Womankind Worldwide

NAWAD
National Association for Women's Action in Development

Building A Feminist Youth-Led Movement to Promote Access to Youth-Friendly Sexual and Reproductive Health Services in Wakiso and Nwoya District

A BASELINE SURVEY REPORT

JULY 2024

About NAWAD

National Association for Women's Action in Development (NAWAD), Registration Number: INDP78772539NB, is a national Women Non-Governmental Organization that started in 2010. The organization was established with the aim of uplifting the status of women and young people especially girls in grassroots communities across Uganda through promotion of their fundamental human rights especially in relation to their economic security, freedom from violence, and the sustainable management of the environment and natural resources. Since its founding, NAWAD has uniquely focused on the family as a key institution for building sustainable communities, emphasizing the inclusion of men as strategic allies for attaining gender equality. The organization believes that *"Putting Women at the Forefront"* and encouraging men to work with them is the only way to develop stable families and communities. NAWAD has also been committed to promoting and protecting the rights of especially marginalized women affected by various challenges such as loss of their land and livelihoods by strengthening grassroots women led Eco-feminist movement to promotes stable and peaceful families where women and girls access equal rights in the different spheres of life.

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Abbreviations

DHOs	District Health Officials
FGDs	Focus Group Discussions
IDIs	In-depth Interviews
IEC	Information, Education, and Communication
KIIs	Key Informant Interviews
NAWAD	National Association of Women's Action in Development
SGBV	Sexual and Gender-Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
VHTs	Village Health Team

Executive summary

This baseline report is part of NAWAD's one-year project, "Building a Feminist Youth-led Movement to Promote Youth-Friendly Sexual and Reproductive Health (SRH) Services," supported by Womankind Worldwide. The project targets young people aged 13-30 years in the districts of Wakiso and Nwoya in Uganda with the primary objective of enhancing improved access to Sexual and Reproductive Health and Rights (SRHR) services among female and male youth, both in-school and out-of-school. The baseline study aimed to assess youth access to SRHR services, attitudes and beliefs including SRHR outcomes for young people. The study assessed the level of knowledge, attitudes, perceptions, and beliefs regarding SRHR among young people and key stakeholders in the two districts. It also sought to identify SRHR service inequality hotspots in the target districts to ensure that interventions were tailored to local needs. Furthermore, the study examined the level of commitment from key duty-bearers to SRHR service delivery to facilitate advocacy for the creation of a youth-led feminist movement that would advocate for SRHR services for both in-school and out-of-school youth. The baseline study provided data that guides the interventions that were implemented. The study employed a cross-sectional design, with a qualitative approach using focus group discussions (FGDs), in-depth interviews (IDIs), and key informant interviews (KIIs) as data collection methods. The study targeted a broad range of participants, including young people aged 13-30, healthcare providers, district health officials, teachers, parents, caregivers, and leaders from local organizations working on SRHR issues.

Key findings

The findings from the baseline study show that youth access to SRHR services in Wakiso and Nwoya Districts remains limited, especially for out-of-school youth and those in rural areas. While health facilities exist in both districts, young people continue to face numerous challenges in accessing these. Young people in our study report that they do not know where to go for services or that when they try, the experience is not welcoming. The participants noted that health facilities are located far from where young people live, particularly in Nwoya District, making it difficult for them to seek services. Even where facilities are available, some youth express concerns about being judged by

health workers or not receiving the services they come for. The services are often designed without considering youth-specific needs, including privacy, confidentiality, and flexible hours. These challenges limit young people's ability to access and utilize essential SRHR services such as family planning, HIV testing, STI screening, and counselling.

The study reveals mixed levels of knowledge and awareness of SRHR issues among young people. Some youth have basic information about sexual health, family planning, and STIs, especially those who have been exposed to SRHR programs in school. However, many others especially out-of-school youth have very limited knowledge of their sexual and reproductive health rights or the services available to them. There are also many misconceptions and myths surrounding SRHR. For example, some youth believe that contraceptives cause infertility or that discussing sex is inappropriate. Attitudes towards SRHR are largely shaped by the community and family, where open discussion about sexuality remains taboo. As a result, young people often lack accurate information and are not empowered to make informed decisions about their reproductive health. Some youth express that even when they have questions or concerns, they do not know who to talk to, due to fear of judgment or punishment.

The study identifies several stakeholders involved in youth SRHR service delivery in Wakiso and Nwoya, including government health facilities, NGOs, community-based organizations, schools, and religious institutions. However, coordination among these actors remains limited, and services are not always consistent or integrated. Some health workers have received training in youth-friendly services, but this is not widespread, and many facilities lack dedicated youth corners or spaces. In terms of policy, while Uganda has supportive frameworks for youth SRHR including the National Adolescent Health Policy implementation on the ground remains weak. The study finds that the level of commitment among duty-bearers varies. Some district officials and health workers are supportive of youth access to SRHR and actively engage in youth-focused programs. However, others are reluctant to prioritize SRHR for young people, either because of limited understanding of its importance or fear of backlash from communities. In some cases, policies that could enhance youth access to services exist but are poorly disseminated or not enforced. This highlights the need for stronger advocacy, accountability, and stakeholder coordination.

The study also reveals that socio-cultural and structural barriers significantly impact young people's ability to access SRHR services. Social norms in both districts discourage open conversations about sex and reproductive health. Young people, especially girls, face stigma when trying to access services like contraceptives or counselling, and those who become pregnant are often blamed or excluded. The fear of being seen at a clinic or judged by adults in the community discourages many from seeking help. Cultural and religious beliefs also influence the way SRHR is perceived, with some parents and leaders opposing comprehensive sexuality education or access to contraceptives for adolescents. Structurally, long distances to health centres, lack of transport, inadequate infrastructure, and unfriendly service delivery models pose real barriers.

In conclusion, this baseline report provides critical insights into the sexual and reproductive health and rights (SRHR) needs of young people in Wakiso and Nwoya Districts. Participants recommended the establishment of youth-friendly corners within health facilities, flexible service hours, and respectful, non-judgmental service delivery all which guided NAWAD's collaboration with health workers to strengthen youth-friendly services and build their capacity through tailored trainings. To counter SRHR misinformation and stigma, young people called for increased access to accurate information through schools, peer-led initiatives, and media platforms. In response, our project rolled out community SRHR dialogues, trained youth peer educators, and developed youth-centred information materials. Community members and stakeholders emphasized the importance of engaging parents and local leaders to shift negative social norms. As a result, our proposed interventions facilitated intergenerational dialogues and involved male and female community leaders in awareness-raising activities. Finally, both youth and stakeholders underscored the need for stronger coordination and policy enforcement at district level. Informed by this, NAWAD worked to strengthen stakeholder engagement through district-level advocacy meetings and partnership-building. It is important to centre the voices of young people and respond directly to their identified needs to make a lasting impact in enhancing youth access to SRHR services and empower them to make informed decisions about their sexual lives

1. INTRODUCTION

NAWAD, with support from Womankind Worldwide, is implementing a one-year project focusing on "Building a Feminist Youth-led Movement to Promote Youth-Friendly Sexual and Reproductive Health (SRH) Services" in Wakiso and Nwoya Districts running from 1 March 2024 to 31st March 2025. The main aim of the project is to promote access to Sexual Reproductive Health Rights (SRHR) services among youth aged between 13-30 years in and out of school. NAWAD conducted a baseline study in the project sites to provide information that would guide the design and implementation of the interventions. This report provides the context, methodology, findings and recommendations from the baseline study.

1.1 Context

Sexual and reproductive health and rights (SRHR) are critical to the well-being of young people, yet in sub-Saharan Africa (SSA), adolescents and young people continue to face significant barriers in accessing comprehensive sexual health information and services (Chandra et al., 2015).While global efforts, such as the Sustainable Development Goals (SDGs), emphasize the importance of universal access to SRHR services, implementation remains uneven across SSA, with many young people lacking youth-friendly, non-judgmental, and accessible services (UNFPA, 2022). In Uganda for example, 25% of adolescent girls aged 15-19 have begun childbearing, and only 30% of sexually active unmarried women use modern contraceptives (UDHS, 2022) making young people to account for 37% of new HIV infections (UNAIDS, 2021). The teenage pregnancy rate in Northern Uganda stands at approximately 28%, higher than the national average, while in Central Uganda it is about 24% (UNFPA, 2021). Early sexual debut is common, with 23% of females and 14% of males engaging in sex before age 15 (UDHS, 2022). Notably, adolescent girls and young women are disproportionately affected, being twice as likely to acquire HIV compared to their male counterparts (UNAIDS, 2021).

Despite the magnitude of these challenges, access to youth-friendly SRH services remains severely limited with only 29% of health facilities estimated to offer youth-friendly services, and even where services exist, they often lack

trained personnel, privacy, flexible hours, and adolescent-specific approaches (MOH, 2020). Restrictive cultural norms and legal constraints further limit young people's autonomy over their reproductive choices (Banke et al., 2020). Uganda has established several national policies and strategies aimed at improving adolescent SRHR, including the National Adolescent Health Policy (2004) and the National Sexuality Education Framework (2018). The government has also launched initiatives such as the National Adolescent Health Strategy MOH (2011) and the provision of youth-friendly corners within health facilities. Despite these efforts, implementation gaps remain a challenge coupled with socio-cultural stigma around youth access to information and use of SRH services and inadequate digital health innovations tailored to the needs of young people (Bukenya et al., 2019). Traditional modes of SRHR education, such as school-based programs, often fail to reach out-of-school youth and those in marginalized communities (Chandra & Amin, 2020).

1.2 The issue of concern

In Wakiso and Nwoya districts sexual and reproductive health (SRH) indicators for young people remain poor. Contraceptive use among adolescents remains low with only 10% of girls and 16% of boys aged 15-19 use any form of modern contraception (UBOS, 2022). NAWAD's project is designed to address these gaps by building a feminist youth-led movement that empowers young people in Wakiso and Nwoya to actively demand for inclusive, accessible, and rights-based SRHR services. This feminist approach centers the voices and leadership of young people who are disproportionately affected and often excluded from decision-making in SRH programming and service delivery.

1.3. Objectives of the project

Main objective

The project seeks to build a feminist youth-led movement to advocate for increased access to youth-friendly SRH services.

The specific objectives of the project

1. Assess the level of knowledge and attitudes towards youth friendly SRH service provision in the 2 project sites.

2. To identify status of youth friendly SRH services in the project sites to inform implementation of the interventions.
3. Establish the current level of commitment of key institutions to SRH service delivery to in and out of school youth.
4. Facilitate advocacy for youth-led feminist movement building for in and out-of school youth through workshops
5. Facilitate awareness creation through community outreaches, multi-stakeholder collaboration meetings and community conversations with parents/caregivers, social-cultural leaders to raise awareness of their role in promoting access to youth-friendly SRH services
6. Train and deploy peer educators as volunteers to cascade the information on youth-friendly SRH services in the community
7. Develop and disseminate user-friendly IEC materials with messages on access to SRH services like talking compounds in schools, stickers, banners
8. Identify existing laws, policies, and ordinances and establish how these facilitate effective youth SRH service delivery.

1.4 The Baseline Survey

NAWAD conducted a baseline survey to benchmark the status of access to and utilization of SRH services by youth in and out of school in the project sites. The study addressed project objectives 1, 2, 3 and 8. The survey covered the two districts of Wakiso and Nwoya and engaged representatives of key institutions including government agencies, social, health, and private sector institutions, working on SRHR issues for young people. Interviews and group discussions were conducted with selected project beneficiaries in the project sites.

2. APPROACH AND METHODOLOGY

2.1 The study Design

This was a participatory study that employed a qualitative cross-sectional design. The cross-sectional design was deemed appropriate as it allowed for the collection of data at a single point in time, capturing in-depth and diverse

perspectives on SRH service delivery to young people. Qualitative methods were key in facilitating a critical analysis of participants' views and experiences regarding access to and utilization of SRH services.

2.2 Study Area

The baseline study was conducted in two districts of Wakiso and Nwoya which are among the NAWAD districts of operation. In Wakiso district, this was conducted in Nampunge subcounty and then Anaka and Olwiyo subcounties for Nwoya district. Below is the map that shows the location of these districts in Uganda.

Figure 1: Location of project Districts in Uganda

Wakiso district, located in central region of Uganda has a young population of about 58% (31 % female). The district has 1520 health facilities. Nwoya district is located in the northern region of the country with 49.4% under the age of 18 and females constituting about 51.2% of the total population (UBOS, 2017). Access to health facilities remain limited with Roman Catholicism being the major denomination (36.2%) and 13.2% Muslims (UBOS, 2017). This religious influence perceptions and acceptance of SRH services, especially among adolescents. Access to Education: 14.1% of children aged 6-15 years in Nwoya District were not attending school. This non-attendance rate was slightly higher among males (13.3%) compared to females with the literacy rate for individuals aged 10 years and above reported at 63.5% (UBOS, 2017) indicating that a significant portion of the population faces challenges in accessing and comprehending educational materials impacting their engagement with sexual SRH information and services.

2.3 Study Population

The study population was composed of young people aged 13 – 30 years. These included; young adolescent (boys and girls) in school, young people (boys and girls) out of school and teenage mothers. The key duty bearers such

as district health officials, youth leaders who are dealing in SRHR issues, district officials, representatives from women led organizations dealing in SRHRR advocacy, teachers and parents were also engaged in the study.

2.4. Sample selection, size and data collection methods

The participants were randomly selected from lists generated by the local leaders, while the key informants were purposively selected based on the role and position in the respective targeted institutions. Data was primarily collected through Focus Group Discussions (FGDs), Key Informant Interviews (KIIs), and In-depth Interviews (IDIs). A total of 14 FGDs were conducted (7 from each district) for both males and females, along with 16 IDIs (8 from each district) with 10 females and 6 males. Further, the study engaged 20 key informants (10 from each district), including District Health Officials (DHOs), healthcare workers, and Village Health Teams (VHTs) from selected health facilities providing SRHR services to young people. Other key informants included representatives from religious institutions (Catholic, Anglican, and Muslim) to capture diverse perspectives on SRHR, representatives from women-led NGOs and youth-led organizations focused on SRHR, parents/caregivers, socio-cultural leaders, and teachers. This diverse category of participants ensured a comprehensive understanding of the factors influencing youth access to SRH services. See Appendix 1 for the details on the sample size by method.

2.5. Data management and Analysis procedures

All interviews and group discussions were audio recorded and later transcribed into narrative reports. Thematic and content analysis was applied. Findings were reported based on the emerging themes, subthemes, and categories using direct quotations from the data.

2.6. Ethical Considerations

All necessary ethical considerations were followed in undertaking the study. For instance, Researchers involved in the study received training on ethical conduct and research integrity such as anonymity and data protection to ensure adherence to ethical guidelines and protocols. Participation in the study was voluntary and freedom of exit at any stage without any consequences was also granted. The participants consented through informed

consent forms before taking part in the study. All minors that participated in this baseline provided assent after parental/guardian consent had been obtained.

Besides this, since the study had minors and vulnerable persons such as teenage mothers and SGBV survivors, the research team was trained on how to handle these groups. Training particularly focused on the ethics of handling research with minors and vulnerable groups and ensure appropriate assenting and consenting procedures were followed. For instance, during the consenting and interview process with minors, each enumerator had a referral form that could be completed if a participant indicated that they wanted to talk to someone, for instance, caregiver, guardian, parent, a health service provider or counsellor. However, during the course of the study no such a case was encountered that required referral.

3. KEY FINDINGS

3.1 Understanding youth Sexual and Reproductive Health Services and Rights.

The study assessed the level of youth knowledge, attitudes (beliefs and perceptions) and norms associated with SRH across key structures and beneficiaries in the two districts.

3.1.1 The level of youth knowledge on the SRHR.

The data highlighted insightful perspectives on what sexual and reproductive health (SRH) services mean to the participants. While the youth demonstrated some awareness about condom use, menstrual hygiene, and HIV testing, a few held narrow or inaccurate definitions of what SRH entails. For example, female youth, associated SRH with personal sexual choices as stated below;

> *Freedom to have sex or to get pregnant when you want to. (IDI female out of school youth)*

> *An individual is free from sexual and reproductive diseases or sexually transmitted diseases…SRH refers to a situation whereby someone is sick like for example a woman is having candida, then she decides to go to the hospital then she is treated…someone is suffering from a reproductive disease then the person is able to get treatment…ability to stay free from Sexual infections like Urinary Tract Infections (UTI) like*

candida and syphilis and those that can be infected like when you had sex…FGD for Girls in School

SRH is about family planning which has very many types, some are vaccinated, others are just put in the body in different body parts, all in all, they can put that or inject you with the vaccine just to prevent you from getting pregnant…I understand sexual and reproductive health rights as the right a woman is supposed to have for example, medication, protection against reproduction in women…. these are freedoms that women should have concerned their reproduction, being free from sexually transmitted diseases.

While the girls appear to understand what SRH entails, they did not have a full understanding of broader topics that constitute SRH such as family planning, HIV testing and counselling, Menstrual health management, Safe Sex education, Antenatal and postnatal care, Treatment of Sexually Transmitted Infections and Support for survivors of sexual violence which are crucial subjects that youth need to be aware of in order to lead a healthy life.

Male youth, often viewed SRH through the lens of female biology and responsibility. A young male stated;

Yes, I do understand SRH, this is women menstruating and that during menstruation, women should be hygienic and use sanitary towels (IDI male youth)

This suggests that SRH is understood as a female issue, with little male inclusion or responsibility. Similarly, a male student explained that;

The SRH services are mostly given to ladies and they include family planning methods like the use of conceptive pills, child spacing and condoms. (IDI male student)

This reinforces the understanding that SRH is something women engage with, while men remain passive observers. This is a problem because it puts all the responsibility of SRH solely on women and keeps men uninvolved, which can lead to poor health and lack of shared decisions in relationships on the matter.

Across both genders, awareness of family planning methods such as contraceptive pills or child spacing was limited. Likewise, few participants,

male or female, mentioned access to services like STI testing, counseling, post-abortion care, or safe delivery services, which are critical components of SRH. These findings point to a shared gap in knowledge, particularly among youth and adolescent parents, and a gender imbalance of SRH that places the responsibility disproportionately on females. Furthermore, the silence or oversimplification of SRH by many participants suggests discomfort the youth have while discussing their sexual and reproductive health which is seen as a taboo in Uganda by most youth.

3.1.2 Youth's attitude towards accessing & utilizing SRH services

It was revealed that cultural and religious beliefs strongly influence perceptions about utilisation of SRH services by the youth in Uganda. Traditional norms in the communities dictate how young people learn about sexuality and SRHR broadly, which will eventually influence access and utilisation of SRH services. The study revealed that girls were often guided by their aunts in discussions around womanhood and their sexuality, while boys are pressured to prove their maturity by engaging in sexual activity with virgin girls, most of which is without their consent. This belief contributes to sexual violence and early pregnancies among the youth.
A key informant noted;

> *In Acholi a fire is set and the aunts sit with the girls and the girls discuss maturity, among the boys they believe that to prove maturity, they have to have sex with a virgin girls which steers up rape and many girls lose virginity against their will at an early stage. (KII Religious leader)*

The findings show that some Christians associate circumcision with conversion to the Islam faith. This perception discourages some young men from undergoing circumcision, despite its benefits to their sexual health like reducing thr risk of getting HIV and other related STIs.
One of the key informants observed;

> *Religion is a barrier to male circumcision, the Christians think that when circumcised, they are being converted to Islam.* (KII Religious leader)

Moreso, family planning was often linked to the killing of unborn children, which some viewed as going against God's purpose for humans to multiply and fill the earth. As a result, the use of sexual and reproductive health (SRH) services such as family planning was unpopular in the study communities.

This negative attitude was largely based on misinformation among the youth. For example, some believed that using contraceptives too much could cause infertility, while others thought that circumcised men are unable to have children.
The Key informants stated:

> *Christians relate family planning to murder of unborn children, hence making it unpopular in Nwoya.* (KII religious leader)

> *There is a saying that when you over use family planning, chances are high you will not produce. Some think that circumcised men cannot reproduce.* (KII Village Health Team member)

> *There is a saying among the youth that when you over use family planning, chances are high you will not produce. Some think that when circumcised men cannot reproduce. (KII VHT).*

These findings highlight the negative perception or attitudes about SRH services in the study communities. This brings to light the false beliefs that contribute to the youth's poor attitude that prevent them from accessing important SRH health services in their communities.

3.2 Current status of Youth-Friendly SRH

3.2.1 Availability, accessibility and quality of Youth Friendly SRH services

This study also focused on youth SRH service availability, accessibility and quality. It was observed that for youth out of school, health centers remained the main point of care, providing essential services such as check-ups, HIV testing, vaccinations, male circumcision, and health education. Teenage mothers, in particular, shared that they received free services like scans, HIV testing, and child immunizations highlighting that some SRH services are available at no cost.
A teenage mother said that;

> *Teenage mothers are given free check-ups, scans and also vaccination of their children. (IDI teenage mother)*

In contrast, in-school youth mainly relied on school-based female guides for SRH information and support. These guides were viewed as approachable and trustworthy, which made it easier for girls to seek help and information.
A female youth stated that;

> *For the school we have female guides whom we can reach out too and they are always available anytime they are needed, and we do not fear them since we are all females. When it comes home, the distance is a bit far and we always use two thousand shillings to the nearest health facility. Some students who have HIV are always talked about by other students which always stigmatize them, and some have even dropout of schools. (IDI female youth in school)*

Notably, the presence of community-based organizations positively influenced how youth received an utilized SRH services in their communities. Their involvement was reported to improve SRH service quality and built community trust, demonstrating the value of partnerships in strengthening youth health systems.

This data underscores the importance of tailored, youth-sensitive approaches that consider different environments where young people live and learn. When services are embedded in trusted institutions like schools or community organizations and supported by professional guidance, youth are more likely to engage, understand, and benefit from SRH care. Investing in such multi-layered support systems is key to improving both uptake and outcomes. A key informant stated;

> *When the organizations came in to support, people are accessing quality services. The rate of STDs is lowering according to my observation. (KII VHT)*

3.2.2 Barriers to Youth Friendly SRH services

The findings highlight a number of barriers to availability, accessibility and quality of SRH services by the youth.
A Key Informant said that;

> *Most of these services are only got through the health centers. They are not easily got by the youth because some youth fear to go to the health centers. Among the services there is male circumcision, sensitization of*

people on STDs, to a minor case, I see provision of sanitary pads. (KII Religious leader)

These barriers range from social, physical to economic huddles impacting on utilization of SRH services by the young people.

Socially, participants indicated sexuality matters are regarded as private matters and youth are not open to adults about them. Youth feel uncomfortable or afraid to seek SRH services at health centers, and information from their parents as they feared that they would be judged by the adults for being sexually active at a young age. As raised by parents;

The youth aged 16-18 years are hesitant to approach older individuals for counseling and guidance regarding the access of SRH services. FGD, Parents, Wakiso.

16-18 year olds find difficulties because they are not informed about these services and they are shy, they also fear to approach those who are older or exposed for counselling and guidance. (FGD parents to youth)

This puts them at risk of taking inaccurate information from their peers who know little or nothing on youth-friendly SRH services. Youth with disabilities or who are not smart and clean were noted to experience exclusion and discrimination especially from health centre service providers. Female youth stated;

If you are total villager and when you go to the health center when you are dirty, it is not easy to access these services. We also have mentally disturbed people who find it very hard to access these services. (IDI female youth out of school)

We access information on the SRHR issues from our friends and peers. (FGD female youth out of school)

Other voices pointing to social barriers are highlighted below;

Socially, Peer influence is a major issue hindering youth from accessing the services. Also Christians and Muslims do not associate themselves with the use family planning, we preach against it as it contradicts our

faith and Gods expectation of being fruitful and filling the earth. (KII Religious Leader)

Some voices pointed to deep-rooted around producing many children and thus discouraged family planning as these youth observed;

We still have men in the community that still believe in those days that women used to give birth as many as possible so they don't allow women to use family planning. (FGD female youth out of school)

Economic barriers manifested by vicious cycles of poverty among the youth were reported. It was noted that the youth cannot afford to purchase the medicine prescribed to them after receiving these services. In addition, parents cannot afford to give money to youth to access these services this was reported to force young girls into unwanted sexual activities; for instance, young girls sell their bodies for sex in exchange for money to get money to access SRH services. Such relationships were expose the young girls to unwanted pregnancies and STDs. A young girl shared;

I have a friend of mine for her case she asks something from home and it is not provided to her she is a group member of a group that does prostitution, so she has to sell her body to get what she wants. (FGD girls in school)

On **physical accessibility**, the long distances travelled to the nearest health facility were said to be a deterrent to utilization of SRH services by the youth. Some voices indicated that while the boys and girls in school especially the girls have female SRH mentors (nurses and counselors) and are comfortable seeking SRH services, those out of school face have difficulties in accessing the services due to the long distances to health facilities in their communities. Some walk up to 4km to access these services, and lack of money for transport to the facilities and to buy medicine as well. Female youth shared that;

For us in Patira, we can move 4km to the health center in Anaka because there in the village we just have only small clinic which sell only simple medicines. (FGD female youth in school)

Issue of lack of transport stops me from accessing and utilizing the services due to long distances…(FGD female youth out of school-Nwoya)

These findings highlight the need for differentiated approaches to youth-friendly SRH service delivery in community health centers, schools and churches, that address the unique barriers faced by youth in different settings, ensuring that services are more accessible, affordable, and culturally sensitive to their needs.

3.3. Key structures of SRH service delivery

3.3.1 SRH service provision for in-school youth

In this study, we sought to establish the level of commitment of key structures to SRH service delivery to in-school and out of school youth focusing on both government and non-government structures and we found out that schools play a vital role in providing SRH services to in-school youth through counseling, sensitization, and support programs like girls talk where girls can feel free to ask and receive appropriate SRH information They have dedicated counselors, female mentors, and senior women teachers who educate students on issues of sexual abstinence, personal hygiene, and self-defense skills in case of sexual violence. In some schools, there were reported open discussions undertaken to sensitize youth on relationships, the dangers of premarital sex, and proper hygiene, making sure that they get accurate and appropriate information about their SRH rights. Teachers in one of the schools visited revealed;

> *We have school programs and routines are mandatory. So if we have called on girls talk, all girls must be there. These talks are helping them [girls] to get accurate SRH information. (KII teacher)*

> *In this school, we always have open talks. Open talks about the way they have to relate as boys and girls. Then dangers of premarital sex, we educate them, sensitize and keep reminding them. We caution on hygiene, personal hygiene, and then we also give them the self-defense skills in case of situations like rape. (KII Teacher)*

A student mentioned that their school had structured programs such as purity clubs that provide sanitary pads and guidance from senior woman and man teachers, which is an effort by the school administration to provide SRH services to their students. These efforts indicate a notable commitment by schools to SRH service delivery. A young girl in school informed us that;

> *We have a purity club in our school that always provides us with sanitary pads. We also have counselling and guidance from the senior woman. (FGD female youth in school)*

3.3.2 SRH service provision for out of school youth

For out-of-school youth, SRH services are primarily accessed through health centers, community health workers, and outreach programs by Non-Governmental Organizations (NGOs). One of the male youths reported his experience:

> *You have to go the health worker direct so that you are helped. Going to the health worker and telling him/ her your problem then they see how to help, either through giving medicine to prevent diseases, for instance with HIV I am given PEPS (IDI youth out of school)*

Some youth receive information from local religious and cultural leaders, Village Health Teams (VHTs), and peers. However, concerns about poor service delivery at government health facilities were raised by the youth, such as long waiting times and absentee health workers. Furthermore, some health workers lack the necessary skills to provide certain SRH services, such as inserting and removing IUDs which risks the young women to infections, and inadequate contraceptive protection, ultimately compromising their reproductive health and well-being.These are the voices of the youth and their parents concerning this;

> *At the government hospital, we stay from morning up to afternoon where health workers will go for lunch even without working on us and even afternoon you will seat and will not see any health worker talking to you then after they will say go back home for us we are tired. (FGD female youth out of school)*

Some health workers are not well qualified for instance in family planning some health workers don't know how to insert and remove the IUD. (FGD Parents)

Moreso, some young women and men are unaware of where to access SRH services from in their communities due to inadequate sensitization as emphasized by a religious leader. This highlights the need for youth to be informed about their SRH rights and services that are available at the community health centres.

The services are available at the health centres but the youth don't know where to access them due to lack of sensitization. (KII religious leader)

The survey findings indicate that organizations play a critical role in bringing SRH services closer to female youth both in-school and out-of-school.
One of the youth and Key Informant observed:

When the organizations came in to support, people are accessing quality services. The rate of STDs is lowering according to my observation. (KII VHT)

While some efforts are being made to improve SRH outreach to youth, especially by the Government of Uganda, the barriers indicate the need for more commitment and structural improvements to ensure effective service delivery to out-of-school youth. The findings indicate there were no policies and ordinances for SRH service provision at district level.

3.4 Role of youth led movements

Peer networks continue to play an important role in how young people access information about sexual and reproductive health and rights (SRHR). As one youth out of school shared;

We access information on the SRHR issues from our friends and peers. (FGD youth out of school)

This highlights the central role of peer-to-peer communication in SRHR awareness. Many youth may feel more comfortable discussing sensitive topics like sexuality and relationships with their peers rather than with adults or health workers. This comfort makes peer-led spaces a valuable entry point for

SRHR education. However, while peer engagement is a strength of youth-led movements, it also points to a critical need for accurate and reliable information. Without support from trained professionals or access to verified resources, these informal channels risk spreading misinformation. Therefore, investing in the capacity-building of youth-led groups ensures they not only remain relatable messengers but also become trusted and informed advocates for safe, inclusive SRHR practices.

3.5 Suggestion for improving Youth SRH services.

Youth emphasized the need for more inclusive sexual and reproductive health (SRH) services, especially for people living with disabilities. A female youth stated;

> *There is need to have organizations that cater for people living with disability because they are always discriminated when are part of other groups not their own. (IDI male youth in school)*

Additionally, youth also acknowledged the fact that they do not have access to information on the affordable SRH services lie family planning, HIV testing in their community health centres and yet they need them to lead a healthy life as it is their rights. A male youth emphasized that;

> *We need information on SRHR and services that are affordable for the youth in our community. (IDI male youth in school)*

Parents also emphasized the importance of youth taking responsibility for their own health by actively seeking out SRHR services fro informed adults or health centres. One parent remarked, highlighting a need for increased motivation and awareness among youth.;

> *According to youth it's locally difficult to work with sometimes they organize a place but still youth will not go so I urge youth to wake up and go for SRHRS. (FGD parents)*

Furthermore, a parent strongly recommended that NGOs like NAWAD to continue engaging with the communities to ensure youth voices are heard and acted upon. As one parent stated;

I request NGO like NAWAD to continue coming back to them so that what they are saying here should be heard and worked on for example, Olwiyo has to be considered first because Olwiyo has a high rate of disease...(FGD youth parent)

This highlights the need for a consistent NGO presence that listens to community concerns and prioritizes areas with high vulnerability, such as Olwiyo. Sustained engagement can build trust, improve service delivery, and ensure that interventions are targeted where they are most needed. Parents, when empowered as advocates, play a key role in influencing positive health outcomes for youth in their communities.

Finally, A Village Health Team (VHT) member emphasized the importance of using creative and accessible approaches to improve youth access to SRH services. They stated;

We can organise sensitizations, increase supplies and bring the services closer to the young people. Sensitization can be done through radio, drama. (KII VHT)

This suggestion highlights the value of using youth-friendly communication channels like drama and radio to raise awareness. It also stresses the need for decentralizing services bringing them nearer to where youth live which can reduce transport costs and stigma. The VHT perspective reinforces that community-based, culturally appropriate strategies are vital in bridging gaps in knowledge and access to SRHR services among youth.

The suggestions gathered from youth, parents, and community actors reflect a strong desire for more inclusive, accessible, and youth-centred SRH services. There is a clear call to bring services closer to the communities. These insights provide a practical roadmap for designing interventions that are both responsive and sustainable in regards to providing youth with appropriate information on their SRHS and rights.

4. Conclusion and Recommendations

4.1 Conclusions

Understanding youth Sexual and Reproductive Health Services and Rights.

The findings reveal significant gaps in youth knowledge and attitudes towards Sexual and Reproductive Health and Rights (SRHR). While some awareness exists, particularly around condoms, menstruation, and HIV testing, many youths still hold narrow, gendered, or inaccurate understandings of SRHR. The prevailing perception that SRHR is a "female issue" highlights a worrying trend of male disengagement and the burdening of women with sole responsibility for reproductive health.

Moreover, deep-rooted cultural and religious beliefs continue to shape negative attitudes and misinformation around services such as family planning, male circumcision, and contraceptive use. Myths linking family planning to infertility and moral wrongdoing, or viewing male circumcision as religious conversion from Christianity to Islam, have led to stigma and low youth SRH service uptake. These beliefs, passed on through informal community structures and reinforced by silence around sexuality, hinder the development of informed, empowered youth.

Addressing these issues will require culturally sensitive but assertive strategies that promote accurate SRHR education, challenge harmful norms, and encourage open dialogue, particularly involving boys and young men as active participants in SRHR through capacity trainings on the matter to change their mindsets. Only by shifting both knowledge and attitudes can youth fully understand and claim their sexual and reproductive health rights.

Current status of Youth-Friendly SRH Services

While health centers remain essential in providing key services, the integration of SRH services into trusted institutions such as schools and community organizations significantly enhances service delivery and utilization by the youth. These institutions need to work together to facilitate proper availability and accessibility of SRH services by the youth through collaborative meetings and trainings on the matter. However, barriers such as social stigmas, economic challenges, and physical accessibility issues hinder many youths from fully utilizing these services. Addressing these barriers through tailored, culturally sensitive approaches, improved community engagement like community campaigns to deliver appropriate SRH information to youth and community at large is essential to ensure that all youth, regardless of their socio-economic status or educational background, have access to the support and care they need. Overcoming these challenges requires a multi-faceted approach that combines service accessibility with education, empowerment, and social support systems to ensure youth are informed and able to make healthy decisions.

Key structures of SRH service delivery

Institutions like schools are pivotal in providing SRH services to in-school youth through counselling, sensitization, and programs like "girls talk," where students receive valuable and appropriate information on sexual health. These programs, along with dedicated counsellors and mentors, help students gain knowledge on sexual abstinence and hygiene. Talks about referral pathways for youth experiencing sexual violence need to be provided to these youth through these trainings. In contrast, out-of-school youth primarily access SRH services through health centres, community health workers, and outreach programs from NGOs. However, challenges such as long waiting times, absenteeism of health workers, and inadequately trained staff at government health centres hinder the accessibility and quality of services for out-of-school youth. Moreover, many young people remain unaware of where to access SRH services due to insufficient community sensitization. Despite these challenges, the involvement of organizations has significantly improved access to SRH services, and their role in providing quality services and raising awareness is crucial. However, the findings also highlight the need for more structural improvements like more trained health workers to provide SRH services to youth and a stronger commitment to ensure that out-of-school youth receive adequate SRH services.

Role of youth led movements

We found that peer networks serve as a crucial channel through which young women and men, particularly those out of school, access information on their sexual and reproductive health and rights (SRHR). Many youths feel more at ease discussing sensitive topics like sexuality and relationships with their peers rather than with adults or health professionals. This makes peer-to-peer training and communication a valuable avenue for SRHR education. However, while these interactions can foster openness and trust, there is a risk of misinformation when youth lack access to accurate, evidence-based knowledge. To address this, it is essential to strengthen the capacity of youth-led groups by providing training and credible resources on the available SRH services in their communities and how they can acces them. This ensures that peer educators remain relatable while also becoming reliable sources of accurate SRHR information and support.

4.2 Recommendations for improving youth-friendly SRH services and advocacy

Based on the findings, the following recommendation are made;

1. Inclusiveness and gender equality

- Advocate for the inclusion of both boys and girls in all activities/interventions, especially in SRHR advocacy work. The requires promotion of the equal involvement and motivation of both male and female youth in SRHR advocacy.
- Focus on male involvement in SRHR initiatives as change agents has a potential for creating sustainable youth SRHR outcomes.

2. Youth education and sensitization

- Continuous sensitization of young people on SRHR and life skills (e.g., consequences of early sex, responsible behaviour). Organize open discussions, seminars, and workshops and social media platforms to disseminate SRHR information.

3. Access to services and resources

- Promote increased accessibility and availability of youth friendly SRH services to meet the needs of both girls and boys. Providing medical outreaches and services, especially in hard-to-reach areas, including mobile health camps would come in handy. This needs financing for medical outreach and distribution of supplies to youth
- Advocate for the establishment of well-equipped health centers at the community or village level.
- Develop skills programs for youth to earn income that supports access to SRH services.

4. Youth empowerment and participation

- Encourage youth to form groups and collectively seek help from leaders and service providers in their communities. This requires training of youth in advocacy to encourage self-advocacy in SRHR matters and involvement of female and male youth stakeholders in policy discussions.
- Strengthen partnerships between institutions, such as health workers, teachers, parents, religious leaders, and policy makers, to support SRH initiatives for youth.
- Encourage peer leadership and education, promoting participation of youth from various backgrounds.

- Organize SRHR Youth-Gather Conferences to sensitize both youth and parents.

5. Community and parental involvement

- Sensitize and engage parents (male and female) to play an active role in the upbringing and education of their children on SRH matters.
- Promote collaborative efforts between schools, institutions, and religious organizations for youth development (e.g., bible study, youth camps).

6. Creating supportive environments

- Advocate for schools to provide safe spaces for young people to freely express themselves and promote stigma free environment particularly for the marginalized groups such as PWDs, and promote inclusivity.
- Promote openness among young people and raise awareness about unacceptable societal practices.
- Foster non-judgmental attitudes in the youth and design youth-friendly services to encourage participation.

7. Collaboration and partnerships

- Strengthen partnerships among diverse stakeholders to maximize the impact of SRH programs and services for youth. Institutions and organizations should collaborate as partners for better results in SRHR interventions.

Appendices

Appendix 1: Sample size

District	Category of participants	Method	Gender	Sample size (FGDs of 8-10 participants)	Total (FGDs)
Nwoya district	Youth in-school aged13-18	FGD	Girls	1	2
			Boys	1	
	Youth out of school aged 19-30	FGD	Girls	1	2
			Boys	1	
	Community (Parents/Guardians/Caregivers etc. to the youth)	FGD	Female	1	3
			Males	1	
			Mixed	1	
Wakiso district	Youth in-school aged13-18	FGD	Girls	1	2
			Boys	1	
	Youth out of school aged19-30	FGD	Girls	1	2
			Boys	1	
	Community (Parents/Guardians/Caregivers etc. to the youth)	FGD	Female	1	3
			Males	1	
			Mixed	1	
Sub-total					14
Nwoya district	Teenage mothers	IDI	Girls	2	2
	Adolescents	IDI	Girls	2	4
			Boys	2	
	Older adolescents	IDI	Female	1	2
			Males	1	
Wakiso	Teenage mothers	IDI	Girls	2	2
	Adolescents	IDI	Girls	2	4
			Boys	2	
	Older adolescents	IDI	Female	1	2

district					
Sub-total					**16**
Nwoya district	Head Teachers, Religious leader, VHT, DHO, Women led Organization representatives, Youth led organization representatives,	KIIs	Females	3	5
			Males	2	
Wakiso district	Head Teachers, Religious leader, VHT, DHO, Women led Organization representatives, Youth led organization representatives	KIIs	Female	3	5
			Males	2	
Sub-total					10
Total					**40**

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