Sexual and Reproductive Health and Rights Challenges among Ugandan Youth during COVID-19 Pandemic lockdown: An online Cross-Sectional Study

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Abstract

Background The COVID-19 pandemic threatens access to sexual and reproductive health and rights. With global health emergencies, there is often a total reversal of priorities and sexual and reproductive health rights services may become challenging. The aim of this study was to establish the challenges to sexual and reproductive health and rights among Ugandan youth during the lockdown due to COVID-19 pandemic.

Methods This was an online cross-sectional study carried out from April 2020 to May 2020 in Uganda. An online questionnaire was used and participants aged 18 to 30 years recruited using the snowballing approach. The statistical analysis was done using STATA version 14.

Results Out of 724 participants, 203 (28%) reported not having information and/or education concerning sexual and reproductive health (SRH). About a quarter of the participants (26.5%) reported not having testing and treatment services of Sexual transmitted Infections available during the lockdown. Lack of transport means was the commonest (68.7%) limiting factor to access to SRH services during the lockdown followed by the long distance from home to health facility where to get the services (55.2%), cost of services (42.2%) and curfew (39.1%). Sexually transmitted diseases were the commonest (40.4%) challenge relating to SRH during this lockdown followed by unwanted pregnancy (32.4%) and sexual abuses (32.4%). The Multivariate Regression Analysis shows that challenges were more prevalent among the co-habiting youth [APR: 2.3 (1.6 - 3.29), p<0.001] followed by unemployed (Volunteer or unpaid) [APR: 1.6 (1.03 - 2.64), p: 0.037] than others participants.

Conclusions The findings of this study show that Ugandan youths have challenges to access to SRHR information and services during lockdown due to COVID-19. Cohabiting and unemployed participants were mostly affected among Ugandan youths. Lack of transport means and cost of services were the limiting factors to access SRHR services among youths. Therefore, effective measures should be put in place to ensure access and availability of SRHR for Ugandan youths during the COVID-19 lockdown.

Plain English Summary

The world is facing a global health crisis due to the current COVID-19 pandemic which is causing disruptions in accessing sexual and reproductive health and rights with related challenges. An online cross-sectional study was conducted to establish the challenges to sexual and reproductive health and rights (SRHR) among Ugandan youth during COVID-19 Pandemic lockdown. A sample of Ugandan youth filled the pre-structured online questionnaire. Data was analysed to identify the SRHR challenges and the associated factors. The results showed that Ugandan youths have challenges to access to SRHR information and services. Cohabiting and unemployed participants were mostly affected and lack of transport means and cost of services were the limiting factors to access SRHR services.

The above findings suggested that effective measures should be put in place to ensure access and availability of sexual and reproductive health and rights for Ugandan youth in order to avoid challenges related the COVID-19 lockdown.

Introduction

On 11th March, 2020, the World Health Organization (WHO) declared COVID-19 a pandemic [1]. According to the WHO, as of 7th July 2020, there were a total 11,500,302 confirmed cases (507,187 confirmed in Africa), including 535,759 deaths (11 959 in Africa) or case fatality ratio of 4.7% (2.4% in Africa), reported globally, and the numbers continue to rise rapidly [2–3].

The COVID-19 outbreak has induced fear across the world and has now spread to all inhabited continents affecting nearly all countries including Uganda. Uganda announced a lockdown and dawn to dusk curfew on 20th March, 2020 and as of 7th July 2020, Uganda had reported 971 confirmed cases of COVID-19 with 896 recoveries and without any reported death [2].

Governments are gearing up their response to rapidly reduce disease spread with many countries having chosen to apply mass quarantine, shutdown or social distancing [4]. In the midst of COVID-19 spread in Uganda and as the Government implements different pandemic control measures, access to sexual and reproductive health services and care are being severely curtailed which is negatively affecting young people's lives directly and indirectly [5]. Experience in the past epidemics has shown that lack of access to essential health services and shut-down of services unrelated to the epidemic response, resulted in more deaths than the epidemic itself [6].

From previous Ebola outbreaks in Western Africa, media and grey reports identified concerns about rising levels of adolescent pregnancy due to the increased time that girls are out of school whilst educational institutions are closed, taking more responsibility in caring roles, increased early marriage or engaging in increased transactional sex [7]. Reports also indicate that girls suffer more sexual violence and exploitation when they are isolated, quarantined or moved to other areas to escape the virus [7–8]. While data are scarce, reports from China, the United Kingdom, the United States, and other countries, suggest an increase in domestic violence cases since the COVID-19 outbreak [9]. During humanitarian crisis, sexual violence increases, lack of family planning supplies and services leads to the spread of sexually transmitted infections (STIs) and unintended pregnancies [8, 10].

Challenges in accessing sexual and reproductive health information and services - including contraception, safe abortion and HIV medications have potential to exacerbate the risks especially to girls' and women's health and lives [7]. Given the impact of COVID-19 to health systems, the Inter-Agency Working Group (IAWG) on Reproductive Health has recommended that comprehensive sexual and reproductive health services should be maintained as long as the system is not overstretched with COVID-19 case management [11].

With COVID-19 already causing disruptions in meeting family planning needs, clinical staff occupied with the COVID-19 response may not have time to provide services, or may lack personal protective equipment to provide services safely. In some setting, the health workforce has been reassigned to COVID-19

care hence reducing the capacity in other services. This has resulted in health facilities in many places closing or limiting services, youth and in particular women are refraining from visiting health facilities due to fears about COVID-19 exposure or due to movement restrictions, supply chain disruptions are limiting availability of contraceptives in many places, and stock-outs of many contraceptive methods being anticipated in more than a dozen lowest-income countries [12]. Product shortages and lack of access to trained providers or clinics mean that women may be unable to use their preferred method of contraception, or may instead use a less effective short-term method, or may discontinue contraceptive use entirely [13].

The Government of Uganda issued directives to protect pregnant women's access to maternity services, but access to essential sexual and reproductive health information and services such as contraceptives and other family planning packages like condoms, access to Antiretrovirals (ARVs) and menstrual health materials by young people have not been prioritized during the lockdown [14]. The transfer of already limited resources to deal with the pandemic and the absence of health care workers from their original duty may cause interruptions in regular provision of essential SRH services, increasing the risk of unintended pregnancies and sexually transmitted infections. SRH outcomes may worsen due to gender-based violence (GBV) which can increase the risk of chronic health conditions, disability, HIV transmission, pregnancy complications and even death [7–8]. News reports are confirming rise in gender base violence, unwanted pregnancy among young girls, unsafe abortion, closure of antenatal care services in some of public health facilities, and a sharp decline in women seeking SRH services [14]. Although the Ministry of Health and donors had come up with a strategy of establishing youth-friendly corners at health facilities to increase the uptake of SRH services by Ugandans youth, they are currently closed [14].

The United Nations defines youth as those persons between the ages of 15 and 24 years [15] but the African Union defines youth or young people as every person between the ages of 15 and 35 years [16] and the Uganda youth policy defines youth as all young persons, female and male, aged 12 to 30 years [17]. The Uganda and Health Survey of 2016 points to over 25% teenage pregnancies, among sexually active young people by the age of 16 years, and the unmet family planning need in the country stood at 28% [18]. Even before the pandemic, the Ugandan health system rarely offered young people the sexual and reproductive health services designed to meet their needs and with limited respect for their rights to dignity and privacy [19]. With the COVID-19 pandemic, access to sexual and reproductive health services, including family planning, emergency obstetric and antenatal care, and gender-based violence prevention and management services are essential to save lives. While physical distancing and lockdown act as barrier, reliable data on adolescents and young people's sexual and reproductive health care-seeking behaviour and their access to sexual and reproductive health rights (SRHR) services since the beginning of the COVID-19 pandemic lockdown are relatively scarce. Additionally, there is a paucity of data on challenges of SRHR among Ugandans youth during the lockdown. This study was carried out to explore young people's SRHR challenges during COVID-19 pandemics and to determine the factors associated with these challenges among Ugandan youths.

Methods

Study design and setting

A nationwide cross-sectional online survey was conducted during the months of April and May, 2020 among the youth in Uganda using a snowball sampling technique.

Study Participants

This study was focused on Ugandan youths aged 18 to 30 years and living in any of the four regions (Northern, Central, Eastern and Western) of the country at the time of the study. The Ugandan youths aged 18 to 30 years constitute 22.9% (10,326,072.351) of Ugandan population standing at 44,269,594 in 2019 according to the national bureau of statistics [20]. All Ugandan youth able to consent (18 years and above) and with a minimal computer literacy level and assumed to have access and able to operate on WhatsApp, tweet or Facebook were eligible to participate in the survey. Those who had filled the form but for some reason were unable to submit the questionnaire were automatically not reflected and therefore excluded in the data base for the survey.

Data Collection and Instrument

An online semi-structured modified questionnaire of the study about sexual, reproductive health needs, and rights of young people in Uganda [21] was developed using Google forms: (https://docs.google.com/forms/d/1lTJzHk6B1j923zm8uFbwK6nXBOn98_TpFYTqCxe6wj8/edit?edit_requested=true), with a required consent form that had to be filled before accessing the questionnaire. The questionnaire was administered for a period of 14 days using snowball sampling technique. The Ugandan youths living in Uganda at the time and aged 18–30 years were encouraged to participate and also notify others to do so by forwarding to them the link to the survey tool. On receiving and clicking the link, the participants were auto-directed to the informed consent page of the survey tool. After reading the preamble, accepting to participate in the study, they were directed to the survey questionnaire which started with demographic details followed by a set of questions on sexual and reproductive health information and services.

The questionnaire was anonymous and focused on several key constructs including: (1) socio-demographics characteristics (age, sex, profession, location, educational level, marital status and residence),(2) Overview about COVID-19 (3), access to sexual and reproductive health information and services during the lockdown, (4) The limiting factors to access sexual and reproductive health information and services and (5) The sexual and reproductive health problems or challenges that Ugandan youth were facing during the lockdown.

Data Processing and analysis plan

Questionnaires were pretested and subjected to serial reviews to ensure correctness and appropriateness to the local context. The statistical analysis was done using STATA version 14, whereby categorical variables were presented using frequencies, graphs and/or figures whereas continuous variables were presented using means, standard deviations (SD). Social demographics with factors related to overview about COVID-19, sexual and reproductive health information and services during the lockdown, factors affecting accessibility of sexual and reproductive health information and services and sexual and reproductive health challenges were compared using Chi-square and p-values respectively for categorical variables.

Multivariate regression analysis to establish association and prevalence ratios of having faced any challenge in accessing Sexual and Reproductive Health information or of having had any problem relating to sexual and reproductive health and rights and services during this lockdown with Socio-demographics was done using the Poisson Regression and presented as Adjusted Prevalence ratios (APR).

Ethical Considerations

This study received ethical consideration from Kampala International University Institutional Research Ethical Committee (UG-REC-023/202018). Data was collected online and the consent form was attached to the anonymous questionnaire and only those who accepted to participate in the study voluntary were able to fill the questionnaire.

Results

A total of seven hundred thirty-three (733) participants completed the online questionnaire. Nine (9) participants were excluded from the survey because they were above 30 years of age, thus the final sample size considered was seven hundred twenty-four (724).

Socio-demographic characteristics of participants

Out of 724 participants, 56.4% were male and 78.0% were living single. As shown in Table 1 below, the mean age of the respondents was 24.4 (SD ± 2.8) years. The majority (87.2%) had attained an educational level of college/university while 27.2% were salaried employees. The majority of participants were either from Central Uganda (37.8%), or Western Uganda (35.1%).

Table 1
Socio-demographic characteristics of participants

Variable	Frequency N (Percent)	Mean (SD)
Sample size	724 (100)	
Sex		
Female	316 (43.6)	
Male	408 (56.4)	
Mean Age in complete years		24.4 (2.8)
Age group in years		
18 to 24	395 (54.6)	
25 to 30	329 (45.4)	
Marital status		
Living single	555 (78.0)	
Married	81 (11.2)	
Cohabiting	78 (10.8)	
Education level		
College/University	631 (87.1)	
Vocational or Technical Institution	46 (6.4)	
Secondary School and below	47 (6.5)	
Location/Region in Uganda		
Central Uganda	274 (37.8)	
Western Uganda	254 (35.1)	
Eastern Uganda	122 (16.9)	
Northern Uganda	74 (10.2)	
Employment status		
School	337 (46.5)	
Paid employment (employee on a salary)	197 (27.2)	
Self-employed (Business/Income Generating Activity)	62 (8.6)	
Unemployed: No structured activity	69 (9.5)	
Unemployed: Volunteer or unpaid work	59 (8.1)	

Access to sexual and reproductive services of participants during lockdown COVID-19

Out of 724 participants, 203(28.0%) reported not having information and/or education concerning sexual and reproductive health. The participants 26.5% reported not having testing and treatment services of STIs available during this lockdown and 197(27.2%) reported difficulty in accessing their preferred modern contraceptive during this lockdown. HIV testing and Counselling services were not available for 159(22.0%) participants and of 62 participants who were on HIV treatment, 50(80%) reported difficulty in accessing HIV drugs during the study period. Out of 316 female participants, 127 (40.0%) did not easily access menstrual health products such as sanitary pads. Forty-four (44) females were pregnant or had delivered at the time of the study and among them 8(18.2%) reported not to easily accessing Pre-, peri-, or post-natal health care during the Lockdown. Twenty-four 24(54.5%) female participants had an abortion during lockdown and 5(20.8%) of these were unable to access post abortion care services. Other elements are mentioned in Table 2.

Table 2
Access to sexual and reproductive health services of participants during lockdown COVID-19

Variables	All (%) 724 (100%)	p-value
Availability of information and/or education concerning sexual and reproductive health		**0.664**
No	203 (28.0%)	
Yes	521 (72.0%)	
There are testing and treatment services of STIs available during this Lockdown		**0.005**
No	195 (26.9%)	
Yes	315 (43.5%)	
Don't know	214 (29.6%)	
How easily are you able to access your preferred modern contraceptive during this lockdown		**0.001**
Not Easily	197 (27.2%)	
Easily	132 (18.2%)	
Not Applicable	395 (54.6%)	
HIV testing and Counselling services are accessed during this lockdown		**0.014**
No	159 (22%)	
Yes	349 (48.2%)	
Don't know	216 (29.8%)	
Currently on HIV (ARVs) medication		**0.033**
No	662 (91.4%)	
Yes	62 (8.6%)	
If yes, how easily are you able to access to Antiretroviral therapy (medication) during this lockdown		**0.054**
Not Easily	50 (6.9%)	
Easily	12 (1.7%)	
Not Applicable	662 (91.4%)	
If female, are you able to access menstrual health products such as sanitary?		**0.001**
Not Easily	127 (17.5%)	
Easily	189 (26.1%)	
Not Applicable	408 (56.4%)	
If you are pregnant or you have delivered, are Pre-, peri-, and post-natal health care available during this Lockdown?		**0.001**
Yes	36 (81.8%)	
No	8 (18.2%)	
If you had abortion, are post abortion care services offered during this Lockdown?		**0.001**
Yes	19 (79.2%)	
No	5 (20.8%)	

Of the 357 participants reported using family planning methods, 320 (44.2%) were on modern methods and 37 (5.1%) on traditional. A half (50.7%) of the participants were not using any family planning method during the study period.

Out of the 320 participants who were using modern contraceptive during the lockdown, 232 (72.5%) were using condoms followed by 33 (10.3%) who used Emergency pills, 22 (6.9%) IUD, 20 (6.3%) injection and 13 (4.1%) were using implants as shown in **Fig. 2** below.

Having a Limiting factor and a Challenge with Social Demographics

The ordered logistic regression shown in Table 3, shows that the limiting factors were 2.3 times more prevalent (APR:2.3 (1.55–3.33, p < 0.001) among cohabiting participants and 1.7 times more prevalent among the unemployed and non-salaried participants [APR:1.7 (1.07–2.85), p:0.025] than other participants.

Table 3
Multivariate Regression Analysis using Poisson Regression of having a limiting factor and a challenge with social demographics

Variable	APR (95%CI)	P-Value
Sex		**0.955**
Female	1	
Male	1 (0.73–1.35)	
Age group in years		**0.592**
18 to 24	1	
25 to 30	1.1 (0.76–1.60)	
Marital status		**< 0.001**
Single	1	
Married	1.4 (0.92–2.27)	0.110
Cohabiting	2.3 (1.55–3.33)	0.001
Education level		**0.001**
College/University	1	
Vocational or Technical Institution	0.5 (0.30–0.75)	0.001
Secondary School and below	0.8 (0.48–1.45)	0.518
Location/Region in Uganda		**0.796**
Central Uganda	1	
Western Uganda	1 (0.71–1.50)	0.856
Eastern Uganda	1.2 (0.79–1.78)	0.400
Northern Uganda	0.9 (0.53–1.6)	0.762
Employment status		**0.219**
School	1	
Paid employment (employee on a salary)	1.2 (0.74–1.83)	0.503
Self-employed (Business/Income Generating Activity)	1.3 (0.78–2.32)	0.288
Unemployed: No structured activity	0.8 (0.36–1.60)	0.464
Unemployed: Volunteer or unpaid work	1.7 (1.03–2.74)	0.038

APR: Adjusted Prevalence ratios

Challenges relating to sexual and reproductive health and rights with Socio-demographics

The Multivariate regression analysis shows that challenges relating to sexual and reproductive health and rights were 2.3 more prevalent among cohabiting [APR: 2.3 (1.6–3.29), p < 0.001] followed by unemployed (Volunteer or unpaid) [APR: 1.6 (1.03–2.64), p: 0.037] than others participants.

Table 4
Challenges relating to sexual and reproductive health and rights with Socio-demographics using Poisson Regression

	Poisson Regression	
Variable	**APR (95%CI)**	**P-Value**
Sex		**0.994**
Female	1	
Male	1 (0.74–1.35)	
Age group in years		**0.661**
18 to 24	1	
25 to 30	1.1 (0.76–1.54)	
Marital status		**< 0.001**
Single	1	
Married	1.5 (0.99–2.32)	0.055
Cohabiting	2.3 (1.60–3.29)	< 0.001
Education level		**0.001**
College/University	1	
Vocational or Technical Institution	0.5 (0.31–0.74)	0.001
Secondary School	0.8 (0.45–1.33)	0.355
Location/Region in Uganda		**0.748**
Central Uganda	1	
Western Uganda	1.1 (0.75–1.53)	0.692
Eastern Uganda	1.2 (0.82–1.79)	0.338
Northern Uganda	0.9 (0.55–1.59)	0.811
Employment status		**0.198**
School	1	
Paid employment (employee on a salary)	1.2 (0.76–1.76)	0.502
Self-employed (Business/Income Generating Activity)	1.2 (0.73–2.09)	0.438
Unemployed: No structured activity	0.7 (0.33–1.44)	0.323
Unemployed: Volunteer or unpaid work	1.6 (1.03–2.64)	0.037
AOR: Adjusted Odds ratio		

Discussion

While Uganda was under lockdown, one of the measures observed during the COVID-19 pandemic, there was a need to study the status of Ugandan youth about sexual and reproductive health and rights services. The youth remain underserved by these services despite their demonstrated need. The Government of Uganda has put in place public health emergency directives and partially lifted the travel ban for pregnant women and people living with HIV/AIDS but access to essential SRHR services such as contraceptives and other family planning packages like condoms, access to ARVs and menstrual health materials by young people have not been prioritized during the lockdown [14]. In this study, we found lack of access to information and services of SRHR during this lockdown (Table 2). These finding support the lack of accessing the information and services among youth worldwide which impact on the future life of a country [7]. It was reported that less than 10% of adolescent women accessed health facilities and information about family planning in 70 developing countries despite the momentum in implementing SRH in most countries [22].

With global health emergencies, there is a total reversal of priorities and, as a result, the availability, accessibility and affordability of SRHR services has become challenging [7]. During the pandemic, lack of resources may reduce access to SRH and increase maternal and childhood mortality rates [7]. The same findings were found in some other countries while studying the attitudes of health professionals to adolescent SRH issues concerning provision of services in Kenya, Zambia [23], Swaziland [24], and Uganda [25] and the study confirmed reported experiences of young people. Particularly in Uganda, two major surveys conducted among university students indicated that young people had limited access to sexual and reproductive health services and HIV/AIDS-related programmes despite their engagement in high-risk sexual behaviours [26–27]. The West Africa's large, multi-country Ebola Virus Disease (EVD) outbreak of 2014–2016 tells us that there were significant impacts on SRH, particularly in the early stages of that outbreak, largely related to health facility closures [28].

In Sierra Leone alone, one study estimated that they were an additional 3600 maternal deaths, neonatal deaths and stillbirths related to the decrease in health service utilization during the EVD outbreak [29]. Another study from Guinea found a decrease of 51% in Family Planning (FP) visits during the outbreak [30]. There is significant unmet need for information, education, and services for sexual and reproductive health for married and unmarried young people [31].

Family planning was reported being used during lockdown among which modern methods uptake was 44.2%. A study done by Thongmixay *et al.* found similar results that preventive measures that youth used were condoms, oral pills and emergency pills [32]. Our findings are similar to a study done in suburban Shanghai, whereby a youth-friendly intervention program providing information, skills, and services to promote safe sex behaviour (contraception and condom use) compared with a control group; both unmarried females and males aged 15–24 years, showed that the intervention group was 14.59 times more likely to use contraceptives at onset of intercourse, if it occurred [33]. Furthermore, direct access to the modern methods of contraception is important for all types of contraception and especially for emergency, since they are most effective within 72 hours after unprotected intercourse – the earlier it is used the more effective the result [34]. Common barriers to full access and utilization of underutilized long-term contraceptives includes: insufficient supply and deficient quality [34]. Our study found that most of participants (87.2%) had educational level of college/University (Table 1) which could explain their high use of modern methods. Similar findings were reported in a previous study that analysed a trend and pattern of modern contraceptive use in Uganda and showed that there was an increased odd of use of modern contraceptives including long term contraceptives among women with primary and post primary education [35]. Comparably, in an Afghanistan Health Survey (AHS) 2012 indicated that female participants with secondary education or above were 1.62 times more likely to use SRHS unlike their counterparts [36]. This was similar to earlier study findings which noted a positive correlation between contraceptive use and level of education [37].

Having no transport (68.7%) was the commonest limiting factors to access SRHR services and information during the lockdown followed by distance from home and were to get the services (55.2%), cost of services (42.2%) and curfew (39.1%). The high percentage of no transport as the commonest limiting factors to access the SRHR in our study can be explained by the status of lockdown during the study period which was limiting access to private cars and taxis in order to avoid the spread of the COVID-19 in the community as one of the measures implemented by the Ugandan Government. This finding may also imply that the lockdown may have affected more youth from poorer household with no private means of transport. During the lockdown, less economical activities were allowed in the country and to that a curfew was imposed starting from 7 pm to 6am. Having no transport means, a curfew and the cost of services during the study period and as most of our participants use modern methods which require having money to afford SRHR services could predispose participants to having challenges related to SRHR.

In our study, challenges were more prevalent among the co-habiting followed by unemployed (Volunteer or unpaid) than other participants. In Uganda, reproductive health of adolescents is dependent on several complex and often independent factors including social-cultural influences (such as family, peers and communities), and access to health services, education and employment opportunities [38]. Amooti-Kaguna & Nuwah revealed that in many cases, young people do not reveal their reproductive health problems and tend not to use the healthcare services they actually need and it was found that it may be due to inadequate information, limited access to financial resources or negative attitudes of health workers [38].

Despite positive advances in health services, sexual and reproductive ill-health remains one of the greatest challenges facing young people. Each year, there are over six million unintended pregnancies among adolescents, most of whom do not have access to modern contraceptive methods [39]. In 2008, over 1.2 million unintended pregnancies occurred in Uganda and these accounted more than half of 2.2 million pregnancies in the country [40]. Also, two thirds (64%) of women reported early sexual debut before the age of 18 years [19].

Studies have shown the importance of SRH services is essential to prevent unwanted pregnancies and unsafe abortion, and to reduce maternal and child mortality as well as positively affecting poverty reduction and women empowerment [41]. Our results show that cohabiting exposes 2.3 times participants to limiting factor and a challenge relating to sexual and reproductive health and rights followed by unemployed (Volunteer or unpaid) was 1.7 times associated with limiting factor and a challenge relating to sexual and reproductive health and rights than other participants. These findings may also imply that cohabiting and being unemployed could predispose the person to have STDs and unwanted pregnancy which were the commonest challenges faced by our participants in our study. Cohabiting and being unemployed predispose to shortage of money and limited means of transport and yet it was shown that limited means of transport, cost of services and curfew were the most limiting factors to SRHR among our participants and these can explain our findings. This finding may also imply an increase in transactional sex among young girls and women as experienced in other pandemics. A factor highlighted as being behind the spike in pregnancy during the Ebola outbreak was extreme poverty, with girls reportedly having sex in exchange for water, food or other forms of financial protection [42].

Studies have shown the importance of SRH services is essential to prevent unwanted pregnancies and unsafe abortion, and to reduce maternal and child mortality as well as reducing poverty and empowering women [41].

Our study revealed that among the challenges faced during the lockdown, STIs (40.4%) were the commonest challenges relating to sexual and reproductive health and rights during this lockdown followed by unwanted pregnancy (32.4%) and sexual abuses (32.4%). Each year, there are over six million unintended pregnancies among adolescents, most of whom do not have access to modern contraceptive methods [39]. In 2008, over 1.2 million unintended pregnancies occurred in Uganda and these accounted for more than half of 2.2 million pregnancies in the country [40]. The Uganda and Health Survey of 2016 points to over 25% teenage pregnancies, among sexually active young people by the age of 16 years, and the unmet family planning need in the country stands at 28% [18]. The reported lack of means of transport as limiting factors to access the services could explain the challenges faced by the Uganda youths during lockdown and to that challenges were more prevalent among cohabited participants and unemployed (Volunteer or unpaid) participants. The lack of accessing STIs tests could also be one of the main SRHR challenges faced by youth. This finding highlights the need for STIs and HIV self-testing for youth in Uganda and the urgency to ensure such integration of such interventions as the government implements measures to manage the pandemics.

Although this study was essential during the lockdown, it had several limitations. The study was limited to youth who have smartphones with internet connectivity and have an understanding of English. Those with no smartphones and internet connectivity were locked out especially the rural population and any other would be participant unable to access the online form. This study only included the educated Ugandans youth, so it cannot be generalizable to the whole youth population.

Conclusion

The findings of this study show that Ugandan youth have challenges to access sexual and reproductive health and right services during lockdown due to COVID-19. Poorer young people and in particular girls and women may have been affected more with the pandemic. Cohabiting participants were mostly affected among Ugandan youths. Lack of transport means and cost of services were the limiting factors to access SRHR services among youths. Being unemployed and cohabiting were the predisposing factors to the youth to have challenges such as STIs and unwanted pregnancies. These findings could inform policymakers where to allocate resources most efficiently on SRHR among Ugandan youth and special emphasis should be put on poorer youth especially women. There is a need for Uganda government together with civil society organisations to incorporate SRHR into covid-19 responses from the outset. This will support the youth to access information and services related to SRHR with the view of having services that would cater for the even unemployed youth, and this could reduce the challenges pointed out in the study.

Abbreviations

APR: Adjusted Prevalence Ratio

CI: Confident Interval

COVID-19: Coronavirus Disease 2019

CSG: Coronavirus Study Group

DRC: Democratic Republique of the Congo

HIV: Human Immunodeficiency Virus

MOH: Ministry of Health

SARs: Severe Acute Respiratory Syndrome Coronavirus 2

SRHR: Sexual and Reproductive Health and Rights

UBOS: Uganda Bureau of Statistics

WHO: World Health Organisation

Declarations

Data availability

The data used to obtain the findings is available from the corresponding author FKS and the authors SBM and RS on a reasonable request.

Ethical approval and consent to participate

Expedited ethical approval was acquired from the Institutional Review Board of Kampala International University (UG-REC-023/202018). Consent to participate was obtained through online acceptance.

Consent for publication

Not applicable

Competing interest

Authors declare no competing interest.

Authors contributions

SBM and FKS was the principal investigators, conceived and designed the survey, supervised the online data collection and critically reviewed the manuscript. YM analysed data; KT, SOA reviewed the manuscript development and revised the data tool. JCR revised the methodology. HW and LKK participated in online data collection; RS, CK and PK critically reviewed the manuscript. All authors read and approved the final manuscript.

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Figures

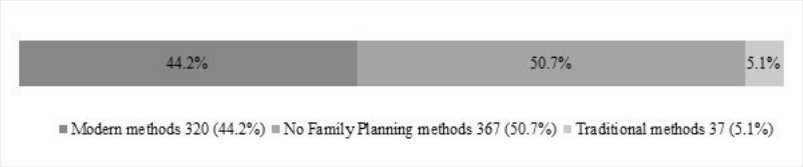

Figure 1

Showing methods of family planning used by the participants

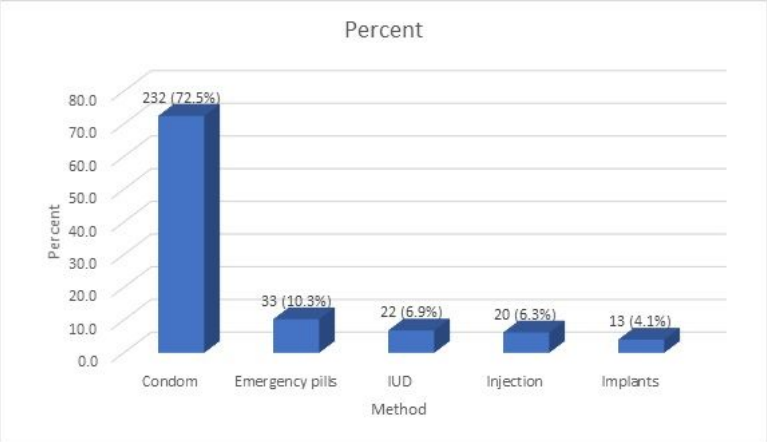

Figure 2

Showing participants using which modern family planning method.Showing participants using which modern family planning method.

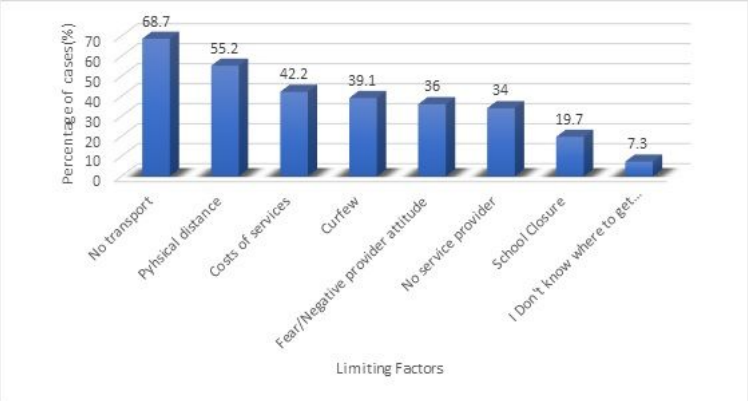

Figure 3

Limiting factors to access Sexual and Reproductive health services and information during the lockdown. *I Don't know where to get services from

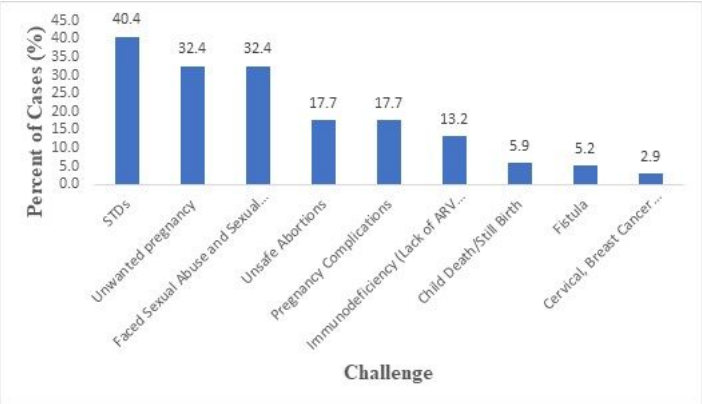

Figure 4

Challenges relating to sexual and reproductive health and rights during this lockdown. *Faced Sexual Abuse and Sexual Harassment **Immunodeficiency (Lack of ARV Drugs) ***Cervical, Breast Cancer Complications