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Young People's Access to Sexual and Reproductive Health Services in Uganda

Young people in Uganda face a range of challenges in accessing sexual and reproductive health (SRH) services. These barriers can be particularly pronounced for women, refugees and other vulnerable groups, and are often shaped by broader societal norms and structures.

In Uganda, many young people are sexually active, and early marriage is common. Pregnancy and HIV rates remain high among young people, and more than half of adolescent and young women (AYW) aged 15–19 have experienced physical or sexual violence. While contraceptive use is increasing, the need for family planning services is still acute and unwanted pregnancies, unsafe abortions, and risks to maternal and child health remain a concern.

This fact sheet summarizes key findings from a qualitative study conducted by the Guttmacher Institute, in collaboration with Makerere University School of Public Health, which explores the impact of social norms on access to SRH information and services among young people aged 15–24, in four districts in Uganda. The study relied on focus group discussions with young people in both refugee and non-refugee communities in the regions of West Nile and Eastern Uganda, and included both in-school and out-of-school participants. The sections below provide insights on how advocates and health care providers can better serve these groups. The fact sheet includes a summary of the study organized by key themes, with actionable recommendations presented under each theme.

Autonomy

Respondents reported care denials and other limitations on autonomy, often rooted in social stigma surrounding premarital sexual activity, as well as expectations that young married women must have children. These social norms pose significant barriers to the autonomy and SRH access of young women in particular.

- Focus group participants reported that health centers sometimes required unmarried young women to have parental consent to access reproductive health services such as contraception, although this permission is not required by national health guidelines. This imposes a barrier for young people whose parents disapprove of premarital sex or have concerns about specific contraceptive methods or their side effects. Married young women also face barriers, as health workers may insist they get their partner's approval before accessing SRH services.
- Participants reported that, given stigma around premarital sex and abortion and the difficulty accessing safe abortion services, young people often turn instead to unsafe practices or informal abortion providers. They also mentioned that young women face barriers to accessing postabortion care, which is particularly important given the lack of safe abortion options.

  We cannot get [postabortion care] because you may go to the health facility and the health workers ask for your parent and yet you didn't want your parent to know anything related to the abortion that you had done. At the health facility, they tell you to go and bring a parent because we are still young and we cannot decide for ourselves. (AYW participant, aged 15–19, Namayingo)

Recommendations

- Health care providers must respect young people's rights to bodily autonomy and informed consent, based on an accurate understanding of national laws and guidelines. This is particularly vital for AYW accessing SRH services.
- It is essential to train all service providers to understand the unique needs of young people, including their need for privacy, confidentiality, accurate and age-appropriate information, and nonjudgmental care.
- Health workers should receive periodic in-service training on best practices for providing a full range of SRH care to adolescents and young people, including critical and potentially lifesaving postabortion care.

Educational and Financial Equity

Respondents reported significant gaps and disparities in education on sexual and reproductive health and rights. These and other educational deficits not only undermine individual autonomy—particularly for young women—but also increase vulnerability to economic exploitation.

Focus group participants also highlighted common misconceptions and negative attitudes among health care workers and educators with regard to youth accessing SRH services, patterns which may exacerbate financial and gender-based inequities.

- Participants reported that young women face discrimination in health care and educational settings, from health professionals who believe they are too young to be sexually active and

who deny them access to condoms while demonstrating condom use only for young men.

When [trainers] come, they only call the boys alone; I guess it's because those condoms are worn by the boys so it is them to learn how to wear them, not the girls. I think even if the girls are called too, they will not turn up. They will be shy…at the health facility, the young girls and women are not given family planning because they tell them that they are too young to be given family planning. (AYW refugee participant, aged 20–24, Terego)

- Participants also cited inadequate educational and economic opportunities as a contributing factor to sexual violence and transactional sex, wherein younger, poorer people could be more easily coerced to have sex in exchange for money.

Recommendations

- To help mitigate the negative impact of misinformation and misconceptions, Uganda's Sexuality Education Framework needs to be strengthened and widely implemented, to raise awareness of sexual and reproductive health and rights (SRHR) issues.
- Educational interventions need to engage both men and women, ensuring both have comprehensive knowledge on topics that are typically considered relevant only for women, such as menstruation and fertile windows, to ensure equal education and understanding of SRHR.
- Increased support for young people's continuing education is needed to improve both their self-esteem and financial circumstances, particularly for those who have left school early. The development of accessible information sources, such as a reliable and toll-free government hotline and an app, are recommended to help disseminate SRHR information. This would be particularly helpful for high-risk groups, such as young people engaging in sex work and those out of school. Providing youth with life skills, including health and financial literacy, can foster their autonomy and economic opportunities and improve their access to SRH services.

Community Support

Participants reported that parent–adolescent communication about SRH was limited. Young people who have sex before marriage are often seen by society as "out of control," violating religious and cultural norms. As a result, they face scrutiny and discrimination.

- Some respondents said that parents believed family planning services could promote promiscuity or lead adolescents to work in the sex industry. Other parents were said to worry that contraception could cause future infertility.
- Some participants reported that community members may isolate sexually active young people due to fear that they could influence others who have not yet had sex. Some said that premarital sexual activity could result in serious social consequences for adolescent and young men (AYM), such as incarceration or forced exile.

  …as soon as the community finds out; they will immediately take you to the boy responsible for having sex with the girl for marriage. Making the boys who slept with the girls pay and sometimes taking them to prison for correction purposes…. (AYM refugee participant, aged 18–21, Madi Okollo)
- Young women who engage in premarital sex may also face ostracization from the community, loss of educational opportunities or forced marriage.

  Usually when such things happen some parents may choose to drop you out of school by stopping to pay the child's school fees. (AYM refugee participant, aged 18–21, Madi Okollo)

Recommendations

- Educational interventions focused on the parent–adolescent relationship should be implemented in the community, to foster communication and address social norms that keep young people from seeking health services. These interventions can also help dispel harmful misinformation such as the belief that comprehensive sexuality education will lead young people to have sex earlier.

Health Facility Improvements

Many participants recognized the value of SRH services. However, due to logistical and financial barriers, some young people were said to avoid public health facilities, where they also feared being seen and judged by the community.

- Participants suggested that long wait times for appointments and a lack of privacy at public health facilities deterred young women from seeking SRH services and information.
- Some also reported that shortages of essential medications, as well as hidden or unexpected fees for services, force adolescents to seek care at private clinics, despite financial constraints, or to purchase medicine from informal providers or drug sellers.

  [You] may reach the health facility and tell the health specialist the problem, and they give the bad news that there are no drugs available. It requires you to buy and at that time you may not have money because they say that the drugs needed to treat STDs are expensive and it requires care. [This situation] may require you to buy [traditional medicines] and treat yourself. (AYW participant, aged 15–19, Mayuge)

Recommendations

- Public health facilities should prioritize adequate staffing to be able to efficiently provide high quality SRH services. They should also maintain a full stock of essential SRH supplies to avoid unnecessary referrals to private facilities.
- Health facilities should be transparent about service fees.
- Health facilities should be equipped with patient rooms that provide auditory and visual privacy for all people who receive information or care.

Access for Marginalized Communities

Participants from marginalized communities—including refugee respondents, disabled respondents, and respondents residing in remote communities—reported additional barriers to accessing SRH information.

- Participants reported that health care staff shortages, long distances to facilities and limited community outreach make it difficult for some populations to obtain necessary SRH resources and care. Refugees also reported language barriers, making it difficult to discuss sexual and reproductive health issues with health care providers.

  Sometimes due to the language barrier, it will be very hard for someone to ask for drugs [to treat an STI]. They will instead test you for malaria which will make you not go back because what you want has not been treated. (AYW refugee participant, aged 20–24, Madi Okollo)

Recommendations

- Providing resources for health outreach workers to access refugee communities, especially those in remote areas, is critical to ensuring that SRH information reaches those who need it.
- Outreach should be tailored to target communities. Leaders in these communities can help to disseminate health information and help facilitate translation to local languages and dialects.
- Communication barriers for people with hearing, motor and other disabilities should be addressed with interpreters, sign-language specialists, and user-friendly equipment, facilitating greater access to SRH services.

Note on Focus Group Discussions

Twenty-four focus group discussions (FGDs) were conducted in 2023 with refugees in Madi Okollo and Terego in the West Nile, and with non-refugees in Mayuge and Namayingo in Eastern Uganda. A total of 46 males aged 18–21 and 114 females aged 15–19 and 20–24 participated in the FGDs. Inclusion of marginalized and vulnerable populations, including sex workers and out-of-school youth, was a priority in the group selection process.

Find this fact sheet at https://www.guttmacher.org/fact-sheet/young-peoples-access-sexual-and-reproductive-health-services-uganda

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