



East African Journal of Health and Science

ejhs.eanso.org

Volume 8 Issue 3, 2025

Print ISSN: 2707-3912 | Online ISSN: 2707-3920

Title DOI: <https://doi.org/10.37284/2707-3920>



EAST AFRICAN
NATURE &
SCIENCE
ORGANIZATION

Original Article

Adolescent and Youth Reproductive Health Treatment-Seeking Behaviour in the Post COVID-19 Pandemic in Gulu City, Northern Uganda

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Article DOI: <https://doi.org/10.37284/eajhs.8.3.4046>

Date Published: ABSTRACT

21 November 2025

Keywords:
*Adolescent
Youth,
Sexual
Reproductive
Health,
Treatment-seeking
behaviour,
Northern Uganda.*

Introduction: The COVID-19 pandemic and lockdown from March 2020 to 2022 had massive effects on adolescent and youth reproductive health treatment-seeking behaviour in Acholi Sub-Region in Northern Uganda. Sexual reproductive health and STIs-related treatment-seeking was examined among adolescents and youth attending a public Sexual Reproductive Health clinic in Gulu Regional Referral Hospital and Reproductive Health-Uganda facility in Gulu City. **Methodology:** Using a qualitative approach, the study explored adolescent and youth knowledge, practice, and perspective on reproductive health treatment seeking, and why they make the choices they make. It delves into non-statistical data like texts, interviews, observations, and images to uncover rich insights, perceptions, meanings, and patterns in the SRH of young persons. **Findings:** Treatment-seeking was perceived as the action of searching for help for SRH problems from informal or formal sources. More women than men sought care in the government sector. Similarly, more women than men went to the informal health sector, mostly to traditional healers. Young persons confided in their peers and shunned seeking treatment from government hospitals due to stigma. **Conclusion:** The response of young people to STI infections and treatment-seeking behaviour was never predictable. Social-cultural stereotypes, misinformation, and lack of access to information on SRH and STIs continue to exist. Most adolescents and youth continue to seek self-medication. **Recommendations:** The study recommends strengthening community-based services, integration of technology to provide confidential information and remote consultations, developing crisis-reproductive health systems, and a more targeted public education campaign.

APA CITATION

Alidri, A., Uramba, E. K., Anicia, F., Apio, W., Ochen, P., Kabwijamu, P., Okello, S., Giramiya, E., Musaasizi, R., Tumanye, S., Awor, S. & Nyamungu, P. (2025). Adolescent and Youth Reproductive Health Treatment-Seeking Behaviour in the Post COVID-19 Pandemic in Gulu City, Northern Uganda. *East African Journal of Health and Science*, 8(3), 208-219. <https://doi.org/10.37284/eajhs.8.3.4046>

CHICAGO CITATION

Alidri, Agatha, Emily Kayeny Uramba, Filda Anicia, Winnie Apio, Patrick Ochen, Patrick Kabwijamu, Simon Okello, Esther Giramiya, Richard Musaasizi, Samson Tumanye, Susan Awor and Proscovia Nyamungu. 2025. "Adolescent and Youth Reproductive Health Treatment-Seeking Behaviour in the Post COVID-19 Pandemic in Gulu City, Northern Uganda". *East African Journal of Health and Science* 8 (3), 208-219. <https://doi.org/10.37284/eajhs.8.3.4046>

HARVARD CITATION

Alidri, A., Uramba, E. K., Anicia, F., Apio, W., Ochen, P., Kabwijamu, P., Okello, S., Giramiya, E., Musaasizi, R., Tumanye, S., Awor, S. & Nyamungu, P. (2025). "Adolescent and Youth Reproductive Health Treatment-Seeking Behaviour in the Post COVID-19 Pandemic in Gulu City, Northern Uganda", *East African Journal of Health and Science*, 8(3), pp. 208-219. doi: 10.37284/eajhs.8.3.4046

IEEE CITATION

A., Alidri, E. K., Uramba, F., Anicia, W., Apio, P., Ochen, P., Kabwijamu, S., Okello, E., Giramiya, R., Musaasizi, S., Tumanye, S., Awor & P., Nyamungu "Adolescent and Youth Reproductive Health Treatment-Seeking Behaviour in the Post COVID-19 Pandemic in Gulu City, Northern Uganda", *EAJHS*, vol. 8, no. 3, pp. 208-219, Nov. 2025.

MLA CITATION

Alidri, Agatha, Emily Kayeny Uramba, Filda Anicia, Winnie Apio, Patrick Ochen, Patrick Kabwijamu, Simon Okello, Esther Giramiya, Richard Musaasizi, Samson Tumanye, Susan Awor & Proscovia Nyamungu. "Adolescent and Youth Reproductive Health Treatment-Seeking Behaviour in the Post COVID-19 Pandemic in Gulu City, Northern Uganda". *East African Journal of Health and Science*, Vol. 8, no. 3, Nov. 2025, pp. 208-219, doi:10.37284/eajhs.8.3.4046.

INTRODUCTION

The COVID-19 pandemic and lockdown from March 2020 to 2022 had massive effects on adolescent and youth reproductive health treatment-seeking behaviour in the Acholi Sub-Region in Northern Uganda. The sub-region comprising nine (09) districts: Gulu, Amuru, Nwoya, Omoro, Kitgum, Lamwo, Pader, Agago, and Gulu City in 2014 had a population of 1,470,554 and 2,044,355 (985,339 [males] & 1,059,016 [females]). In 2024 (Uganda Bureau of Statistics [UBOS], 2024). Children attending primary education were 434,021 (222,041 males & 211,980 females) and those attending secondary education were 187,537 (males 81,736 & females 105,801). Number of Learners aged 6-12 attending Primary 237,100 (males 115,882 & females 121,218), and Number of Learners aged 13-18 attending Secondary stood at 74,819 (males 40,464 & females 34,355 (UBOS, 2024). This has implications for adolescent and youth reproductive health, as vulnerable adolescent girls had been sexually abused at 10 years old.

Sexual Reproductive Health and STIs-related treatment-seeking was examined among adolescents and youth attending a public Sexual Reproductive Health clinic in Gulu Regional Referral Hospital and Reproductive Health-Uganda facility in Gulu City. Sexually transmitted infections (STIs), including syphilis, chlamydia,

gonorrhea, trichomoniasis, and genital herpes, are globally a major public health problem. Chlamydia trachomatis and Neisseria gonorrhoeae (N. gonorrhoeae) infections have a detrimental influence, including disseminated infection, tubal-factor infertility, pelvic inflammation, and ectopic pregnancy. The risk of acquiring or transmitting human immunodeficiency virus infection may greatly increase due to the presence of STIs. Generally, STIs severely impair the quality of life, with physical, psychological, and social consequences" (Du et al., 2022, p. 2). It becomes paramount that studies and interventions toward adolescent and youth reproductive health is strategically addressed.

Delayed seeking of health care may partially explain high rates of sexually transmitted diseases among adolescents and youth. Seeking health care plays a crucial role in controlling sexually transmitted diseases, as longer durations of untreated infection raise the risk of serious complications and increase the likelihood of transmission to others. (Fortenberry, 1997, p. 417). Menstrual conditions are another form of SRH-related problem (Kabir et al., 2014, p. 3). It is often given less attention, yet its effect on adolescents and youth is enormous. Key problems include: Lower abdominal pain, pain in the lower back, excessive bleeding causing anaemia, irregular menstruation patterns, nausea, headache,

vertigo, and weakness. The adolescents and youth with menstrual-related problems often seek health from qualified physicians, doctors, medical assistants, nurses (Health Worker), school nurses and matrons, Indigenous practitioners, and Pharmacy problem. Other problems include soreness on the inner side of the thigh, and burning during urination, genital ulcer/sore, and excessive bleeding (Kabir et al., 2014, p. 4).

This study is therefore based on the specific objectives of: 1) to investigate adolescent and youth reactions/responses when faced with SRH related problems during and after COVID-19 in northern Uganda, 2) to explore the adolescents and youth Sexual Reproductive health treatment seeking behaviour during and after COVID-19 in northern Uganda; 3) to investigate where adolescents and youth seek sexual and reproductive health help; and 4) to explore the reasons why the adolescents and youth seek sexual and reproductive health help from the preferred sources when faced with sexual and reproductive health related problems.

The World Health Organization (WHO) reported that globally, “Four curable STIs-syphilis (*Treponema pallidum*), gonorrhoea (*Neisseria gonorrhoeae*), chlamydia (*Chlamydia trachomatis*) and trichomoniasis (*Trichomonas vaginalis*)-cause more than 1 million infections each day. Numerous countries reported increases in cases of adult and congenital syphilis after the COVID-19 pandemic” (WHO, 2024, p. viii). Human papillomavirus (HPV)-related cancer is an emerging SRH problem among young people (WHO, 2024, p. 12). This places a high STI burden among adolescents and youth globally and within a country.

The adolescents and youth are an age group considered vulnerable. The WHO defines adolescents as individuals between the ages of 10 and 19 years (WHO, 1977). Adolescence is a unique stage of human development marked by rapid physical, cognitive, and social changes as individuals transition from childhood to adulthood. During this period, adolescents undergo significant growth that influences their

emotions, thinking, decision-making, and relationships. It is a critical time for establishing the foundations of lifelong health and well-being (Sawyer et al. 2018, p.1). Despite the increasing debate regarding the age of adolescence, this definition was considered appropriate for this study as it is accepted by international organisations such as the WHO and the UNICEF. This study considers this age range more homogeneous and comparable in terms of lifecycle (Aguirre et al., 2020, p. 2). Sexually transmitted infections have important health consequences, and adolescents and young people are particularly at risk (Newton-Levinson et al., 2017, p. 319). However, the treatment-seeking behaviour requires further study.

Aguirre et al. (2020) define treatment-seeking as “the action of actively searching for help” for SRH problems, including informal (family, friends) or formal (health professionals) sources, based on interpersonal and social abilities (Aguirre et al., 2020, p. 2). Health seeking behavior could be influenced by characteristics of the patient (gender, age, education, and motivation), characteristics of the cultural setting of the patient (gender roles and conceptions about health and disease), characteristics of the disease (such as type of complaint, severity, acute or chronic), and characteristics of the health service (accessibility, costs, quality of care, and waiting times). Insight into factors that make people decide why, when, and where to seek care can improve the programs that focus on STI management and health education in communities (Voeten, 2004, p. 265). “Perceptions of illness, knowledge, and understanding of illness are socially and culturally constructed, as are actions taken with regard to treatment. In all of these areas, important gender differences exist” (Tanner & Vlassoff, 1998, p. 525).

Understanding adolescents' and youth's care and treatment-seeking practices and the underlying reasons for them can help inform policies and strategies aimed at improving the accessibility and acceptability of STI care and treatment services. However, there is limited information available on care and help-seeking for STIs (Newton-

Levinson et al., 2017, p. 319). Therefore, it is important to understand the youth's motivations for seeking treatment for sexual health and their preferences with regard to where they get such care and help.

“HIV (Human Immunodeficiency Virus), Hepatitis, and sexually transmitted infections result in 2.5 million deaths each year, and new data suggest that more people died from Hepatitis-related causes, 1.3 million in 2022 compared to 2019. More than 1 million new infections occur each day, the majority of which are sexually transmitted.” WHO further reported that “new HIV and viral hepatitis infections are not declining as fast as they should to achieve the goals of the 2030 Agenda for Sustainable Development” (World Health Organization, 2024, p. vii).

The immense burden of STIs may be distributed disproportionately at the geographical and age levels due to income, health services, lack of treatment, and stigmatisation (Du et al., 2022, p. 2). It is very important to strengthen sexual health education in schools, including functional knowledge and skills to practice, adopt, and maintain healthy behaviours for preventing STIs. As more young people have access to mobile phones, professional Apps that provide an anonymous, free, and voluntary platform for information could be considered. Getting treatment for partners may be effective in reducing STI incidence in youth. Effective STI prevention interventions include screening, contact tracing of sexual partners, and promoting effective barrier contraception. STI counselling and testing lead to positive sexual behaviour changes. Hence, improving the quality rather than quantity of primary health care is particularly important in stigmatisation (Du et al., 2022, p. 11). Understanding the difficulties around help-seeking behaviours and facilitating access to timely and effective treatment is essential for preventing the escalation of [STIs] and mental health problems among adolescents (Aguirre et al., 2020, p. 2).

Barriers to treatment or Help-seeking include: Stigma, defined as the fear of being socially sanctioned or disgraced, leading to hiding or preventing certain actions or behaviours, including the misreporting of Sexual health problems. Stigma has been described through different concepts such as “stigma”, “fear of stigmatisation”, “community stigma”, “perceived stigma”, and “self-stigma”. Family beliefs are considered barriers associated with adolescents’ and youth family beliefs toward SRH health services and treatment (Newton-Levinson et al., 2017, pp. 319, 321 & Aguirre et al., 2020, p. 14). Barriers related to problems with communication and distrust towards health professionals, negative past experiences with SRH services, and believing that the treatment is not going to be helpful. This was especially true for studies including immigrant and refugee populations, which referred to cultural barriers, including taboos about SRH, and a lack of cultural sensitivity in services as a significant barrier.

SRH and sex education and literacy, which refers to the ability to use Sexual Reproductive Health and Sex Education information to recognise, manage, and prevent SRH problems and make informed decisions about help-seeking and professional support. Critical problems related to Sexual Reproductive health and sex education literacy include poor recognition of SRH conditions (self and others) and lack of awareness of available sources of help. Autonomy and Adolescents’ attitudes towards help-seeking are characterised by a perceived need for self-sufficiency and autonomy, and fears of confidentiality breaches are barriers. Problems regarding service and personnel availability, and other structural factors, including cost, transportation, and waiting times, are often obstacles to help-seeking. This is a significant barrier among rural and immigrant populations.

The relationship between symptomatology and help-seeking was evident, with psychological distress and isolation symptoms linked to negative help-seeking behaviours. Previous positive or negative experience with health workers and services, or help-seeking, influences the response

of young people towards treatment seeking. Being familiar with the sources of help and good symptom and problem recognition motivates them to seek treatment from a source. Having a trust and committed relationship with relevant health workers, adults such as parents, schoolteachers, and counsellors, also facilitated seeking help among adolescents and youth (Aguirre et al., 2020, p. 14).

The choice of treatment provider is also critical in the management of adolescent and youth SRH-related problems. The quality of STI case management varies between health sectors and types of Reproductive health service providers. Seeking treatment from health service providers who provide effective care will not only cure the STIs but also reduce transmission of current and future infections if people follow up advice on condom use, partner referral, and sexual risk reduction strategies (Voeten, 2004, p. 265).

Gender and Treatment-seeking Behaviour

In a study on STD treatment seeking, Voeten et al. (2004) noted that more women than men sought care in the government sector. Similarly, more women than men went to the informal health sector, mostly to traditional healers. The main reasons for men and women for choosing a particular treatment provider were convenience or nearness of the facility location, the assumed high quality of care, and affordability (Voeten, 2004, p. 267). Literature indicates that women in most societies tend to be the ones who are often poorly informed about disease risks and possibilities for prevention and cure (Rathgeber and Vlassoff, 1993; Vlassoff et al., 1995). On the other hand, women carry the major share of responsibility for the well-being of the household in most societies. It is argued that the peculiar nature of women's responsibilities both in economic production and within the family may have a profound impact on the extent to which they are affected by tropical diseases and their responses to disease. This responsibility is rarely matched by autonomy to make decisions or by access to the necessary resources. Women may have to ask permission from others: husbands, mothers-in-law, senior

household males, before being permitted to seek care.

In some cultures, women cannot visit health centres (or elsewhere) unaccompanied, and the lack of a male chaperon may make it impossible for women to act upon their desire to go for treatment (Vlassoff et al., 1995; Khattab, 1993). Consequently, women's use of health services and preventive measures against sexually reproductive health-related problems and other health challenges is often problematic. In addition, research has shown that health services are often insensitive to women and tend to blame them when they come late for treatment (Tanner & Vlassoff, 1998, p. 526). Gender often constitutes barriers to successfully accessing sexual and reproductive health services (Newton-Levinson et al., 2017, p. 324). Rathgeber and Vlassoff (1993) studied tropical disease further, suggesting that the gender relations of health are of considerable significance in explaining the differential consequences of disease on women, men, and children (Rathgeber and Vlassoff, 1993, p. 513). This makes it important to disaggregate gender in SRH.

Statement of the Problem

Studies have shown that adolescents and youth are “not seeking treatment, resorting to self-treatment, or waiting to access care, suggesting that many youths still do not seek timely care for STIs” (Newton-Levinson et al., 2017, p. 319). When faced with an STI or other SRH concern, many youths did not seek timely care or care from a formal health care system (Newton-Levinson et al., 2017, p. 321). Youth in developing countries are not seeking timely and appropriate medical care, which has significant implications for further transmission of STIs (Newton-Levinson et al., 2017, p. 327). Most studies were based on help-seeking intentions rather than actual behaviours (Aguirre et al., 2020, p. 14). Similarly, “most studies on health care-seeking behaviour for STIs have been clinic-based”. However, this study adopts the social approach and argues that health is social and therefore requires a social understanding of its interventions and

management. This study sought to establish why and where adolescents and youth go for treatment when they have or suspect they have an STI or are pregnant. Who do they first contact? Where do they go to find informal support and treatment? The study sought to establish the adolescent and youth behaviour when they know or suspect that they have an STI or are pregnant. Where do they get health support, care, and information?

Conceptualising Treatment Seeking

Health care and treatment seeking include pursuing formal medical care as well as seeking help from other sources, including formal or informal (Newton-Levinson et al., 2017, p. 319). Fortenberry (1997) defines health care seeking as the interval between recognition of a health problem and its clinical resolution, and the accompanying cognitive and behavioural responses (Fortenberry, 1997, p. 417). When people needed treatment, it involved two main phases. The first was evaluating the problem, which meant investigating what was wrong and if they needed to see a doctor. The second phase was taking action by actually seeking treatment. When there was a delay after someone realised they needed treatment, that was called the "procrastination" phase. Often, the reasons for the delay might be personal or out of their hands (Fortenberry, 1997, p. 417).

RESEARCH METHODOLOGY

Using a qualitative approach, the study explored adolescent and youth knowledge, practice, and perspective on reproductive health treatment seeking, and why they make the choices they make. The qualitative research approach enabled the understanding of complex human experiences, behaviours, and perspectives by exploring "how", "where", and "why" adolescents and youth seek treatment for SRH-related problems. It explored adolescent and youth perception of health treatment-seeking behaviour and its implications for the young people. It delves into non-statistical data like texts, interviews, observations, and images to uncover rich insights, meanings, and patterns in the SRH of young persons.

The study period was 2022-2024, during the critical period of the COVID-19 lockdown, during which northern Uganda registered increased cases of sexually reproductive health-related issues. The study was conducted among adolescents (10-19 years) and youth (15-35 years) according to the African Union (AU). This definition is widely used in their global reports and statistics on demographics, education, employment, and health. The study was undertaken with 20 adolescents and 20 youth, seeking treatment in Gulu Regional Referral Hospital and Reproductive Health- Uganda facility in Gulu City. It also included the screened and tests which were reactive during the community medical outreaches jointly undertaken with Gulu Regional Referral Hospital Adolescent Clinic and Reproductive Health Uganda in Gulu City.

A Short home follow-up of two weeks was undertaken by 20 health workers to evaluate the treatment adherence behaviour and recovery of the 20 adolescents and 20 youth in the first two weeks of treatment. This was followed by the long home follow-up of the same group for 4 weeks to explore their post-treatment health behaviour. Each health worker made a follow-up of two clients. The home follow-ups were limited to Gulu City suburbs (Pece, Olailong, and Kanyagoga), and the participants were expected to be located within a radius of 2km for easy access and follow-up. The home follow-ups were followed by four Focused Group Discussions, each comprising 12 members: one for females only, another for males only, the third group contained both female and male participants, and the fourth FGD was for clients attending the Antiretroviral Therapy (ART) clinic who shared their lived experiences during the COVID-19 pandemic and post-pandemic period.

Data collected was transcribed, coded, and arranged under key themes: perception of treatment-seeking behaviour, response to teenage pregnancies and unwanted pregnancies, response to STI infection, and reasons for the kind of response to SRH-related problems. The analysis involved the qualitative content and thematic

procedures that directly addressed the study's research questions.

FINDINGS AND DISCUSSIONS

Conceptualising Health-seeking Behaviours

The study established that health-seeking behaviour was not limited to pursuing formal medical care and seeking help from formal sources. From the one-on-one in-depth interviews and Focus Group Discussions (FGDs), the participants understood health-seeking behaviour as their action and reaction when they experience symptoms of illness, including STIs, the decisions they take to visit formal or informal sources, and reasons for or for not visiting the mentioned sources. This was in response to the questions: how, when, where, and why individuals seek or do not seek health care services when faced with symptoms of STIs or any other health problem.

The participants perceived informal health-seeking behaviour as disclosing and confiding in their peers on their health issues, seeking advice from peers, elderly women, and social media, and seeking help from clinics and drug shops, and visiting traditional healers or herbalists.

The study participants observed that due to the fear of infection, and the restrictions in movement during the COVID-19 Pandemic and lockdown, reduced access to clinics, contraception, post-abortion care, antenatal care, and STI treatment among adolescents and youth.

Adolescents and Youth's Response to Teenage Pregnancies and Unwanted Pregnancies

Childbearing among adolescent girls aged 10-19 by sub-region indicated that in Acholi, 5.2 adolescent girls had a live birth, 1.9 were Pregnant with their first child, and 7.1 had begun childbearing. In the year 2024, Acholi Sub-region registered an Adolescent Birth Rate number among women aged 10-19 years at 264,555. Adolescent birth rate (Per 1,000 women) in 2024 stood at 31.1, which remains on the higher side (UBOS, 2024).

During the one-on-one interview with adolescent girls, the study noted that out of 10 adolescent

girls, 06 had their first sexual experience between ages 15 and 19 arising from intergenerational sexual relations. This took the form of adolescents under 18 who are legally considered minors relating with older adults, often due to coercion (rape and incest) and exploitation involving exchange of favour, gifts, money, and support, especially to the vulnerable adolescent girls. In an interview with a 15-year-old adolescent, she disclosed that when her mother decided to separate from her father, who is a truck driver, he resorted to abusing her. Whenever she resisted his advances or threatened to report him to the authorities, he would beat her up and threaten to throw her out of the home. Unfortunately, when she got pregnant, her father disappeared, leaving her to take care of herself. It was not until one day when she collapsed in town that a passerby came to her aid.

During an FGD, the adolescent girls noted that it was more stigmatising to be told one was pregnant. During a one-on-one interview, an adolescent disclosed that, following her conception, she went to a private clinic where she was administered misoprostol, and shortly, the fetus was evacuated, and she returned home in the evening without causing any suspicion. Blum et al. (2007) observed that "abortion using misoprostol is slowly gaining attention as an easy to use, feasible, and low cost means of uterine evacuation, and could revolutionise treatment for this indication" (Blum et al., 2007, p. S186).

An adolescent mother confided that when she missed her menstrual period for two months and began feeling sickly, her peers noted her body change and suspected she was pregnant. She confided in them that she had had an intimate relationship with two different young men and had no idea whose pregnancy it was. They advised her to buy a urine-based pregnancy self-test kit from the pharmacy to ascertain the pregnancy. This affirms Fortenberry's (1997) assertion that discussing reproductive health and sexually transmitted disease-related problems with others was a common behavioural response to the problem among the adolescents and youth (Fortenberry, 1997, p. 419).

When she had a pregnancy test and two red strip lines appeared, her immediate thought was to terminate the pregnancy rather than going to the antenatal clinic. She instead visited Gulu Regional Referral Hospital Adolescent Clinic in the disguise of being sick. When the Medical officer was taking the history of her sickness, he referred her to take some Laboratory tests. The pregnancy tested positive, and she contacted a female nurse to help her terminate the pregnancy. However, the nurse counselled her against aborting, and encouraged her to keep the baby, who might become a president or her only child. Through the psycho-social support, she was able to go through the nine months and is now carrying her beautiful daughter. In a Focus Group Discussion with female adolescents, they noted that young adolescents feared pregnancy than STIs, which could be quietly treated, unlike pregnancy, which is seen by everyone, let alone the embarrassment, responsibility, and suffering that follows.

Similarly, an orphaned female youth confided that when she got pregnant the second time after giving birth to a baby who had been rejected by her first boyfriend, she opted to abort this pregnancy at two months. She was still going through the pain and shame of rejection. She noted that it was after this second conception that she went for an Implant inserted under the skin of her arm, which would last up to 3 years, but would remove it in case of any complication. A health worker noted that a contraceptive implant is a hormonal method that is convenient for sexually active young women. She reiterated that the commonly used brand in the market is Nexplanon. As Rowlands & Searle (2014, p.75) reiterated, the health worker explained that the contraceptive implant uses hormones which prevent ovulation, thicken cervical mucus to block the sperm, and thin the uterine lining to prevent implantation, therefore, preventing conception. She further noted that when properly inserted, it is over 99% effective and mostly preferred by young women.

Adolescents and Youth's Response to STI Infection

When asked how they responded when they were diagnosed with an STI, the female participants reported that their response varied with the situation they were going through. Before the COVID-19 lockdown, life was good, and they could have money for their personal needs. But during and after the pandemic, life was difficult, and some of them were engaged in sexual activities that led to STI infection, unwanted pregnancies, and unsafe abortion, causing blood clots, incomplete abortion, and retained tissue, which became infected, causing sepsis.

A 15-year-old adolescent confided that when she had an STI following her first sexual relation with an older man, she learnt her lesson and since then she had abstained from sex. The experience was so traumatising, and she was not sure whether she had not been infected with HIV. She lied to her parents that she had Typhoid fever and needed money for treatment. She then received treatment from a private clinic where she was tested for HIV, which was non-reactive, and got treatment for the STI. This affirms Fortenberry's view that SRH-related problems among young people also resembled adult patterns in that avoiding sex and discussing the problem with others were common (Fortenberry, 1997, p. 419).

The FGDs for clients attending the ART (Anti-Retroviral Therapy) clinic indicated that the reactions depended on the nature of the STI. A female youth reported that when she was tested HIV positive following her engagement in multiple unprotected sex activities, her world crumbled. She entered into a depression, she was withdrawn, lost appetite, lost weight, and began to fall sick frequently until she was once admitted to the hospital and put on Anti-Retroviral drugs (ARVs) medications used to treat HIV. When she got better, she began living a reckless life, having unprotected sex and always taking hard liquor. Another female participant disclosed that when she tested positive, she decided that she would also infect other men the way they had intentionally infected her. From the clinic, she

called her close male associates and infected two men on the same day. She continued to lure unsuspecting young and older men into unprotected sex.

The study established that out of 10 participants who were tested HIV positive, all began having unprotected sex, but ensured that they had emergency pills or were on Birth Control Pills. The Daily Monitor paper reports indicate that the new infections in Gulu City are mainly among the youth. Citing Ms. Florence Oyella, the disease focal person, the paper reported that, between October and December 2023, Gulu City registered 307 new HIV infections of the 17,775 people tested. Between January and December 2024, a total of 391 new infections were registered out of 9,864 people tested. Between April and June 2024, a total of 404 new infections were registered from the 27,012 people tested (Monitor Newspaper, Tuesday, September 10, 2024).

Abortion and Incomplete Abortions

In a community outreach in the Cet-kana community, a parent reported that, having conceived during the lockdown, his daughter resorted to crude methods of abortion using the poisonous Wandering Jew plant. This often destroyed their uterus due to an incomplete abortion. A woman further noted that whereas her neighbour's daughter lost her uterus, in her case, she lost her daughter to a crude abortion. In the FGD with the young people attending the SRH clinic, the girls confided that their peers were misled to abort by inserting a sharp object and a stick through the cervix to rupture the membrane sac to terminate the pregnancy, but it ended up in heavy bleeding and death of the girls resulting from the retained tissue becoming infected. It was alleged that in one of the private clinics, a pair of forceps was inserted through the cervix to pierce the fetus and pull out the body parts. Blum et al. noted that, whereas surgical management has been the standard of care worldwide for many years, and its safety and effectiveness are well proven in the context of high-quality medical care, it is sometimes less desirable to women and especially adolescents and youth, and some

providers, who may prefer immediate treatment (2007, p. S186). Fear of stigma, legal consequences, or lack of access may prevent adolescents, youth, and women from seeking timely medical help, especially during abortion, putting their lives at high risk.

Reasons for Seeking Help from Peers and Elderly Women in the Community

During the school visits, some adolescents and youth reported that parents refused to talk about Sexual Reproductive health issues and often feigned ignorance about it. On the other hand, some young people acknowledged that they were shy to disclose and discuss their SRH problems with their parents and guardians. They also noted that the fear of judgment from parents and guardians made them seek help and advice from peers and other sources. A student noted that the community often associates STIs with 'sexual immorality' and being involved in premarital sex.

A male learner reported that during COVID-19, he developed symptoms of an STI, and he had penile discharge. He confided that on return to school, a number of his peers exhibited symptoms of STIs in the visual aid being used during the health education. But they could not access teachers to educate them on their condition.

The participants noted that discussing reproductive health-related issues with parents is considered a cultural taboo. During a community engagement visit to a refugee settlement, a participant disclosed that in their culture, as a father, it is taboo to discuss a daughter's reproductive health issues or give sex education to the girls. He acknowledged that the information being shared with the adolescents and youth on their Sexual Reproductive Health (SRH) related issues was very important and reiterated that the project team has regular sessions in schools. The adolescents and youth observed that it was difficult to discuss their sexual reproductive health issues with parents due to cultural taboos and fear of judgment from parents. Some youth also reported that parents refused to talk about these matters or that they felt they had lost the ability to talk with their parents. One adolescent

lamented that it was not in their culture to discuss their private sex life.

The negative attitude of health workers towards young persons who were seeking treatment for STIs and the manner in which they handled their clients drove the adolescents and youth to seek care from informal sources, including peers and herbalists. The study showed that out of every ten young girls who visited the formal health facilities for STI-related problems, reported that they were scorned, especially by the female health workers who called them names and did not want to see them express pain or cry. The female health workers would question them as to why they went into sex when they were underage teenage girls and ordered them to stop crying. The young females reported that they preferred visiting drug shops and private clinics when their condition worsened because the health workers in the private clinics were more friendly. A female health worker acknowledged that before they were trained on adolescent-friendly care and service, most of the female health workers were unfriendly to the young females.

Reasons for Procrastination

Procrastination, a phase of delay, is attributed to a number of reasons. In a one-on-one interview with the learners, they were asked questions on their knowledge, infection, health-seeking behaviour, and reasons for their form of decision. In an interview with a female adolescent learner, when asked if she had knowledge of STIs, she responded affirmatively. When further asked if she had been infected with any form of STI and the decisions she made, she confirmed that at 15 years during the COVID-19 lockdown down she had experienced itching and bad vaginal discharge and odour, which developed after an intimate relation with a man who was older than her. However, she could not disclose it for fear of being stigmatised, the parents would open a defilement case with the police, and the parents would stop paying her school fees. In an FGD, the female participants revealed that their parents would force them to go back to the man who

infected them, even when the situation was not good.

Lack of knowledge on STIs was attributed to the delay in seeking treatment. A 16-year-old male adolescent who turned out for a counselling session disclosed that he was experiencing a painful greenish penile discharge, which he had no knowledge about until he saw the STI visual aid. He further explained that the senior male teacher and his biology teacher had never told them about such discharges except wet dreams.

Availability of alternative sources of help, including drug shops and pharmacies, was visited for over-the-counter medication. Self-medication was often resorted to in order to keep their health condition confidential. In a Focus Group Discussion, the participants noted that they had preferred self-medication and buying antibiotic capsule drugs, including Metronidazole, Doxycycline, Tetracycline, Ciprofloxacin, Azithromycin, Erythromycin, Cefixime, Amoxicillin, Ampicillin, Cloxacillin, and Dicloxacillin, among others. A number of girls confided in douching in response to symptoms. This confirms the study by Fortenberry (1997, p. 419), that douching was used by most females who exhibited symptoms of STIs. Limited family support was another reason that male adolescents and youth were not effectively seeking treatment, which took a longer period. From the visits to the city suburbs, the study established that female adolescents and youth from lower household incomes, more enthusiastic in acquiring knowledge and more committed to taking the prescribed medications. There was more procrastination observed among the male adolescents and youth who would only adhere to the treatment when monitored or coerced by an older person.

CONCLUSION

The COVID-19 pandemic and lockdown had enormous consequences for adolescent and youth sexual reproductive health treatment-seeking behaviour in the Acholi sub-region in northern Uganda. The adolescent and youth response to STI infections and their treatment-seeking

behaviour was never predictable and was determined by the social-cultural conditions in the family and community. There was widespread misinformation and a lack of access to information on SRH and STI-related issues among youth, resulting in most adolescents and youth seeking self-medication. The limited availability of youth-friendly services in the health facilities during the COVID-19 lockdown drove the young people, and especially women, to alternative sources of treatment, including drug shops, private clinics, and consulting a traditional herbalist, whom they referred to as “Health Centre Two” in the village. The study concluded that health being social, interventions towards adolescent and youth sexual reproductive health-related issues should target their social life and cultural stereotypes.

RECOMMENDATIONS

Based on these findings, the following recommendations are proposed:

Strengthen Community-Based Services: Healthcare providers should explore models that bring SRH services closer to young people, such as mobile clinics and community health workers, especially during crises.

Integrate Technology: The use of technology, such as mobile health applications and telehealth services, should be explored to provide confidential information and remote consultations.

Develop Crisis-Responsive Health Systems: Policymakers should develop and implement plans that ensure the continuity of essential services like SRH during future public health emergencies.

Public Education Campaigns: There is a critical need for targeted public education campaigns to reduce the stigma associated with SRH services and rebuild trust in healthcare facilities.

Research Protocol Approval

The research protocol was approved by Gulu University Research Ethics Committee (GUREC-2022-241).

Acknowledgement

This research and publication were undertaken under the CONSCOV Project 2022 to 2025, funded by the Ministry of Foreign Affairs of Denmark.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the writing and publication of this paper.

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