The Addressing Neglected Areas of Sexual and Reproductive Health and Rights in Sub-Saharan Africa (ANeSA) Initiative

A situational analysis of the adolescent sexual and reproductive health (ASRH) landscape in Southwestern and Northern Uganda

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Background

Adolescent sexual and reproductive health (ASRH) remains a critical public health concern in Uganda, a country with one of the youngest populations globally, and where adolescents aged 10–19 years accounted for 25% of the total population (1). Nationally, 25% of girls aged 15–19 and 1% of those under 15 had already begun childbearing in 2016 (2). The prevalence of teenage pregnancy among in-school girls increased from 1.8% before the pandemic to 11.6% during the COVID-19 school closures, which heightened adolescents' exposure to sexual violence, early marriage, and unprotected sex (3,4). The drivers of early pregnancy include entrenched gender inequality, school dropout, lack of safe spaces for adolescents to express their needs, and limited access to contraception and accurate reproductive information (5).

The consequences of adolescent childbearing are wide-ranging and lifelong. Evidence shows that pregnant adolescent girls face heightened risks of complications during childbirth and unsafe abortion (6). Adolescent pregnancy also exposes girls to stigma, discrimination, and interrupted education. Pregnancy accounted for nearly 59% of school dropouts in Uganda in 2012 (7,8). Both the World Health Organization (WHO) and the World Bank have highlighted how adolescent childbearing perpetuates cycles of poverty and marginalization and emphasize the urgent need for comprehensive, multi-sectoral interventions to address these issues (9,10).

Despite the availability of SRHR services in some areas, adolescent utilization remains low. For example, a study in Lira City West revealed that only 42% (162 out of 386) of the youth had used SRHR services in the past 12 months (11). The most accessed services included family planning, voluntary HIV counseling and testing (VCT), and general counseling (11,12).

Uganda currently hosts more than 1.8 million refugees and asylum seekers, making it Africa's leading refugee-hosting nation and the sixth largest worldwide (13). Major settlements, such as Bidi Bidi in Yumbe District (north) and Nakivale in Isingiro District (southwest), accommodate large populations displaced mainly from South Sudan and the Democratic Republic of the Congo (DRC), as well as Burundi and Rwanda (13). Since January 2022, over 443,000 refugees have entered Uganda, including approximately 69,000 Sudanese refugees following the outbreak of violence in 2023 (13). Over half (55%) of Uganda's refugee population is under 18 years old (14), underscoring the urgency of adolescent-focused programming. Despite Uganda's progressive refugee policies, as articulated in the 2006 Refugee Act and 2010 Refugee Regulations (15,16), adolescents in refugee and host communities face heightened risks of early marriage, sexual violence, survival sex, and lack of access to SRHR services (17–19). In some settlements, girls as young as 10 engage in transactional sex to meet basic needs, with little or no access to SRH information or services (20,21).

Against this backdrop, ANeSA is supporting two projects in Uganda:

(i) **Project 1 – Caregiver Adolescent Sexual and Reproductive Health Communication Among Refugees and Host Communities in Southwestern and Northern Uganda (CONNECT):** This project focuses on Nakivale Refugee Settlement in Isingiro District and Bidi Bidi Refugee Settlement in Yumbe District, examining caregiver–adolescent SRH communication and the vulnerabilities faced by adolescents in refugee and host communities.

(ii) **Project 2 – Enhancing Integration of Adolescent Family Planning and Post-Abortion Care in Northern Uganda: A Citizen Science, Gender-Transformative Approach:** This project is implemented in Lira District, where adolescent childbearing and unintended pregnancies remain among the highest in the country. The project addresses persistent gaps in family planning (FP) and post-abortion care (PAC).

In the sections that follow, we provide a situational analysis of the two regions where these projects are being implemented.

Objectives

i. Map relevant national policies governing ASRHR, family planning uptake, abortion, and post-abortion care utilization in Uganda to identify implementation gaps and opportunities.
ii. Identify policy engagement and findings presentation platforms/opportunities.
iii. Highlight effective or ineffective practices /interventions on ASRHR communication, family planning uptake, abortion, and post-abortion care utilization

Adolescent SRHR landscape in BidiBidi and Nakivale

Adolescent SRHR remains largely compromised in Bidi Bidi and Nakivale. Research conducted in Bidibidi found that around 25% of refugee adolescents have ever had sex and face high risks of unwanted pregnancies, STIs, including HIV, exploitation, and limited access to care utilization of SRH services, despite pressing risk exposure (e.g., unprotected sex, unintended pregnancy, STIs) (21,22). Health service utilization is also low, as many adolescents lack awareness of available SRHR services, with multiple barriers including stigma, distance, and perceived irrelevance (21). Stigmatization discourages many from accessing care or speaking out, as survivors' risk being shunned by their communities (23). Furthermore, refugee adolescents and youth in Bidibidi express uncertainty about engaging in formal SRHR discussions, often pointing to mistrust and discomfort when interacting with health workers, peer educators, or caregivers. Although they have a strong need for accurate information, they find it difficult to communicate with adults in settings that do not feel safe or free from judgment (18).

Recent data from a study in Bidibidi and Palorinya shows a teenage pregnancy rate of 34.0% in the Palorinya and Bidi Bidi refugee settlements, with lifetime use of modern contraceptives at 13.8% and current use at 7.5% among adolescent girls aged 15-19 (59). Earlier data further confirm a high adolescent

pregnancy burden: between January 2020 and September 2022, over 4,000 girls under 18 made their first antenatal care visit, and nearly 2,000 teenage deliveries took place, equating to roughly 1,400 adolescent pregnancies per year (25).

In Nakivale, many adolescents lack basic SRHR knowledge. Qualitative evidence (7) highlights that displacement-related poverty and gendered power dynamics expose girls to transactional sex, often in exchange for essential items such as food, sanitary pads, or transport. This is especially prevalent among out-of-school adolescents or orphans who lack support systems. Reports indicate that girls as young as 10 engage in survival sex with little to no access to contraception or protection (19). Nearly 30% of adolescents living in the settlement are sexually active, and over 10% have experienced coerced sex, indicating a high level of vulnerability (19). Some adolescents in the settlement are unaware of how HIV is transmitted or prevented, cannot identify common STIs, or do not know how to prevent pregnancy. Many girls also miss school due to menstruation-related issues, and only a minority have ever accessed SRHR services (19). Experiences of sexual violence, including forced sex during conflict, in transit, or within camps, are common. A 2022 Humanitarian Violence Against Children Survey (HVACS) (27) across all 13 refugee settlements in Uganda found that nearly 50% of young adults aged 18–24 experienced violence before turning 18, and 40% of boys and 32% of girls aged 13–17 experienced violence in the past year alone. Among 18–24-year-olds, 73% of females and 53% of males reported their first experience of sexual violence occurred after resettlement, with the impact leading to school disruption—over 25% of adolescent girls and more than 50% of adolescent boys missed school due to sexual violence. Although 55% of females and 73% of males knew where to seek help, only 5% of females and 17% of males sought assistance, and of those, just 3% of females and 17% of males received support, with many cases perpetrated by relatives, teachers, and community members.

Recent data (28) from Nakivale's host community (Mbarara District) reveal mixed levels of caregiver readiness and ability to engage in SRHR communication. Many adolescents prefer to receive SRHR information from parents or guardians, but open conversations are often limited by fear, shame, or cultural taboos, especially around topics beyond menstruation (19). Among caregivers of adolescents aged 10–14, 63.4% are highly comfortable discussing SRHR, while 32% express moderate comfort, and 4.9% are not comfortable at all (28). Female caregivers tend to report higher comfort levels (63%) than their male counterparts, particularly when discussing less sensitive topics such as general health and hygiene. However, topics like menstruation, contraception, reproductive health, and puberty remain significantly more difficult for both genders. These comfort levels are also influenced by the caregiver's own SRHR knowledge and attitudes. While 84% of caregivers demonstrate a moderate understanding of SRHR issues, only 13% have high knowledge, and 3% report low knowledge—again, with female caregivers showing slightly higher knowledge levels than males. Despite this relative comfort and knowledge among some, attitudes toward adolescent sexuality remain predominantly negative. Data indicate that 84% of caregivers hold negative views on SRHR, 14.5% hold moderate attitudes, and only 0.7% express positive

views. Female caregivers, despite being more involved in everyday adolescent life, are more likely than males to hold social beliefs, moral judgments, and cultural norms that view adolescent sexuality as inappropriate, shameful, or dangerous. Caregiver–adolescent relationships also vary significantly. Only 16% of caregivers report strong emotional connectedness with adolescents, 49% report medium levels of connectedness, and 34% report low levels. Meanwhile, 33%—mostly women—say they are highly involved in their adolescents' lives. However, many caregivers lack the language, confidence, or tools to discuss issues like sexual debut, safe relationships, or gender-based violence.

No direct quantitative data could be found on caregiver SRHR communication or knowledge levels in Bidibidi. These findings indirectly reflect gaps in household-level caregiver–adolescent communication on sexuality and SRH issues.

In refugee and host communities alike, caregiver-adolescent SRHR communication is shaped by cultural norms. For example, in South Sudanese families in the refugee settlements, early marriage may be seen as protective or economically necessary and complicates efforts to delay sexual debut or improve girls' agency (16–18). In contrast, Congolese families in Nakivale may come from matrilineal cultures, where women have a stronger voice; however, this does not always translate into openness to SRHR (29). Caregivers in southwestern Uganda (though not refugee-specific) often feel uncomfortable or ill-equipped to address SRHR topics, especially beyond hygiene or menstruation, due to tradition, emotional unease, and limited information (28). Families in refugee settlements are frequently restructured by migration, death, or separation, and traditional caregiving models may collapse or reconfigure. In both settlements, caregiving roles are frequently assumed by extended family members such as grandparents, aunts, or older siblings, many of whom lack the necessary knowledge, confidence, or language to engage in meaningful SRHR conversations, particularly in reconfigured or disrupted family units. Therefore, instead of proactive guidance, SRHR communication tends to be reactive, limited to general advice on hygiene or menstruation, and avoids more sensitive topics such as contraception, relationships, HIV, and premarital sex. Many caregivers lack adequate knowledge on SRHR communication and feel unprepared or uncomfortable discussing SRHR, and few programs support or equip them to change this (28).

Adolescents themselves are confused and doubtful about SRHR communication. In humanitarian assessments, many say they do not know whom to trust with questions about sex, menstruation, or relationships (19,21). Some report that parents simply say "don't talk to boys" or "avoid girls" without further explanation. Others fear punishment or stigma if they disclose experiences of violence or peer pressure. This approach, however, leaves adolescents vulnerable to misinformation and to risk. Girls also bear the brunt of moral policing and protectionist parenting, while boys are frequently left without guidance (19,21).

Adolescent pregnancy in Northern Uganda

Northern Uganda, particularly Lira District, continues to face critical challenges in addressing ASRHR. The region remains heavily affected by high teenage pregnancy rates, low uptake of FP services, and inadequate access to safe abortion and PAC. Adolescent pregnancies remain particularly widespread in Northern Uganda, with a 26.7% prevalence**,** exceeding the national average of 25% (2,30). Similar patterns have been observed in neighboring areas such as Oyam District, where 68.9% of adolescents had unintended pregnancy during COVID-19 (3). By 2021, health facilities across the Lango sub-region were reporting an increase in antenatal care visits by teenage girls, reflecting both a rise in adolescent pregnancies and a growing demand for maternal health services (31).

Multiple behavioral, familial, and social predictors of teenage pregnancy have been identified among girls aged 13-19 years in Lira, including multiple sexual partners, peer pressure, sexual abuse, early marriage, and irregular contraceptive use (5). A January 2023 cross-sectional survey among young people aged 15–24 years across Ojwina, Adyel, and Lira City West confirmed that SRHR service utilization is seriously limited by gaps in SRHR knowledge, access to services, and provider attitudes (11).

Adolescents' access to contraceptives in Northern Uganda

The recent data from Uganda Demographic and Health Survey (UDHS) 2022 shows that the modern contraceptive prevalence rate (mCPR) among adolescents aged 15–19 remains low, with only 9% currently using a modern contraceptive method. Among sexually active unmarried adolescents, 33% reported using modern contraception, compared to significantly lower levels among their married peers (60). Unmet need for modern contraception continues to be disproportionately high among sexually active unmarried adolescents (42%) compared to married adolescents (28%), highlighting persistent barriers to access and use among young people (60). More recent data from the 2022 UDHS indicate that 21.8% of married adolescent girls (15–19) and 37.2% of sexually active, unmarried adolescent girls in Uganda use a modern contraceptive method (34). In 2024, only 31.7% of youth aged 15–24 had adequate access to family planning. Although 64.6% of adolescents knew about the availability of contraceptive methods at nearby health facilities, 79.3% considered those facilities physically accessible, and significant service-related and socio-cultural barriers persist. Only 61.3% of adolescents found healthcare providers to be respectful, while just two-thirds (66.7%) considered SRHR services youth-friendly (12). Furthermore, 57.7% of adolescents reported a lack of privacy during consultations, 77.2% fear mistreatment by providers, and 66.2% could make independent decisions regarding contraceptive use (12). In 2023, only 1 in 13 adolescents were using modern contraception in refugee settlements of Northern Uganda (24).

A key barrier to accessing family planning services among adolescents in Lira is limited and inaccurate knowledge. Many adolescents continue to rely on unsafe and ineffective alternatives, such as using paracetamol or traditional herbal remedies as contraceptives (11,12). Peer influence is a common source of misinformation, as many adolescents depend on equally uninformed friends for guidance on FP use

(11,12). Negative perceptions toward family planning are widespread and often shaped by deeply rooted cultural taboos surrounding adolescent sexuality. Adolescents, especially those affiliated with religions such as Christianity and Muslims, perceive FP as an advocacy for homosexuality and immorality (12). Many young people and community members remain skeptical of reproductive health programs and question the transparency, privacy, and intentions behind such interventions (12). Some even fear being seen by friends, family members, or health workers who know them when seeking FP services (12).

Adolescents' access to abortion and post abortion care (PAC) in Northern Uganda

Ugandan law permits abortion only when the mother's life is at risk. Women seeking abortion and healthcare providers in Uganda often struggle to determine when abortion is legally allowed due to the inconsistent interpretation of laws and policies by law enforcement and the courts. (35). Uganda's 2006 National Policy Guidelines for Sexual and Reproductive Health and Rights expand the grounds for legal abortion to include cases of rape, incest, and fetal anomaly. However, a lack of clarity and the fear of legal repercussions often deter healthcare providers from offering safe abortion services, leading many adolescents to turn to self-induced or hidden procedures, which are often unsafe (36).

Unsafe abortions account for 39.8% of cases in Lira, with only 42% of women receiving post-abortion care, significantly driving maternal mortality and disproportionately impacting adolescents (30). A facility-based study at Gulu Regional Referral Hospital found that only 21.1% of women receiving PAC used at least four core PAC services (counselling, emergency treatment, family planning, linkage to SRHR services, community provider cooperation) (37). Predictors of utilizing these services include having a supportive partner, existing knowledge of PAC services, being nulliparous or low parity, and receiving care in settings where privacy was respected (37).

Adolescents face unique vulnerabilities in this context. There are Youth-friendly corners established in some Lira health facilities by actors such as the Lira Diocese, which offer health education and basic SRHR counseling tailored to youth (e.g., HIV prevention, life skills) (38). However, for many, a hospital-based PAC is not youth-friendly or confidential. Adolescents often delay seeking care and are likely to be treated at facilities without full PAC readiness, which increases the risk of severe complications and morbidity (35). They often delay seeking care because of stigma, limited knowledge of available services, and distrust of health providers (39). As a result, adolescents, particularly those unmarried, are more likely to arrive with advanced complications and to be treated in poorly resourced facilities with limited readiness to deliver complete PAC packages (37,39).

Beyond utilization gaps, satisfaction with PAC is shaped by person-centered care dynamics. A separate survey in Lira city among 370 women receiving PAC found that the median person-centered maternity care score (the typical quality of respectful and supportive care women received during childbirth) was 21.5 out of 36, with communication and autonomy scoring a median of 9 out of 18, dignity/respect 6 out

of 9, and supportive care 8 out of 9 (39). Higher communication and autonomy scores were significantly associated with increased satisfaction, suggesting that adolescents' satisfaction can improve if providers prioritize respectful, empowering communication (39). This means that while women in Lira generally reported fairly good experiences with dignity, respect, and supportive care, many felt gaps in communication and autonomy: areas where providers did not always explain clearly, listen, or involve women in decisions. Since higher scores in these areas were linked to greater satisfaction, these suggest that improving how providers communicate and empower women could substantially raise satisfaction with post-abortion care, especially for adolescents who are more vulnerable to feeling disrespected or excluded.

Policy and legislation on adolescent SRHR in Uganda

We identified six policy documents: three strategies, two implementation frameworks, and one guideline, all of which are referred to as "Policy (ies)" in this document. Their focus areas included SRHR, family planning and contraceptive use, adolescent health, child marriage, and comprehensive sexuality education (CSE). No district-level policies were available for the study sites (Table 1).

Table 1: Availability of policy documents

Document type	Number reviewed (n=6)	Focus areas
Strategy	3	SRHR, CEFM, adolescent health
Implementation framework	2	Family planning and contraceptive use, CSE
Guideline	1	Adolescent health

The identified policies include:

i. The Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Ageing Sharpened Plan for Uganda 2020/21 – 2024/25 (40), which was refined and focused to address gaps and accelerate progress in adolescent health, reduce early pregnancy, and increase adolescents' access to contraception and adolescent-friendly services.

ii. The Second National Family Planning Costed Implementation Plan 2020/21- 2024/25 (FP-CIP II) (41) aims to increase modern contraceptive use among all women, including adolescents, to reduce unmet need and unintended pregnancies.

iii. The Adolescent Health Policy Guidelines and Service Standards 2012 (42), which outlines priorities for improving adolescent health, including, expanding access different family planning methods with confidential and youth-friendly counselling; strengthening maternal and newborn care through antenatal services, skilled delivery, and postnatal follow-up; providing comprehensive sexual and reproductive health education both in and out of schools; integrating HIV prevention, testing, and treatment into adolescent services; and promoting nutrition, mental health support, and adolescent participation in health programming.

iv. The National Strategy to End Child Marriage and Teenage Pregnancy 2022/2023 – 2026/2027 (43), which aims to reduce early marriage through:

- **Advocacy:** professional development targeting frontline staff, improving health facility-to-facility linkages, generating and using robust data and evidence to inform programs and policies, creating an electronic centralized child sex offenders' database, and scaling up usage of technological innovations to facilitate reporting, response, and information sharing.
- **Legal enforcement:** Harmonizing laws on the definition of a child/teenager, child marriage, teenage pregnancy, witness protection, and related punishments; developing and enforcing district ordinances and community by-laws to outlaw child marriage and teenage pregnancy; simplifying, translating, and disseminating laws and policies on SRHR and promoting girls' education; sensitizing the public and duty-bearers on child rights and SRHR; strengthen law enforcement to address child marriage and teenage pregnancy.
- **Community engagement**: This includes promoting positive parenting, safeguarding and reintegrating teenage mothers and their children, and strengthening the skills and resilience of adolescent mothers. It also involves enhancing community systems through reporting and referral pathways, preventive measures, and greater engagement of boys and men. In addition, it includes mobilizing families, leaders, and communities to address child marriage, teenage pregnancy, trafficking, FGM, and cross-border cases, as well as raising awareness through inclusive IEC materials, edutainment, media engagement, and efforts to counter harmful cultural practices and online risks. It also calls for building the capacity of stakeholders and children, recognizing community-level initiatives, and advancing role models and champions to promote girls' education and contribute to ending child marriage and teenage pregnancy.

v. The National Sexuality Education Framework 2018 (44) aims to standardize SRHR education across the country. This framework targets caregivers, adolescents, and communities, prioritizes caregiver-adolescent communication to increase SRHR education, promote access and uptake of SRHR services, and reduce risky sexual behaviors. It provides structured guidance for comprehensive sexuality education in schools, though its rollout has been controversial and inconsistent. For example, the policy has faced religious backlash in Catholic schools where it is

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supposed to be implemented. Many Catholics strongly opposed the government's mandated sex education, accusing schools of teaching ideas they considered inappropriate and "against the word of God" (45). Disagreements with religious leaders delayed implementation, prompting the Ministry of Education to negotiate (46). Additionally, public outcries over comprehensive sexuality education erupted in 2016 over claims that children were being taught "homosexuality" by international NGOs (47).

vi. The National Adolescent Health Strategy 2011-2015 (48): This policy was designed to target both school-attending and out-of-school children across the country. Some of the provisions introduced in the 2011 changes include promoting parental education on SRHR by integrating the model with health services and the government community programs. It upholds adolescents' rights to non-discrimination, privacy, confidentiality, participation, and access to SRHR services, and promotes adolescent-friendly care that is respectful, confidential, and equitable. It also ensures access to pregnancy and maternity care, protects the right of adolescent mothers to continue education, and includes mechanisms for monitoring and accountability through disaggregated data and youth participation. However, it does not explicitly mention comprehensive sexuality education, guarantee access to the full range of contraceptives without consent barriers, or provide for safe abortion and post-abortion care (Table 2).

Adolescent SRHR policy provision

We assessed the six policy documents to determine whether they explicitly address core ASRHR domains. The review focused on whether policies uphold rights and non-discrimination (including privacy, confidentiality, and equitable access regardless of age, gender, marital status, or disability), require health services to be adolescent-friendly in line with WHO standards (trained providers, respectful care, confidentiality, accessibility, affordability, and equity), mandate CSE in and out of school as per UNESCO guidance, guarantee access to a full range of contraceptive methods without age, spousal, or parental consent barriers, ensure that pregnant and parenting adolescents have access to non-discriminatory maternal health services and are supported to continue their education, provide access to safe abortion and post-abortion care where legal, and establish systems for monitoring and accountability through disaggregated data collection and adolescent participation in policy review.

All six reviewed policies explicitly uphold adolescents' rights and non-discrimination. Five policies include provisions for adolescent-friendly services, and five address comprehensive sexuality education.

Contraceptive access is incorporated in three policies, while support for pregnancy, maternity care, and school re-entry is present in four. Safe abortion and post-abortion care are covered in three policies, and monitoring and accountability mechanisms, including disaggregated data collection and adolescent participation in policy review, are also addressed in three policies.

The findings are summarized in Table 2.

Table 2: Adolescent SRHR policy provisions

Policy	Rights and Non-Discrimination	Adolescent-friendly services	CSE	Contraceptive access	Pregnancy, maternity care, and school re-entry	Safe abortion and post-abortion care	Monitoring and accountability
Reproductive, Maternal, Newborn, Child, Adolescent, and Healthy Aging Sharpened Plan for Uganda 2022/23–2026/27	✔	✔	✔	✔	✔	✔	×
The Second National Family Planning Costed Implementation Plan 2020/21- 2024/25 (FP-CIP II)"	✔	✔	✔	✔	✔	✔	×
Adolescent Health Policy Guidelines and Service Standards 2012	✔	✔	✔	✔	✔	✔	✔
The National Strategy to End Child Marriage and Teenage Pregnancy 2022/2023 – 2026/2027	✔	✔	✔	×	×	×	×
National Sexuality Education Framework 2018	×	✔	✔	×	×	×	×
The national Adolescent Health Strategy 2011-2015	✔	✔	×	×	✔	×	✔

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Actors participating in the formulation and implementation of policies

The identified policies identify a wide and diverse set of actors engaged in their formulation and implementation. These actors span across multiple levels of governance and include (i) state actors such as ministries, agencies, parliament, regulatory bodies, planning institutions, and local government structures; and (ii) non-state actors, including faith-based and civil society organizations, non-governmental organizations, professional associations, technical committees and working groups, private sector actors, media, research and academic institutions, development partners, international agencies, as well as individuals, communities, cultural leaders, and adolescents and young people. The detailed list of actors is presented in Table 3.

Table 3: Actors in the formulation and implementation of policies

State actors
- Ministry of Health (Reproductive and Child Health Department, District Health Teams, Health System Divisions, Health Facilities), Local Government (District Health Management Team, HSD Management Team, Health Unit Management Committees, Local Govt Councils) - Parliamentarians - Office of the Prime Minister - Ministry of Finance, Planning and Economic Development - Ministry of Gender, Labour and Social Development (MGLSD) - Ministry of Education and Sports (MoES) - Ministry of Local Government - Ministry of Lands, Housing, and Urban Development - Ministry of Justice and Constitutional Affairs / Judiciary and Law and Order sector - Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) - Ministry of Water and Environment (MoWE) - Ministry of Internal Affairs (MoIA) - National Planning Authority (NPA) - National Population Council (NPC)

- National Drug Authority (NDA) - National Medical Stores (NMS) - Uganda Bureau of Statistics (UBOS) - Ministry of Information - Uganda Communications Commission - Uganda Broadcasting Corporation - National Curriculum Development Centre - Uganda AIDS Commission
Non-state Actors
Faith-based organizations Inter-Religious Council of Uganda, Uganda Joint Christian Council, other faith-based organizations
Civil society organizations and non-governmental organizations Joy for Children, Uganda Family Planning Consortium, Kawempe Adolescent Centre, Naguru Teenage Centre
International agencies/development partners United Nations Population Fund, United Nations Children's Fund, World Health Organization, United States Agency for International Development, World Bank, Pathfinder International, Global Fund, International Non-Governmental Organizations, Inter-Agency Coordination Committee, and regional organizations.
Professional organizations)
Technical committees and working groups Maternal and Child Health Technical Working Group, Family Planning and Reproductive Health Commodity Security Working Group, Medicines Procurement and Management Technical Working Group, Technical Advisory Committee for Adolescent Health, District Committee on Adolescent Health,

HIV and AIDS Technical Working Group, National HIV Prevention Committee
Private sector Private providers, commercial businesses
Individuals/communities/youth Cultural leaders, traditional health practitioners, elders, community leaders, para-social workers, village health teams, adolescents and young people (both male and female), faith leaders
Media
Research and academic institutions Makerere University Department of Obstetrics and Gynecology

Gaps/challenges that may affect policy implementation

Governance gaps

Although Uganda has developed several policy instruments to address SRHR and ASRH issues, the implementation of these instruments remains weak. This is due to the segmented and piecemeal development of guidelines and tools, as well as the limited use of levers necessary to drive effective implementation. Technical oversight and accountability mechanisms are described as inadequate, which constrains the capacity to make necessary system or delivery modifications. Health sector governance structures are noted to be particularly weak at subnational levels, where district and health facility managers face competing responsibilities and limited resources. At lower levels, health service committees and facility management committees are identified as key mechanisms for participatory governance; however, the persistent barriers to the dissemination and application of family planning policies, standards, and guidelines remain (58)

Funding resource constraints
Funding gaps consistently challenge the implementation of five RMNCAH policies. Major issues include insufficient budget allocations, inefficient resource use, and high reliance on external donor funding. Resource shortfalls are evident in the poor distribution of referral facilities, a lack of neonatal care equipment, inadequate cold chain equipment for oxytocin, and insufficient storage for family planning commodities, resulting in stock-outs. Moreover, inadequate district-level funding limits the integration of interventions into local government plans, weakens policy dissemination, and reduces ownership among local actors. The lack of written standards for sexuality education further hampers implementation. Overall, policies remain only partially implemented, with some tasks dependent on short-term NGO programs, rather than sustainable solutions.

Human resource constraints
Human resource challenges stem from two key policy issues: The Reproductive and Child Health Department operates at only 41 percent staffing capacity, and nearly half of the districts lack a substantive Assistant District Health Office, straining decentralized governance and oversight. Additionally, inequalities in human resource distribution, low health worker productivity due to rotational midwifery shifts, chronic absenteeism (with 50 percent of staff not available, especially at low-level facilities), and deficits in critical skills for managing emergencies and various patient groups exacerbate these issues. Village health teams are mostly informal and voluntary, with limited recognition and support. Further challenges include staff accommodation shortages, insufficient numbers of pharmacy staff, inadequate capacity building, missing standard operating procedures and job aids, high attrition rates among health workers, and excessive workloads.

Service delivery limitations
Five policies outline limitations in service delivery. These include inadequate and late deliveries from national medical stores, an inability to respond to emergency orders, and poorly coordinated service delivery across all levels of care. Services are described as episodic, fragmented around donor-funded projects, unevenly distributed, and centered on providers rather than clients. Low levels of client satisfaction are also highlighted, with only 31 percent of clients expressing satisfaction with services at public health facilities or in the community. Dissatisfaction is attributed to long queues, lack of 24-hour services, and poor responsiveness, including a lack of respect and courtesy from healthcare workers. Family planning counselling is inadequate, with few women receiving counselling after giving birth or following a miscarriage. Only two in five family planning users report receiving comprehensive information on contraceptive methods, and adolescents are the least likely to have received such information from community health workers or village health teams. Service delivery gaps also extend to poor integration of family planning into other services, such as HIV prevention. Adolescents face additional barriers, including long waiting times, a lack of privacy, and rude service providers. Other reported challenges include inadequate access to child protection services, adolescent-responsive service

delivery models, quality education, and birth registration and certification. Some documents also report that sexuality education programs, including the Presidential Initiative on AIDS Strategy for Communication to the Youth, have focused more on HIV/AIDS education rather than covering the broader range of sexuality topics. Most interventions are reported to focus on single issues such as education, skills development, sexual and reproductive health, or economic empowerment, which limits their overall effectiveness in holistically addressing child marriage and teenage pregnancy.

Weak coordination and fragmentation

Three policies highlight challenges with coordination and fragmentation. Weak coordination of different funding streams, especially for family planning commodities, is a recurring issue. Poor implementation of a multi-sectoral approach is reported, alongside weak coordination of partner outreach services, which limits opportunities to build synergies between public and private sector actors. The family planning program is described as failing to tailor interventions to address sub-regional socio-demographic and geographical contexts. Inequities across regions are also noted, with disparities in access to information, services, quality, and demand satisfaction. Some districts are reported to perform better than others due to the presence of implementing partners, while in other areas, fragmented projects contribute to poor coverage.

Sociocultural and political barriers

Three policies identify socio-cultural and political barriers. Limited implementation of social and behaviour change communication interventions is noted, alongside a limited desire to space births among younger women. Inequities in access to family planning are reported across different socio-economic groups, with modern contraceptive use varying significantly by social and economic status. Gender dynamics are also noted, with 20 percent of women using modern contraception reporting that their partner does not know, and 15 percent of users stating that the decision to use contraception was made by their partner or someone else. Some women using contraception clandestinely have experienced gender-based violence, which has sometimes been extended to service providers. Limited male engagement and support are also highlighted. Although the Ministry of Health launched the Uganda Male Involvement Strategy in 2014, dissemination was limited, and resources for implementation were inadequate.

Political influences are also reported, with some politicians encouraging high fertility by telling constituents that larger populations lead to more resources and development or using such messages to gain votes. High discontinuation rates of contraception are also reported, with 52 percent of women discontinuing in 2020, mainly due to fear of side effects. Widespread resistance to reforms in the Marriage and Divorce Bill is also noted, reflecting entrenched social norms, male bias, and reluctance to recognize women's rights within marriage.

Legal barriers

Although Uganda has several legal and policy instruments aimed at protecting sexual and reproductive health, strict abortion restrictions force many women and girls toward unsafe methods. Implementation gaps in laws (e.g., post-abortion care), weak oversight, and limited enforcement exacerbate the problem (61).

Data and monitoring challenges

Three documents identify challenges in data and monitoring. Data collected by health facilities are rarely utilized at the point of collection, which reduces incentives for improving data quality (62). One contributor to this issue is that the Health Management Information System is not uniform across levels, with many centres still relying on paper-based systems (64). Furthermore, facilities are reported not to retain patient records beyond individual patient cards or registers, which restricts longitudinal follow-up and family-centered care. These system limitations, combined with increasing demands for disaggregated data and additional health indicators, add to the workload of health workers. As a result, reporting now consumes up to one-third of consultation time, potentially undermining the quality of care.

In Uganda, the Family Planning Costed Implementation (FP-CIP I) performance monitoring plan included over 35 strategic outcomes, many of which went unmonitored because they were project-focused. Stock-outs, weak logistics, MIS, and limited visibility of contraceptive consumption at service points were also identified among key challenges. (63)

External influences

One policy identified external influences on policy implementation. These include regional challenges such as child trafficking, cross-border child marriages, and FGM practices from neighboring countries such as South Sudan and Kenya (65).

Outdated or lacking policies

Uganda has numerous RMNCAH policies and guidelines in place. However, many are not fully operational or uniformly implemented at the district levels. Some policies remain underused, outdated, or poorly disseminated, with weak monitoring and accountability mechanisms undermining their effectiveness (66).

Table 4: Policy implementation gaps

Policy/legislation	Level	Operational status	Focus area	Implementation gaps
Reproductive, Maternal, Newborn, Child, Adolescent, and Healthy Aging Sharpened Plan for Uganda 2022/23–2026/27	National	Operational	SRHR	✔ **Governance gaps:** segmented and piecemeal development of guidelines and tools; limited use of levers necessary to drive effective implementation; weak accountability; weak subnational governance structures ✔ **Funding and resource constraints:** insufficient budget allocation; inadequate RMNCAH funding; inefficient resource use; geographical maldistribution of referral facilities; lack of inpatient neonatal care equipment; lack of storage and cold chain equipment; community health is mostly externally funded ✔ **Human resource constraints**: Low staffing; lack of a substantive Assistant District Health Officer; inequalities in the distribution of human resources; low health worker productivity; health workers lack critical skills to manage emergencies and adolescents; informal and voluntary village health teams; inadequate staff accommodation; shortage of pharmacy staff ✔ **Service delivery limitations:** Inadequate and late deliveries; inability to respond to emergencies; poor coordination of service delivery; service delivery is episodic, uneven, fragmented around funder projects, and centered on providers; low client satisfaction with public healthcare; limited access and quality of adolescent health services ✔ **Weak coordination and fragmentation**: weak coordination of family planning funding
The Second National Family Planning Costed Implementation	National	Operational	Family planning	✔ **Governance gaps:** Poor dissemination and application of policies and guidelines at all care levels ✔ **Human resource constraints:** poor capacity building of health workers; low staffing; poor provider skills and knowledge; lack of operating procedures and job aides; health workers' absenteeism and attrition

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Plan 2020/21-2024/25 (FP-CIP II)				✔ **Service delivery limitations**: Poor integration of family planning into other services, such as HIV prevention; adolescents are the least likely to have received FP information from community health workers or village health teams; lack of standard operating procedures on providing youth-friendly services ✔ **Weak coordination and fragmentation**: poor implementation of a multisectoral approach; weak coordination of outreach services; existing FP programs do not tailor interventions for different contexts; inequities in family planning across regions ✔ **Data and monitoring challenges**: Data collected by health facilities are rarely used at the point of collection; The Health Management Information System is not uniform across levels; many centers rely on paper-based systems; increasing demands for disaggregated data and additional health indicators have added to the workload of health workers ✔ **Socio-cultural and political barriers**: limited desire to space children among young girls; inequities in access to family planning across different socio-economic groups; limited male support for FP; gender-based violence against FP users
Adolescent Health Policy Guidelines and Service Standards 2012	National	Not specified	Adolescent health	✔ **Service delivery limitations**: long waiting times, lack of privacy, and rude service providers prevent adolescents from using SRH services; lack of adolescent-responsive service delivery models
The National Strategy to End Child Marriage and Teenage Pregnancy 2022/2023 – 2026/2027	National	Operational	CEFM	✔ **Funding and resource constraints**: Inadequate funding at the district level ✔ **Service delivery limitations**: Most national interventions do not address child marriage and teenage pregnancy; inadequate access to child protection services, quality education, and birth registration and certification; **Weak coordination and fragmentation**: Largely fragmented implementation efforts ✔ **Socio-cultural and political barriers**: politicization of child marriage and teenage pregnancy programs; politicians do not include child marriage and teenage pregnancy

				interventions in their plans and budgets; widespread resistance to the Marriage and Divorce Bill ✔ **Data and monitoring challenges**: Lack of outcome indicators and risk analysis before implementation ✔ **Legal barriers**: legal gaps; inadequate implementation and enforcement of child protection policies and laws ✔ **External influences**: regional child trafficking, cross-border child marriages, FGM practices from Kenya and South Sudan
National Sexuality Education Framework 2018	National	Not specified	Sexuality education	✔ **Funding and resource constraints:** Lack of written material on standards for CSE provision ✔ **Governance gaps**: Dependence on development partners, CSOs, FBOs, and cultural institutions ✔ **Service delivery limitations**: Little emphasis on CSE
The national Adolescent Health Strategy 2011-2015	National	Outdated	Adolescent health	✔ Funding and resource constraints: Dependence on internationally funded youth programs developed by NGOs ✔ **Legal barriers**: Ugandan law greatly restricts abortion, leading to unsafe abortions among girls and women; a decline in the school health program meant to teach CSE

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Policy implementation opportunities identified in the policy documents

Government support and commitment

Six policy documents highlight strong government support and commitment. The Ministry of Education and Sports has made efforts to integrate ASRH into the mainstream curriculum, committing to review, update, disseminate, and implement a national sexuality education framework for both in- and out-of-school young people. The Ministry further recognizes sexuality education as a critical component of school health programs designed to empower young people with age-appropriate, culturally and religiously sensitive information and life skills for safe and healthy life choices. In addition, government programming has emphasized creating a conducive national legal and policy framework to address child marriage and teenage pregnancy, with mandates conferred upon the Ministry of Health, Ministry of Gender, Labour and Social Development, Ministry of Finance, Planning and Economic Development, and local governments to mobilize resources and re-orient existing services to meet adolescent health needs. Uganda has also demonstrated high-level political support by making global commitments, including to FP2020, the Sustainable Development Goals, and the Global Strategy for Women, Children, and Adolescents' Health. Evidence-based High Impact Practices in family planning have been identified to guide country programs, while investments in health infrastructure have enabled the establishment of at least one Health Centre III in each sub-county. The government has also improved the availability of reproductive, maternal, newborn, child, and adolescent health commodities.

Technological innovation

One policy document highlighted opportunities related to technological innovation. The government has begun digitizing logistics management information systems from the national to the community level through the expansion of the National Medical Stores Plus system, the Client Self-Service Portal, and the District Health Information System ordering applications for both public and private not-for-profit health facilities. The adoption of electronic logistics management information systems has further strengthened the supply chain. In addition, the inclusion of reproductive, maternal, newborn, child, and adolescent health services in electronic medical records systems has the potential to improve continuity of care by tracking individuals from preconception through pregnancy, childbirth, childhood, adolescence, and adulthood. This integration also supports the sharing of health information between outpatient departments and hospitals, thereby enhancing evidence-based decision-making.

Legal and policy support

Two policies emphasized the enabling role of the legal and policy environment in supporting adolescent health. Legislative frameworks such as the 1995 Constitution of Uganda, the 1997 Decentralization Act, the Universal Primary Education Policy, the Children's Act, the Penal Code Act, the Local Government Act of 1998, and the Sexual Offences Bill provide a basis for protecting adolescents' rights and health. Sector policies further reinforce this by explicitly including provisions for family planning services, post-abortion

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care, and adolescent health support. Family planning is recognized as a key intervention to reduce maternal mortality and is prioritized in national policies and strategic frameworks.

Donor support

Donor support was recognized as an important opportunity in two policies. Development partners contribute significant financial resources for adolescent health, particularly through the procurement of family planning commodities. Financial data indicate that donor funding for family planning commodities has consistently exceeded government contributions.

Improvements in service delivery

One policy document highlighted service delivery opportunities. This includes progress being made in building the capacity of health workers to quantify needs, order commodities, manage inventory, and maintain accurate records for family planning commodities.

Alignment with national policies and international conventions

Four documents highlighted opportunities created by the alignment of Uganda's frameworks with both national and international commitments. The second Family Planning Costed Implementation Plan (2020/21–2024/25) is consistent with national family planning policies, the reproductive, maternal, newborn, child, and adolescent health investment case, and international frameworks such as the Sustainable Development Goals, particularly target 3.7 on universal access to sexual and reproductive health and family planning.

Uganda is also a signatory to numerous international and regional conventions aimed at protecting the rights of children, adolescents, and women. These include the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on Consent to Marriage, the African Charter on the Rights and Welfare of the Child, and the Maputo Protocol, among others. Collectively, these legal instruments strengthen Uganda's obligations to protect adolescents from harmful practices such as child marriage, to ensure access to sexual and reproductive health services, and to uphold the rights of young people within the broader context of national development.

Caregiver-adolescent SRHR communication interventions in Uganda's refugee and host communities

We reviewed three projects that focused on caregiver SRHR communication and adolescent SRHR knowledge outcomes. One notable intervention is a CSE programme implemented for 13 months from June 2016 to July 2017. Mbarara University of Science and Technology led the programme in partnership with the Medical Centre of the University of Munich, Vrije Universiteit Brussel, and Ghent University. It was delivered in 15 primary schools across South-Western Uganda. (49). This program showed significant effects on increasing adolescents' SRHR knowledge. It consisted of eight interactive sessions covering

topics such as puberty, emotions and relationships, decision-making, knowing rights and responsibilities, STIs and HIV, reproduction and pregnancy prevention, media influence, and gender and sexuality. Activities included group brainstorming, case scenario analysis, role-playing, mixed-gender discussions, and labeling diagrams of the reproductive system. Among pupils in intervention schools, knowledge of SRHR doubled. Positive shifts were observed in delaying sex and reporting inappropriate sexual advances. However, changes in other factors being investigated, such as self-esteem, gender-equitable norms, and body image, were negligible.

In another intervention, the "Narratives of Most Significant Change project" (17), a caregiver-focused SRHR communication training was piloted. This intervention was conducted over 3 months from October 2021 to November 2021 in 6 villages in Rwebishekye parish, Mbarara district-south-western Uganda. The programme demonstrated positive effects on improving caregiver–adolescent SRHR communication. Activities involved structured training modules delivered over multiple sessions, which focused on equipping 98 caregivers (26 males and 72 females), especially parents and guardians of adolescents aged 10–14, with the knowledge, confidence, and conversational tools needed for effective SRHR dialogue. The intervention included follow-up qualitative interviews to collect real-life stories of change. Caregivers reported increased openness to discuss SRHR issues, greater knowledge, better attitudes, and stronger relationships with their children. However, many conversations were still limited to topics that caregivers found less sensitive. The intervention was well-received due to strong community engagement, trusted delivery agents, and alignment with participant values. Each module employed participatory methods, including group discussions, community mapping, storytelling, and role-playing, to foster personal reflection and skill development.

Key mechanisms of success included: (i) raising parental awareness of youth SRHR needs, (ii) encouraging open dialogue, (iii) stimulating shared and co-parenting practices, and (iv) building rapport with delivery agents. Parents/caregivers (both male and female) felt more confident engaging with adolescents, who in turn reported improved access to guidance and information. Implementation was influenced by local culture, socio-economic conditions, and the COVID-19 pandemic.

Table 5: Summary of ASRH communication interventions

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Intervention	Setting	Target groups	Implementers	Duration	Core components	Reported effects/outcomes	Notes
Comprehensive sexuality education (CSE) programme in primary schools	15 primary schools, South-Western Uganda	Primary-school adolescents	Mbarara University of Science and Technology; LMU Medical Center (University of Munich); Vrije Universiteit Brussel; Ghent University	13 months (Jun 2016–Jul 2017)	Eight interactive sessions on puberty; emotions/relationships; decision-making; rights/responsibilities; STIs/HIV; reproduction & pregnancy prevention; media influence; gender & sexuality. Methods: group brainstorming, case scenarios, role-play, mixed-gender discussions, labeling reproductive system diagrams	SRHR knowledge doubled among intervention pupils; positive shifts in delaying sex and reporting inappropriate advances; negligible change in self-esteem, gender-equitable norms, and body image.	School-based, structured CSE delivered with participatory methods.
Narratives of Most Significant Change	6 villages (South-Western Uganda)	Caregivers (male/female) of adolescents aged 10–14	Not specified	2 months (Oct–Nov 2021)	Structured multi-session training to build SRHR knowledge, confidence, and conversational tools; follow-up qualitative interviews capturing stories of change.	Improved caregiver–adolescent SRHR communication; increased caregiver openness, knowledge, and attitudes;	Many conversations remained limited to less-sensitive topics

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						strengthened relationships	
Process evaluation of a parent-child communication on adolescent health programme	Six rural villages, South-Western Uganda	Parents/caregivers (male/female) and adolescents	Not specified	6 months (2016–17)	Two phases: (1) three modules on parenting skills, cultural values, adolescent SRHR; (2) five modules on puberty, relationships, STIs, pregnancy prevention. Participatory delivery: group discussions, community mapping, storytelling, role-play; strong community engagement and trusted delivery agents.	Improved caregiver–adolescent SRHR communication; parents were more confident; adolescents reported better access to guidance/information.	Success mechanisms: raised parental awareness, open dialogue, shared/co-parenting, rapport with facilitators; implementation shaped by culture, socio-economic factors, and COVID-19.

Adolescent family planning and post-abortion care interventions in Lira and similar settings

We reviewed four projects that tested the effect of interventions on abortion/post-abortion and family planning uptake. One is a randomized controlled trial conducted across 151 social franchise clinics that deliver sexual and reproductive health services in urban and peri-urban communities in Uganda that tested a behavioral intervention to increase adolescent uptake of family planning (50). The intervention was conducted by ideas42, MSI Reproductive Choices, and Marie Stopes Uganda over a 15-month baseline and 6-month intervention period from 2018–2020. The intervention used simple, scalable components: adolescent-friendly clinic materials, "refer-a-friend" cards for adolescents, and, for some clinics, staff training in youth-friendly service provision. Results showed a 45% increase in adolescent client visits in the pooled intervention group compared to the control. Clinics with full youth-friendly service training saw the greatest impact, with a 62% increase, or over seven additional adolescent clients per clinic per month.

The GREAT program (51) is a strong example of a gender-transformative adolescent SRHR intervention. Implemented by Save the Children Federation and the University of California Care International from June 2012 to October 2014 in post-conflict Lira and Amuru districts, the GREAT program employs a life-stage approach, targeting unmarried adolescents (10–14 and 15–19 years), married adolescents, and adults. The project tested the effect of interventions on inequitable gender attitudes and behaviours; GBV; and SRH knowledge and behaviours among adolescents and their communities. It combined a Community action cycle led by local leaders, a 50-episode radio drama, community health worker linkages to FP/RH services, and a participatory toolkit for adolescents and community groups. Statistically significant improvements were observed across outcomes related to gender equity, gender-based violence, and sexual and reproductive health among older and newly married adolescents as well as adults. Among older adolescents, results included improvements in attitudes towards gender equity, household roles, and sexual and reproductive health, with a reduction in self-reported perpetration of sexual violence by boys. For married adolescents, positive effects were observed in household role distribution, attitudes towards gender-based violence, and a reduction in violent reactions towards partners. Collectively, the findings demonstrate that community-based, multi-component interventions can shift attitudes and behaviours related to gender, violence, and sexual and reproductive health among adolescents and their communities in post-conflict settings.

Another relevant intervention is a randomized controlled trial conducted by Makerere University and partners from May to July 2019 among adolescent refugee girls aged 15–19 years (52). The intervention tested whether peer counselling could increase same-day acceptance of a modern contraceptive method among female refugee adolescents in Palabek Refugee Settlement, Northern Uganda. Sexually active girls aged 15–19 who wanted to delay pregnancy and were not using contraception were recruited. They were randomly assigned either to receive counselling from trained peers in private settings or routine group counselling from nurses at health facilities. In the end, results showed that girls who received peer

counselling were more likely to start using contraception the same day compared to those who got routine counselling. Injectables and implants were the most common choices. Fear of side effects and partner opposition were the main reasons some girls did not take up contraception. Uptake was also higher among girls whose partners had a tertiary education.

In terms of post-abortion care, a district-level multicenter randomized equivalence trial (53) conducted by Makerere University and Karolinska Institutet across Uganda's rural and lower-tier health facilities assessed whether midwives can safely and effectively provide treatment for incomplete abortion. The study was carried out in six facilities between April 2013 and July 2014. Eligible providers were physicians and midwives already engaged in post-abortion care, all of whom underwent a standardized five-day training covering diagnosis, treatment with misoprostol and manual vacuum aspiration, and contraceptive counseling. Women and adolescents were assessed for eligibility and were randomized to either the midwife group or the physician group. The study confirmed midwives were as effective and safe as physicians, with high acceptability among clients. Adolescents and young women reported feeling calm and reassured under midwife care, although side effects such as bleeding slightly affected their overall satisfaction.

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Table 6: Summary of family planning and abortion/post-abortion interventions

Intervention	Setting	Target groups	Implementer(s)	Duration	Core components	Reported effects/outcomes	Notes
Behavioral intervention to increase adolescent uptake of family planning	Social franchise clinics delivering SRH services in urban and peri-urban communities in Uganda	Girls aged 15–19 years	ideas42, MSI Reproductive Choices, Marie Stopes Uganda	2018–2020	Adolescent-friendly clinic materials; "refer-a-friend" cards; youth-friendly service training for some clinics	45% increase in adolescent visits in the pooled intervention group; clinics with full youth-friendly training saw a 62% increase (7 more adolescent clients per clinic per month)	Demonstrates the scalability and effectiveness of behavioral nudges combined with provider training
Gender Roles, Equality, and Transformations (GREAT) program	Post-conflict districts of Lira and Amuru, Northern Uganda	Unmarried adolescents (10–14, 15–19), married adolescents (15–19), adults	Save the Children Federation, University of California, CARE International	June 2012 – October 2014	Community action cycle led by leaders; 50-episode radio drama; CHW linkages to FP/RH; participatory toolkit for adolescents and community groups	Improvements in gender equity, GBV attitudes, and SRH knowledge/behaviors among older and married adolescents and adults; reduced self-reported sexual violence among boys; improved household role sharing and reduced partner violence among married adolescents	Shows the effectiveness of multi-component community interventions in shifting gender, violence, and SRH outcomes

Peer counselling for contraceptive uptake among refugee adolescents	Palabek Refugee Settlement, Northern Uganda	Sexually active refugee girls aged 15–19 wanting to delay pregnancy	Makerere University and partners	May – July 2019	Peer counselling in private vs. routine nurse group counselling	Higher same-day contraceptive uptake in peer counselling group; injectables and implants most common; main barriers included fear of side effects and partner opposition; uptake higher if partner had a tertiary education	Demonstrates the feasibility of peer-delivered counselling in humanitarian settings
Treatment of incomplete abortion with misoprostol by physicians and midwives	Six rural and district-level facilities in Uganda	Women and adolescents with incomplete abortion	Makerere University, Karolinska Institutet	April 2013 – July 2014	Five-day standardized training for midwives and physicians on diagnosis, misoprostol use, MVA, and contraception counselling	Midwives are equally effective and safe as physicians (95.8% vs. 96.7% complete abortion rates); no serious adverse events; adolescents and young women reported calmness and reassurance under midwife care, though side effects (e.g., bleeding) slightly reduced satisfaction	Supports task-shifting to midwives in post-abortion care

SRH engagement platforms in Lira, Bidibidi, and Nakivale

Several multi-stakeholder platforms facilitate SRH engagement in Lira, Bidibidi, and Nakivale. In Lira, the Center for Sexual and Reproductive Health and Rights (SET-SRHR) at Lira University (54) serves as a multidisciplinary forum for SRHR education, training, research, and capacity-building across Northern Uganda and beyond. In Bidibidi Refugee Settlement, two platforms are particularly active: stakeholder music and life-skills meetings (55) convened by Brass for Africa and partners, which use community music and skills-based training to engage youth and local actors on SRHR; and the CHASE Africa Partner Network(56), which coordinates non-governmental organizations and community stakeholders to deliver SRHR outreach and mobilization. In Nakivale Refugee Settlement, the Rwenzori Centre for Research and Advocacy (RCRA)(57), supported by CHASE Africa, leads a multi-stakeholder outreach programme that integrates community dialogues, mobile clinics, and household visits to extend SRHR services to both refugees and host communities.

Table 7: SRH engagement platforms in Lira, Bidibid, and Nakivale

Knowledge Translation Platform/Forum	Purpose/Focus	Lead actors
SET-SRHR — Center for Sexual and Reproductive Health and Rights **(LIRA)**	A multidisciplinary platform facilitating SRHR education, training, research, and capacity-building in Northern Uganda and beyond.	Lira University
Stakeholder music and life-skills meetings-Bidibidi (Brass for Africa)	Multi-sectoral stakeholder forum using community music and life-skills training to engage youth and local actors on SRHR.	Brass for Africa, the MUSIC Connects program, the Office of the Prime Minister of Uganda, the United Nations High Commissioner for Refugees, the International Rescue Committee, Finn Church Aid, and local community leaders
CHASE Africa Partner Network-**Bidibidi**	Coordination among NGOs and community stakeholders to conduct SRHR outreach and community mobilization in Bidibidi.	CHASE Africa, RICE–West Nile, with implementation partners in the settlement

Rwenzori Centre for Research and Advocacy (RCRA) SRH programme-Nakivale	Multi-stakeholder outreach combining community dialogues, mobile clinics, and household visits to deliver SRHR services in Nakivale	Rwenzori Centre for Research and Advocacy (RCRA), supported by CHASE Africa

Conclusion

Uganda has made progress in strengthening the policy environment for adolescent sexual and reproductive health and rights (ASRHR). However, adolescents, particularly those in refugee-hosting districts, continue to face significant barriers to accessing and utilizing services. Teenage pregnancy, child marriage, and unmet need for family planning remain high, driven by entrenched cultural norms, poverty, and gender inequality. National frameworks uphold rights and set out opportunities to address adolescent SRHR, but implementation is inconsistent, and many adolescents still lack access to confidential, affordable, and respectful care.

Policies such as the Adolescent Health Policy Guidelines (2012), the Family Planning Costed Implementation Plan II (2020–25), and the Strategy to End Child Marriage and Teenage Pregnancy (2022–27) show commitment to advancing adolescent SRHR, but gaps remain in the areas of contraceptive access, safe abortion and post-abortion care, and comprehensive sexuality education. The review also finds that while most policies include adolescent-friendly services and uphold rights and non-discrimination, few have strong mechanisms for accountability and monitoring.

Interventions implemented in schools and communities, such as comprehensive sexuality education programs, caregiver–adolescent communication initiatives, and parenting–skills–based approaches, demonstrate promising results in improving SRHR knowledge, strengthening communication, and increasing awareness. Overall, Uganda has a strong policy base, but gaps in service access, weak accountability mechanisms, and challenges in scaling up successful initiatives continue to reduce impact. Addressing these challenges requires consistent implementation, improved coordination, and strengthened systems for adolescent engagement and accountability.

Research gaps

- Limited disaggregated data restricts the identification of the most at-risk adolescents.
- SRHR interventions reviewed (school-based CSE, caregiver communication, community dialogues) have not been rigorously evaluated for effectiveness or scalability.
- Gaps in evidence on adolescent access to a full range of methods, especially long-acting reversible contraceptives (LARCs).
- Inadequate evidence on coverage, quality, and outcomes of CSE implementation in both in- and out-of-school settings.
- Weak monitoring and accountability across policies limit the availability of evidence to track progress and guide adjustments.

Advocacy gaps

- Resistance and inconsistent rollout of the National Sexuality Education Framework undermine access to accurate SRHR information.

- Fragmented collaboration among actors and platforms leads to duplication and gaps in service delivery
- Inconsistent implementation and weak enforcement of policies reduce their intended impact.
- Persistent socio-cultural resistance, particularly around sexuality education and adolescent contraceptive access, undermines policy and program uptake.
- Adolescent participation in decision-making and accountability processes is still minimal.

Recommendations

- Ministry of Health (MoH), NGOs, and Community-Based Organizations (CBOs) to train alternative caregivers (e.g., grandparents, siblings) on adolescent SRHR communication.
- Local Government, Cultural Leaders, Civil Society Organizations (CSOs to address cultural barriers through community dialogues involving elders and leaders.)
- Ministry of Gender, Community Leaders, and Parent Associations to promote gender-inclusive parenting education.
- Ministry of Information, Media Houses, and Community Radio Stations to normalize open SRHR communication using mass media and local storytelling.
- Ministry of Health, Academic Institutions, NGOs to develop culturally adapted SRHR communication guides for caregivers.
- Local CSOs, Religious & Cultural Leaders, County/District Health Teams, to facilitate community dialogue circles to reduce negative attitudes toward adolescent sexuality.
- Ministry of Health, District Health Offices, and Facility Managers to expand adolescent-friendly SRHR services by creating confidential spaces, training providers, and offering flexible service hours and digital platforms.
- NGOs, Community Health Workers, Youth Networks to develop mobile outreach and peer educator programs to reach out-of-school adolescents.
- MoH, Family Planning Service Providers, and Youth Organizations to provide targeted contraceptive education and services to vulnerable age groups.
- Schools, Community Groups, Parenting Programs to strengthen caregiver–adolescent bonding through regular joint activities.
- Ministry of Education, Ministry of Gender, NGOs to strengthen school re-entry policies and economic empowerment programs for adolescent mothers.
- Schools, NGOs, and Faith-Based Organizations (FBOs) to introduce life skills training and mentorship programs targeting high-risk adolescents.
- UNHCR, Refugee-Led Organizations, NGOs to promote gender-sensitive parenting support groups in refugee communities.
- MoH, Private Sector Providers, Donor Partners to develop and scale up adolescent-responsive family planning services emphasizing privacy and respectful care.

- MoH, Teacher Training Colleges, Religious Councils to train and sensitize health workers, religious leaders, and teachers on adolescent rights and gender-sensitive FP counseling.
- Youth Organizations, ICT Ministry, NGOs to introduce digital and peer education platforms for FP information and referrals.
- MoH, Youth Advisory Boards, NGOs to include adolescent voices in service design using participatory methods.
- MoH, District Health Offices, and Professional Councils to increase readiness of lower-level health facilities to provide comprehensive PAC, including training midwives and equipping facilities.
- Ministry of Justice, MoH, Legal Aid NGOs to clarify and disseminate legal and policy information on abortion and PAC to providers and communities.
- Health Facility Managers, MoH, to prioritize adolescent-friendly PAC environments emphasizing confidentiality and dignity.
- Community Health Volunteers, NGOs, and District Health Teams to develop community referral systems and awareness campaigns to reduce delays in seeking PAC.
- MoH, Policy Units, Legal Reform Commissions to update outdated national policies and translate them into a district framework.
- Ministry of Education, Curriculum Development Institutes to accelerate review and implementation of the national sexuality education framework.
- Ministry of Justice, Parliament, and Human Rights Commissions to consolidate legal and policy frameworks to protect adolescent rights.
- Ministry of Finance, Development Partners, and MoH to maximize donor commitments by aligning partner funding with government priorities.
- National Planning Authorities, MoH, and MoE to strengthen coordination across ministries and integrate adolescent SRHR into district plans.
- Ministry of Finance, MoH, and Parliament to increase domestic funding for adolescent SRHR and reduce donor dependence.
- Inter-Ministerial Committees, National Youth Councils to align multi-sectoral ASRHR efforts across education, gender, justice, and health with national priorities.
- MoH, National Statistics Bureau, Donors to improve monitoring through adolescent-specific indicators and digital health tools.

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