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ORIGINAL RESEARCH

Bridging Participation Gaps: A Community-Led Inception for Integrating Comprehensive Adolescent-Friendly Family Planning and Post-Abortion Care (CAFFP–PAC) into Primary Healthcare Facilities in Northern Uganda

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Background: Conventional top-down health interventions often exclude adolescents and community stakeholders from service design and implementation, resulting in low uptake and a mismatch with young people's needs. The CAFFP–PAC initiative in Northern Uganda sought to explore how a community-led, adolescent-centered inception process could support integration of adolescent-friendly family planning and post-abortion care into primary healthcare services.

Methods: A participatory qualitative design was employed during an inception meeting in Lira City on April 1, 2025, guided by principles of community-based participatory research and citizen science. A total of 110 purposively selected stakeholders including adolescents, youth mentors, parents, educators, health professionals, and cultural and religious leaders engaged in dialogue circles, breakout sessions, simulations, and visual storytelling to co-develop integration strategies. Data were collected through audio recordings, field notes, and participatory tools, and analyzed using Braun and Clarke's thematic analysis framework.

Results: Six themes emerged: (1) meaningful participation of adolescents and stakeholders; (2) adolescent-friendly and confidential service environments; (3) health system readiness and provider attitudes; (4) addressing socio-cultural and gender norms; (5) integration strategies for CAFFP–PAC in primary care; and (6) sustained engagement and feedback mechanisms. Adolescents emphasized safe, private, and respectful care environments, while stakeholders stressed community ownership, trust-building, and reliance on local structures. Youth mentors, cultural leaders, and school clubs were identified as key enablers for service uptake.

Conclusion: A community-led inception process centered on adolescents and local voices is feasible and essential for successful CAFFP–PAC integration in Northern Uganda. Findings highlight the need to shift from provider-centered models to inclusive, participatory approaches that leverage community assets, foster adolescent agency, and ensure sustained engagement. Such approaches are vital for enhancing service accessibility, responsiveness, and sustainability in resource-constrained settings.

Keywords: adolescents, family planning, post-abortion care, community participation, reproductive health, citizen science, gender norms, primary healthcare integration

Background

Globally, adolescents face a triple burden of sexual, reproductive, and mental health challenges. In 2025, an estimated 21 million pregnancies occurred among adolescent girls aged 15–19 in low- and middle-income countries (LMICs),

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nearly half of which were unintended—resulting in approximately 12 million births and 3.9 million unsafe abortions.[1] Sub-Saharan Africa bears a disproportionate share of this burden. Only 22% of adolescents in the region with contraceptive needs access modern methods, and of the 53 million adolescent girls in Sub-Saharan Africa, about 7.5 million have an unmet need for contraception driving some of the highest global rates of adolescent pregnancy and unsafe abortion.[2] These figures likely underestimate the crisis, as data on younger adolescents aged 10–14 remain scarce, yet available evidence suggests that their outcomes could be even worse due to higher biological vulnerability, increased stigma, and greater barriers to accessing services.[3] While these statistics illustrate the scale of the problem, less attention has been given to the theoretical underpinnings of adolescent SRH research, particularly how power dynamics, agency, and participation frameworks shape the availability and accessibility of services. This study therefore contributes by addressing both the empirical service gaps and the theoretical omission of adolescent-centered participation within SRH research. These realities highlight the urgent need for adolescent-friendly sexual and reproductive health (SRH) services that are accessible, confidential, non-judgmental, and tailored to the lived experiences of young people across all adolescent age groups.

Historically, the design and delivery of adolescent family planning (FP) and post-abortion care (PAC) services have relied heavily on top-down approaches driven largely by governments, donors, and external experts.[4] These models, while structured and resource-efficient, often exclude the very individuals they intend to serve. Adolescents and community stakeholders are rarely involved in shaping interventions, leading to mismatches between services offered and actual needs. Studies have documented how barriers such as judgmental provider attitudes, lack of confidentiality, and youth-unfriendly environments deter adolescents from accessing SRH services.[5,6] Furthermore, many interventions fail to address deeper socio-cultural and gender norms that influence adolescent behavior and access.[7] From a theoretical perspective, such top-down approaches are grounded in biomedical and service-delivery models that assume adolescents are passive recipients rather than active co-creators of health systems. By critiquing this orientation, the CAFFP–PAC initiative draws on participatory and rights-based frameworks to re-theorize adolescents as central agents in shaping SRH interventions.

Emerging global frameworks now advocate for participatory, rights-based approaches that position adolescents as active agents rather than passive beneficiaries.[8] This includes integrating citizen science where adolescents and other non-academic stakeholders participate in research and co-design solutions with gender-transformative strategies that aim to shift harmful gender norms.[9] Despite this growing recognition, few projects in Uganda have fully embraced such approaches, especially in contexts with limited infrastructure and high socio-cultural resistance. To address these gaps, the Enhancing Integration of Adolescent Family Planning and Post-Abortion Care in Northern Uganda: A Citizen Science, Gender-Transformative Approach (CAFFP–PAC) initiative was conceptualized. The project seeks to replace conventional, provider-centered models with adolescent-led, community-driven processes that center local voices and realities in the design and delivery of comprehensive FP and PAC services. Methodologically, this approach extends beyond descriptive accounts of adolescent SRH barriers by offering a structured model for operationalizing citizen science and gender-transformative theory in low-resource, post-conflict settings.

A critical component of this shift is the project inception phase, which lays the groundwork for effective implementation through stakeholder engagement, problem framing, and contextual analysis. However, inception in many projects continues to follow a conventional top-down approach driven by pre-designed frameworks, expert consultations, and desk reviews, with minimal local participation. This method, while often aligned with institutional and donor timelines, sidelines community knowledge, diminishes ownership, and reduces long-term sustainability. Recognizing these limitations, the CAFFP–PAC project held an inclusive inception meeting on April 1, 2025, in Lira. The event brought together adolescents, youth mentors, parents, teachers, local government representatives, and community-based organizations. Through this participatory process, locally rooted strategies for improving access and equity were co-developed—demonstrating the power and potential of a community-led inception model.

In Uganda, adolescent sexual and reproductive health (SRH) challenges remain severe, especially in Northern regions grappling with the lasting effects of conflict, poverty, and fragile health systems. Each year, an estimated 57,000 abortions occur among girls aged 15–19, with 63% of adolescent pregnancies reported as unintended.[10] Despite the need, only 29.9% of sexually active unmarried girls in this age group use modern contraception, leaving

a significant proportion with unmet needs.[11] In Northern Uganda, access to youth-centered SRH and post-abortion care (PAC) services is further constrained by geographic barriers, provider stigma, and cultural norms. These realities highlight the urgent need for participatory, adolescent-sensitive, and community-led approaches. By grounding its inception in such principles, the CAFFP–PAC initiative seeks to bridge service gaps, empower adolescents, and foster local ownership. This dual focus addressing service delivery while also advancing theoretical and methodological debates around participation positions the study as a contribution to both practical program design and broader SRH scholarship. This paper explores the lessons from this community-led process and their implications for designing inclusive, contextually relevant adolescent health programs in resource-limited settings.

Materials and Methods

Study Design

This study employed a participatory qualitative research design grounded in stakeholder-engaged inquiry, conducted during the inception phase of the CAFFP–PAC project. Guided by community-based participatory research and citizen science principles, the approach emphasized inclusive planning and the co-creation of interventions. Special emphasis was placed on privileging the lived experiences and perspectives of adolescents to ensure their voices directly informed the design and integration of adolescent-friendly family planning and post-abortion care services. Unlike conventional descriptive inception reports, this design was deliberately chosen to respond to the core research objective of "bridging participation gaps" by centering adolescents and community actors as co-creators rather than passive informants. The study sought to incorporate diverse perspectives, particularly those of adolescents, in identifying priorities and shaping the design of adolescent-friendly family planning and post-abortion care services in Northern Uganda. As part of the broader CAFFP–PAC initiative, an inception meeting was held to engage key stakeholders in discussions on how family planning and post-abortion care services can be effectively integrated into primary healthcare. Insights from adolescents were explicitly analyzed and triangulated with other stakeholder inputs to ensure they guided study conclusions and recommendations.

Study Setting

The inception meeting was held at Margarita Hotel in Lira City, located in the Lango sub-region of Northern Uganda. Lira City serves as a major urban center in the region and is home to a mix of urban and peri-urban populations, making it a strategic location for convening stakeholders from both rural and urban healthcare settings. The region has experienced significant public health challenges, particularly among adolescents, including limited access to comprehensive sexual and reproductive health services.[12] The meeting venue was selected for its accessibility and capacity to accommodate diverse participants. This inclusive setting provided a conducive environment for open dialogue, shared learning, and collaborative planning toward the integration of adolescent-friendly family planning and post-abortion care services within the region's primary healthcare system.

Participants

A total of 110 participants (58 males, 52 females) were purposively selected to ensure diverse representation across age, gender, and institutional roles, with attention to gender balance within subgroups such as teachers, mentors, and community leaders. The selection strategy emphasized inclusion of both institutional and community actors involved in SRH and post-abortion care services. Among the participants, 25 adolescents aged 10–19 were intentionally oversampled relative to other stakeholders to privilege their perspectives. Other participants included representatives from Lira University (22), Lira City and District local government (19), community-based organizations such as GLOFORD Uganda (9), teachers and parents (4), youth mentors (6 master coaches), clan leaders (5), religious leaders (4), and media professionals (5). This combination allowed triangulation while maintaining adolescent voices at the center.

Data Collection Approach

The inception meeting, held on April 1, 2025, at Margarita Hotel in Lira City, served as the central platform for data collection. To reduce power dynamics and enhance adolescent engagement, storytelling and creative participatory methods (role-plays, poem recitations, skits) were used alongside traditional presentations, replacing or supplementing PowerPoint formats for younger participants. Techniques included stakeholder mapping and power analysis, small group discussions, brainstorming sessions with idea walls, anonymous feedback cards, plenary reflections, and interactive Q&A panels. Facilitators and rapporteurs documented proceedings through detailed flipchart notes and field observations. Visual aids such as PowerPoint presentations and short video documentaries were used to introduce key issues around adolescent SRH and PAC. These methods were specifically tailored to ensure adolescents could express their lived experiences without being overshadowed by institutional participants.

Participatory techniques emphasized experiential learning and empathy-building. Breakout sessions featured access mapping and simulation exercises in which participants visualized the physical, social, and cultural barriers adolescents face when seeking SRH and PAC services. Role-playing activities, including poem recitations and drama skits, allowed adolescents to directly represent their experiences. This approach enabled adolescents to actively shape discussion themes and ensured their perspectives informed the study's findings. Expert panelists and district health officials contextualized discussions by presenting local data and service gaps, stimulating active dialogue around evidence-based solutions. Simulation exercises and role-plays were systematically analyzed by transcribing verbal outputs, observing group dynamics, and coding behaviors alongside textual data, ensuring methodological rigor.

Procedure

The inception session began with an opening presentation by the principal and co-investigators, who provided a comprehensive overview of the CAFFP–PAC project. They outlined the project's objectives, scope, ethical safeguards, and anticipated outcomes to ensure that all participants understood the purpose of the study and their key role in shaping strategies for integrating CAFFP–PAC into primary healthcare facilities in Northern Uganda. This was followed by a series of structured participatory activities, including rotating dialogue circles, breakout sessions, and plenary discussions. Adolescents' contributions were actively solicited in each session and given dedicated time and space to ensure they were not overshadowed by adult stakeholders. Data were collected through audio recordings (with participants' consent), supplemented by detailed notes taken by trained research assistants. Structured templates were used to capture outputs from role-plays, simulations, and storytelling, which were then thematically coded alongside traditional qualitative data to ensure systematic integration. The session concluded with a reflective plenary, where emerging themes were synthesized, and participants reaffirmed their commitment to continued collaboration throughout the project's implementation.

Prior to the participatory engagements, a set of ground rules was established to foster a respectful, inclusive, and productive environment. These principles included active listening, respectful interaction, open and honest sharing of personal and community experiences, and a commitment to staying focused on adolescent sexual and reproductive health and rights (SRHR). A collaborative spirit was emphasized to encourage shared ownership of outcomes, as highlighted by the Principal Investigator. The discussion was further grounded in evidence, with statistical insights presented by the Lira District and City Biostatistician and other experts to guide and enrich participant contributions with local data. These guidelines shaped the tone of the session, ensuring that all voices especially, those of adolescents and other marginalized groups were meaningfully included in the co-creation process and that the dialogue remained solution-oriented and contextually relevant.

Data Analysis

All audio recordings and field notes from the inception meeting were transcribed verbatim and analyzed using Braun and Clarke's six-phase thematic analysis framework,[13] ensuring a systematic and rigorous interpretation of qualitative data. The process began with familiarization and open coding to identify recurring patterns, key phrases, and emerging ideas across the data. Codes emerging from adolescents' contributions were flagged and given priority during theme

development to ensure their perspectives shaped conclusions. These initial codes were then organized into broader categories through axial coding to generate meaningful themes related to the integration of CAFFP–PAC into primary healthcare facilities. One co-author (AK) conducted an early review of the transcripts to identify gaps and refine the coding frame, ensuring consistency and depth in data interpretation. Two researchers (MKA and SU) independently coded the data, and any differences in theme development or code application were resolved through collaborative dialogue. Analytical attention was particularly paid to codes derived from adolescent contributions, ensuring their perspectives were privileged in theme development and interpretation. Themes were not only identified based on their frequency of occurrence but also on the richness and relevance of supporting quotes, which were included to amplify participants' authentic voices and provide contextual depth.

Special attention was given to variation across stakeholder groups, including adolescents, health workers, local leaders, educators, and policymakers. Triangulation of transcripts, field notes, and audio recordings ensured comprehensive understanding of adolescent and community perspectives. Outputs from participatory exercises (role-plays, simulations, story-based activities) were coded thematically and triangulated with transcript data, ensuring comprehensive interpretation. A virtual validation session with adolescents and other stakeholders further confirmed that the themes accurately reflected adolescents' lived experiences. Audit trails documented all analysis steps, supporting transparency and confirmability. While this manuscript focuses on the inception phase, the CAFFP–PAC project is part of a multi-year initiative, with subsequent phases dedicated to implementing and evaluating interventions to observe long-term outcomes.

Ethical Considerations

Although the inception meeting was primarily a community engagement activity and did not initially require formal ethical clearance, the broader study protocol was subsequently reviewed and approved by the Lira University Research Ethics Committee (LUREC-2024-309) and registered with the Uganda National Council for Science and Technology (UNCST-HS6030ES). The study was conducted in full compliance with the principles outlined in the Declaration of Helsinki. Verbal informed consent was obtained from all adult participants, while assent was secured from adolescent participants in the presence of a parent or guardian to ensure the ethical inclusion of minors. The verbal informed consent process was reviewed and approved by the Lira University Research Ethics Committee as acceptable for this study. The consent process also explicitly included permission for the use of anonymized responses and direct quotes in publications. Participants were assured of confidentiality, voluntary participation, and their right to withdraw from discussions at any stage without any consequences. To strengthen ethical practice, invitations were formally issued through official letters and followed up with phone calls to ensure clarity and informed participation. Facilitators were trained on child safeguarding protocols and ethical engagement with diverse stakeholders, reinforcing the commitment to uphold national and international standards for community-based participatory research. A safe, respectful, and non-judgmental environment was intentionally created to foster open dialogue, particularly among vulnerable groups such as adolescents and teen mothers. Additionally, to address the potential for re-traumatization during discussions of sensitive experiences such as abortion, trained facilitators were available to provide immediate emotional support, and participants were offered referrals to qualified psychosocial counselors and adolescent-friendly health services as needed. This measure was included to ensure psychological well-being and ethical handling of distress during the process.

Results

Demographic Information

The inception meeting convened 110 participants, including 58 males and 52 females, who were purposively selected to represent a wide range of age groups, institutional affiliations, and lived experiences relevant to adolescent sexual and reproductive health and rights (SRHR) in Northern Uganda. This diverse group included 25 adolescents aged 10 to 19 years, encompassing both in-school and out-of-school youth from urban and rural settings. Adult participants comprised representatives from Lira University (22), local government health and education offices at the district and city levels (19), members of the community-based organization GLOFORD Uganda (9), teachers and parents (4), as well as youth

mentors, including six master coaches specialized in adolescent engagement. Additionally, the meeting involved cultural leaders (5), religious leaders (4), and media professionals (5). By purposively involving multiple sectors, the study goes beyond traditional health facility assessments to integrate the voices of those directly affected, demonstrating a participatory, community-led model for service design.

Themes and Subthemes

Thematic content analysis revealed six major themes that captured the diverse perspectives and lived experiences of participants regarding the integration of CAFFP–PAC into primary healthcare services in Northern Uganda. These themes reflect a broad consensus on the importance of inclusive, community-driven approaches and the need to center adolescents in both the design and delivery of services. Importantly, the findings highlight innovative mechanisms for participatory co-design, peer engagement, and culturally sensitive integration that contribute new insights to the field.

Theme 1: Meaningful Participation of Adolescents and Community Stakeholders

Narratives from participants revealed a shared recognition of the value of meaningful participation, especially involving adolescents and community actors not only as recipients but as co-designers and decision-makers in the development and integration of CAFFP–PAC services. Participants emphasized that past interventions often excluded the very people most affected by the outcomes—adolescents themselves. Under this theme, three subthemes highlight actionable strategies to enhance adolescent voice, leverage community structures, and utilize youth mentors as change agents.

Subtheme 1.1: Adolescents as Active Agents in Program Design

Participants strongly criticized the widespread use of top-down approaches in designing reproductive health programs, particularly those concerning adolescents. Many shared frustrations about being left out of conversations that directly affected their lives, explaining that decisions were often made by adults or external actors who lacked understanding of their specific needs and daily challenges. They emphasized that their involvement from the earliest stages of program design not merely as token participants, but as true partners results in services that are more relevant, accessible, and effective. One female adolescent reflected:

> Usually, we just hear about these programs after everything is already decided… But during this meeting, when they involved us from the start, asking what we really go through, we felt like we could help shape the program to fit our lives better. We know what works for us, what challenges we face, and how we want to be treated. It makes a big difference when they listen and act on what we say.

Her words emphasize early and authentic engagement, allowing adolescents to actively shape services and enhancing dignity, empowerment, and ownership.

A male adolescent added:

> Sometimes we feel like adults just see us as small children… But here, when they sat with us, asked for our opinions, and truly listened, it felt different. The questions they asked were serious, and we could tell they wanted to understand—not just to hear us talk but to use our ideas. It made me feel like we were not just children, but people who have something important to contribute to fixing these problems in our communities.

Together, these voices advocate for a departure from superficial consultations toward sustained co-creation, strengthening program relevance, uptake, and impact.

Subtheme 1.2: Inclusion of Community Structures for Ownership

Participants emphasized the vital role that existing community structures such as Village Health Teams (VHTs), school health clubs, and parent-teacher associations (PTAs) could play in ensuring sustainability and effectiveness of CAFFP–PAC programs. These structures provide trusted channels for mobilization, education, and follow-up, bridging gaps between health services and adolescents.

> The Village Health Teams and school health clubs already know these young people very well…sometimes even better than health workers. If we engage them more, they can identify adolescents who may need help and follow up respectfully and consistently, noted a teacher.

A religious leader added:

> Religious groups and PTAs are already trusted by parents and youth alike. If equipped with proper training about family planning and post-abortion care, we can guide young people to the right services—without judgment.

Integrating these community structures enhances local ownership, accountability, and sustainability, ensuring interventions extend beyond healthcare facilities.

Subtheme 1.3: Youth Mentors as Trusted Connectors

Youth mentors emerged as critical links between adolescents and health providers, leveraging relatability, cultural understanding, and shared experiences to reduce fear and stigma.

> They come from our communities, know what it feels like to face judgment, and can link us to services without embarrassment…sometimes it's easier to ask them questions than an adult or health worker, explained a male adolescent.

A female youth mentor emphasized:

> They see us as friends or older siblings, not authority figures. With training, we can guide them responsibly and help them get the right services. It's not just about talking; it's about walking with them through the whole process and making sure they feel safe.

Participants highlighted that formally integrating youth mentors into CAFFP–PAC could significantly increase adolescent engagement, utilization, and satisfaction.

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Theme 2: Creating Adolescent-Friendly and Confidential Service Environments

A central theme that emerged from the data was the critical importance of creating health service environments that are physically, emotionally, and socially welcoming to adolescents. Participants emphasized that even when services are technically available, many young people avoid seeking care due to uninviting clinic atmospheres, fears about confidentiality breaches, and the lack of private time with providers. Adolescents and service providers alike underscored the value of redesigning health facilities to make them more youth-centered, supportive, and respectful of young people's unique developmental and psychosocial needs.

Subtheme 2.1: Importance of Safe, Youth-Centered Spaces

Participants in the study emphasized that the physical environment of health facilities plays a significant role in shaping adolescents' comfort levels, trust, and willingness to seek sexual and reproductive health services, particularly family

planning and post-abortion care. Adolescents described how many existing clinics feel cold, clinical, and adult-centered, with sterile colors, intimidating signage, or unfriendly reception areas, which created a sense of fear and alienation.

In contrast, they shared positive responses to spaces that were intentionally designed to be youth-friendly featuring bright colors, youth-relevant posters, murals, informational materials tailored for adolescents, and visual cues that reflect inclusivity and acceptance. One adolescent participant vividly described how clinic ambiance affects their experience:

> When we walk into some clinics, it feels like we're entering a place meant only for older people. But when a clinic has bright colors, friendly posters about youth health, or even simple artwork, it feels like we are welcome there. It's not just about the services—they need to show us through the environment that we are accepted and understood.

Adding to this, a female teacher recounted a powerful observation from one of her students:

> One of the girls told me after visiting the clinic that the waiting area looked like a punishment room. She said it felt like she was being judged just by sitting there, and it scared her from wanting to go back. That really struck me because if young people feel that uncomfortable just waiting, how can we expect them to come back for services that are already difficult to talk about?

Participants collectively emphasized that youth-centered design elements such as colorful seating areas, dedicated adolescent corners, youth-friendly educational materials, and posters showing positive images of young people send a powerful signal that adolescents are not only tolerated but valued and welcomed. Such design changes can reduce anxiety, boost confidence, and encourage repeat visits, particularly for sensitive services like CAFFP–PAC. Moreover, participants stressed that these changes should not be superficial but part of broader efforts to create respectful, adolescent-responsive services where young people feel physically and emotionally safe.

Subtheme 2.2: Ensuring Privacy and Confidentiality

Across all stakeholder groups including adolescents, parents, community leaders, and health workers, privacy and confidentiality emerged as non-negotiable components of adolescent-responsive sexual and reproductive health services, particularly for sensitive services such as family planning and post-abortion care. Participants stressed that without robust protections for privacy, adolescents would simply avoid seeking care out of fear of exposure, judgment, or gossip within their communities.

Adolescents, especially in small, tightly connected rural settings, expressed acute anxiety about being seen or overheard when accessing services. Many shared that the fear of being recognized by neighbors, relatives, or peers at health facilities often outweighed their desire to seek needed care.

> In our village, everyone knows each other's business. If people see you going to the clinic for family planning, word spreads fast. Sometimes it feels safer not to go at all than to risk being talked about. — Female adolescent, rural community

A health worker participating in a plenary discussion highlighted this barrier, emphasizing the need for structural changes within health facilities:

> Sometimes we forget that privacy is not just about closing a door—it's about creating a safe environment where a girl can speak without fear of being seen or overheard. In our clinics, we need to set aside spaces where adolescents can talk freely. Even having a dedicated room where she knows nobody can walk in or listen would make a big difference. It's not just about comfort; it's about whether she will even come back.

Similarly, a rural parent offered a candid reflection on why many adolescents avoid clinics altogether:

> In our communities, everyone knows everyone. A girl might want to get help, but if she thinks she will meet her aunt or neighbor at the clinic, she will just stay home. They are afraid of being seen, afraid of people talking. Unless the clinic can guarantee privacy, they won't go—no matter how much they need help.

Participants agreed that privacy is not merely an ethical obligation but a practical determinant of service utilization. They called for urgent attention to clinic design, staff training, and confidentiality protocols, ensuring that adolescents can access services discreetly and without fear. Key recommendations emerging from the discussions included establishing private consultation rooms specifically for adolescents, training health workers on confidentiality, non-judgmental

communication, and discreet service delivery, implementing appointment systems that minimize the chances of adolescents encountering known community members during visits, and reinforcing confidentiality through clear, visible signage and community outreach.

Collectively, these reflections reveal that without assured privacy, even the most well-designed services will remain out of reach for many adolescents. Addressing this barrier is essential for achieving both equity and effectiveness in CAFFP–PAC service delivery.

Subtheme 2.3: Time Alone with Health Providers

Participants repeatedly emphasized that adolescents need private one-on-one time with health providers, free from parental or third-party presence. Many young people expressed reluctance to speak openly when accompanied by a parent or guardian. Health workers noted that creating space for confidential adolescent-provider dialogue was critical to effective care.

> Teens need some private time with their provider so they can speak freely without fear their parents will know. — Youth feedback

This insight reveals the tension between cultural expectations of parental involvement and the adolescent's need for autonomy and confidentiality in healthcare. Service protocols that allow for confidential consultations—while still respecting legal frameworks—can greatly enhance the quality of adolescent care and improve trust in the health system.

Theme 3: Health System Readiness and Provider Attitudes

One of the most consistent concerns raised by participants was the readiness of the health system to deliver adolescent-responsive services. This included not only infrastructure and coordination, but also the attitudes, communication skills, and sensitivity of frontline health providers. Adolescents repeatedly stressed that provider behavior is a major determinant of whether or not they seek or return for care.

Subtheme 3.1: Training on Youth-Friendly and Nonjudgmental Care

Participants across the study repeatedly emphasized the critical importance of respectful, nonjudgmental, and youth-friendly care as a foundation for effective adolescent health services. Adolescents described experiences of being dismissed, ridiculed, or judged by health workers, which created deep discomfort and deterred them from seeking essential services like contraception and post-abortion care. Many participants noted that negative interactions with healthcare providers led to long-lasting mistrust and avoidance of services.

One female adolescent expressed this frustration clearly, highlighting how the tone, words, and attitude of health providers can make or break the adolescent health experience:

> It's not just about having services; it's about how we are treated when we go for them. Some health workers speak harshly, others judge us,……. If providers don't change their attitude, no girl will go back. Training should focus on how they talk to us and treat us……with respect, with kindness. We are already scared to ask for help, and if we are met with rude words or laughter, we won't even think of returning.

A male youth echoed this, sharing his personal discomfort with the way some health workers behave:

> Sometimes when we ask questions about condoms or protection, the nurses just laugh or make fun of us. It makes you feel stupid and ashamed, like you did something wrong by asking. That needs to change. We need people who can answer our questions seriously without making us feel bad. Otherwise, we just stop asking.

Throughout the discussions, participants consistently called for continuous training and mentorship for health workers, emphasizing the need for ongoing programs rather than one-off workshops. These programs should focus on adolescent rights and dignity, confidentiality and privacy, empathetic and supportive communication, and fostering nonjudgmental attitudes toward adolescent sexuality.

Participants stressed that respectful treatment is not an added benefit but a basic, essential requirement for effective service delivery. Without it, adolescents will simply withdraw from care, leaving their sexual and reproductive health

needs unmet. This subtheme highlights that creating safe, welcoming, and respectful health environments starts with transforming provider attitudes and practices, making youth-friendly care the norm, not the exception.

Subtheme 3.2: Building Trust Through Inclusive Dialogue

Throughout the study, trust emerged as a fundamental bridge between adolescents and the health system. Participants frequently emphasized the importance of open, inclusive dialogue that brought together adolescents, parents, health providers, community leaders, and other key actors. These moments of collective discussion were described as powerful opportunities for breaking down stigma, fostering understanding, and encouraging shared responsibility for adolescent reproductive health.

Many adolescents noted that being part of such conversations helped normalize their experiences, reducing feelings of shame and isolation. These discussions were not perceived merely as formal meetings or consultation sessions but as transformative spaces where mutual learning, healing, and relationship-building took place. Through these shared forums, power imbalances were softened, allowing adolescents to speak openly and adults to listen without judgment. A youth mentor reflected on the emotional impact of these discussions, describing how seeing different groups engage openly gave her hope for lasting change. She explained,

> When I see parents, nurses, community leaders, and us youths sitting together, listening to each other, and speaking openly like this, I feel hopeful. This is how real change starts—when everyone hears directly from us, and we hear from them too. It makes you realize that we're not on opposite sides, and we can all work together to make things better.

Similarly, a female adolescent shared how hearing others speak openly about their struggles provided her with comfort and reassurance. She remarked,

> Honestly, before this meeting, I felt like I was the only one facing these problems. But hearing others talk about the same struggles—about the fear, the pressure, and even mistakes—made me feel less ashamed. It reminded me that I'm not alone and that others also understand what I'm going through. Her statement illustrates the emotional relief and sense of belonging that can arise when adolescents are given a safe space to share and hear from their peers and adults alike.

Participants widely agreed that inclusive dialogue has the potential to dismantle stigma and misinformation surrounding adolescent sexual and reproductive health. These discussions created opportunities for empathy to replace judgment, and for shared problem-solving to emerge. Participants also emphasized that such spaces should not be treated as one-off consultations but as ongoing processes that build lasting relational trust between adolescents, their families, community structures, and health providers.

Importantly, these dialogues were seen not only as a means of collecting feedback or informing programs but as essential interventions in themselves. They fostered social cohesion, built confidence among adolescents, and encouraged collective accountability for improving adolescent health services. Creating regular opportunities for open, respectful conversations among diverse community groups can therefore serve as a crucial mechanism for enhancing trust, promoting adolescent agency, and strengthening the overall effectiveness and sustainability of programs such as CAFFP–PAC.

Theme 4: Addressing Socio-Cultural and Gender Norms

Participants across all groups recognized that health interventions aimed at improving adolescent reproductive health cannot be effective without addressing the broader socio-cultural and gender norms that shape adolescent behavior and decision-making. Many acknowledged that adolescents face a complex environment where fear, shame, and stigma are deeply embedded within families and communities. These social pressures severely restrict adolescent agency and freedom to seek care, especially for sensitive services like family planning and post-abortion care. Without confronting these underlying norms, even well-designed health programs risk limited uptake and sustainability.

Subtheme 4.1: Overcoming Fear and Stigma

Adolescents repeatedly noted that, despite increased availability of services, internalized fears about being judged particularly by parents and close family members remain one of the biggest barriers to accessing care. The fear of

parental discovery of their sexual activity often discourages young people from seeking family planning or post-abortion services. This fear is compounded by community gossip and labeling, which can lead to adolescents, especially girls, being branded as promiscuous or "spoilt" simply for attending a clinic.

> Many adolescents are scared their parents will find out they are sexually active…girls fear being labeled as spoilt if they visit a clinic, explained one participant.

These insights underline the critical importance of not only ensuring confidentiality within clinical settings but also extending stigma reduction efforts beyond the clinic walls. Adolescents emphasized the need for safe and supportive spaces within their homes and communities where open conversations about sexual and reproductive health can occur without fear of judgment or punishment. This calls for integrated approaches that combine health education, community dialogue, and mobilization to shift harmful norms and empower adolescents to exercise their reproductive rights. Addressing fear and stigma requires engaging not only adolescents but also parents, community leaders, and other key influencers in culturally sensitive conversations that challenge existing taboos and promote acceptance. Without this broader socio-cultural change, adolescents' access to comprehensive adolescent-friendly family planning and post-abortion care services will remain severely constrained.

Subtheme 4.2: Engaging Cultural and Religious Leaders

Participants across stakeholder groups consistently highlighted the pivotal role that cultural and religious leaders play in shaping community values, beliefs, and behaviors related to adolescent sexuality and reproductive health. These figures hold significant influence over what is deemed socially acceptable, and their endorsement or opposition can profoundly impact community attitudes toward adolescent-friendly family planning and post-abortion care services.

> Religious and clan leaders influence what is acceptable Engaging them helps shift community attitudes, noted a clan leader.

Supporting this view, a city health official remarked,

> When the elders talk, people listen. If they support adolescent care, others will follow.

Together, these perspectives emphasize the critical importance of intentionally involving traditional and religious authorities in program design and implementation. Engaging these leaders in culturally sensitive dialogue not only helps to align health interventions with community values but also creates a platform for challenging harmful norms that restrict adolescent access to care. By fostering collaboration with cultural custodians, programs can gain legitimacy, enhance community buy-in, and create an enabling environment where adolescent reproductive rights are respected and supported.

Theme 5: Integration Strategies for CAFFP–PAC in Primary Healthcare

Participants provided insights into how family planning and post-abortion care services could be successfully integrated into the existing health system, while remaining adolescent-responsive.

Subtheme 5.1: Coordinated and Accessible Service Delivery

Stakeholders stressed the need to offer CAFFP and PAC services in the same location and at the same time to reduce logistical barriers.

> Integration means family planning and post-abortion care are available at the same place and time, reducing missed opportunities. If a girl comes for care and has to return another day for counseling, she may never come back. — Health worker

This highlights how coordination reduces dropout rates, saves time, and increases service uptake—especially for adolescents navigating multiple hurdles to care.

Subtheme 5.2: Leveraging Local Resources and Linkages

Rather than reinventing the wheel, participants recommended maximizing the use of existing community platforms and school-based initiatives.

> We already have school health clubs and community groups. What's needed is to bring them together with health centers. The partnerships are already there, we just need to connect the dots. — CBO representative

Strengthening these linkages ensures sustainability and scalability, while grounding the intervention in local realities.

Subtheme 5.3: Participatory Planning and Use of Local Data

The community-led inception approach was praised for surfacing critical context-specific issues and co-creating solutions.

> The inception meeting helped uncover the social, cultural, and structural barriers that need to be addressed together. Also, without listening to us, they would never have known how hard it is to reach the clinic from our village — District official

Together, these voices affirm the value of participatory diagnostics for designing contextually relevant, adolescent-centered services.

Theme 6: Sustained Engagement and Feedback Mechanisms

Participants emphasized that participation should not end at inception. Regular feedback loops and ongoing youth involvement were seen as essential for responsiveness and accountability.

Subtheme 6.1: Institutionalizing Youth Participation Structures

Participants across various sectors emphasized the need to formalize adolescent involvement through structured, ongoing mechanisms that embed youth participation within health service governance. Rather than one-off consultations or ad hoc meetings, establishing permanent youth advisory groups was widely recommended as a way to ensure that adolescents remain active co-creators throughout the design, implementation, and evaluation of health programs such as CAFFP–PAC. A representative from Lira University highlighted this approach, noting,

> Form youth advisory groups to sit with health facility teams regularly. That will make the services responsive.

Embedding such youth groups within formal governance and decision-making structures sends a clear message that adolescent voices are not tokenistic but carry real weight and influence. It also ensures continuity and sustainability, avoiding gaps or declines in youth engagement over time. Furthermore, institutionalizing youth participation fosters a culture of accountability, transparency, and inclusivity, which benefits not only adolescents but the broader community and health system. Participants emphasized that these youth participation structures should be well supported with capacity building, clear mandates, and resources to operate effectively. They envisioned these groups as bridges linking adolescents to providers and policymakers, enabling meaningful dialogue, co-design, and shared ownership of health services.

Subtheme 6.2: Continuous Review and Feedback Loops

Participants stressed the importance of establishing regular and structured opportunities for review and reflection throughout the lifespan of adolescent health programs. Many emphasized that a single inception meeting or consultation, while valuable, is insufficient to capture evolving needs or address emerging challenges. Instead, ongoing check-ins, periodic meetings, and community forums were seen as essential to maintaining momentum, ensuring accountability, and adapting interventions based on real-time experiences and feedback. A district youth officer captured this perspective, saying,

> This meeting is good, but it should not be the last. We must keep reviewing together as the project goes on.

By institutionalizing continuous feedback loops, programs can foster sustained relationships among adolescents, health providers, community members, and other stakeholders. These ongoing engagements allow for the timely identification of gaps, challenges, or unintended consequences and provide a platform for collaboratively refining strategies to better meet the needs of adolescents. Such adaptive programming, informed by regular dialogue and shared learning, is essential to the success and sustainability of initiatives like the Comprehensive Adolescent-Friendly Family Planning

and Post-Abortion Care program. It ensures that services remain relevant, accessible, and sensitive to the realities of the communities they serve.

Discussion

This article aimed to explore how a community-led approach could support the effective integration of CAFFP–PAC services while addressing participation gaps among adolescents and key stakeholders in Northern Uganda. Our findings are grounded in the participatory inception process, reflecting adolescents' direct input and perspectives alongside those of other stakeholders. Six key themes emerged that captured these diverse viewpoints. First, participants emphasized the need for meaningful participation, with adolescents calling for involvement from the design stage and stakeholders advocating for the use of trusted structures like Village Health Teams, school clubs, and youth mentors. Second, the importance of adolescent-friendly and confidential service environments was highlighted, including safe spaces, privacy during consultations, and provider respect. Third, participants stressed health system readiness and provider attitudes, calling for training, inclusive dialogue, and youth-friendly staff selection. Fourth, socio-cultural and gender norms, particularly fear of stigma and parental judgment, were identified as major barriers, highlighting the role of cultural and religious leaders in shifting attitudes. Fifth, participants recommended practical integration strategies like co-located services and participatory planning. Finally, sustained youth engagement through advisory structures and regular feedback mechanisms was seen as essential. These findings affirm that a community-led, adolescent-centered model—anchored in empowerment principles—is vital for effective CAFFP–PAC integration into primary healthcare.

Our study contributes to the growing body of evidence emphasizing that meaningful adolescent participation is not merely a best practice but a foundational requirement for effective integration of adolescent-friendly family planning and PAC into primary healthcare. The findings illustrate that when adolescents are genuinely engaged from the inception phase as operationalized in the CAFFP–PAC initiative services become more relevant, trusted, and utilized. This aligns with existing literature by Chandra-Mouli et al[5] and World Health Organization,[14] which advocate for youth engagement in SRH programming, but our study explicitly situates this engagement within a rights-based empowerment framework, showing how adolescents' agency can shape service design and uptake. By mobilizing trusted community structures like Village Health Teams, school clubs, and youth mentors, and institutionalizing feedback mechanisms through youth advisory groups, our findings demonstrate how a community-led model can address both structural and relational barriers that have historically hindered adolescent access to SRH and PAC. This adds practical, context-specific insight to the literature, illustrating how participatory approaches operationalize adolescent empowerment in post-conflict, resource-limited settings.

Our results underscore that adolescent-friendly and confidential service environments are essential to uptake, including safe clinic spaces, privacy during consultations, and provider respect. These factors were emphasized across adolescents, parents, and health workers, reflecting their universal relevance. Prior studies such as Nalwadda et al,[6] and Ninsiima et al,[15] document how unwelcoming environments and judgmental providers deter adolescents, but our findings provide context-specific depth by highlighting subtler elements such as clinic aesthetics, adolescent-only spaces, and time alone with providers, linking these directly to adolescents' feelings of empowerment and autonomy. The emphasis on confidentiality as a non-negotiable component of care reinforces the need for systemic reforms, including youth-centered infrastructure, provider training on respectful care, and protocols that safeguard adolescent autonomy, situating these practical steps within a broader empowerment-oriented framework.

Health system readiness and provider attitudes emerged as a critical determinant of adolescent engagement. Our findings align with global evidence that adolescents' access to SRH services is often hindered by untrained or judgmental providers.[16,17] However, our study extends this by showing that readiness involves not only structural preparedness but also relational responsiveness: inclusive dialogue, staff mentorship, and deliberate selection of youth-positive providers. Adolescents' perception of being respected and heard reinforces their sense of agency and strengthens service uptake, directly linking participatory engagement to empowerment outcomes. This contribution is particularly relevant for post-conflict Northern Uganda, where systemic gaps and fragile trust necessitate both cultural and structural transformations.

Socio-cultural and gender norms, especially fear of stigma and parental judgment, emerged as significant barriers to adolescent SRH access, a finding consistent with existing literature that highlights stigma as a pervasive barrier to

adolescent SRH service utilization in sub-Saharan Africa. Echoing available literature,[18,19] our results underscore how societal expectations and moral judgments discourage open discussions about adolescent SRH, perpetuating silence and avoidance of care. Importantly, our study highlights the facilitatory role of cultural and religious leaders, positioning them as agents of normative change capable of enhancing adolescents' empowerment. This insight adds aspects by identifying not only the barriers but also the facilitators embedded within communities, suggesting that engaging these leaders in adolescent health initiatives can foster more supportive environments. By involving these leaders in culturally sensitive dialogue, the study demonstrates a mechanism for reshaping community norms and creating supportive environments, bridging the gap between adolescent rights and service availability.

Practical integration strategies for CAFFP–PAC highlighted by participants included co-location of services, leveraging existing community platforms, and participatory planning grounded in local contexts. While prior studies advocate service integration to reduce fragmentation,[20] our study emphasizes how participatory, community-led approaches enhance cultural appropriateness, sustainability, and adolescent ownership. Thus, our study advances the literature by demonstrating the critical importance of community-led, participatory approaches that not only streamline service delivery but also foster local ownership and sustainability. This approach operationalizes empowerment principles by positioning adolescents and local structures as co-creators of service design rather than passive recipients.

Finally, sustained youth engagement and continuous feedback mechanisms, such as youth advisory groups and periodic review meetings, were identified as essential for program responsiveness and accountability. This finding resonates with growing evidence in the literature that highlights youth participation not just as a one-time consultation but as an ongoing process essential for program relevance and effectiveness.[21] Unlike traditional models that treat adolescents as passive recipients, our study adds to the field by illustrating how institutionalizing youth voices within governance and monitoring structures strengthens the adaptability and sustainability of interventions. By embedding these participatory feedback loops within the project lifecycle, programs can better identify emerging challenges, respond dynamically to adolescent needs, and empower young people as active stakeholders rather than beneficiaries thereby addressing a persistent gap in adolescent SRH service delivery in low-resource and post-conflict settings like Northern Uganda.

Strengths and Limitations

One of the key strengths of this study lies in its community-led and participatory approach, which ensured that the voices of adolescents and other local stakeholders were central to the inquiry. The diverse composition of the 110 participants including adolescents, youth mentors, health workers, parents, religious leaders, clan representatives, and institutional actors from Lira University and local government allowed for triangulation of perspectives across various social, cultural, and professional contexts. This inclusivity enhanced the depth and relevance of the findings by capturing both the structural and interpersonal factors influencing the integration of CAFFP–PAC.

Despite its strengths, the study faced several limitations. The one-day stakeholder engagement may have constrained the depth of discussion; however, this was mitigated by using multiple interactive formats such as rotating dialogue circles, breakout sessions, and oral presentations, which encouraged inclusive participation and expression. While the presence of authority figures might have led to social desirability bias particularly, among adolescents the use of smaller, youth-centered breakout groups and careful facilitation by trained moderators helped create a more open environment. Although findings from Lira District and City may not be directly generalizable to all regions in Uganda, the insights remain valuable for similar low-resource, post-conflict, or underserved contexts with limited adolescent access to SRH and PAC services. Additionally, male adolescents were less vocal during discussions; to address this, facilitators actively encouraged contributions from male participants and ensured their inclusion in future follow-up engagements and adolescent-focused program design.

Conclusion

This study highlights the critical role of community-led, adolescent-centered approaches in facilitating the effective integration of CAFFP–PAC services into primary healthcare systems in Northern Uganda. The findings emphasize that bridging participation gaps requires more than technical service delivery; it demands inclusive planning, trust-building,

and sustained engagement with adolescents and key community stakeholders. Meaningful adolescent participation, youth-friendly environments, respectful and nonjudgmental providers, and the active involvement of cultural and religious leaders emerged as pivotal factors in shaping responsive and accessible services. Moreover, leveraging existing community structures and institutionalizing feedback mechanisms were identified as key strategies for ensuring sustainability and accountability.

Data Sharing Statement

The datasets used and/or analyzed during the current study are available from the corresponding authors on reasonable request.

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Disclosure

The authors declare that they have no competing interests for this work.

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