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# Bridging the knowledge gap: accessibility of SRHR information, services and competences of health facilities for adolescents and their care givers in rural Eastern Uganda

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## Abstract

**Introduction** A quarter of Uganda's population is aged 10–19 years and majority live in rural areas. Access to sexual and reproductive health services and rights (SRHR) remains a challenge among this population, contributing to a high teenage pregnancy rate of 24.9% in rural Uganda. The study assessed the accessibility of SRHR information, services and competences of health facilities among adolescents and their care givers in Namutumba and Bugiri districts.

**Methods** A cross-sectional study was conducted. 473 respondents were systematically and randomly recruited after informed consent and/ assent. Data were collected using a pre-tested electronic questionnaire and analyzed using STATA version 14. Descriptive statistics were used to summarize the SRHR indicators. Ethical approval was obtained before data collection.

**Results** 51% of participants were aged between 10 and 19 years. Only 22.6% [107/473, CI:17.7–25.1] of participants had received at least three out of the 13 forms of SRHR/SGBV information. Females significantly had higher access to SRHR information compared to males [24.6%, 95% CI: 19.7–30.3, *P*-value-0.049]. There was no significant differences in the access of SRHR between adolescents and their caretakers. Approximately 41.9% [198/473, CI: 36.2–45.1] agreed to at least three of the eight SRH rights. Half of adolescents had experienced at least one of the nine forms of SGBV, yet only 27% [34/126, CI: 24.3,32.7] shared their experience. Only one health facility offered more than 8 family planning methods and none provided comprehensive SRHR services daily to adolescents. There were no significant differences in the competencies of health facilities between Bugiri and Namutumba districts.

**Conclusion** This study highlights significant gaps in access to SRHR and SGBV services, with limited awareness on SRHR/SGBV and inadequate reporting of SGBV cases due to stigma. Strengthening community support systems,

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enhancing SRHR/SGBV service delivery, and building capacity for youth-friendly programs are essential. Additionally, robust monitoring frameworks are needed to track progress and evaluate the effectiveness of interventions.

**Keywords** Sexual and reproductive health and rights, Sexual gender based violence, Adolescent, Teenage pregnancy

## Background

Every year, an estimated 21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million give birth. Half of these pregnancies are unintended [1]. In 2019, the adolescent birth rate in Africa stood at 97 per 1,000 adolescents, seven times higher than that of the European region at 13.1 per 1000 adolescent girls [2]. Uganda ranked 16th among 25 countries with the highest rates of child marriage in 2017 [3]. And in 2022, the Uganda Demographic and Health Survey reported an estimated teenage pregnancy rate of 23.5%, that increased to 24.9% in rural areas. Busoga recorded the second highest teenage pregnancy rate in the country at 28.4% [4].

Low economic status, low education level, cultural beliefs, risky behaviours, gender-based violence and restricted access to SRHR services have exacerbated this burden in rural Uganda [5]. These challenges have contributed to heightened risks of HIV and other STIs, maternal mortality, early marriages, school drop-out rate and crippling poverty levels, despite the implementation of SRHR projects in the region [5].

The persistently high teenage pregnancy rates highlight a lack of comprehensive evaluation of existing interventions, leaving specific barriers to their success and scalability unclear. Furthermore, most studies focus on national or regional data, neglecting the localized drivers of teenage pregnancies unique to districts like Namutumba and Bugiri.

We conducted a baseline survey with in an Amref Health Africa project on the scale up the reduction of teenage pregnancies. This was to determine the accessibility of SRHR information, services and competences of health facilities among adolescents and their care givers in Namutumba and Bugiri districts. The findings will guide the design and implementation of targeted interventions, inform policy decisions, and serve as a benchmark for evaluating the SRHR program impact over time.

## Methods

### Study design and setting

A cross-sectional study was conducted in the Namutumba and Bugiri districts within Busoga Sub-region of Eastern Uganda from June to July 2023. This study was conducted in Namutumba, Magada, Kagulu, and Bulange sub-counties (Namutumba District) and in Budhaya, Kapyanga, Iwemba, and Bulesa sub-counties (Bugiri District). These were identified as the main hot spots for

teenage pregnancies and therefore, had been selected for the project implementation.

### Study population and eligibility

The target population for this study was adolescents and their caregivers aged 10–49 years residing in the eight sub-counties of Namutumba and Bugiri districts. In Uganda, sexual activity can begin as early as age 10, with reproductive capability extending up to age of 49 years [4, 6]. Participants were enrolled after providing written informed assent and/or consent. Individuals who had lived in the study areas for less than one year or had limited information on teenage pregnancies were excluded.

### Sample size Estimation

Sample size calculation was done using Yumane's method of sample size estimation as indicated in Appendix 1 [7]. Using the project target population of 1,170,000 (Namutumba District 652,600, and Bugiri District 517,400) [8]. With a level of significance – 5%, the estimated sample size was 400. To account for missing information due to non-responses, a 10% increase was made thus adjusting the sample size to 440.

### Sampling procedures and data collection

We purposively sampled eight sub-counties in Namutumba and Bugiri districts since these had the highest teenage pregnancy rates. We used proportionate sampling to select the number of participants to be recruited per sub-county based on the total sub-county population. A total of 473 participants were recruited from each of the following sub-counties: Namutumba- 106, Magada-108, Kagulu-98, Bulange-128, Budhaya-90, Kapyanga-51, Iwemba-45, and Bulesa-67. Stratified simple random sampling was used to select parishes and villages for the study. Then systematic sampling was used by selecting every 4th household in all directions from the village center guided by local council chairpersons. The first household was randomly selected from all 4 households in the four directions; North, South, East and West. An adolescent and their care giver from each household were randomly selected to participate after completing the informed consent and/or assent process. The in-charges of all the health facilities in the six sub-counties of the Bugiri and Namutumba districts were recruited for the study. Electronic questionnaires were administered upon obtaining consent from participants. To ensure data quality, responses were checked daily for completeness.

### Study measures and tools

A pre-tested electronic questionnaire was used to collect data from the participants. The questionnaire captured variables such as socio-demographic information, including age, sex, religion, and occupation. SRHR indicators encompassed experiences of SGBV, awareness of SRHR/SGBV, access to and referral for SRHR/SGBV services. Additionally, SRHR service delivery indicators assessed provider competence in staffing and training, the availability of youth-friendly services, the provision of SRHR/SGBV services, infrastructure, and daily clinic hours dedicated to adolescent health service delivery.

### Data analysis

Data was analyzed using Stata version 14.0 (Stata Corp LLC, College Station, Texas, USA). Categorical variables were summarized using frequencies and percentages. Comparisons between study sub-groups were made using the chi-square test at a 95% level of confidence.

### Results

A total of 473 participants were enrolled for the study: with 253 and 220 participants from Bugiri and Namutumba respectively. Majority of participants were

female at 53.3% [252/473] and more than half were aged between 10 and 19 years [51%, 241/473]. More than half of participants [52%, 246/473] were single/never married and the main occupation for most was being a student/pupil [50.1%, 237/473]. A significantly higher proportion of participants in Namutumba were Anglicans [40.9%, 90/220,  $P < 0.001$ ], while Bugiri had a significantly higher percentage of students/pupils [52.2%, 132/253,  $P < 0.001$ ]. No significant differences were observed in the proportions for other socio-demographic characteristics of Bugiri and Namutumba districts (Table 1).

### Indicators on access of SRHR information in Bugiri and Namutumba district

Only 22.6% [107/473] of participants had received at least 3 out of the 13 forms of SRHR/SGBV information. Majority 73.3% [342/473] indicated government health facilities as the referral points for SRHR services. Less than half of participants; 41.9% [198/473] agreed to at least 3 of the 8 SRH rights. Majority of participants agreed to at least 3 out of the 5 laws on sexual and gender-based violence at 77.0% [364/473]. Only 21.8% [103/473] of the participants felt that they could make pregnancy choices. There were significant differences in access to SRHR/SGBV

**Table 1** Socio-demographical characteristics of 473 participants in eight sub-counties of Bugiri and Namutumba districts

Characteristics	Total n [%]	Bugiri n [%]	Namutumba n [%]	P-value
<b>Sex</b>				
Male	221[46.7]	119[47.0]	102[46.4]	0.884
Female	252[53.3]	134[53.0]	118[53.6]	
<b>Age grouping</b>				
10–19 years	241[51.0]	60[52.6]	61[49.5]	0.303
20–29 years	127[26.8]	67[26.5]	60[27.3]	
30–39 years	64[13.5]	37[14.6]	27[12.3]	
40–49 years	40[8.5]	16[6.3]	24[10.9]	
<b>Religion</b>				
Catholic	92[19.5]	44[17.4]	48[21.8]	< 0.001
Protestant	157[33.2]	67[26.5]	90[40.9]	
Muslim	137[29.0]	78[30.8]	59[26.8]	
Pentecostal	47[9.9]	40[15.8]	7[3.2]	
Others	40[8.5]	24[9.5]	16[7.2]	
<b>Marital status</b>				
Single/Never married	246[52.0]	130[51.4]	116[52.7]	0.620
Married/ Cohabiting	177[37.4]	93[36.8]	84[38.2]	
Divorced/separated	50[10.6]	30[11.8]	9[4.1]	
<b>Major/main occupation</b>				
Student/pupil	237[50.1]	132[52.2]	105[47.7]	< 0.001
Self employed	65[13.7]	17[6.7]	48[21.8]	
Farming	148[31.3]	98[38.7]	50[22.7]	
Formal employment	6[1.3]	3[1.2]	3[1.4]	
Others	17[3.6]	3[1.2]	14[6.4]	
<b>Participant group</b>				
Adolescents	242 [51.2]			
Care givers	231 [48.8]			

**Table 2** Indicators on access of SRHR in Bugiri and Namutumba district among 241 adolescent participants in Bugiri and Namutumba districts

Variable	Category	Overall n [%]	Confidence Intervals	Bugiri n [%]	Namutum- ba n [%]	P-value
# of participants who received at least 3 forms of SRHR/SGBV information		107[22.6]	17.7, 25.1	73[28.9]	34[15.5]	<0.001
Referral points for SRH issues	Government health facilities	<b>342[73.3]</b>		<b>212[85.0]</b>	<b>130[69.9]</b>	<0.001
	VHT	109[23.0]		39[15.4]	70[31.8]	
	NGOs	85[18.0]		5[1.6]	81[36.8]	
	Private health facilities	73[15.4]		56[22.1]	14[7.7]	
	Others	65[13.7]		28[11.1]	37[16.8]	
# of participants who had knowledge on at least 3 SRH rights		198[41.9]	36.2, 45.1	109[43.03]	89[40.63]	0.561
# of participants who knew at least 3 laws on sexual and gender-based violence		364[77.0]	73.1, 81.5	211[83.32]	153[69.38]	<0.001
# of participants who felt they could make pregnancy choices		103[21.8]	18.3,25.7	87[34.39]	16[7.27]	<0.001

**Table 3** Access to SRHR information across socio-demographic characteristics of age, gender and marital status among 473 participants in Bugiri and Namutumba districts

Characteristic	Category	Access to $\geq 3$ forms of SRHR information		95% Confidence Interval		P-value
		n [%]		Lower	Upper	
Sex	Over all (N)	107 [22.6]		17.7	25.1	
	Male	38 [17.2]		12.8	22.8	0.049
	Female	62 [24.6]		19.7	30.3	
Age	10-19years	46 [19.0]		14.5	24.5	0.064
	20-29years	96 [24.4]		17.7	32.6	
	30-39years	45 [29.7]		17.7	32.6	
	40-49years	36 [10.0]		3.8	23.8	
Marital status	Single	48 [19.5]		15	25	0.570
	Married/Living together	42 [23.7]		18	30.6	
	Divorced/widowed	10 [20.0]		11.1	33.3	
Participant group	Adolescents	46 [19.0]		14.5	24.5	0.245
	Caregivers	54 [23.4]		18.4	29.3	

**Table 4** Experience of SGBV among 242 adolescent participants in Bugiri and Namutumba districts

Indicator	Overall n [%]	Confidence Interval	Bugiri n [%]	Namutumba n [%]	P-value
# of adolescents that experienced at least 1 form of SGBV	126[52.1]	48.9,54.7	86[64.7]	41[37.6]	<0.001
# of survivors that have shared their SGBV experience	34[27.0]	24.3,32.7	27[31.4]	7[17.1]	0.09

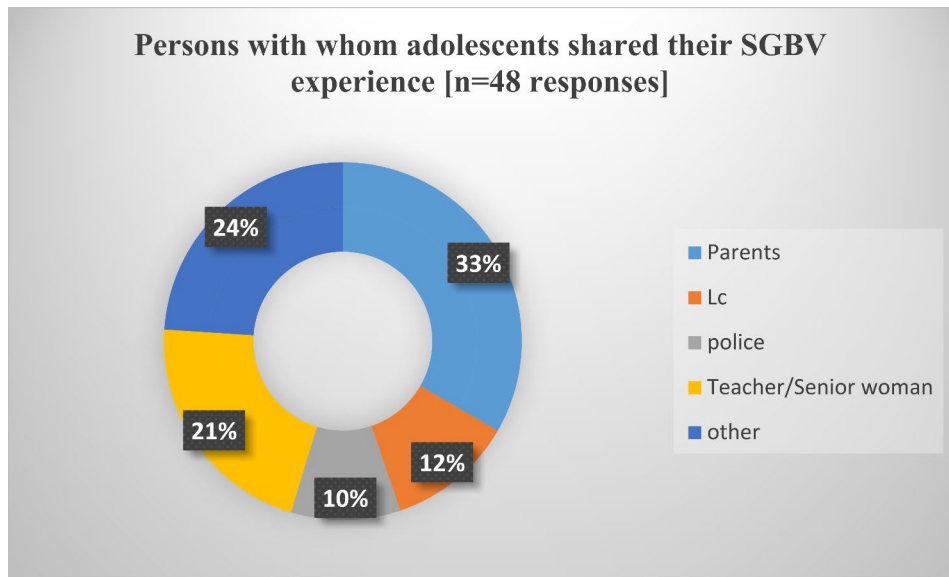
information, referral points for SRH issues, knowledge of the laws on SGBV and ability to make pregnancy choices across bugiri and Namutumba districts [ $P < 0.001$ ] as shown in Table 2.

#### Access to SRHR information across socio-demographic characteristics of age, gender and marital status among 473 participants in Bugiri and Namutumba districts

Compared to men, women significantly had higher access to SRHR information [24.6%, 95% CI: 19.7–30.3,  $P$ -value-0.049]. There was no significant differences in access to SRHR information across the age groups, marital status, adolescents and their care givers (Table 3).

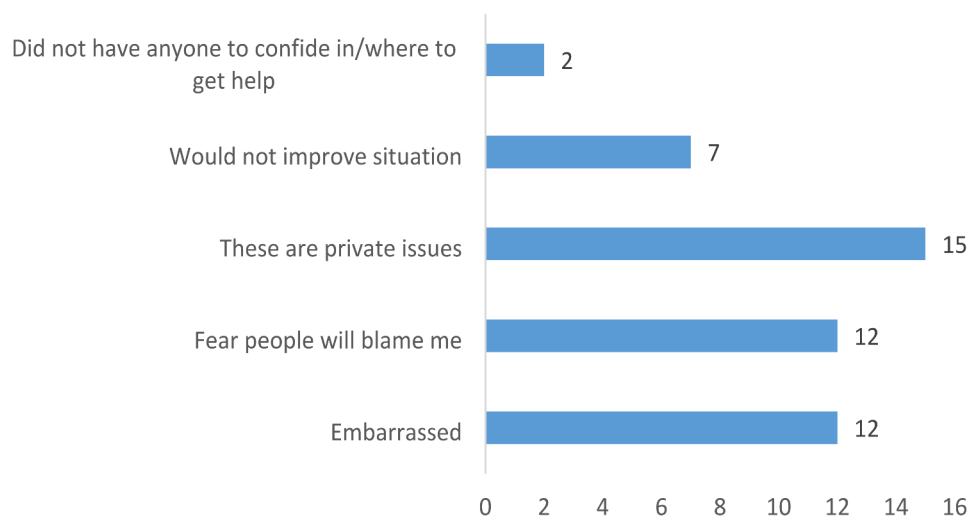
#### Indicators on experience of SGBV in the past 12 months among 241 adolescent participants in Bugiri and Namutumba districts

Half of adolescents had experienced at least one of the nine forms of SGBV, out of which only [27%,34/126, CI:24.3,32.7] shared this experience as shown in Table 4. Most participants shared their SGBV experience with parents – 33% [63/192] and senior woman/teacher – 21% [40/192] as shown in Fig. 1. Experience of SGBV was considered a private issue by 31.3% [15 out of the 48 responses] of participants who didn't share their experience with anyone as shown in Fig. 2.



**Fig. 1** Persons with whom adolescents shared the SGBV experiences

### Participant reasons for not asking help



**Fig. 2** Participant reasons for not sharing the SGBV experience

#### Indicators on competence of health facilities [HF] to provide SRHR/SGBV services

13 government health facilities were assessed. 84.6% [11/13] of HFs had at least 4 of the 8 minimum required staffing, half of which [7/13] had their staff trained in at least 2/8 SGBV areas. 69.2% [9/13] of HFs had staff trained in more than 4 competence areas for family planning. However, only 15.4% [2/13] of HFs offered the 6 SGBV services to adolescents, 1 HF offered more than 8 Family planning methods to adolescents and none of the HFs offered all the SRHR services on daily basis. There were no significant differences in health facility

indicators between Bugiri and Namutumba districts, shown in Table 5.

#### Discussion

Understanding the baseline SRHR indicators is pivotal to the reduction of teenage pregnancies in Namutumba and Bugiri districts in Eastern Uganda. Three SRHR performance indicators were adopted for the reduction of teenage pregnancies in Bugiri and Namutumba districts i.e. access to SRHR/SGBV information, access to SRHR/SGBV services and competence of health facilities to provide SRHR/SGBV services.

**Table 5** Indicators on competence of the 13 [HFs]elected health facilities [HFs] in Bugiri and Namutumba districts to provide SRHR/SGBV [HFs]services

Indicator	Category	Overall n [%]	Bugiri n [%]	Namutumba n [%]	P-value
# of HFs that at least have 4 of the minimum required staffing		11[84.6]	3[60]	8[100]	0.25
# of HFs with staff trained in at least 2 SGBV areas		7[53.8]	3[60]	4[30.7]	0.72
# of HFs with staff trained in at least 3 areas of helping mothers survive		8[61.5]	3[60]	5[62.5]	0.93
# of HFs with staff trained in FP competence areas	> 4	9[69.2]	3[60]	6[75]	0.59
	1-<=3	1[7.7]	0[0]	1[12.5]	
	none	3[23.1]	2[40]	1[12.5]	
# of the HF that offered SGBV services to adolescents	>=6	2[15.4]	1[20]	1[12.5]	0.73
	3->=5	7[53.8]	2[40]	5[62.5]	
	< 3	4[30.8]	2[40]	2[25]	
# of the HF that offered FP methods to adolescents	> 8	1[7.7]	0[0]	1[12.5]	0.80
	6-<=8	8[61.5]	3[60]	5[62.5]	
	3-<=5	3[23.1]	1[20]	2[25]	
	< 3	1[7.7]	1[20]	0[0]	
# of the HFs that offered the SRHR service package on daily basis	All services		0[0]	0[0]	0.25
	At least 4 services	10[76.9]	3[60]	7[87.5]	
	< 4 services	3[23.1]	2[40]	1[12.5]	

#### Access to SRHR/SGBV information

The study showed that only 22.6% received at least three forms of the 13 forms of SRHR/SGBV information, which presents a challenge of limited access to SRHR/SGBV information that impedes informed decision making, utilization of SRHR services and thus an increase in unintended and/ teenage pregnancies. This is consistent with study findings of a national online survey done in Uganda where participants reported an inadequate access to SRHR information [9].

Majority of participants highlighted government health facilities and VHTs as key referral points. This is due to the fact that government health facilities offer broader coverage in rural settings, while VHTs are often located with in communities where the participants reside.

Whereas majority of participants knew three of the five laws on SGBV, less than half agreed to three of the eight SRH rights and thus only one in every five participants felt they could make pregnancy choices. This indicated that most participants were unknowingly vulnerable to violation of their rights which often rendered them powerless to make any informed SRHR decisions especially to do with pregnancy. These finding agree with a study conducted in Ethiopia, where only 33.5% of the participants knew about the right to decide whether or not and when to get pregnant/have children [10].

#### Access to adolescent SRHR/SGBV services

More than half of adolescents had experienced SGBV and only 27% shared/sought for help after the SGBV experience. Participants claimed experiences of SGBV were private issues, while others said they were either embarrassed or feared being blamed for being a victim of SGBV. This finding unearthed the silent burdens of SGBV, the

dire lack of support systems for victimized adolescents and impediment to access to health and legal services. It's no wonder most survivors of SGBV shared their experiences with parents or senior women/teachers, persons who were out of health and legal structures often causing a delay or no intervention to provide SRHR services/ justice to the adolescent survivors of SGBV. These findings are consistent with a systematic review done among women aged 10–24 years that found family members and schools as the most trusted sources for SRH information and support [11].

#### Competence of government health facilities to provide adolescent SRHR/SGBV services

Majority of health facilities had at least four of the required health staff, over 50% were trained in SGBV, FP and helping mothers survive. However, only two health facilities offered six of SGBV services to adolescents and four offered these services on a daily basis. This finding showed that SRHR/SGBV services were still limited, therefore the few adolescents who could access health facilities, often got suboptimal services that didn't adequately meet their SRHR needs. According to studies done in Uganda and Ethiopia; stock out of supplies/ drugs, lack of adolescent friendly services/ youth corners, absenteeism, patient overload and judgmental attitude of health workers often led to the delivery of suboptimal SRHR/SGBV services [12–14].

According to a systematic review done among sub-Saharan countries, several key interventions for youth-friendly health services were highlighted; including the use of evaluative and iterative strategies, training and educating stakeholders, adapting and tailoring youth services to the specific context, engaging youth, modifying

infrastructure, fostering stakeholder interrelationships, and incorporating mHealth and outreach services. However, the review emphasized that a tailored approach, one that is based on a thorough understanding of the local context, including barriers and facilitators is essential for achieving meaningful impact in SRHR programming [15].

### Limitations

Given the sensitive nature of the study, some of the interview questions about experiences of SGBV went unanswered, potentially introducing non-response bias. This was mitigated by maintaining confidentiality and making every effort to have interviewers of the same sex as the participants conduct the interviews.

Purposive sampling of the sub counties could have introduced sampling biases; however, these were minimized by random and proportional sampling, ensuring representation across all participant categories in the survey.

### Conclusion

In conclusion, the findings highlight significant gaps in access to and utilization of SRHR and SGBV services among adolescents and their caretakers. While over half of the participants were aged 10–19 years, only a small fraction had received adequate SRHR information or were aware of their SRH rights. In addition, one in every two adolescents had experienced SGBV, yet only one in four cases was reported. The limited availability of comprehensive SRHR services further deepened the crisis, limiting access to essential care and support.

### Recommendations

To improve adolescent access to SRHR and SGBV services in rural districts, interventions should focus on reducing stigma and strengthening community support systems. Secondly, enhancing rural healthcare systems through capacity-building programs will ensure consistent and adolescent-friendly service delivery. Additionally, reinforcing the monitoring framework is crucial for tracking progress, assessing the impact of interventions, and informing evidence-based policy decisions.

### Abbreviations

FP	Family planning
HF	Health facility
LC	Local council
SRHR	Sexual reproductive health and rights
SGBV	Sexual gender based violence
STIs	Sexually transmitted infections
UBOS	Uganda bureau of statistics
UDHS	Uganda demographical household survey
UNICEF	United nations children's fund
VHT	Village health team
WHO	World health organization

### Glossary

Sex	Defined as binary sex categorization (male/female) that was designated at birth.
Adolescent	Referred to a person aged 10–19 years.
mHealth	Mobile/digital health.

### Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12889-025-22616-4>.

**Supplementary Material 1: Appendix 1:** Math formulae for sample size estimation.  $n = N/1 + N(e)^2 N$  - Target population,  $e$  - level of significance,  $n$  - estimated sample size.

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### Author contributions

PK, TK and MN: Conceptualization, Methodology, Software. SOO, DA and BK: Investigation. PK, TK and MN: resources. SOO and NE: Writing - Original Draft. BK, DA MN and TK: Writing - Review & Editing. NE, SOO and BK: Data Curation and Visualization. PK, MN, DO and TK: Supervision and Project administration. All authors read and approved the final manuscript.

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### Data availability

This data is part of the ongoing SRHR program in AMREF. Therefore, datasets used and analyzed during this study are available from the corresponding author upon reasonable request.

### Declarations

#### Ethics approval and consent to participate

was sought from the Research Ethics Committee of Uganda Christian University – reference UCUREC-2023-730, and Uganda National Council for Science and Technology (UNCST) – reference SS2455ES. Additionally, the DHOs of Bugiri and Namutumba districts granted administrative permission to conduct the survey. All participants provided written and signed informed consent. All data has been anonymized to maintain confidentiality. All methods were carried out following the relevant guidelines and regulations of the Declaration of Helsinki.

#### Consent for publication

Not applicable.

#### Competing interests

The authors declare no competing interests.

**Footnotes**

*Forms of SRHR/SGBV information* included making friends, menstruation and menstrual management, sexual and reproductive health rights, puberty and body image (physical changes and feelings), values, sexually transmitted diseases including HIV, condoms (both male and female), sexual and gender-based violence and related laws, responsible decision making/child pregnancy, healthy and unhealthy relationships, SRHR services, harmful cultural practices, respecting similarities and differences.

*The SRH rights* included right to life, right to equality and freedom from any form of discrimination, right to health care and health protection, right to SRH information and education, right to protection from sexual exploitation, abuse, rape, coercion and prostitution, right to access SRHR services, right to marry or not and a right to have children or not to have.

*The laws on SGBV* included rape is a crime, marital rape (rape of a partner/spouse within marriage) is a crime, committing an act of rape is punishable by death, sexual intercourse with a minor/defilement is a crime, under-age marriage is a crime and age of consent is 18 years and above.

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