random sampling. The informed consent was sought from the selected adolescent girls and each of the participants was given a structured questionnaire and guided on how to respond to the questions. Data collection took place on the 11th and 12th April 2024. The participants returned the filled questionnaires to the researcher and upon reception, the questionnaires were cross-checked for completion, coded, and kept under lock and key only accessible by the researcher.

Data Analysis

The data input process for the duplicate entries made in Epi Data version 3.1 was made using Microsoft Excel and data was cleaned to clear up any discrepancies and verify completeness. Data was then exported into Statistical Package for Social Sciences (SPSS) version 23.0 for final coding and data analysis. The data was then analyzed and variables were described at univariate level using the following metrics; mean, median, frequencies, proportions among others. A Chi-Square test was then used on the variables to determine the bivariate level of

association between the independent and the dependent variables and the results were summarized into Pearson Chi-Square values and a P-value of less than 0.05 was deemed significant. A multivariate logistic regression was conducted to identify the variables with significant association (predictors) with a P-value of less than 0.05 to eliminate the effect of confounding and modifying factors. (A p-value of less than or equal to 0.05 is deemed significant at the multivariate level of analysis).

Ethical Considerations

Institutional Ethical Review Board (Ethical approval)

Ethical approval was sought and obtained from the Lira University Research Ethics Committee (LUREC) before data collection. The LUREC reference number was LUREC-2024-216.

Informed Consent

A written informed consent was sought prior to conducting the study. These consent forms clearly elaborated the study terms and conditions and the participants were given the opportunity to read and understand and raise any concerns. Additionally, a copy of the signed informed consent form was given to the Research participants after the study.

Confidentiality and Privacy.

Participants received assurances that no one else would access their information except the researcher. The questionnaires contained no names, IDs, or other personal information. Additionally, participants responded to questionnaires privately at their own convenient time and place to ensure privacy.

Data Management and Storage Plan.

After data collection, the questionnaires were coded and stored under lock and key only accessible by the researcher. The data was then entered into the password-protected personal computer and stored on the flash disk and password-protected personal computer only accessible by the researcher.

Results

Response rate.

Table 1 Showing Response rate

Variable	Frequency	Percentage (100%)
Duly filled questionnaires	146	87.9
Unfilled questionnaires	24	12.1
Total	**170**	**100**

Socio-demographics

The socio-demographics of the respondents including age, education level, religion, tribe, residence, and school section were ascertained. Table 2 below summarizes how they are distributed among the respondents. As shown in the table, the majority of the respondents were aged 18 years 80(54.8%), were in senior five 49(31.5%), belonged to Anglican 70(47.9%), were of Langi tribe 123(84.2%), resided in urban areas 80(54.8) and were in boarding section 117(80.1%).

Table 1 showing socio-demographic characteristics of participants

Variable	Frequency	Percentage (100%)
Age		
18years	80	54.8
19 years	66	45.2
Class		
Senior One	5	3.4
Senior Two	8	5.5
Senior Three	12	8.2
Senior Four	46	31.5
Senior Five	49	33.6
Senior Six	26	17.8
Religion		

Catholic	50	34.2
Anglican	70	47.9
Pentecostal	24	16.4
Muslim	1	0.7
Adventist	1	0.7
Tribe		
Langi	123	84.2
Acholi	18	12.3
Iteso	3	2.1
Baganda	2	1.4
Residence		
Rural	66	45.2
Urban	80	54.8
School section		
Day scholar	29	19.9
Boarding scholar	117	80.1

Source, Primary data, 2024.

Practices of Sexual and Reproductive Health

Knowledge was measured using 10 questions on a 5-point Likert scale coded as follows; Strongly agree (5), Agree (4), Neutral (3), Disagree (2), and Strongly Disagree (1). The results were summarized in frequency and percentages in Table 4.4 below. The results revealed that 67.1% of the respondents had poor knowledge well and only 32.9% had good knowledge (Figure 3). From the table, the results showed that most of the respondents 72(49.3%) agreed that: they go to a health facility or seek advice from a health worker whenever they have any abnormal symptoms in the genital urinary system and or during menses. The majority of the respondents:141(96.6%), 66(45.2%), 145(99.3%), 132(90.4%), 53(36.3%), and 53(36.3%) were neutral to: "I change my sanitary material at least twice daily during my menstrual period.", "I keep my mother or sister or friend(s) updated when I am menstruating.", "I take baths at least twice daily with water and soap during menses.", "I dispose of used absorbent material (pad) in the toilet.", "I always want to know the HIV status of my boyfriend before having any sexual affairs.", "I have never self-medicated or bought drugs to treat symptoms of STIs and or menstruation." Respectively. Additionally, the majority of the respondents 72(49.3%), 64(43.8%), and 126(86.3%) strongly Disagreed that: "I use painkillers like Panadol to relieve cramps during menses.", "I have had HIV testing and counseling in the past 12 months.", "I use condoms to protect myself from STI and or HIV." Respectively.

As revealed by the mean and standard deviation in Table 4.4 below, the most practiced SRH practice included; "I go to a health facility or seek advice from a health work whenever I have any abnormal symptoms in the genital urinary system and or during my menses." With a mean (Standard deviation) of 3.94 (0.816). Well the least practiced SRH practice was "I use condoms to protect myself from STI and or HIV." 2.40(1.538).

Table 3 shows the SRH practices.

Variables	Mean	Standard deviation	Frequency (percentage %)				
			Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
I change my sanitary materials at least twice daily during my menstrual period.	3.42	0.769	20 (13.7%)	27 (18.5%)	94 (64.4%)	5 (3.4%)	0 (0.0%)

I keep my mother sister or friend(s) updated when I am menstruating.	2.92	1.183	15 (10.3%)	29 (19.9%)	53 (36.3%)	27 (18.5%)	22 (15.1%)
I take baths at least twice daily with water and soap during menses.	3.34	0.747	16 (11.0%)	25 (17.1%)	99 (67.8%)	5 (3.4%)	1 (0.7%)
I dispose of used absorbent material (pad) in the toilet.	3.21	0.840	10 (6.8%)	33 (22.6%)	88 (60.3%)	8 (5.5%)	7 (4.8%)
I use painkillers like Panadol to relieve cramps during menses.	2.58	1.404	15 (10.3%)	34 (23.3%)	17 (11.6%)	34 (23.3%)	46 (31.5%)
I have had HIV testing and counseling in the past 12 months.	2.53	1.287	10 (6.8%)	30 (20.3%)	30 (20.3%)	34 (22.3%)	42 (28.8%)
I use condoms to protect myself from STIs and or HIV.	2.40	1.538	18 (12.3%)	29 (19.9%)	17 (11.6%)	11 (7.5%)	71 (48.6%)
I go to a health facility or seek advice from a health worker whenever I have any abnormal symptoms in the genital urinary system or during my menses.	3.94	0.816	35 (24.0%)	76 (52.1%)	26 (17.8%)	9 (6.2%)	0 (0.0%)
I always want to know the HIV status of my boyfriend before having any sexual affairs.	3.45	0.895	13 (8.9%)	66 (45.2%)	42 (33.9%)	24 (16.4%)	1 (0.7%)
I have never self-medicated or bought drugs to treat symptoms of STIs and or menstruation.	3.30	0.942	12 (8.2%)	54 (37.0%)	49 (33.6%)	28 (19.2%)	3 (2.1%)

Source, primary data, 2024.

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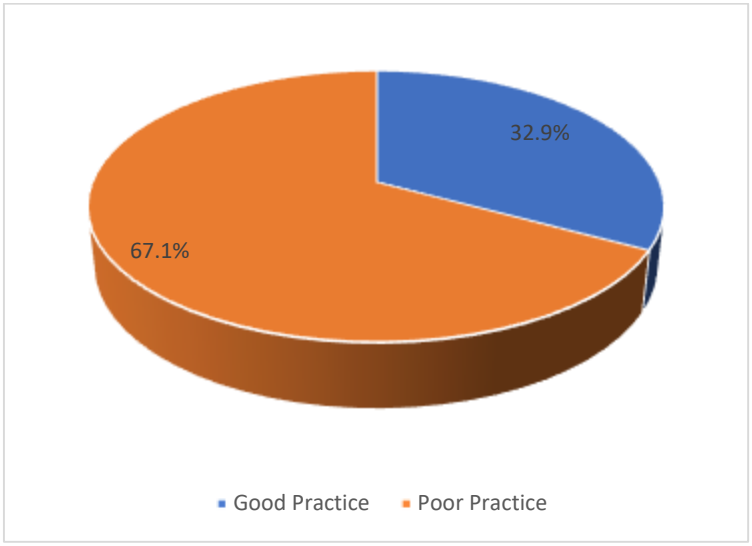

Figure 1 Shows the practices of sexual and reproductive health

Relationship between Socio-demographics and Sexual Reproductive Health Practices of adolescent girls

The Chi-Square test was used to determine the relationship between social demographics and the sexual reproductive health practices of adolescent girls. This was done after recoding the sum values of the 5-point Likert Scale responses on the sexual reproductive health practices to Categorical Variables with the following condition "If the sum of responses was less than or equal to 35, the response was regarded poor well as if the sum of responses was greater than or equal to 36, the mean response was regarded as good." The results are summarized in the table below.

As shown in Table 4:5, the results of the test revealed that Class and residence with [X2 = 20.175, df=5, and P<0.05] and [x2=5.622, df=1, p<0.05] respectively. Hence this implies that the class and residence of the students are responsible for 20.175% and 35.622% of the changes in sexual reproductive health practices of adolescent girls in Lira City Northern Uganda. Well, age, religion, tribe, and school section were not significantly associated with the Sexual and Reproductive Health Practices of adolescent girls in Lira City Northern Uganda.

Table 4 Showing the relationship between socio-demographics and SRH practices

Variable	Frequency (Percentage %)		X^2	Df	P-Value
	Good	**Poor**			
Age			0.664	1	0.415
18	24(30.0%)	56(70.0%)			
19	24(36.4%)	42(63.6%)			
Class			20.175	5	**0.001***
Senior One	3(60.0%)	2(40.0%)			
Senior Two	2(25.0%)	6(75.0%)			
Senior Three	1(8.3%)	11(91.7%)			
Senior four	8(17.4%)	38(82.6%)			
Senior five	18(36.2%)	31(63.3%)			
Senior six	16((61.5%)	10(38.5%)			
Religion			5.529	4	0.237
Catholic	16(32.0%)	34(68.0%)			
Anglican	20(28.6%)	50(71.4%)			
Pentecostal	10(41.7%)	14(58.3%)			
Muslim	1(100.0%)	0(0.0%)			
Adventist	1(100.0%)	0(0.0%)			
Tribe			2.541	3	0.468
Langi	40(32.5%)	83(67.5%)			
Acholi	6(33.3%)	12(66.7%)			
Iteso	2(66.7%)	1(33.3%)			
Baganda	0(0.0%)	2(100.0%)			

Residence			5.622	1	**0.018***
Rural	15(22.7%)	51(77.3%)			
Urban	33(41.3%)	47(58.8%)			
School Section			0.056	1	0.814
Day	9(31.0%)	20(69.0%)		39	78
Boarding	39(33.3%)	78(66.7%)		33.3%	66.7%

Source, primary data, 2024.

Predictors of good Sexual Reproductive Health Practices

At the multivariate level of analysis, 3 variables namely residence, class, and knowledge of SRH that were significant at the bivariate level were run through binary logistic regression at a confidence interval of 95 % to determine the predictors of good SRH practices and the results were summarized in Table 4.7 below. The class attended by adolescent girls was found to have a significantly positive relationship with the practice of SRH. Adolescent girls of senior four, senior five, and senior six were 16.4%, 20.0%, and 18.9% more likely to have good practice [AOR 16.392; 95%CI.8.869-493.315], [AOR 19.996; 95%CI.0.913-516.457] and [AOR 18.940; 95%CI.0.324-548.873] respectively than those in senior one, senior two, and senior three. Additionally, the knowledge of SRH was found to predict SRH practices among adolescent girls. The adolescent girls with good knowledge were 30.9% more likely to have good SRH practices than those with poor knowledge of SRH [AOR 30.854; 95%CI.0.833-618.868].

Table 5 shows the multivariate analysis of the predictors of SRH practices

Variable	Dependent		(AOR)	P-Value
	Good	Poor		
Residence				
Rural	15(22.7%)	51(77.3%)	1.000	
Urban	33(41.3%)	47(58.8%)	0.863(0.222-3.347)	0.831
Class				
Senior one	3(60.0%)	2(40.0%)	1.000	
Senior two	2(25.0%)	6(75.0%)	5.931(0.247-327.423)	0.193
Senior three	1(8.3%)	11(91.7%)	12.171(0.430-407.813)	0.115
Senior Four	8(17.4%)	38(82.6%)	16.392(8.869-493.315)	0.001*
Senior Five	18(36.2%)	31(63.3%)	19.996(0.913-516.457)	0.048*
Senior Six	16((61.5%)	10(38.5%)	18.940(0.324-548.873)	0.021*
Knowledge				
Poor	3(3.4%)	85(96.6%)	1.000	
Good	45(77.6%)	13(22.4%)	30.854(0.833-618.868)	0.000*

Source, primary data, 2024. AOR Adjusted Odds Ratio, Level of significance at ≤0.05.

Discussion

Practices of Sexual and Reproductive Health

The study results showed that close to two-thirds of the secondary school adolescent girls (61.7%) in Lira City have poor SRH practices; particularly, menstrual hygiene and practices of prevention and management of STIs. This finding is by a recent cross-sectional study conducted among young people (15 to 24 years) in Lira City, Northern Uganda which showed that less than a half of the population (42.0%) had good practices regarding the prevention of STIs and HIV/AIDs (Murungi, Benyumiza, Apio, Nekesa, Misuk, et al., 2023).

Similarly, many studies in Sub-Saharan Africa have shown that more than 50% of adolescent girls practice poor menstrual hygiene management (Trant et al., 2022; World Health Organisation, 2018). This is due to inadequate access to resources like absorbent material, and clean water among others (Trant et al., 2022; World Health Organisation, 2018).

However, similar studies conducted in developed countries in Europe and North America showed a high percentage of adolescent girls having good SRH practices (Lameiras-Fernández et al., 2021). This controversy is due to the difference in standards of living which afford adolescent girls in developed countries more access to resources like clean water, better SRH health services as well and access to basic SRH information which enables them to make better-informed decisions about their SRH.

Predictors of Sexual and Reproductive Health Practices

The study found that the classes attended by the adolescent girls and the level of knowledge of SRH were the predictors of SRH practices. Similar findings were observed in studies conducted in Eastern Uganda, Kenya, and France (Ayele, Belay, Kassa, & Worke, 2021; Demisse et al., 2019; Mousa, Alfadhel, & Almubarak, 2021; Patabendige & Goonewardene, 2021). This is justifiable by the fact that adolescent girls attending higher classes of education have had more access to information about SRH and smarter information processing skills leading to better choices and practices of SRH.

Similarly, the study revealed that good knowledge of SRH is a predictor of good SRH practices among secondary school adolescent girls. This study finding is similar to Sabrina et al. (2023) who argued that high levels of knowledge increase confidence and independence in making health-related decision making which increases the adolescents' health-seeking behaviors.

Conclusion

The study findings showed that 60.3% of the adolescent girls aged 18 and 19 years in Lira City had poor knowledge of SRH and 67.1% of them had poor SRH practices. Additionally, the study revealed that attending higher classes and having good knowledge of SRH were predictors of good SRH practices among adolescent girls aged 18 and 19 years in Lira City.

Recommendation

The heads of schools should collaborate with public health facilities in the region to provide outreach of health education and basic SRH services to adolescent girls in schools.

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List of Abbreviations.

AIDs	Acquired Immunodeficiency Syndrome
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund World
WHO	Health Organization

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Conflict of interest

The author declares no conflict of interest.

Author Biography

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