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# The SRHR Gap in Uganda: Why Rights on Paper Are Not Enough for Vulnerable Communities

Evidence for Inclusive SRHR Policy and Practice



Better  
SRHR Services



Inclusion  
for All



Rights  
and Equity



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Evidence



Accountable  
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## FROM RIGHTS TO REAL ACCESS



## What is the SRHR gap?

The SRHR gap is the distance between formal sexual and reproductive health and rights commitments and the real ability of people to access information, services, protection, and accountability.

In practice, this means a person may technically have the right to SRHR services, but still be unable to use them because of stigma, cost, distance, provider bias, lack of privacy, disability-inaccessible facilities, language barriers, weak referral systems, or fear of discrimination.

## Inside this brief

This policy brief examines:

- Why SRHR access remains a policy priority in Uganda
- Which vulnerable groups are being left behind
- Why formal rights fail to translate into real access
- What policy actions are needed to close the SRHR gap
- What Uganda should track to improve accountability and inclusion

## WHAT REAL ACCESS REQUIRES

- 1 Confidential and safe services
- 2 Affordable and reachable care
- 3 Respectful provider behaviour
- 4 Accessible facilities and information
- 5 Youth participation and inclusion
- 6 Complaints that lead to action



## Authorship and acknowledgement

### Authorship

This policy brief was prepared by the African Centre for Social and Population Research (ACSPR).

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ACSPR also acknowledges the contribution of national, regional, and global evidence sources, including Uganda's health-sector reports, demographic and health survey data, refugee statistics, peer-reviewed studies, and policy literature on SRHR access and accountability.

Any errors or omissions remain the responsibility of the author and publisher.

## Conflict of interest statement

The author and publisher declare no conflict of interest in the preparation of this policy brief. The analysis and recommendations presented are based on publicly available evidence and are intended to support evidence-informed policy dialogue, inclusive service delivery, and accountability in sexual and reproductive health and rights in Uganda.

## How this policy brief was developed

This policy brief was developed through a review and synthesis of publicly available evidence, including Uganda's health-sector reports, demographic and health survey data, refugee statistics, peer-reviewed journal articles, policy literature, and regional and global sources on sexual and reproductive health and rights.

The evidence was reviewed to identify barriers affecting vulnerable communities in Uganda, including adolescents and young people, girls and young women, persons with disabilities, refugees and mobile populations, rural and low-income communities, sex workers and other key populations, and urban poor communities.

The brief uses this evidence to identify the gap between formal SRHR rights and lived access, and to propose practical policy actions for more inclusive, confidential, youth-friendly, disability-inclusive, respectful, and accountable SRHR services.



## Acronyms and abbreviations

| Acronym | Meaning                                           |
|---------|---------------------------------------------------|
| ACSPR   | African Centre for Social and Population Research |
| GBV     | Gender-Based Violence                             |
| HIV     | Human Immunodeficiency Virus                      |
| MoH     | Ministry of Health                                |
| OPM     | Office of the Prime Minister                      |
| SRH     | Sexual and Reproductive Health                    |
| SRHR    | Sexual and Reproductive Health and Rights         |
| STI     | Sexually Transmitted Infection                    |
| UBOS    | Uganda Bureau of Statistics                       |
| UNFPA   | United Nations Population Fund                    |
| UNHCR   | United Nations High Commissioner for Refugees     |
| UNICEF  | United Nations Children's Fund                    |
| WHO     | World Health Organization                         |

## Executive summary

Uganda has made important commitments to sexual and reproductive health and rights, but many vulnerable communities still face significant barriers to accessing services. Adolescents, young women, persons with disabilities, refugees, rural poor communities, sex workers, key populations, and urban poor communities may have rights on paper, but still struggle to access confidential, affordable, respectful, disability-inclusive, youth-friendly, and accountable SRHR services in practice.

This policy brief argues that the SRHR gap in Uganda is not only a service-availability problem. It is also a question of equity, implementation, accountability, and lived access. Legal and policy commitments may fail to translate into real access because of legal contradictions, restrictive practices, social norms, provider bias, health-system weaknesses, disability exclusion, displacement-related risks, and weak data systems.

The brief identifies who is being left behind, explains why rights fail in practice, and proposes policy priorities for government, district authorities, health facilities, civil society, humanitarian actors, researchers, and development partners. It calls for practical action to ensure that SRHR services are not only available, but accessible, trusted, safe, inclusive, and accountable.

## Key points

- Rights on paper are not enough. Uganda's SRHR policies and commitments must translate into practical access for vulnerable communities.
- The SRHR gap is driven by multiple barriers. Legal restrictions, social norms, provider bias, weak confidentiality, disability-inaccessible facilities, displacement-related risks, and data gaps continue to limit access.
- Vulnerable communities face layered exclusion. Adolescents, young women, persons with disabilities, refugees, sex workers, rural poor communities, and urban poor communities often experience overlapping barriers.



- Services must be judged by user experience. A service that exists but humiliates, excludes, exposes, or denies people is not truly accessible.
- Uganda needs stronger accountability and data. SRHR monitoring should track not only service availability, but also equity, privacy, affordability, disability inclusion, respectful care, and complaint resolution.

## Why this matters in Uganda

Sexual and reproductive health and rights are central to dignity, health, gender equality, education, economic participation and social justice. Yet for many vulnerable communities in Uganda, rights written in laws, policies and strategies do not always translate into real access to services.

## UGANDA AT GLANCE

### Teenage pregnancy [1]

2016  **25%**

2022  **24%**

**128** births per 1,000 women aged 15–19 in 2022 [1]

**1,961,518**

refugees and asylum seekers as of 31 October 2025 [2]

Uganda's SRHR challenge remains urgent. Teenage pregnancy reduced only slightly from 25% in 2016 to 24% in 2022, with rural areas reporting higher levels than urban areas. The Annual Health Sector Performance Report also reports an adolescent birth rate of 128 births per 1,000 women aged 15–19 in 2022, showing that adolescent reproductive health remains a major policy concern. [1]

Uganda also hosts one of Africa's largest refugee populations. As of 31 October 2025, Uganda hosted approximately 1,961,518 refugees and asylum seekers, creating major planning needs for health, protection and SRHR services in refugee-hosting, border and urban settings. [2]

Young people continue to face social and service-related barriers. A Uganda-focused Guttmacher Institute study on young people aged 15–24 in Busoga and West Nile found that social norms, stigma, fear of parental disapproval, provider attitudes and service barriers shape access to SRH information and services. [3]

For persons with disabilities, Uganda-specific evidence from Kyotera border district shows that young people with disabilities face multiple barriers to SRH information and services, including stigma, discrimination, communication difficulties and health-facility constraints. [4]

These realities show that Uganda's SRHR challenge is not only about having policies. It is about whether the people most affected can reach services, afford them, trust them, use them safely and seek redress when they are denied care.

## The policy problem

### The gap between formal rights and real access

The central problem is the distance between what policies promise and what vulnerable communities can actually access in practice.

A young person may have a right to contraception but still fear being judged at a clinic. A person with disability may have a right to health services but still find the facility physically inaccessible. A refugee adolescent may have a right to care but face language barriers, insecurity or lack of information. A sex worker may have a right to treatment but avoid services because of stigma, criminalisation or fear of exposure.

Global SRHR legal analysis confirms that statutory guarantees do not automatically translate into realised SRHR for marginalised groups. Implementation gaps persist because legal contradictions, socio-cultural norms, discriminatory provider behaviour and health-system shortfalls prevent vulnerable populations from exercising their formal rights. [5,6]

This is the SRHR gap: rights may exist on paper, but access may remain blocked in practice.

## Who is being left behind?

### Adolescents and young people

Young people continue to face social and service-related barriers. A Uganda-focused Guttmacher Institute study on young people aged 15–24 in Busoga and West Nile found that social norms, stigma, fear of parental disapproval, provider attitudes and service barriers shape access to SRH information and services. [3]

For persons with disabilities, Uganda-specific evidence from Kyotera border district shows that young people with disabilities face multiple barriers to SRH information and services, including stigma, discrimination, communication difficulties and health-facility constraints. [4]

These realities show that Uganda's SRHR challenge is not only about having policies. It is about whether the people most affected can reach services, afford them, trust them, use them safely and seek redress when they are denied care.

**Why they are vulnerable:** Limited privacy, income, autonomy and accurate information.

**Common SRHR barriers:** Stigma, misinformation, judgmental providers, lack of confidentiality.

### Girls and young women

**Why they are vulnerable:** Gender inequality, pregnancy stigma and unequal power in relationships.

**Common SRHR barriers:** Early marriage, sexual coercion, school dropout, limited contraceptive autonomy.

### Persons with disabilities

**Why they are vulnerable:** Exclusion from SRHR information, services and decision-making.

**Common SRHR barriers:** Inaccessible facilities, lack of adapted information, provider bias.

### Refugees and mobile populations

**Why they are vulnerable:** Displacement, insecurity, trauma and language barriers.

**Common SRHR barriers:** Weak referral systems, limited information, poor continuity of care.

### Rural and low-income communities

**Why they are vulnerable:** Cost and distance reduce real access.

**Common SRHR barriers:** Transport costs, stockouts, staff shortages, hidden fees.

### Sex workers and key populations

**Why they are vulnerable:** Stigma, criminalisation and violence.

**Common SRHR barriers:** Fear of disclosure, discrimination, harassment, denial of respectful care.

### Urban poor communities

**Why they are vulnerable:** Proximity to services does not always mean access.

**Common SRHR barriers:** Overcrowding, high costs, fragmented services and weak privacy.

## OVERLAPPING EXCLUSION

- 1 Individual: information and autonomy
- 2 Community: stigma and social norms
- 3 Facility: quality and accessibility

Illustrative synthesis of the barriers discussed in this brief.

## Who is being left behind?

### 1. Legal protections may contain hidden restrictions

Progressive laws and policies can still coexist with restrictions that block access. These may include unclear consent rules, age-based limitations, third-party authorisation, restrictive regulations, or contradictions between formal law and customary or religious norms. Such restrictions particularly affect adolescents, young women and marginalised groups. [5,6]

**In practice:** A young person may legally need SRHR information, but facility-level practices or informal gatekeeping may still require parental, partner or third-party approval.

**Policy implication:** Uganda should review whether laws, guidelines and facility-level practices create unnecessary barriers to SRHR access for adolescents and vulnerable groups.

### 2. Social norms can override formal rights

SRHR access is shaped by power inside households, relationships, schools, communities and health facilities. Patriarchal norms, partner coercion, stigma around sexuality and taboos about adolescent SRHR can prevent women and girls from making decisions about contraception, sex, pregnancy, family size and care-seeking. [3,7,8]

**In practice:** A girl may know contraception exists but avoid a health facility because she fears being judged, seen by relatives, or accused of being sexually active.

**Policy implication:** SRHR interventions must go beyond clinics and address the social norms that prevent people from using services.

### 3. Services may exist but still be unsafe unfriendly or inaccessible

A health facility may offer contraception, HIV testing, STI services, maternal care or counselling, but users may still avoid it because of fear of judgment, lack of privacy, breach of confidentiality, long waiting times, stockouts, informal costs or disrespectful treatment. [3,9,10]

For adolescents, this can mean delaying care until pregnancy, infection or violence has already occurred. For sex workers and key populations, stigma and fear of exposure can make services feel unsafe. For persons with disabilities, lack of accessible infrastructure or communication support can make services practically unusable.

**In practice:** A service that exists but humiliates, exposes or excludes users is not truly accessible.

**Policy implication:** Quality, privacy, confidentiality and dignity should be monitored as core SRHR indicators, not treated as optional service features.

### JUDGE SERVICE BY EXPERIENCE

- 1 Can I consult in private?
- 2 Will my information stay confidential?
- 3 Will I be treated with respect?
- 4 Can I communicate and use the facility?
- 5 Can I afford to reach and use care?
- 6 Can I report a problem safely?





## 4. Persons with disabilities face layered exclusion

Persons with disabilities are often left out of SRHR programming. Barriers may include inaccessible buildings, lack of sign language support, inaccessible information formats, provider assumptions that persons with disabilities are not sexually active, and consultations that ignore their autonomy.

Uganda-specific evidence from Kyotera border district found that young people with disabilities face barriers to SRH information and services at individual, community and health-facility levels, including stigma, discrimination, limited knowledge, communication barriers and weak disability-responsive service delivery. [4]

**In practice:** A young person with disability may need SRHR information, but the provider may speak to a caregiver instead of the client, or the facility may lack accessible communication support.

**Policy implication:** Disability inclusion should be built into SRHR planning, facility assessment, provider training, communication materials and monitoring systems.

## 4. Humanitarian and displacement settings increase SRHR risks

Refugees, displaced persons and mobile populations often face additional risks linked to insecurity, language barriers, poverty, trauma, overcrowding and weak service continuity. Humanitarian and displacement settings can also increase risks of gender-based violence where sanitation, lighting, protection and referral systems are weak. [2,11,12]

**In practice:** A refugee adolescent may need care but face language barriers, trauma, overcrowded services or limited information about where to seek help.

**Policy implication:** SRHR services in refugee-hosting and border districts should be integrated with GBV response, mental health, protection, HIV services and community outreach.

## 6. Data gaps hide who is being excluded

National averages can hide deep inequalities. Aggregated data may fail to show whether adolescents with disabilities, refugee girls, sex workers, rural poor communities, ethnic minorities or urban informal-settlement residents are being reached. Weak or aggregated databases can mask disparities and undermine accountability for minority and marginalised populations. [13,14]

**In practice:** A district may appear to be improving overall SRHR access while specific groups remain invisible in the data.

**Policy implication:** Uganda needs SRHR data disaggregated by age, sex, disability, location, poverty, refugee status and other vulnerability markers.

### LOOK BEYOND NATIONAL AVERAGES

- 1 Age and sex
- 2 Disability
- 3 Location
- 4 Poverty
- 5 Refugee status
- 6 Other vulnerability markers

Use disaggregation to identify groups being left behind.



## Policy priorities for Uganda

### 1. Move from policy promises to practical access

**Responsible actors:** Ministry of Health, Parliament, district local governments, regulators and civil society.

Uganda should review how SRHR policies are implemented at facility and community level. The focus should be on whether adolescents and vulnerable groups can actually use services safely and confidentially.

#### Priority actions

- Review laws, policies and facility-level practices that restrict adolescent and vulnerable-group access.
- Remove unnecessary gatekeeping, including informal requirements for partner, parental or third-party approval where these are not legally required.
- Ensure district health teams monitor whether SRHR policies are applied consistently across facilities.
- Translate SRHR rights and guidelines into simple public-facing information.
- Strengthen community awareness on rights, confidentiality and available services.

### 2. Make adolescent and youth-friendly services real

**Responsible actors:** Ministry of Health, district health teams, health facilities, schools, youth organisations and community-based groups.

Youth-friendly services should be judged by what young people experience, not only by whether a facility has a youth corner.

#### Priority actions

- Train providers on adolescent-responsive, confidential and non-judgmental SRHR care.
- Monitor waiting time, privacy, confidentiality and provider attitude.
- Expand SRHR information and services for both in-school and out-of-school young people.
- Use peer educators, youth centres, schools and digital platforms to provide accurate information.
- Involve adolescents and young people in service design, monitoring and feedback.

### 3. Build disability-inclusive SRHR systems

**Responsible actors:** Ministry of Health, National Council for Persons with Disabilities, district local governments, health facilities and organisations of persons with disabilities.

SRHR services should recognise persons with disabilities as rights-holders with autonomy, sexuality and reproductive choices.

#### Priority actions

- Assess health facilities for disability accessibility.
- Provide SRHR information in accessible formats.
- Train providers on disability rights, communication and respectful care.
- Provide sign language or referral support where needed.
- Include persons with disabilities in SRHR planning, monitoring and evaluation.

## SIX POLICY PRIORITIES

- 1 Turn policy into practical access
- 2 Make youth-friendly care real
- 3 Build disability-inclusive systems
- 4 Strengthen respectful accountable care
- 5 Reach displaced and remote populations
- 6 Invest in equity-focused data

### 4. Strengthen respectful and accountable health care

**Responsible actors:** Health facilities, professional councils, district health teams, civil society and community accountability platforms.

Health facilities should be safe spaces where all clients are treated with dignity.

#### Priority actions

- Display patient rights and complaint channels clearly.
- Track service denial, discrimination, confidentiality breaches and informal fees.
- Establish safe reporting channels for adolescents, persons with disabilities, refugees, sex workers and other vulnerable groups.
- Protect complainants from retaliation.
- Include respectful care indicators in supervision tools.
- Require facilities to document how complaints are received, reviewed and resolved.

### 5. Improve access in refugee rural and hard-to-reach settings

**Responsible actors:** Office of the Prime Minister, Ministry of Health, UNHCR, district local governments, humanitarian partners and community organisations.

Services must reach people who cannot easily reach facilities.

#### Priority actions

- Strengthen mobile and outreach SRHR services in refugee-hosting, border and rural districts.
- Provide multilingual SRHR information where needed.
- Integrate SRHR with HIV, GBV, maternal health, mental health and protection services.
- Use community health workers and trusted local organisations for referrals.
- Ensure humanitarian SRHR programming includes safety, lighting, sanitation and GBV referral pathways.

## ACCOUNTABILITY IN PRACTICE

- 1 Display rights and complaint channels
- 2 Provide safe reporting options
- 3 Protect complainants from retaliation
- 4 Review resolve and refer complaints
- 5 Document decisions and follow-up

Suggested process derived from the priority actions in this brief.



## What Uganda should track

| Area                  | Suggested indicators                                                                                                                                              |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Access</b>         | Proportion of facilities offering contraception, STI services, HIV testing, maternal health and adolescent ASRH services; stockout rates for key SRH commodities. |
| <b>Equity</b>         | SRH service use disaggregated by age, sex, disability, location, refugee status and poverty status.                                                               |
| <b>Quality</b>        | Proportion of facilities with private consultation space; proportion of clients reporting respectful care and confidentiality.                                    |
| <b>Accountability</b> | Reported transport costs, informal costs, referral costs and user fees affecting SRH service use.                                                                 |
| <b>Inclusion</b>      | Proportion of facilities with disability-accessible infrastructure, accessible communication and disability-sensitive provider training.                          |
| <b>Safety</b>         | Availability of GBV referral pathways, safe spaces, post-violence care and protection referral mechanisms.                                                        |
| <b>Outcomes</b>       | Teenage pregnancy, unmet need for family planning, adolescent birth rate, STI treatment, school retention and GBV referrals.                                      |

## Conclusion

Uganda's SRHR challenge is not simply a lack of policies. It is the gap between formal rights and real access.

For vulnerable communities, SRHR access depends on whether services are confidential, affordable, respectful, disability-inclusive, youth-friendly and accountable. Closing this gap requires Uganda to move from legal commitments to lived realities by investing in inclusive service delivery, community education, youth participation, disability inclusion, better data and accountability mechanisms.

Rights on paper are not enough. SRHR must be accessible, respectful, inclusive and real.

## How to cite



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## References and further reading

- [1] Ministry of Health Uganda. (2024). Annual health sector performance report 2022/23. Ministry of Health Uganda.
- [2] UNHCR & Office of the Prime Minister Uganda. (2025). Uganda refugee statistics: October 2025. UNHCR Operational Data Portal.
- [3] Bukenya, J. N., Ssekamatte, T., Komuhendo, R., & Stillman, M. (2025). Young people's access to sexual and reproductive health services in Uganda: Understanding barriers and facilitators. Guttmacher Institute.
- [4] Odo, L. W., Ndugga, P., & Kwagala, B. (2025). "We don't see a future in them..." barriers to accessing sexual and reproductive health information and services among young people with disabilities in Kyotera border district. BMC Public Health, 25, Article 3660. <https://doi.org/10.1186/s12889-025-25008-w>
- [5] Ferguson, L., Anderson, M., Liang, M., & Filmer-Wilson, E. (2024). Why a good law is not always good enough: A global review of restrictions to supportive laws for sexual and reproductive health and rights. BMJ Global Health, 9. <https://doi.org/10.1136/bmjgh-2023-014100>
- [6] Schaaf, M., & Khosla, R. (2021). Necessary but not sufficient: A scoping review of legal accountability for sexual and reproductive health in low-income and middle-income countries. BMJ Global Health, 6. <https://doi.org/10.1136/bmjgh-2021-006033>
- [7] Khanna, R., Sheth, M., Talati, P., Damor, K., & Chauhan, B. (2022). Social and economic marginalisation and sexual and reproductive health and rights of urban poor young women: A qualitative study from Vadodara, Gujarat, India. Sexual and Reproductive Health Matters, 29. <https://doi.org/10.1080/26410397.2022.2059898>
- [8] Gilbert, H. N., Mukherjee, J., Kasmani, M. N., & Knipper, M. (2026). The double dominion over women's bodies as a barrier to exercising sexual and reproductive rights: A mixed-methods study in La Ladrillera, Mexico. The Lancet Regional Health - Americas, 59. <https://doi.org/10.1016/j.lana.2026.101493>
- [9] Boydell, V., Schaaf, M., George, A., Brinkerhoff, D., Van Belle, S., & Khosla, R. (2019). Building a transformative agenda for accountability in SRHR: Lessons learned from SRHR and accountability literatures. Sexual and Reproductive Health Matters, 27, 64-75. <https://doi.org/10.1080/26410397.2019.1622357>
- [10] Center for Health, Human Rights and Development. (2024). Annual report 2024. CEHURD.
- [11] Aibangbee, M., Micheal, S., Mapedzahama, V., Liamputtong, P., Pithavadian, R., Hossain, Z. S., Mpofu, E., & Dune, T. (2023). Migrant and refugee youth's sexual and reproductive health and rights: A scoping review to inform policies and programs. International Journal of Public Health, 68. <https://doi.org/10.3389/ijph.2023.1605801>
- [12] Tirado, V., Chu, J., Hanson, C., Ekström, A., & Kågesten, A. (2020). Barriers and facilitators for the sexual and reproductive health and rights of young people in refugee contexts globally: A scoping review. PLOS ONE, 15. <https://doi.org/10.1371/journal.pone.0236316>
- [13] Hopkins, J., Narasimhan, M., Aujla, M., Silva, R., & Mandil, A. (2024). The importance of insufficient national data on sexual and reproductive health and rights in international databases. eClinicalMedicine, 70. <https://doi.org/10.1016/j.eclim.2024.102554>
- [14] Uganda Bureau of Statistics, Ministry of Health Uganda, UNICEF, & UNFPA. (2023). Uganda demographic and health survey 2022. UBOS and ICF.
- [15] Akwara, E., Pinchoff, J., Abularrage, T. F., White, C., & Ngo, T. (2023). The urban environment and disparities in sexual and reproductive health outcomes in the Global South: A scoping review. Journal of Urban Health. <https://doi.org/10.1007/s11524-023-00724-z>
- [16] Alonso, J. P., Cejas, C. A., Berrueta, M., Vázquez, P., Perrotta, G., Formia, S., Pirsch, S., Ballivian, J., Zavala, D., López, A., & Belizán, M. (2024). Barriers to advancing the sexual and reproductive health agenda in Latin America: A qualitative study of key informants' perspectives. Reproductive Health, 21. <https://doi.org/10.1186/s12978-024-01927-6>
- [17] Arnott, G., Odallo, B., Nakubulwa, T., Lily, F. B., & Dhami, S. S. (2025). Accountability for sexual and reproductive health and rights in humanitarian and disaster situations. Health and Human Rights, 27, 51-64.
- [18] Bongomin, F., & August, E. T. (2026). Advancing sexual and reproductive health and rights in Africa. Women's Health, 22. <https://doi.org/10.1177/17455057261426794>
- [19] Burns, L., Pitt, H., Pham, M. D., Thanh, V., Azzopardi, P. S., & Thomas, S. (2026). Adolescent sexual and reproductive health and rights policy for ethnic minority girls in Vietnam: A qualitative study with policy makers and service providers. Global Health Action, 19. <https://doi.org/10.1080/16549716.2026.2619306>
- [20] Habikigeni, B. D., Parfaite, U. M. M., Siddig, E., & Ndicunguye, V. M. (2025). A critical evaluation of adolescent sexual and reproductive health and rights in Rwanda. AJOG Global Reports, 6. <https://doi.org/10.1016/j.xagr.2025.100594>
- [21] Ministry of Health Uganda. (2025). Annual report on multi-sectoral efforts to end teenage pregnancy and child marriage, FY 2024/25. Ministry of Health Uganda.
- [22] OECD. (2025). Transforming laws and norms to achieve universal sexual and reproductive health and rights. OECD Development Policy Papers. <https://doi.org/10.1787/9244e414-en>
- [23] Pomati, M. (2026). Co-producing sexual and reproductive health and rights indicators: Repurposing the consensual poverty approach for out-of-school girls. Child Indicators Research, 19, 1219-1250. <https://doi.org/10.1007/s12187-026-10337-y>
- [24] UNAIDS. (2019). Communities at the centre: Global AIDS update - Eastern and Southern Africa. UNAIDS.
- [25] UNFPA. (2024). State of world population report 2024. UNFPA.
- [26] UNFPA East and Southern Africa Regional Office, & WHO. (2024). Unlocking the future: Advancing universal sexual and reproductive health and rights within universal health coverage in East and Southern Africa. UNFPA ESARO and WHO.



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