

Sex Education

Sexuality, Society and Learning

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/csed20>

Parent–child communication on sexual and reproductive health in border districts of Eastern Uganda

Peter Kisaakye, Patricia Ndugga, Elizabeth Kwagala, Martin Kayitale Mbonye, Fred Ngabirano & Stephen Ojiambo Wandera

To cite this article: Peter Kisaakye, Patricia Ndugga, Elizabeth Kwagala, Martin Kayitale Mbonye, Fred Ngabirano & Stephen Ojiambo Wandera (2022): Parent–child communication on sexual and reproductive health in border districts of Eastern Uganda, Sex Education, DOI: [10.1080/14681811.2022.2135500](https://doi.org/10.1080/14681811.2022.2135500)

To link to this article: <https://doi.org/10.1080/14681811.2022.2135500>



Published online: 24 Oct 2022.



Submit your article to this journal [↗](#)



View related articles [↗](#)





View Crossmark data [↗](#)

SHORT REPORT



Parent-child communication on sexual and reproductive health in border districts of Eastern Uganda

Peter Kisaakye ^a, Patricia Ndugga^a, Elizabeth Kwagala ^a, Martin Kayitale Mbonye^a, Fred Ngabirano^b and Stephen Ojiambo Wandera^a

^aDepartment of Population Studies, Makerere University, Kampala, Uganda; ^bDepartment of Children and Youth Affairs, Ministry of Gender, Labour and Social Development, Kampala, Uganda

ABSTRACT

Parent-child communication concerning sexual and reproductive health (SRH) has significant potential to reduce children's risky sexual behaviour. Despite these benefits, few parents communicate with their children about SRH issues in Uganda. Using multi-stage stratified sampling in a cross-sectional survey, we estimated the prevalence and investigated the factors that were associated with recent parent-child communication among 600 children (10-17 years) in border districts of Uganda (Busia and Tororo). Results indicated that 61% of children reported to having received parent-child communication on SRH. Communication was more likely to happen among children living in urban areas (OR=4.88; 95% CI=1.79-13.33), boys (OR=1.84; 95% CI=1.13-3.00), those aged 15-19 years (OR=2.59; 95% CI=1.51-4.46) and among children from households that owned a mobile phone (OR=2.11; 95% CI=1.05-4.21) than their counterparts. Parent-child communication was also higher among children who were comfortable discussing SRH issues (OR=27.12; 95% CI=16.02-45.89) and children from Tororo district (OR=2.34; 95% CI=1.36-4.01). The findings provide a rich understanding of the factors associated with Parent-child communication in the border districts of Uganda. These results provide a basis for policy enactment or revision regarding the encouragement of parent-child communication about SRH in Uganda.

ARTICLE HISTORY

Received 11 March 2022
Accepted 10 October 2022

KEYWORDS

Parent-child communication; sexual and reproductive health; border districts; Busia; Tororo; Uganda

Background

Internationally, children face negative sexual and reproductive health (SRH) outcomes such as unplanned pregnancy, unsafe abortion, HIV and gender-based violence, as they transition from childhood to adulthood (United Nations Educational Scientific and Cultural Organization 2018). These negative SRH outcomes may partly be attributed to poverty, peer pressure and inadequate SRH knowledge (Akers, Holland, and Bost 2011; Blake et al. 2001; Manu et al. 2015), among other variables. Studies have shown the value of SRH knowledge received from parents (Akers, Holland, and Bost 2011; Wang et al. 2014; Wight and Fullerton 2013).

Parent–child communication about SRH has the potential to reduce children’s risky sexual behaviours provided accurate information is made available in an age-appropriate form that children can understand (Muhwezi et al. 2015; Phillips and Mychailyszyn 2021). Parent–child communication can bring about change in children’s attitudes, norms, practices and knowledge about sexual behaviour. For example, Bastien and colleagues observed that parent–child communication can delay the age at which young people first have sex and can lead to better sexual negotiation skills (Bastien, Kajula, and Muhwezi 2011). Additionally, there is some evidence to suggest that parent–child communication has the potential to improve academic grades of children (Mahuro and Hungi 2016), leads to better use of modern contraception (Ojebuyi, Fagbamigbe, and Akinola 2019), makes children more empowered against HIV (Poulsen et al. 2010), and leads to healthier sexual behaviour (Muhwezi et al. 2015).

However, relatively few parents in Uganda communicate with their children on SRH matters (Akers, Holland, and Bost 2011; Ashcraft and Murray 2017; Blake et al. 2001; Wang et al. 2014; Wight and Fullerton 2013; Muhwezi et al. 2015; Kamangu, John, and Nyakoki 2017). And most SRH programmes to date have targeted school-going children (Wamoyi et al. 2010) in urban areas. Few studies have investigated parent–child communication related to SRH in border districts in particular. The main objectives of this paper are two-fold. First, to estimate the prevalence of parent–child communication and, second, to examine the factors associated with parent–child communication among children in Busia and Tororo – two Eastern Uganda border districts with highly mobile populations and busy commercial activities – which provide increased opportunities for engaging in risky sexual behaviour.

Data and methods

Study design

The study adopted a cross-sectional quantitative research design.

Study population and study area

The study population were children aged 10–17 years living in the border districts of Busia and Tororo in Eastern Uganda. In this paper, we refer to a child as any person of the age 10–17 years. Children (either a boy or girl) living either with their biological parent(s) or a guardian were eligible for interview. The predominant ethnic groups in the study districts are the Samia and Itesot people in Busia, and the Japhadola and Itesot people in Tororo. Busia and Tororo have a population of 323,662 and 517,082, respectively, according to the 2014 National Population and Housing Census (Uganda Bureau of Statistics 2016). Both share borders with Kenya and host the busiest ports of entry in the country. They have a diverse population comprising truck drivers and 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 (Hallett et al. 2006; Morris, Morris, and Ferguson 2009; Bechange et al. 2010; Apondi et al. 2011; Twa-Twa 1997). The main religion in the area is Christianity, while the main economic activities

are cross-border trade, small-scale business, subsistence farming, sand mining, stone quarrying and gold mining.

Sampling

A multi-stage stratified sampling design was used. In each district, two sub-counties were randomly selected. From Tororo district, Malaba TC (urban) and Mella subcounty (rural) were selected. In Busia district, Dabani (peri-urban) and Buhehe (rural) were selected using random numbers generated by Microsoft Office Excel. 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 chosen using simple random sampling from these parishes. The villages selected are shown in Figure 1.

From each village, simple random sampling was used to select households with children (aged 10–17 years) to participate in the survey. A household here refers to a group of people who live and eat together (Randall et al. 2015). Only one child (10–17 years) was randomly selected from each household for interview. We made a maximum of three callbacks for respondents who were not found to be at home for interview. A total of 600 children were interviewed to complete the survey. The sample size was determined using the Kish formula (1967), assuming a design effect of 2, at a 95% confidence level. In addition, we used Uganda-wise information to estimate the desired sample size, assuming that 39% of children aged 10–14 years received health information from parents, with

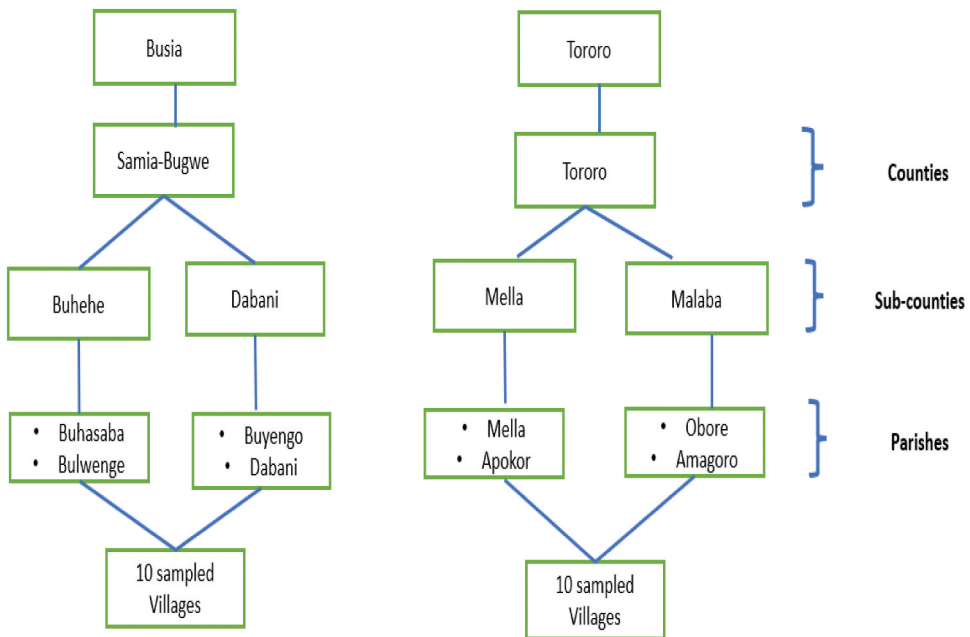


Figure 1. Sampling procedure.

a 10% change in condom use following parent–child communication in Get Up Speak Out Programme for adolescents (Development Expertise Centre 2022; International Planned Parenthood Federation 2022; Renzaho et al. 2017; Katahoire et al. 2019).

Data collection

Data were collected by trained research assistants between 2 and 18 May 2021 by means of computer-assisted personal interviews (CAPI) utilising Open Data Kit (ODK) software. Research assistants had experience working with children and how to ask sensitive questions. Interviews were conducted in English and in local languages (Lusamia, Adhola and Ateso) with translated questionnaires. The interview lasted between 30 minutes to an hour.

Survey data collection tools were developed by adapting questions from existing measures and questionnaires for parent–child communication relating to SRH (Dessie, Berhane, and Worku 2015; Miller et al. 1998; Sales et al. 2008; Seif, Kohi, and Moshiro 2017). We measured the outcome variable parent–child communication relating to SRH (Akers, Holland, and Bost 2011; Wight and Fullerton 2013) using the Parent-Adolescent Communication Scale (PACS), which covers five items (sex, condom use, protection from STI, protection from HIV and pregnancy prevention) (Usonwu, Ahmad, and Curtis-Tyler 2021). We examined the frequency of parent–child communication about SRH (Sales et al. 2008). This is an internationally validated tool used in the USA and Kenya (Miller et al. 1998; Poulsen et al. 2010). The STI questions were adapted from those asked in the Uganda Demographic and Health Surveys and the Population HIV Impact Assessment Surveys (Uganda Bureau of Statistics and ICF 2018; Ministry of Health Uganda 2019).

The survey tool collected information on demographic and socio-economic factors, sexual behaviour, communication between parents and children on sexuality, sexually transmitted infections, family support and COVID-19. To reduce possible social desirability bias, research assistants were given training with a focus on developing rapport and trust with the children. Interviews were conducted between an interviewer and child of the same sex in an open space within the household compound which offered privacy, so responses were not heard by parents. Children were assured of confidentiality.

Because data collection occurred during the COVID-19 pandemic, WHO (2020) ethical standards for research during public health emergencies (World Health Organisation 2020) were followed. The research team was provided with face masks and pocket sanitisers for use during fieldwork.

Variables and measures

Outcome variable

Parent–child communication about SRH was measured over the last 6 months. Recent parent–child communication about SRH was measured by means of responses to binary questions (1 = Yes, 0 = No) in relation to each of the following indicators:

- Physical or sexual development;
- Abstinence from sex or when it is right to have sex;

- Avoid or report bad touches (inappropriate touching);
- Circumstances under which it is possible to conceive;
- Preventing conception;
- Condom use;
- Sexually transmitted diseases;
- HIV and AIDS; and
- How to handle sexual pressure.

Responses to each of the questions were 'Yes' or 'No'. A respondent who answered 'Yes' to any of the questions was coded as 'Yes' – had had a recent discussion with parents about SRH issues, otherwise 'No' – had not have a recent discussion with parents about SRH issues.

Explanatory variables

Explanatory variables included demographic (sex, age and marital status), socio-economic factors (education, residence, religion, current employment status, having a radio, television or mobile phone) and behavioural variables (STI experience, whether parents talk about abstinence from sex), and family support (Zimet et al. 1988). By 'STI experience', we referred to whether someone had ever had an STI. It should be noted that, in this study, we were interested in discussion between children and their parents (either one parent or both parents).

The family support scale had four questions as follows: a) My family really tries to help me; b) I get the emotional help and support I need from my family; c) I can talk about my problems with my family and d) My family is willing to help me make decisions. The responses to these four measures were coded so that higher scores indicated higher levels of family support (Zimet et al. 1988; Sales et al. 2008). We generated row totals for all variables (a, b, c and d) for each respondent. The maximum score was 20, and the minimum score was 4. We then generated the mean score for all respondents that was used as a cut-off – 14. Respondents with a total score of 14 or less had lower levels of support, while respondents with a total score of 15 or more had higher levels of support. In this paper, 'family' includes both nuclear (mother, father and children) and extended (grandparents, aunts/uncles, and cousins) family types (Georgas et al. 2001).

Data management and analysis

All the tools used in the study were pre-tested in another border community that was not included in the study. Frequency distributions, Chi-square tests and multivariable logistic regression models were used. We tested at 5%, 1% and 0.1% level of significance. Regression analyses were conducted to identify the determinants of parent-child communication about SRH in eastern Uganda. Statistical analysis was conducted using STATA version 15 (StataCorp 2017).

Ethical considerations

This study received ethical review and clearance by the TASO Research and Ethics Committee (approval number:TASOREC/003/2021-UG-REC-009) and approved, cleared

and registered by the Uganda National Council for Science and Technology (UNCST registration number SS748ES). Permission to conduct the study was obtained from district leaders prior to approaching participants. Participation in the study was voluntary. We obtained verbal assent to conduct the study from all children or minors, in addition to parental approval. However, mature, or emancipated minors (married, pregnant, have children or earn a living or lead an independent life) provided individual verbal consent (without a parent) before the interview. Prospective participants were assured of confidentiality.

Results

Characteristics of the sample

Table 1 shows the distribution of children. The majority of the children lived in rural areas (93%), were not married (98%) and were enrolled in school (92%). More than three-quarters (76%) of them had never had sex, did not report STIs (77%), and had high levels of family support (63%). About half of the children (same proportion of children) were female, in the age group 10–14 years and came from households that did not own a radio (52%). Seven children out of every 10 had received primary education. Most children were Catholic (40%), were from households that did not own a television (84%), had a mobile phone (87%) and had not talked to their parents about abstinence from sex (53%).

Prevalence of recent parent-child communication and SRH topics discussed

The prevalence of parent–child communication on SRH was estimated to be 61%. Figure 2 shows the topics discussed by parents with their children (as reported by children). Frequently discussed topics were abstinence (47%) followed by HIV and AIDS (45%), while contraception (9%) and condom use (13%) were the least discussed.

Association between selected factors and recent parent-child communication about SRH

Table 2 shows the relationship between recent parent–child communication about SRH. Factors associated with recent parent–child communication about SRH included place of residence (8.402, 0.004), age (15.673, 0.000), religion (9.449, 0.024), ownership of a mobile phone (7.448, 0.006), employment status (7.781, 0.005), ease in discussing SRH (233.614, 0.000), family support (18.200, 0.000), and study district (32.496, 0.000). Parent–child communication about SRH was higher among children living in urban areas (82%), those aged 15–19 years (70%), Catholic children (67%), children from households that owned a mobile phone (64%), those whose parents worked in the agricultural or casual sector (73%), with ease in discussing SRH (90%), who received higher family support (68%) and who came from Tororo (73%).

Table 1. Frequency distribution of sampled children.

Variable	Frequency (n)	Percent (%)
Sex		
Male	289	48.2
Female	311	51.8
Age		
Mean age = 14 years; SD = 2 years		
10–14	314	52.3
15–17	286	47.7
Marital status		
Never married	588	98.0
Ever married	12	2.0
Place of residence		
Urban	44	7.3
Rural	556	92.7
Goes to school		
No	46	7.7
Yes	554	92.3
Highest level of education		
No education	86	14.3
Primary	448	74.7
Secondary or tertiary	66	11.0
Religion		
Catholic	239	39.8
Anglican	203	33.8
Pentecostal	128	21.3
Muslim or others	30	5.0
Household owns a radio		
No	313	52.2
Yes	287	47.8
Household owns a television		
No	505	84.2
Yes	95	15.8
Household owns a mobile phone		
No	80	13.3
Yes	520	86.7
Current employment status		
Agriculture/craft/casual	111	18.5
Student	489	81.5
Ever had sex		
No	455	75.8
Yes	145	24.2
Self-reported STI experience		
No	463	77.2
Yes	137	22.8
Family support		
Lower	221	36.8
Higher	379	63.2
Talk to parents about abstinence from sex		
No	316	52.7
Yes	284	47.3
Study district		
Busia	300	50.0
Tororo	300	50.0
Total	600	100

Determinants of parent–child communication on SRH among children

Table 3 shows the determinants of parent–child communication on SRH issues. Recent discussion was more likely to happen among children living in urban areas (OR = 4.88; 95% CI = 1.79–13.33), boys and young men (OR = 1.84; 95% CI = 1.13–3.00), those aged 15–19 years (OR = 2.59; 95% CI = 1.51–4.46) and among children from households that

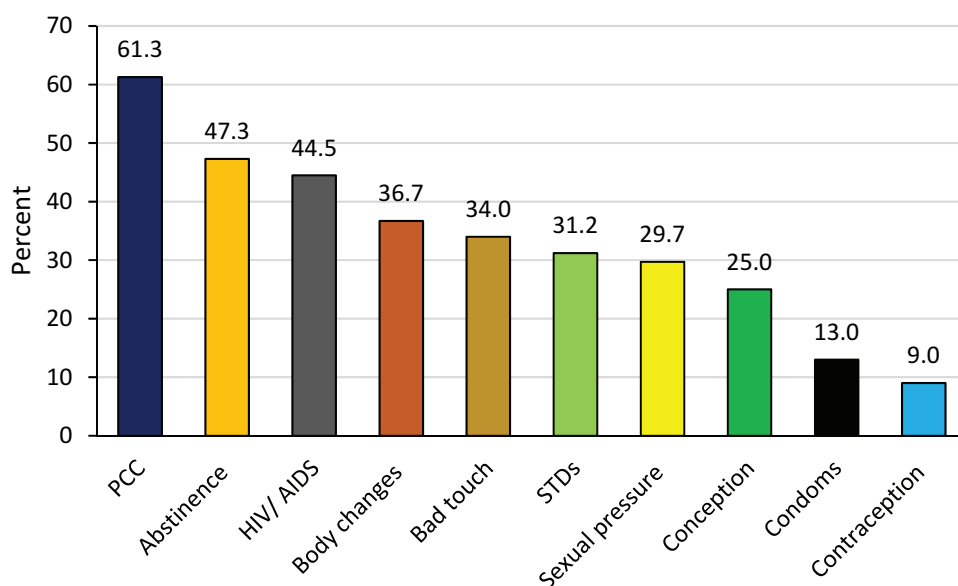


Figure 2. Discussed SRH topics with parents in the last 6 months.

owned a mobile phone (OR = 2.11; 95% CI = 1.05–4.21) than their counterparts. Recent parent–child communication about SRH issues was also higher among children who were comfortable discussing SRH issues (OR = 27.12; 95% CI = 16.02–45.89) and children from Tororo district (OR = 2.34; 95% CI = 1.36–4.01). Recent parent–child communication about SRH was lower among Muslims (OR = 0.33; 95% CI = 0.11–0.99) than Catholics.

Discussion

This study aimed to estimate the prevalence of parent–child communication about SRH and identify the factors associated with parent–child communication about SRH. Six out of 10 children (61%) reported parent–child communication about SRH with their parents in the last 6 months. This finding was unexpected and challenges the notion that parent–child communication about SRH is taboo.

Discussion about SRH issues was significantly associated with living in an urban area, being in the 15–17 year age group, being a boy or a young man, the household owning a phone, being comfortable discussing SRH issues with parents and coming from Tororo district. Conversely, Muslim children were less likely to discuss SRH issues with parents compared to Christians.

Surprisingly, male children were more likely to engage in parent–child communication about SRH issues than their female counterparts. However, this finding is contrary to those in previous studies which have suggested that in parent–child communication the focus is on girls who are considered more vulnerable than boys (Mbachu et al. 2020; Bastien, Kajula, and Muhwezi 2011). Prior studies have also tended to show that more parents talk with their daughters than with their sons about SRH issues

Table 2. Association between selected factors and recent (last 6 months) parent–child communication about SRH among children in Busia and Tororo (computed).

Variable	Discussed SRH with parents in the last 6 months		Chi-Square (<i>p</i> -value)
	No	Yes	
Total	38.7 (232)	61.3 (368)	
Sex			0.086 (0.769)
Male	38.1 (110/289)	61.9 (179/289)	
Female	39.2 (122/311)	60.8 (189/311)	
Age			15.673 (0.000***)
10–14	46.2 (145/314)	53.8 (169/314)	
15–17	30.4 (87/286)	69.6 (199/286)	
Marital status			0.663 (0.415)
Never married	38.4 (226/588)	61.6 (362/588)	
Ever married	50.0 (6/12)	50.0 (6/12)	
Place of residence			8.402 (0.004**)
Urban	18.2 (8/44)	81.8 (36/44)	
Rural	40.3 (224/556)	59.7 (332/556)	
Go to school			0.486 (0.486)
No	43.5 (20/46)	56.5 (26/46)	
Yes	38.3 (212/554)	61.7 (342/554)	
Highest level of education			3.166 (0.205)
No education	30.2 (26/86)	69.8 (60/86)	
Primary	40.4 (181/448)	59.6 (267/448)	
Secondary or tertiary	37.9 (25/66)	62.1 (41/66)	
Religion			9.449 (0.024*)
Catholic	32.6 (78/239)	67.4 (161/239)	
Anglican	46.8 (95/203)	53.2 (108/203)	
Pentecostal	37.5 (48/128)	62.5 (80/128)	
Muslim or others	36.7 (11/30)	63.3 (19/30)	
Household own a radio			0.027 (0.870)
No	39.0 (122/313)	61.0 (191/313)	
Yes	38.3 (110/287)	61.7 (177/287)	
Household own a television			0.735 (0.391)
No	39.4 (199/505)	60.6 (306/505)	
Yes	34.7 (33/95)	65.3 (62/95)	
Household own a mobile phone			7.448 (0.006**)
No	52.5 (42/80)	47.5 (38/80)	
Yes	36.5 (190/520)	63.5 (330/520)	
Current employment status			7.781 (0.005**)
Agriculture/craft/casual	27.0 (30/111)	73.0 (81/111)	
Student	41.3 (202/489)	58.7 (287/489)	
Comfortable discussing SRH issues			233.614 (0.000***)
No	71.5 (198/277)	28.5 (79/277)	
Yes	10.5 (34/323)	89.5 (289/323)	
Ever had sex			2.413 (0.120)
No	36.9 (168/455)	63.1 (287/455)	
Yes	44.1 (64/145)	55.9 (81/145)	
Self-reported STI experience			3.212 (0.073)
No	40.6 (188/463)	59.4 (275/463)	
Yes	32.1 (44/137)	67.9 (93/137)	
Family support			18.200 (0.000***)
Lower	49.8 (110/221)	50.2 (111/221)	
Higher	32.2 (122/379)	67.8 (257/379)	
Study district			32.496 (0.000***)
Busia	50.0 (150/300)	50.0 (150/300)	
Tororo	27.3 (82/300)	72.7 (218/300)	

Note: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Table 3. Multivariate results.

Variable	Discussed in last 6 months	
	Odds	95% CI
Sex (RC =female)		
Male	1.84*	1.13–3.00
Age (RC = 10–14)		
15–17	2.59***	1.51–4.46
Place of residence (RC = rural)		
Urban	4.88**	1.79–13.33
Go to school (RC = yes)		
No	0.60	0.22–1.65
Highest level of education (RC = no education)		
Primary	1.18	0.46–3.00
Secondary or tertiary	0.59	0.17–2.06
Religion (RC = Catholic)		
Anglican	0.62	0.36–1.07
Pentecostal	1.56	0.82–2.96
Muslim or others	0.33*	0.11–0.99
Household own a radio (RC = no)		
Yes	1.31	0.80–2.13
Household own a mobile phone (RC = no)		
Yes	2.11*	1.05–4.21
Current employment status (RC = student)		
Agriculture/craft/casual	1.97	0.73–5.34
Comfortable discussing SRH issues (RC = no)		
Yes	27.12***	16.02–45.89
Self-reported STI experience (RC =no)		
Yes	1.06	0.60–1.87
Ever had sex (RC = no)		
Yes	0.76	0.41–1.39
Family support (RC =lower)		
Higher	1.04	0.64–1.68
Study district (RC = Busia)		
Tororo	2.34**	1.36–4.01

Note: * = $p < 0.05$; ** = $p < 0.01$; *** = $p < 0.001$.

Ease of discussing SRH issues is important, particularly in contexts where discussion of topics to do with sexuality is restrained. Children who were comfortable discussing SRH with their parents were more likely to do so. Ease in discussing SRH issues implies a good child–parent relationship. In the current study, we established that both children and parents commonly discussed sexual abstinence, HIV and AIDS and bodily changes, while the least discussed topics were contraception and condoms. These results may partly be explained by the fact that many African parents have conservative attitudes towards adolescent sex and are less likely to communicate with their children about condoms and contraceptives which connote sex – an embarrassing and uncomfortable topic as opposed to preventing HIV and sexual abstinence.

Conclusions

The main objectives of this study were to estimate the prevalence of parent–child communication about STH and to identify its determinants in border districts of Busia and Tororo. The findings indicate that parent–child communication is still far from universal in the border districts studied and reveal that parent–child communication

was positively associated with residence in an urban area, being male, being older (15–19 years) and living in a household with a mobile phone.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

We received funding from the Government of Uganda in support of this study through the Makerere University Research and Innovations Fund

ORCID

Peter Kisaakye  <http://orcid.org/0000-0003-1859-2078>

Elizabeth Kwagala  <http://orcid.org/0000-0002-1095-0072>

Informed consent statement

Verbal consent and assent were obtained from subjects involved in the study.

Data availability statement

The datasets used in this study are available from the corresponding author on request.

References

- Akers, A. Y., C. L. Holland, and J. Bost. 2011. "Interventions to Improve Parental Communication about Sex: A Systematic Review." *Pediatrics* 127 (3): 494–510. doi:[10.1542/peds.2010-2194](https://doi.org/10.1542/peds.2010-2194).
- Apondi, R., R. Bunnell, J. Paul Ekwaru, D. Moore, S. Bechange, K. Khana, R. King, J. Campbell, J. Tappero, and J. Mermin. 2011. "Sexual Behavior and HIV Transmission Risk of Ugandan Adults Taking Antiretroviral Therapy: 3 Year follow-up." *AIDS* 25 (10): 1317–1327. doi:[10.1097/QAD.0b013e328347f775](https://doi.org/10.1097/QAD.0b013e328347f775).
- Ashcraft, A. M., and P. J. Murray. 2017. "Talking to Parents about Adolescent Sexuality." *Pediatric Clinics* 64 (2): 305–320. doi:[10.1016/j.pcl.2016.11.002](https://doi.org/10.1016/j.pcl.2016.11.002).
- Bastien, S., L. J. Kajula, and W. W. Muhwezi. 2011. "A Review of Studies of Parent-Child Communication about Sexuality and HIV/AIDS in sub-Saharan Africa." *Reproductive Health* 8 (1): 25. doi:[10.1186/1742-4755-8-25](https://doi.org/10.1186/1742-4755-8-25).
- Bechange, S., R. Bunnell, A. Awor, D. Moore, R. King, J. Mermin, J. Tappero, K. Khana, and B. Bartholow. 2010. "Two-Year Follow-Up of Sexual Behavior among HIV-Uninfected Household Members of Adults Taking Antiretroviral Therapy in Uganda: No Evidence of Disinhibition." *AIDS & Behavior* 14 (4): 816–823. doi:[10.1007/s10461-008-9481-2](https://doi.org/10.1007/s10461-008-9481-2).
- Blake, S. M., L. Simkin, R. Ledsky, C. Perkins, and J. M. Calabrese. 2001. "Effects of a Parent-Child Communications Intervention on Young Adolescents' Risk for Early Onset of Sexual Intercourse." *Family Planning Perspectives* 33 (2): 52–61. doi:[10.2307/2673750](https://doi.org/10.2307/2673750).
- Dessie, Y., Y. Berhane, A. Worku, and J. L. Wallander. 2015. "Parent-Adolescent Sexual and Reproductive Health Communication Is Very Limited and Associated with Adolescent Poor Behavioral Beliefs and Subjective Norms: Evidence from a Community Based Cross-Sectional Study in Eastern Ethiopia." *PLOS ONE* 10 (7): e0129941. doi:[10.1371/journal.pone.0129941](https://doi.org/10.1371/journal.pone.0129941).

- Development Expertise Centre. "Get Up Speak Out (GUSO) Project." <https://decethiopia.org/program/gender-life-skills-development/get-up-speak-out-guso-project/> Accessed 8 October 2022.
- Georgas, J., K. Mylonas, T. Bafiti, Y. H. Poortinga, S. Christakopoulou, C. Kagitcibasi, K. Kwak, et al. 2001. "Functional Relationships in the Nuclear and Extended Family: A 16-culture Study." *International Journal of Psychology* 36 (5): 289–300. doi:10.1080/00207590143000045.
- Hallett, T. B., J. Aberle-Grasse, G. Bello, L. M. Boulos, M. P. A. Cayemittes, B. Cheluget, J. Chipeta, et al. 2006. "Declines in HIV Prevalence Can Be Associated with Changing Sexual Behaviour in Uganda, Urban Kenya, Zimbabwe, and Urban Haiti." *Sexually Transmitted Infections* 82 (suppl 1): i1. doi:10.1136/sti.2005.016014.
- International Planned Parenthood Federation. "Get up Speak Out for Youth Rights." <https://www.ippf.org/get-up-speak-out-youth-rights> Accessed 8 October 2022.
- Kamangu, A. A., M. R. John, and S. J. Nyakoki. 2017. "Barriers to Parent-Child Communication on Sexual and Reproductive Health Issues in East Africa: A Review of Qualitative Research in Four Countries." *Journal of African Studies and Development* 9 (4): 45–50. doi:10.5897/JASD2016.0410.
- Katahoire, A. R., C. Banura, W. Winstons Muhwezi, S. Bastien, A. Wubs, K.-I. Klepp, and L. Edvard Aarø. 2019. "Effects of a School-Based Intervention on Frequency and Quality of Adolescent-Parent/Caregiver Sexuality Communication: Results from a Randomized-Controlled Trial in Uganda." *AIDS & Behavior* 23 (1): 91–104. doi:10.1007/s10461-018-2249-4.
- Mahuro, G. M., N. Hungi, and S. Lamb. 2016. "Parental Participation Improves Student Academic Achievement: A Case of Iganga and Mayuge Districts in Uganda." *Cogent Education* 3 (1): 1264170. doi:10.1080/2331186X.2016.1264170.
- Manu, A. A., C. Jonathan Mba, G. Quansah Asare, K. Odoi-Agyarko, and R. Kofi Oduro Asante. 2015. "Parent-Child Communication about Sexual and Reproductive Health: Evidence from the Brong Ahafo Region, Ghana." *Reproductive Health* 12 (1): 16. doi:10.1186/s12978-015-0003-1.
- Mbachu, C. O., I. Clara Agu, I. Eze, C. Agu, U. Ezenwaka, N. Ezumah, and O. Onwujekwe. 2020. "Exploring Issues in Caregivers and Parent Communication of Sexual and Reproductive Health Matters with Adolescents in Ebonyi State, Nigeria." *BMC Public Health* 20 (1): 77. doi:10.1186/s12889-019-8058-5.
- Miller, K. S., B. A. Kotchick, S. Dorsey, R. Forehand, and A. Y. Ham. 1998. "Family Communication about Sex: What Are Parents Saying and Are Their Adolescents Listening?" *Family Planning Perspectives* 30 (5): 218–235. doi:10.2307/2991607.
- Morris, C. N., S. R. Morris, and A. G. Ferguson. 2009. "Sexual Behavior of Female Sex Workers and Access to Condoms in Kenya and Uganda on the Trans-Africa Highway." *AIDS & Behavior* 13 (5): 860–865. doi:10.1007/s10461-008-9431-z.
- Muhwezi, W. W., A. Ruhweza Katahoire, C. Banura, H. Mugooda, D. Kwesiga, S. Bastien, and K.-I. Klepp. 2015. "Perceptions and Experiences of Adolescents, Parents and School Administrators Regarding Adolescent-Parent Communication on Sexual and Reproductive Health Issues in Urban and Rural Uganda." *Reproductive Health* 12 (1): 110. doi:10.1186/s12978-015-0099-3.
- Ojebuyi, B. R., A. Francis Fagbamigbe, and O. Olugbenga Akinola. 2019. "Prevalence of and Factors Influencing Parent-Child Communication about HIV/AIDS, and Sexual and Reproductive Health Issues in Nigeria." *SAGE Open* 9 (1): 2158244019833880. doi:10.1177/2158244019833880.
- Phillips, S., and M. Mychailyszyn. 2021. "A Review of Parent-Child Interaction Therapy (PCIT): Applications for Youth Anxiety." *Children and Youth Services Review* 125: 105986. doi:10.1016/j.childyouth.2021.105986.
- Poulsen, M. N., K. S. Miller, C. Lin, A. Fasula, H. Vandenhoudt, S. C. Wyckoff, J. Ochura, C. O. Obong'o, and R. Forehand. 2010. "Factors Associated with Parent-Child Communication about HIV/AIDS in the United States and Kenya: A Cross-Cultural Comparison." *AIDS & Behavior* 14 (5): 1083–1094. doi:10.1007/s10461-009-9612-4.
- Randall, S., E. Coast, P. Antoine, N. Compaore, F.-B. Dial, A. Fanghanel, S. Ba Gning, B. Gnoumou Thiombiano, V. Golaz, and S. Ojiambo Wandera. 2015. "UN Census "Households" and Local Interpretations in Africa since Independence." *SAGE Open* 5 (2): 2158244015589353. doi:10.1177/2158244015589353.

- Renzaho, A. M. N., J. K. Kamara, N. Georgeou, G. Kamanga, and M. Ciccozzi. 2017. "Sexual, Reproductive Health Needs, and Rights of Young People in Slum Areas of Kampala, Uganda: A Cross Sectional Study." *PLOS ONE* 12 (1): e0169721. doi:10.1371/journal.pone.0169721.
- Sales, J. M., R. R. Milhausen, G. M. Wingood, R. J. DiClemente, L. F. Salazar, and R. A. Crosby. 2008. "Validation of a Parent-Adolescent Communication Scale for Use in STD/HIV Prevention Interventions." *Health Education & Behavior* 35 (3): 332–345. doi:10.1177/1090198106293524.
- Seif, S. A., T. W. Kohi, and C. S. Moshiri. 2017. "Caregiver-adolescent Communication on Sexual and Reproductive Health: A Cross-sectional Study in Unguja-Tanzania Zanzibar." *BMC Public Health* 18 (1): 31. doi:10.1186/s12889-017-4591-2.
- StataCorp. 2017. *Stata Statistical Software: Release 15*. College Station, TX: StataCorp LLC.
- Twa-Twa, J. M. 1997. "The Role of the Environment in the Sexual Activity of School Students in Tororo and Pallisa Districts of Uganda." *Health Transition Review* 7: 67–81. <https://www.jstor.org/stable/40652293>
- Uganda Bureau of Statistics, and ICF. "Uganda Demographic and Health Survey 2016." <https://microdata.worldbank.org/index.php/catalog/2979#:~:text=The%202016%20Uganda%20Demographic%20and%20Health%20Survey%20%282016,Bugisu%2C%20Karamoja%2C%20Teso%2C%20Kigezi%2C%20Ankole%2C%20and%20West%20Nile%29> Accessed 8 October 2022.
- United Nations Educational Scientific and Cultural Organization. "International Technical Guidance on Sexuality Education." https://bangkok.unesco.org/sites/default/files/assets/article/Education/files/UNESCO-International-technical-guidance-on-sexuality-education_flyer%20EN.pdf#:~:text=The%20International%20technical%20guidance%20on%20sexuality%20education%20is,approaches%20for%20planning%2C%20delivering%20and%20monitoring%20CSE%20programmes Accessed 8 October 2022.
- Usonwu, I., R. Ahmad, and K. Curtis-Tyler. 2021. "Parent-adolescent Communication on Adolescent Sexual and Reproductive Health in sub-Saharan Africa: A Qualitative Review and Thematic Synthesis." *Reproductive Health* 18 (1): 202. doi:10.1186/s12978-021-01246-0.
- Wamoyi, J., A. Fenwick, M. Urassa, B. Zaba, and W. Stones. 2010. "Parent-child Communication about Sexual and Reproductive Health in Rural Tanzania: Implications for Young People's Sexual Health Interventions." *Reproductive Health* 7 (1): 6. doi:10.1186/1742-4755-7-6.
- Wang, B., B. Stanton, L. Deveaux, X. Li, V. Koci, and S. Lunn. 2014. "The Impact of Parent Involvement in an Effective Adolescent Risk Reduction Intervention on Sexual Risk Communication and Adolescent Outcomes." *AIDS Education & Prevention* 26 (6): 500–520. doi:10.1521/aeap.2014.26.6.500.
- Wight, D., and D. Fullerton. 2013. "A Review of Interventions with Parents to Promote the Sexual Health of Their Children." *Journal of Adolescent Health* 52 (1): 4–27. doi:10.1016/j.jadohealth.2012.04.014.
- World Health Organisation. "Ethical Standards for Research during Public Health Emergencies: Distilling Existing Guidance to Support COVID-19 R&D." <https://www.who.int/publications/i/item/WHO-RFH-20.1> Accessed 8 October 2022.
- Zimet, G. D., N. W. Dahlem, S. G. Zimet, and G. K. Farley. 1988. "The Multidimensional Scale of Perceived Social Support." *Journal of Personality Assessment* 52 (1): 30–41. doi:10.1207/s15327752jpa5201_2.