

“If your mother does not teach you, the world will...”: A qualitative study of parent-adolescent communication on sexual and reproductive health issues in Border districts of eastern Uganda

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Abstract

Background

Adolescents (10–19 years) in developing countries experience a host of sexual and reproductive (SRH) challenges, with detrimental SRH and socio-economic consequences. These include early sexual debut, sexually transmitted infections including HIV, unsafe abortions, teenage pregnancy, and early childbearing. Parent-adolescent communication about SRH has significant potential to reduce adolescents' risky sexual behaviors. However, communication between parents and adolescents is limited. We assessed the facilitators and barriers to parent-adolescent communication about sexual and reproductive health in two border districts of Eastern Uganda.

Methods

A community-based cross-sectional qualitative study was conducted in the border districts of Busia and Tororo in Eastern Uganda. Data collection entailed 8 Focus Group Discussions comprising parents, adolescents (10–17 years) and 26 Key Informants. Interviews were audio-recorded, transcribed, and translated into English. Thematic analysis was conducted with the aid of NVIVO 12 software.

Results

Parent-adolescent communication about SRH was not common. Facilitators of parent-adolescent communication were: good parent-child relationship, role of the mother, education level, and exposure of the parent. Parents are, however, limited by sexual and reproductive health-related cultural norms, inadequate capacity for parents to address pertinent SRH issues, busy schedules, poor modeling by parents, and inability to meet children's /household basic needs.

Conclusion

Parents' ability to communicate with their children is hindered by cultural barriers and inadequate knowledge. There is a need to equip parents with adequate information and skills to ease communication. Additionally, parent-adolescent communication on sexual and reproductive health should be integrated into parenting interventions so as to improve SRH communication between parents and children.

Introduction

Globally, adolescents aged 10–19 years in sub-Saharan Africa (SSA) bear a disproportionate burden of sexual and reproductive health (SRH) challenges (1–3). The region accounts for the highest rates of early marriage, adolescent pregnancy, unsafe abortions, complications during pregnancy and childbirth (4),

and HIV transmission (5) which contribute to high morbidity and mortality rates. The World Health Organization estimates that one in 20 adolescents contract a sexually transmitted infection (STI) each year (6). In Uganda, 25% of adolescents aged 15–19 years were already mothers or pregnant with their first child in 2016 (7).

Access to timely sexual and reproductive health information and services is fundamental in improving SRH outcomes for adolescents. Studies elsewhere have shown that media, peers, school teachers, and health workers are the main source of SRH information among adolescents (8–10). However, some of this information from peers may be incorrect leading to misrepresentation making young people vulnerable to poor sexual and reproductive health outcomes.

Some studies have shown that young people also prefer obtaining SRH information from parents (11–14). Parent-adolescent communication on SRH issues has the potential to prevent children's involvement in risky sexual behaviors and empower them with decision-making skills (15–17). Despite these benefits, such important conversations seldom occur in many settings in SSA.

In Uganda, just like most SSA countries, several factors prevent discussions between parents and children. Parents are generally uncomfortable discussing sex-related issues with their children and have inadequate knowledge and skills to communicate effectively on SRH issues (18, 19). A qualitative review on barriers to parent-child communication on SRH issues in East Africa found gender differences, level of education, parents' occupations, religion, and social-cultural norms as key barriers to communication about SRH (20).

Previous studies on parent-child communication about SRH in Uganda have targeted school-going children (18, 21). However, focusing on only in-school children misses the opportunity of understanding the parents' context and their influence on young people's sexual behavior (22). These studies have only been conducted in urban and peri-urban settings (18). To the best of our knowledge, there are no published studies on parent-adolescent communication on sexual and reproductive health in border districts of Uganda. The situation in the border districts of Uganda is dire owing to the cross-border trade and transient populations, which elevate the risk of poor SRH outcomes. This study aimed to fill this gap by assessing the practices, barriers, and facilitators of parent-adolescent communication about SRH in two Eastern Uganda border districts; which have highly mobile populations and busy commercial activities-which provide increased opportunities for engaging in risky sexual behaviors.

Methods

Study design and setting

We used a cross-sectional qualitative research design to gain a deeper understanding of the facilitators and barriers of parent-adolescent communication on SRH issues in two border districts of Busia and Tororo, located in Eastern Uganda. According to the 2014 National Population and Housing Census (23), Busia and Tororo have a population of 323,662 and 517,082 respectively. Busia and Tororo share borders

with Kenya and host the busiest ports of entry in Uganda. The population in the districts is diverse comprising truck drivers among other transporters, cross-border traders, sex workers, border officials, border town residents, and tourists/visitors. Populations living in border towns report poorer SRH outcomes such as early sexual debut, high rates of teenage pregnancy, and higher HIV vulnerability (24). Data collection was conducted between 2nd and 18th May, 2021.

Study population

The study population were all parents of adolescents aged 10–17 years, adolescent boys and girls aged 10–17 years, and key informants. While the World Health Organization classifies adolescents as those aged 10–19-year-old, our study focused on 10-17-year-olds due to the unique legal and policy implications faced by this age group as compared to older 18–19 year-olds who are of legal age of consent. Parents in this study referred to a biological mother/father or female/male guardian of the adolescent who must have lived continuously with the adolescent for at least one year prior to the data collection.

Sampling

A multi-stage stratified sampling design was used. From each district, two subcounties were randomly selected. A total of four sub-counties were selected – two from each district. From Tororo, Malaba TC (urban) and Mella subcounty (rural) were selected. In Busia district, Dabani (peri-urban) and Buhehe (rural) were selected using computer random numbers using Microsoft Office Excel programme. From each sub-county, two parishes were randomly selected. From Malaba TC, Obore and Amagoro parishes were selected. From Mella, Apokor and Mella parishes were selected. From Dabani, Buyengo and Dabani parishes were selected. From Buhehe, Bulwenge and Buhasaba parishes were selected. Finally, a total of 10 villages were selected using simple random sampling from these parishes. From each village, purposive sampling was used to identify households with parents who have children aged 10–17 years. Only one child and one parent was randomly selected from each household for interview. Parents with adolescent children were identified with the help of local leaders in the community.

Data collection methods and tools

We conducted Focus group discussions (FGDs) and Key Informant Interviews (KIs) with parents, children and key informants. We conducted 8 FGDs with fathers (n = 2), mothers (n = 2), male (n = 2) and female (n = 2) adolescents in separate specific gender- groups. The FGDs were disaggregated by sex to allow for free expression of views during the discussion of potentially sensitive issues. Owing to the observation of the COVID 19 standard operating procedures (SOPs), each FGD had six participants and lasted approximately 1 hour and 30 minutes. All FGDs were conducted by a moderator and a note-taker. Consent from participants was sought to audio record the discussions.

Given the sensitivity of this topic and cultural tradition in the study contexts, participants were interviewed by an interviewer of the same sex. All research assistants were trained on research ethics, principles of qualitative data collection, and the study procedures and instruments. The research assistants were

experienced in working with children, as well as adults, collecting data on sensitive topics, including sexual behavior, and were proficient in the local languages. FGDs were conducted in the local languages of Lusamia, Japhadola and Ateso which are predominantly spoken in the study area. To ensure privacy, the FGDs were held in an open space (within the household compound) which offered privacy during the interviews with children so that their responses are not heard by their parents. FGD participants were provided with refreshments as compensation for their time.

Additionally, a total of 26 KIIs (12 in Tororo and 14 in Busia) were conducted in English using a semi-structured interview guide. The duration of the interviews ranged from 30 to 45 minutes. We engaged four categories of key informants that work with children: Non-Governmental Organizations such as Child Fund, Community Based Organizations, officers from the District Local Government, and community representatives consisting of religious and cultural leaders.

Data Collection Tools

Interview guides and key informant interview guides were used to collect data. The interview guides focused on areas such as timing and frequency of communication, barriers, and facilitators of parent-adolescent communication, and the parenting style.

Data analysis

Following fieldwork, audio files from interviews were transcribed then translated into English. Handwritten notes were used to supplement information gaps from the audio-recorded transcripts. An initial coding frame was then developed. The data were then analyzed using thematic analysis. The first step was to manually read through interview guides and a few interview transcripts, from which initial themes were developed. The rest of the transcripts were then read to expand the codes. The developed themes were then entered as codes into NVIVO 12 software. Codes were derived inductively from the data and deductively from interview tools.

Results

Characteristics of participants

A total of 24 adolescent girls and boys (aged 10–17 years) took part in 4 FGDs. All were unmarried and resided with either biological parents or relatives. Most adolescents were in school while a few engaged in farming and petty trade to earn an income. Each parent FGD had six participants aged between 25 and 56 years. All were married.

We selected 26 Key informants, 11 females and 15 males. Their ages ranged between 40 and 75 years, while their years of work experience were between 5 and 40 years. The participants comprised six religious leaders, two cultural leaders, ten leaders from the District Local Government, one from a community-based organization, and seven non-government organization leaders.

Participants emphasized that not many parents talk to their children about SRH. Estimates of parents that communicated with their children about SRH were about three in ten or less. Most of these discussions were initiated by parents rather than the children. The discussions mainly focused on abstinence, HIV/AIDs, and risks associated with night movements. Topics on contraceptive use and condom use were rarely discussed. This is illustrated in the following excerpt:

“Parents fear telling their children to use condoms because they feel the child will engage in sex knowing that it was the mother who advised her.” (Girl, FGD, Busia)

SRH communication was often triggered by a negative situation occurring in the community (such as a neighbor’s teenage daughter falling pregnant).

Most of these talks between parents and children occur at least twice a month although three parents felt these conversations should be conducted daily.

Facilitators of parent-adolescent communication on SRH issues

The following themes emerged as facilitators: good parent-child relationship, the role of the mother, education level, and exposure of the parent.

Good parent-child relationship

Some participants mentioned that having a good relationship and open communication between parents and children facilitated discussion of sexual and reproductive health issues. A good relationship makes parents approachable, making it possible for children to initiate SRH conversations as illustrated in the following excerpts.

“When you befriend your child, she can share her secrets with you, for example, she can say ‘there is a boy interested in me’... Now as the mother when a child tells you this, use this chance to advise her.” (Mother, FGD, Tororo)

“If the child and parent are free with each other, it is easy for them to talk. You may be willing to talk to her, but she isn’t free with you, she will end up seeking advice from the neighbors or friends just because she is not free with you.” (Mother, FGD, Busia)

Relatedly, the study found that parents who closely monitor and take a keen interest in their children and their behaviors are likely to discuss SRH matters with their children. Observed changes in the behavior of the child created an opportunity for a parent to talk to the child. As one mother stated:

“When she [daughter] started to dress badly, I realized it was time to have the talk. Even when I found her with the wrong friends, I talked to her” (Mother, FGD, Tororo).

Role of the mother

Participants' narratives suggest that mothers were key in influencing parent-child communication. Given their gender role in child-rearing, mothers dominated parent-child communication on SRH matters. Various participants argued that mothers spend more time with their children, which creates a bond and a close relationship that eases the communication process. Key informants made the following observations:

"Mothers are always available to talk to children. They are gentler when dealing with children than the fathers (KI, Busia)

"Most of the children associate with their mums, so, it's easy for them to tell their mum what is happening to their bodies." (KI, Tororo)

Others referred to mothers as mediators between the father and the child, who can be trusted with secrets and usually find ways of helping children to address SRH issues. As the following quote illustrates, adolescents confided in their mothers

"When you tell her [mother] about something, she will not tell the neighbors about your issue, she will keep it a secret." (Girl, FGD, Busia)

Mothers were also considered sympathetic and less harsh which made them more approachable.

"Most children are afraid of their fathers, Even if it is a boy and he wants a book, they will still come to you the mother... They fear their fathers because they are hostile to them..." (Mother, FGD, Busia)

However, not all participants agreed. Some felt that some mothers were unable to advise their children because of fear and embarrassment.

"Some mothers shy away from such conversations, yet they are supposed to guide the girls." (Mother, FGD, Tororo)

Education level and exposure of the parent

Educated parents were better positioned to communicate with their children about SRH. Such parents are more knowledgeable and able to respond to technical SRH questions raised by children, as this comment illustrates:

"Educated parents have the information so they can explain some of these things to their children. When I look at a parent who is a school dropout- what information will he or she give to a child?" (KI, Tororo)

Barriers to Parent-child communication on SRH

The barriers to parent-adolescent communication about SRH include; cultural norms, ill-prepared parents, use of authoritative and reprimanding language, parents misunderstanding their children, the delegation of the role to the mothers, late initiation of SRH discussions, poor modeling by parents, poverty, and limited time (on the part of parents). These are discussed as follows:

SRH cultural norms

Cultural norms that promote the use of paternal aunties and uncles to communicate about SRH limit parent-adolescent communication. Such norms contribute to the discomfort in discussing SRH issues and the use of indirect language by the parents. Most of the parents and children reported that they found discussions on SRH issues embarrassing. According to a key informant:

“Parents feel that things to do with sexual health should not be discussed between a parent and a child. They consider it a taboo.” (KI, Tororo)

“...things like boys seducing you is your secret because you feel shy sharing such information with your parent and so you keep it as your secret.” (Girl, FGD, Busia)

Parents who speak to the children about SRH do so in parables, which limits comprehension. They believe that words associated with SRH are obscene and would expose children to inappropriate information that could result in experimenting with sex. For example, the expression *“If your mother does not teach you, the world will...”* that was made by a girl from Tororo means that if morals, values, and good character are not imparted at home, then you will learn from hard knocks or problems that result from a lack of or neglect of instruction. Another young girl reported:

“She speaks but you don’t understand what she is saying, and she doesn’t understand you well” (Girl, FGD, Busia).

Culturally sensitive topics omitted from discussions included sexual intercourse, contraception, and cultural preparation of girls for marriage that involve genital mutilation.

“...sex is difficult to talk about.... For instance telling them that ‘if you are to have sex, do this and that’ most parents cannot say that to the children.” (Mothers, FGD, Busia)

In addition to the cultural taboos surrounding parent-child communication of SRH issues, some participants raised issues of serious parental neglect where young people in Busia and Tororo participate in the popular funeral fundraising gathering **“Disco Matanga”** that takes place late at night. Children (as young as four years) that attend this gathering unaccompanied by parents are exposed to defilement/rape and unwanted pregnancy.

“...when someone dies, there is always fundraising done at night so the girls go for other things rather than what would have taken them there. In most cases, it ends at around two a.m in the morning and then they start music until the wee hours ...”

This is evidence that parents are not effectively communicating or closely monitoring their children.

Parents are ill-equipped to communicate about SRH

Many parents lack the knowledge, appropriate skills, and approaches to communicate with their children. Parents also lack confidence and exposure to initiate such conversations. This is attributed to low levels of education. Referring to such parents, key informants made the following remarks:

“First of all they do not have the information. They do not know when and what to tell their kids. When they hear that you are going to talk about sexual reproductive health, they think you are promoting immorality ...” (KI, Tororo).

Use of authoritative and reprimanding language by parents

When most parents talk to their children, they use authoritative, reprimanding language, especially when they observe cases of teenage pregnancy in the community. Respondents reported that fathers are tough, harsh, and instill fear in the children. Some threaten and use corporal punishment to discipline or warn young people concerning inappropriate behavior, especially sexual activity. Owing to the harsh approach used by fathers, most girls and some boys prefer sharing their concerns with mothers. A young person reported:

“There are some fathers you tell your concerns, but they just start quarreling, accusing you of being spoilt. This creates fear and makes children keep quiet.” (Boy, FGD, Busia)

Some, especially fathers, refuse to talk to the children about SRH. Many young girls reported that they had such experiences.

“Daddy is harsh. He does not like discussing such issues... When it comes to such issues, he says ‘go and talk to your mother.’” (Girl, FGD, Tororo)

As a result, many children do not communicate with their parents. They tend to be shy, and fear punishment. They detest the harsh language used by some parents and only communicate in case of a crisis. The children report that some parents curse the children and tell them not to revert to them in case of problems. This approach can be counter-productive and contributes to rebellion and early marriages. In addition to attributing early marriages to the inability to cater for children’s needs, a mother confirmed the children’s observations:

“Some girls get married at an early age because of us the parents. Sometimes, we are very hostile and yet if you don’t take good care of the children... The child will run away and get her own home.” (Mother, FGD, Busia)

Many parents indicated that harsh language is used in an endeavor to make the children understand the severity of the issues at stake. Such language is also used when the children are disobedient, for instance, when they break household curfew regulations. This approach is expected to ensure that children do not start or continue with inappropriate behavior.

“I think you need to be harsh and threaten them with police involvement because that is the only way they understand. Whatever the child does comes back to you the mother....So in a way we need to be harsh to them so that they take whatever we tell them seriously.” (Mother, Busia, FGD)

“You need to be tough with them because if you bring up such issues in a joking way, then she will take it lightly as a joke. That said, there are some sensitive issues that you ought to bring out in a polite way to earn their respect and confidence like things to do with their menstrual periods for the very first time.” (Mother, Busia, FGD)

Delegation of the parent-adolescent communication role to the mothers

Study participants noted that many fathers abdicate their roles of communicating about SRH to the mothers. They send the children, including boys to the mothers for counsel. Excessive alcohol consumption is a challenge. Some parents, especially fathers, get drunk and are negligent.

“Fathers rarely have time because most of them report to a Malwa [alcohol drinking] joint at six am ... They go back home after 9 or 10 p.m. just to sleep. They do not have time for children.” (KI, Tororo)

In some cases, guardians (who are not biological parents) are hesitant to communicate about SRH and hardly provide guidance. For instance, grandparents tend to pamper and “spoil” children; and have limited control over them. Some parents expect teachers to inform or teach children about SRH, yet teachers rarely do so. A key informant reported that the moment he will learn that SRH has been integrated into the curriculum, then many parents inclusive, will not discuss SRH with children. Some parents, especially single parents engage teachers, and friends to talk to their children. This is particularly the case if the gender differs, for instance, if a single mother has only sons. Parents even expect peers of the children to communicate about SRH.

Concerning the gender of the parent that communicates to the children, ideally, mothers are expected to speak to girls and fathers to the boys. This approach foregoes the advantages of having both parents talk to the children. A father observed:

“It’s very hard for the daughter to tell the father her secrets.” (Father, Busia FGD).

When a father wishes to do something for his daughter, many do so through the mother. Although they are supposed to be guided by the father (or uncles) many revert to the mothers. According to a Tororo key informant, “they grow up like trees”, without guidance or direction.

Late initiation of discussions on SRH

Many parents are not aware of when the children start learning about sexual activity and other SRH issues, the sources of information or modeling, and when they start sexual activity. It was also noted that parents tend to start such conversations with children of at least 14 years, which is considered the most vulnerable age group since they have started experiencing changes in their bodies

“Some children start sex activities before ten years. By the time parents consider talking to them e.g. at 15 years, it is too late” (KI, Tororo)

For instance, a case of a 12 and 13-year-old couple that had a baby was reported in the Tororo district. Parents and children only communicate where there is a crisis.

“Most parents wait for the problem to occur and that is when they come to talk to the children and during this time the parents really have no kind words for the child.” (Mother, Busia, FGD).

“There are things that you have to tell your parent no matter what like rape or defilement because you might need care.” (Girl, Busia, FGD).

Poor modeling by parents

Communication includes the parents’ conduct as well as guidance. Many participants noted that some families especially in urban areas stay in one-roomed houses, which exposes children to adult activities. A boy that had his sexual debut at 12 years indicated that they were acting out “mummy and daddy”; doing what their parents do.

“In slums, parents and their children just sleep in the same room ... there is no privacy, boys and girls are sleeping together and probably the parents are sleeping in the same room” (KI, Busia)

Poverty

Poverty is a major hindrance to appropriate SRH communication. In such a context, some parents (inadvertently) encourage transactional sex by telling their children to accept gifts in cash or kind from prospective partners (for family sustenance). Children who contribute to the survival of the family are rarely reprimanded, making the children believe that such activities are acceptable.

“If there is a scarcity of resources in a family, and a girl comes home with something to eat, it becomes hard for the mother to stop her from such behaviors...” (Girl, FGD, Busia)

Parents do not cater for many of their children’s needs. Therefore, many children become sexually active in efforts to get sanitary pads + and food among others.

“If you do not provide children’s basic needs, they will not value your advice.” (KI, Tororo)

Such children may decide that they can survive on their own. Parents who cannot afford school fees send the children to hawk goods, where some of them become victims of truck drivers’ (among other men) sexual advances. When children get pregnant, owing to poverty, parents force them to get married irrespective of their age. Such situations encourage child labor, early sex, and early marriages.

Busy parents

Many participants reported that parents were too busy to dedicate time to talk to their children about SRH. Many parents are involved in cross-border trade. They leave early in the morning and return late at night when they are tired, and the children are asleep. Some parents are absent for months, mothers inclusive. In some cases, even the mothers who are expected to be available are also extremely busy. Owing to work demands, some parents do not stay with their children. Such children are least likely to receive information and guidance on SRH.

Discussion

To date, few qualitative studies have explored parent-adolescent communication of SRH issues in SSA, particularly in border areas. Our study assessed the facilitators and barriers of parent-adolescent

communication on SRH in two border districts of Eastern Uganda. We captured the views of predominantly 10-17-year-old adolescents, parents, and key Informants. The findings highlight several important points that are useful for designing interventions to improve parent-adolescent communication among parents and children.

This study found that few parents adequately communicate with their children about sexual and reproductive health issues. This finding was not surprising since communication among parents and children is hindered by the prevalent social norms which could perhaps affect the quality and effectiveness of SRH discussions.

The discussions mainly focused on abstinence and HIV/AIDS. This finding is also consistent with the findings of Wamoyi, Fenwick (22), Mbachu, Agu (25), and Seif and Moshiro (26). A possible explanation might be that this is a border setting, where the predominant activity is cross-border trade characterized by risky activities such as prostitution and cross-generational sex which expose young people to unwanted pregnancy, and HIV/AIDS, hence, parents' emphasis on perceived effective preventive measures.

This study also found that parents avoided topics on condoms and contraception. This finding was also reported by (27) (22). Parents' failure to discuss contraception may arise from parents' fear that such communication would be interpreted as an encouragement for sexual activity. Premarital sexual activity especially among adolescents is strongly discouraged in many SSA settings (28–30) and thus discussions on SRH focus emphasize abstinence rather than contraception. Selective SRH topic discussions by parents violate adolescents' rights to comprehensive and accurate health information.

Findings show parents adopted a harsh and authoritarian approach to SRH communication, which made it difficult for children to openly discuss their SRH concerns. Moreover, these discussions often started in later adolescence (after 14 years) after adolescents had already engaged in sexual activity. Such communication is unlikely to impact adolescents' sexual behavior. These findings underscore the urgency of enabling parents to initiate SRH communication with adolescents at younger ages, to avoid unwanted pregnancies and associated negative SRH outcomes.

In this study, parents recognize the contribution of cultural and religious barriers to their limited capacity to effectively communicate with their children on SRH issues. As a result, adolescents are missing vital and beneficial SRH information and guidance. This social taboo as a hindrance to sexual education has been found in other studies, like those in Asia, Africa, and other countries in the Western Pacific [29].

Parental absence due to the pressures of work further limited the opportunities for parent-child interaction. Absentee parents are also less likely to have a close trusting relationship with their children, which affects the communication process as documented by other studies in SSA (20, 31, 32). Absenteeism was more commonly reported among fathers than mothers. Mothers have more time to bond with the children which ease SRH discussions. These results reflect those of a study from Jordan and Syria which also found that mothers are more approachable concerning SRH matters (33).

The socioeconomic status of households presented significant barriers to SRH communication. Parents with insufficient resources to support their families felt ill-equipped or positioned to question cross-generational relationships involving the daughters owing the gifts and financial rewards that contributed to the survival of the households. This also accords with findings from Ethiopia which also found that poor parents are less likely to discuss SRH issues with their children (34).

Conclusion

This study set out to assess the barriers and facilitators of parent-adolescent communication about sexual and reproductive health issues in border districts of Eastern Uganda. This study has shown that only a few parents discuss SRH issues with their children. The study has also shown that parent-adolescent communication about sexual issues is greater when there is open communication between parents and children. Conversely, parent-adolescent communication about sexual issues is reduced when parents have inadequate SRH information, are uncomfortable discussing SRH issues with children, and when children perceive their parents as authoritative and use reprimanding language. Given the potential that parent-child communication about sexual issues has in reducing risky sexual behavior, the findings suggest the need to equip parents with adequate information and skills to ease communication. Additionally, parent-adolescent communication on SRH should be integrated into parenting interventions so as to improve SRH communication between parents and children.

Abbreviations

FGD: Focus Group Discussion

KII: Key Informant Interview

SRH: Sexual and reproductive health

STI: Sexually transmitted infection

SSA: sub-Saharan Africa

Declarations

Ethics approval and consent to participate

The study was approved by the TASO Research and Ethics Committee (approval number: TASO REC/003/2021-UG-REC-009) and was registered by the Uganda National Council for Science and Technology (registration number SS748ES). Additional authorization to conduct the study was obtained from district leaders before approaching individual participants. Informed consent was obtained from all participants. In the case of minors, assent was sought in addition to parental consent. To maintain the confidentiality of the information and the privacy of the participants, only selected participants and the

moderators attended the sessions. Personal identifiers and locator information were not recorded, and any identifying information accidentally mentioned was removed from the text before the analysis. We confirm that all methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

Not applicable

Availability of data and materials

The datasets used during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that there is no competing interest.

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