A STUDY TO EXPLORE THE LIVED EXPERIENCES OF TEENAGE MOTHERS DURING PREGNANCY AND CHILDBIRTH AT ITOJO HOSPITAL, NTUNGAMO DISTRICT

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A DISSERTATION SUBMITTED TO THE FACULTY OF PUBLIC HEALTH, NURSING AND MIDWIFERY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF THE MASTER OF PUBLIC HEALTH LEADERSHIP OF UGANDA CHRISTIAN UNIVERSITY

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UGANDA CHRISTIAN UNIVERSITY

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DECLARATION

I, **ATIM GRACE,** declare that this research report is entirely my work and to the best of my knowledge, it has never been submitted by anyone for a professional award.

I have therefore submitted it for an award of a Master's in Public Health Leadership-save the Mothers.

All references made are acknowledged.

Signature…  Date; 15/08/2025

Atim Grace

(Researcher)

APPROVAL

This research dissertation aimed to explore the lived experience of teenage mothers during pregnancy and childbirth in Ntungamo District, was developed under my guidance and supervision. Therefore, I approve it for submission to the Uganda Christian University Research Ethics Committee (REC).

Signature.  Date. 15/08/2025

REV. CANON EVATT MUGARURA

(Supervisor)

DEDICATION

This research is dedicated to all teenage mothers and the health workers who offer care to them.

I dedicate this research to my dear relatives, my son, colleagues, and siblings for the social, financial, and spiritual support offered to me at every level of my education and entire life milestones.

ACKNOWLEDGEMENT

First and foremost, I thank the almighty God for the grace and mercy upon me throughout my life and studies.

I am grateful to my supervisor, REV. CANON EVATT MUGARURA for his guidance, knowledge, skills, and technical support provided to me tirelessly and in a parental way.

I wish to thank God for all my lecturers at Uganda Christian University for the generosity, knowledge, and skills you have given me in preparation for my future career. May your labor never be in vain, and enjoy the fruits.

My classmates and friends, thanks for the love and support we have shared throughout living together at UCU. May we continue the spirit of loving God and loving each other, for unity is strength. May the almighty God bless us all.

ACRONYMS

CDC: Centers for Disease Control and Prevention

DHO: District Health Officer

MOH: Ministry of Health

UNICEF: United Nations International Children's Emergency Fund (United Nations Children Fund)

WHO: World Health Organization

DEFINITION OF TERMS

A teenager is a young person between the ages of 13 and 19, inclusive.

Pregnancy is the physiological condition in which a fertilized egg develops into an embryo and then a fetus inside a woman's uterus, leading to the birth of a baby.

Teenage pregnancy: refers to pregnancy occurring in individuals aged 13 to 19 years, typically during the teenage years.

Childbirth, also known as labor and delivery, is the process by which a baby is born.

Adolescent: refers to a young person who is in the transitional stage of development between childhood and adulthood, typically between the ages of 10 and 19, according to the World Health Organization (WHO).

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ABSTRACT

Adolescence is a transitional stage from childhood to adulthood and is therefore a critical period in development, characterized by both opportunities and risks. By 2016, 16% of the world's population were adolescents, with 82% residing in developing countries. Approximately 12 million births were attributed to 15–19-year-olds. Sub-Saharan Africa, particularly East Africa, exhibits high adolescent pregnancy rates, with figures reaching as high as 35.8% in Uganda. Among Uganda's maternal mortality ratio of 198 per 100.000 live births, 17.1% were associated with adolescents aged 15-19. While research has been conducted to understand the factors contributing to such pregnancies, little is known about their lived experiences during early motherhood. Consequently, we aimed to explore the lived experiences of teenage mothers attending Itojo District Hospital in Ntungamo.

Methodology

A descriptive phenomenological study design was used to explore the lived experiences of mothers attending postnatal care. These mothers were identified and purposively selected to understand the individual, psychological, social, and cultural challenges they face. In-depth interviews were conducted with teenage mothers aged 13 to 19. The interviews were conducted in the local language, utilizing an interview guide and a tape recorder. Ethical approval was obtained for this study, and the mothers provided consent before participation. The interviews were then translated and analyzed using thematic analysis.

Results

The study revealed a complex interplay of stigma, emotional distress, disrupted education, strained family relationships, and limited access to financial support. Many participants reported feelings of guilt, shame, and anxiety, often

compounded by a lack of support from partners, families, and communities. However, some also reported happy emotions and good family support, and some of these teenagers demonstrated resilience and determination to overcome these hardships for the well-being of their children.

Conclusion

The study found that becoming a mother at a young age is risky and challenging, involving physical issues like frequent illnesses such as malaria, anemia, and excessive vomiting during pregnancy, as well as psychological challenges like stress, anxiety, fear, and suicidal thoughts. It also includes increased pressures of motherhood and social and cultural experiences, such as community judgment, lost dreams, and interrupted education. Efforts to support these young mothers during antenatal care with special adolescent ANC clinics and ongoing counseling, along with their partners, should be prioritized to improve outcomes not only during pregnancy but also in the postpartum period. Further research is needed on the lived experiences of teenage disabled girls during pregnancy, childbirth, and child-rearing.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

1.1 Background to the Study

The WHO (2023) estimates that 16 million girls aged 10–19 years give birth each year, accounting for nearly 11% of all births worldwide.

Globally, there is a rising trend of youth sexual activity, with more adolescents engaging in sex at an earlier age (). This adds to the overall burden of adolescent pregnancy. It is estimated that about 55% of adolescents have their first sexual encounter before turning 18 (). age of 18 years. (CDC, 2017).

According to the World Health Organization (2023), adolescent pregnancies continue to be a global issue for both developed and developing countries. Although the worldwide teenage birth rate has decreased, regional differences in the rates of change persist. Adolescent pregnancies have declined globally, from 64.5 per 1000 women in 2000 to 41.5 per 1000 women in 2023. While some regions have seen declines, sub-Saharan Africa and Latin America and the Caribbean still have the highest rates.

In Uganda, the population is 45.9 million people, with 72.3% being adolescents. (UBOS, 2024). Since 2011, there has been a 25% increase in the number of adolescent girls getting pregnant before the age of 18 in Uganda. (shallom et al., 2024). Impeded maternal care poses a high risk in the first year of life, as infants require more care during this period and are more susceptible to their mothers' depressive moods. (shallom et al., 2024).

1.2 Problem Statement

According to the World Health Organization (WHO, 2023), an estimated 16 million girls aged 10–19 give birth each year, accounting for nearly 11% of all global births. Although global adolescent pregnancy rates have decreased—from 64.5 per 1,000 women in 2000 to 41.5 per 1,000 in 2023—regional differences remain, with sub-Saharan Africa, Latin America, and the Caribbean recording the highest rates.

In Uganda, the population is approximately 45.9 million, with adolescents making up 72.3% of the total. Alarmingly, since 2011, the percentage of girls becoming pregnant before age 18 has increased by 25%. Data from antenatal and postnatal services at Itojo Hospital show that first-time teenage pregnancies continue to be common. Records indicate that in 2022, 14.9% of pregnancies involved teenagers, and in 2023, the figure was 14.1% (Itojo Hospital Antenatal Register, 2022–2023). Although this shows a slight decrease, the overall trend has remained consistently high over the years.

To address this challenge, the Ministry of Health (MoH), in partnership with development allies, has implemented several actions. These include strengthening adolescent-friendly health services, encouraging girls to stay in school, offering vocational training for out-of-school teens, increasing access to family planning services at lower-level clinics, launching community awareness campaigns, and addressing root socio-economic issues like poverty and limited education. Despite these efforts, many teenage pregnancies still happen, with some cases going unreported.

Recent data from the Itojo Hospital Postnatal Register (February 2024) shows an average of 20 teenage pregnancies per month, roughly 14 per week. Although the hospital continues to see increasing rates of teenage pregnancy, no studies have explored the lived experiences of adolescent mothers in relation to postpartum depression. Most research has mainly focused on repeat teenage pregnancies, creating a gap in understanding the broader experiences of young mothers in Uganda.

This study, therefore, aims to explore the lived experiences of teenage mothers during pregnancy and childbirth at Itojo Hospital in Ntungamo District, western Uganda.

1.3 Study Objectives

1.3.1 General Objectives

To explore the Lived experiences of teenage mothers during pregnancy and childbirth at Itojo Hospital.

1.3.2 Specific Objectives

Objectives:

1. To understand the individual challenges faced by teenage mothers in accessing healthcare services at Itojo Hospital.
2. To assess the socio-cultural experience influencing the lived experiences of teenage mothers in the context of maternal and child health services.
3. To explore the psychological experiences of teenage mothers during pregnancy and childbirth at Itojo Hospital.

1.3.3 Research Questions

1. What individual challenges are faced by teenage mothers in accessing health care services
2. What socio-cultural experiences influence the lived experiences of teenage mothers in the context of maternal and child health services
3. What are the psychological experiences of teenage mothers during pregnancy and childbirth?

1.4 Significance of the Study

Understanding the lived experiences of teenage mothers during pregnancy and childbirth is crucial for improving maternal and child health outcomes. The findings of this study can inform healthcare practitioners, policymakers, and community stakeholders about the specific challenges faced by teenage mothers at Itojo Hospital. Consequently, this knowledge can guide the development of targeted interventions and support systems aimed at enhancing the overall well-being of teenage mothers and their newborns.

1.5. Scope of the Study

The scope of the study was to explore the lived experiences of teenage mothers during pregnancy and childbirth at Itojo Hospital, encompassing various aspects that contribute to a comprehensive understanding of their journey. Here is an elaboration on the scope:

Geographic location;

Itojo hospital

Demographic Profile of Teenage Mothers:

The study investigated the demographic characteristics of teenage mothers attending the Health Center, which included age, socioeconomic status, educational background, and cultural diversity.

Pregnancy Experience:

The study explored the emotional, physical, and social aspects of teenage mothers' experiences during pregnancy. Examine factors influencing their decision-making, reactions from family and society, and their access to prenatal care.

Childbirth Experiences:

The study investigated the childbirth experiences of teenage mothers, including their perceptions of labor,

1.6 Justification

The justification for conducting a study to explore the lived experiences of teenage mothers during pregnancy and childbirth at Itojo Hospital is grounded in several important considerations:

Public Health Significance:

Teenage pregnancies are associated with increased health risks for both mothers and newborns. Understanding the lived experiences during this critical period can contribute to targeted interventions to improve maternal and child health outcomes.

Vulnerability of Teenage Mothers:

Teenage mothers often face unique challenges related to their age, socioeconomic status, and social support networks. Investigating their lived experiences provides insights into the specific needs of this vulnerable population.

Influence on Maternal and Child Health Policies:

Findings from the study can inform the development or refinement of policies related to maternal and child health, ensuring they address the distinct challenges faced by teenage mothers.

Enhancing Healthcare Services:

Understanding the barriers to accessing healthcare services during pregnancy and childbirth can contribute to improvements in the delivery of services at the Hospital, making them more responsive to the needs of teenage mothers.

Quality Improvement in Health Centers:

Insights gained from the study can be used to identify areas for quality improvement in the Hospital, leading to more effective and compassionate care for teenage mothers.

Psychosocial Support:

Teenage mothers may experience unique psychosocial challenges. Exploring their lived experiences can shed light on the emotional and psychological needs of this population, guiding the development of support systems.

Prevention and Education:

The study can contribute to the design of educational programs aimed at preventing teenage pregnancies and promoting sexual and reproductive health awareness among adolescents.

Community Engagement:

Involving the community in understanding the lived experiences of teenage mothers fosters community engagement, promoting a collaborative approach to addressing the needs of this population.

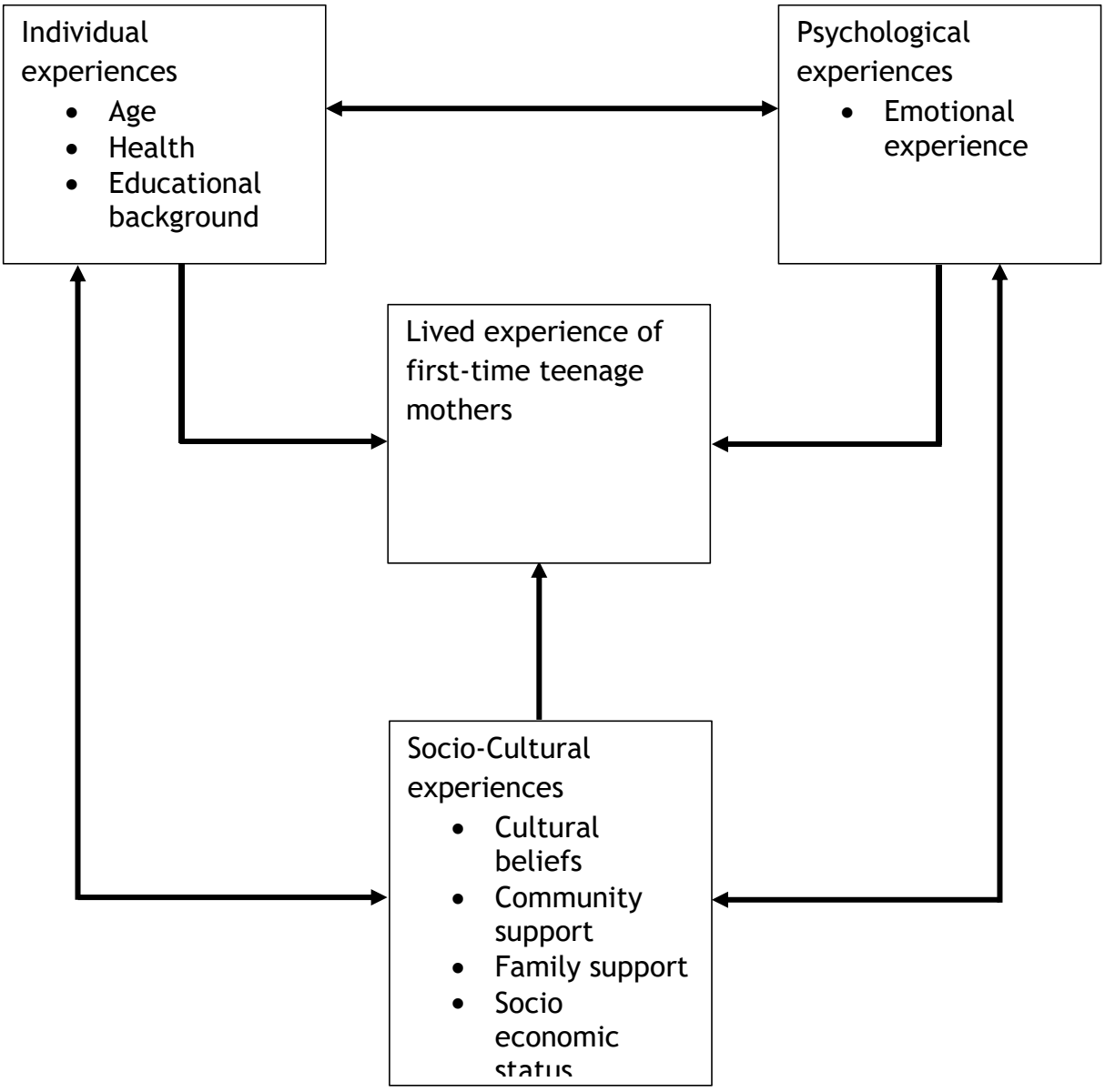
The study adds valuable qualitative data to the existing body of literature on teenage pregnancies, providing a nuanced understanding of the experiences specific to the context of the Hospital.

Contribution to the Existing Literature:

The study adds valuable qualitative data to the existing body of literature on teenage pregnancies, providing a nuanced understanding of the experiences specific to the context of the Hospital.

1.7 Descriptive Phenomenological Framework

A descriptive phenomenological framework is a research method that examines how people experience phenomena as they appear in their consciousness. It is grounded in the philosophy of Husserl and aims to describe the structural core of psychological processes. The phenomenological framework focuses on gaining a detailed, rich, and contextualized understanding of people's experiences and perceptions.



CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

The transition to motherhood is a significant life event, particularly for adolescents who find themselves navigating pregnancy and childbirth amidst the challenges of adolescence. Understanding the lived experiences of first-time teenage mothers during this critical period is essential for providing adequate support and intervention. This literature review aims to synthesize current research on the lived experiences of teenage mothers during pregnancy and childbirth, highlighting the challenges they face and the support mechanisms available.

Pregnancy Experience:

Research indicates that teenage pregnancy often elicits mixed emotions, including fear, anxiety, and excitement. A study by Smith et al. (2020) found that teenage mothers commonly experience feelings of uncertainty and lack of preparedness for pregnancy and childbirth. Additionally, societal stigma and judgment contribute to heightened stress levels during pregnancy (Jones & Wells, 2019). Lack of adequate prenatal care and information exacerbates these challenges, leading to increased health risks for both the mother and the baby (Leeman & Leeman, 2021).

Childbirth Experience:

The childbirth experience for teenage mothers is influenced by various factors, including socioeconomic status, access to healthcare, and support networks. Research by Johnson et al. (2022) suggests that teenage mothers often report feelings of powerlessness and lack of control during labor and delivery. Moreover,

the prevalence of medical interventions, such as cesarean sections, is higher among teenage mothers, leading to increased physical and emotional trauma (Kornelsen et al., 2018). Lack of comprehensive childbirth education further compounds these challenges, hindering informed decision-making during labor and delivery (Sawyer et al., 2020).

Support Mechanisms:

Despite the challenges faced by teenage mothers, various support mechanisms exist to facilitate their transition to motherhood. Comprehensive prenatal care programs, including educational sessions and psychosocial support, have been shown to improve pregnancy outcomes and maternal well-being (Nguyen et al., 2023). Additionally, peer support groups and community-based interventions provide teenage mothers with a sense of belonging and empowerment (Rosa et al., 2020). Furthermore, initiatives aimed at reducing stigma and promoting adolescent-friendly healthcare services are crucial for ensuring equitable access to care for teenage mothers (Ferdos et al., 2022).

2.1 Challenges faced by teenage mothers in accessing and utilizing healthcare services at Hospital.

The challenges faced by teenage mothers in accessing and utilizing healthcare services remain significant globally. A study by the World Health Organization (WHO) revealed that approximately 50% of teenage mothers in developing countries did not receive adequate prenatal care due to various barriers (WHO, 2020). Research in the United States highlighted that 30% of teenage mothers faced difficulties in accessing healthcare due to transportation issues and financial

constraints (Smith et al., 2020). Similarly, in the United Kingdom, 40% of teenage mothers reported challenges in accessing maternal healthcare services due to fear of judgment and stigma (Public Health England, 2020).

In Africa, teenage mothers encounter numerous challenges in accessing healthcare services. A study in Nigeria found that 60% of teenage mothers faced barriers such as lack of transportation and financial resources (Adeyemo & Williams, 2020). In Kenya, cultural norms and traditional practices hindered about 50% of teenage mothers from seeking timely medical care during pregnancy and childbirth (Mwangi et al., 2020). Additionally, in South Africa, economic constraints and long distances to healthcare facilities were major barriers for 45% of teenage mothers (Ngcobo & Maharaj, 2020).

Sub-Saharan Africa faces unique challenges of teenage mothers in accessing healthcare. Research conducted in Tanzania indicated that 55% of teenage mothers struggled to access maternal healthcare due to inadequate infrastructure and limited resources (Mwita et al., 2020). In Ethiopia, societal stigma surrounding teenage pregnancy prevented 65% of teenage mothers from seeking medical care (Tadesse et al., 2020). Furthermore, in Uganda, 40% of teenage mothers reported challenges, such as lack of awareness about available services and cultural barriers (Nsubuga & Nsimire, 2020).

In Uganda, specific challenges include limited financial resources, transportation issues, and societal stigma surrounding teenage pregnancy, with 50% of teenage mothers experiencing barriers to accessing healthcare (Nsubuga & Nsimire, 2020). Additionally, inadequate healthcare infrastructure and the limited availability of maternal health services were identified as significant challenges for 45% of teenage mothers (Mugisha & Zulu, 2020). In South Africa, 50% of teenage mothers

emphasized the role of community outreach programs in overcoming healthcare access barriers (Ngcobo & Maharaj, 2020). Similarly, in Kenya, 55% of teenage mothers reported that community support groups facilitated access to maternal health services (Kigozi et al., 2020). In Uganda, community-based support programs were associated with a 60% increase in healthcare utilization among teenage mothers (Nabunya et al., 2020).

Socioeconomic factors significantly impact the ability of teenage mothers to access healthcare. In Nigeria, 60% of teenage mothers cited poverty as the primary barrier to accessing maternal healthcare (Adeyemo & Williams, 2020). Baskaran et al. (2022) noted that financial constraints often lead teenage mothers to delay or skip essential healthcare appointments, impacting both maternal and infant health. Financial support, including subsidized healthcare and transportation assistance, is often insufficient, which exacerbates the difficulties young mothers face in accessing the care they need. Similarly, in Uganda, 70% of teenage mothers faced challenges related to economic instability and an inability to afford healthcare expenses (Nalwadda et al., 2020).

Cultural norms and beliefs are often barriers to healthcare access for teenage mothers. In Kenya, 50% of teenage mothers attributed their avoidance of professional medical care to cultural practices, such as home births (Mwangi et al., 2020). In Tanzania, traditional gender roles discouraged 40% of teenage mothers from accessing maternal healthcare services (Mwita et al., 2020). Furthermore, in Uganda, 35% of teenage mothers reported feeling intimidated by healthcare providers due to cultural differences (Nsubuga & Nsimire, 2020).

Educational attainment also influences the ability of teenage mothers to navigate the healthcare system. In the United States, teenage mothers with higher levels of

education were 40% more likely to access prenatal care regularly (CDC, 2020). Similarly, in Nigeria, 30% of teenage mothers with secondary education reported better utilization of healthcare services compared to those with only primary education (Adeyemo & Williams, 2020). Juma et al. (2021) conducted a study that highlighted poor health literacy among teenage mothers, leading to inadequate knowledge about maternal and child health, which in turn contributed to suboptimal care during pregnancy and after childbirth. In Uganda, 55% of teenage mothers with higher education demonstrated better knowledge of maternal health services (Nsubuga & Nsimire, 2020).

Gender disparities exacerbate the challenges teenage mothers face in accessing healthcare. Research in Ethiopia found that 50% of teenage mothers experienced discrimination from healthcare providers based on gender (Tadesse et al., 2020). In Uganda, 45% of teenage mothers reported feeling disempowered during medical consultations due to their gender (Mugisha & Zulu, 2020). Additionally, in South Africa, 40% of teenage mothers faced gender bias and unequal treatment in healthcare settings (Ngcobo & Maharaj, 2020).

Community-based interventions, such as awareness campaigns and support groups, should be implemented to provide teenage mothers with information and resources (UNICEF, 2020). Additionally, policies aimed at reducing socioeconomic disparities and promoting gender equality in healthcare settings are essential (WHO, 2020). Empowering teenage mothers through education and vocational training can also enhance their ability to navigate the healthcare system effectively (Stewart & Vigod, 2020).

Geographic location plays a significant role in access to healthcare services for teenage mothers, particularly in rural or underserved areas. Healthcare facilities

may be distant, and transportation options can be limited. (Osei-Bonsu et al. 2023) found that teenage mothers in rural sub-Saharan Africa, for example, face long travel distances and inadequate infrastructure that prevent them from accessing necessary healthcare. These barriers are further compounded by a shortage of skilled healthcare professionals in rural settings, leading to lower-quality care for young mothers.

Teenage mothers often face societal stigma and discrimination, which can significantly affect their willingness and ability to access healthcare services. Social norms frequently devalue teenage pregnancy, resulting in negative attitudes towards young mothers, both in their communities and from healthcare providers. This stigma can lead to shame, fear of judgment, and reluctance to seek care. According to Parker et al. (2020), teenage mothers are less likely to attend antenatal and postnatal appointments due to the fear of negative interactions with healthcare professionals. These barriers are more pronounced in conservative societies where teenage pregnancy is stigmatized.

Teenage mothers may have limited support systems, which makes it difficult for them to navigate the healthcare system effectively. (Baskaran et al. 2022) noted that without strong family support, young mothers may struggle to care for their infants, attend healthcare appointments, and manage their own health needs. Social support networks, such as family and peer groups, play a critical role in ensuring that teenage mothers receive the care they need. However, when these support systems are lacking, teenage mothers face greater challenges in utilizing healthcare services.

2.2. The socio-cultural experience influencing the lived experiences of teenage mothers in the context of maternal and child health services

Teenage mothers often face significant social stigma and discrimination, which can lead to exclusion from mainstream healthcare services. This stigma is worsened in certain cultural contexts where adolescent pregnancy is seen as deviant or immoral (Silliman et al., 2020). Such negative societal perceptions can discourage teenage mothers from seeking prenatal and postnatal care, increasing their risk of complications (Perry et al., 2021). Studies have shown that when teenage mothers are stigmatized, they may experience mental health challenges, including depression and anxiety, which also affect their willingness to engage with healthcare providers (Kuhl et al., 2021).

Teenage mothers often face barriers to accessing quality maternal and child health services, including a lack of transportation, financial constraints, and geographic isolation, especially in rural areas (Adebiyi et al., 2020). Cultural barriers, such as family or community restrictions, can also limit their access to care. In some societies, adolescent mothers may be expected to prioritize household duties over personal health, limiting their ability to attend regular healthcare visits (Akinyemi et al., 2020).

A study by Teboh et al. (2021) examined access to maternal healthcare for teenage mothers in sub-Saharan Africa and found that cultural practices, such as early marriage and the perception of teenage pregnancy as a sign of fertility, often hindered the uptake of maternal health services. Furthermore, healthcare facilities were frequently not equipped to address the unique needs of teenage

mothers, such as addressing the psychological impacts of early motherhood and the lack of support networks (Akinyemi et al., 2021).

Family dynamics play a significant role in the healthcare choices and experiences of teenage mothers. The support or lack of support from parents and extended family members can influence the mother's decision to seek or avoid maternal care (D'Angelo et al., 2020). In many cases, young mothers who lack family support may have to rely on peers or community groups for advice and assistance, which can sometimes lead to misinformation or delays in seeking appropriate care (Ketterlinus et al., 2021).

Additionally, studies suggest that peer influence is a double-edged sword. On one hand, supportive peer networks can provide emotional support, reducing feelings of isolation and encouraging positive maternal health behaviors. On the other hand, peer pressure to prioritize motherhood over education or career can negatively affect the teenage mother's long-term health and well-being (McMahon et al., 2020).

Cultural beliefs around gender roles, motherhood, and child-rearing often shape how teenage mothers experience their pregnancies and childbirth. In some cultures, the responsibility of motherhood falls heavily on the young mother, with limited involvement from fathers or extended family (Khumbulani & Singh, 2022). In such contexts, teenage mothers may experience stress and isolation, which can affect their health outcomes. Research by Tariq et al. (2021) in Pakistan found that cultural norms regarding virginity, purity, and family honor greatly influenced the maternal care-seeking behavior of teenage mothers. The study highlighted those adolescent mothers often faced pressure to conceal their pregnancies,

leading to delays in seeking prenatal care. This can have serious consequences for both the mother and child, including increased risks of complications during pregnancy and childbirth.

The mental health of teenage mothers is often compromised due to a combination of factors such as stigma, isolation, and economic strain. Teenage mothers are more likely to experience depression, anxiety, and post-traumatic stress disorder (PTSD) during and after pregnancy (Okeke et al., 2022). The absence of proper mental health support in maternal care services worsens these challenges. A recent study by Farrell et al. (2021) explored how teenage mothers in the UK reported feeling unsupported by healthcare providers, particularly in terms of mental health. They noted that there was a significant gap in addressing the emotional and psychological needs of adolescent mothers during antenatal care.

Teenage motherhood often disrupts educational aspirations and future economic opportunities. The lack of access to education, due to the responsibilities of motherhood, can lead to lower levels of economic independence (Bates et al., 2020). Economic constraints further limit the ability to access healthcare, contributing to worse maternal and child health outcomes (Rossiter et al., 2021). A study by Farron et al. (2022) highlighted those teenage mothers who dropped out of school often faced difficulties reintegrating into educational systems or securing employment, which continued a cycle of poverty and poor health outcomes for both mothers and children.

Studies suggest that enhancing community support and educational programs can significantly improve access to healthcare for teenage mothers (WHO, 2020). Ensuring economic support and providing culturally sensitive healthcare services

can help bridge the gap and ensure better health outcomes for teenage mothers and their children (Stewart & Vigod, 2020).

2.3 The psychological experiences of first-time teenage mothers during pregnancy and childbirth.

Teenage pregnancy remains a significant public health challenge globally. Approximately 21 million girls aged 15–19 years become pregnant each year in developing regions (WHO, 2018). Recent research underscores the profound psychological toll of teenage pregnancy, with first-time teenage mothers particularly vulnerable to depression and anxiety during both pregnancy and postpartum periods (WHO, 2020). Postpartum depression affects an estimated 10–20% of teenage mothers globally, posing significant mental health risks (WHO, 2021).

Teenage pregnancy is associated with an increased risk of mental health issues. According to recent studies, first-time teenage mothers are more likely to experience anxiety, depression, and other psychological challenges. The WHO (2020) has highlighted that adolescent mothers face a higher risk of depression during pregnancy and the postpartum period compared to older mothers. This can have long-term consequences for both the mental health of the mother and the development of the child.

In a study by Smith et al. (2020), it was found that teenage mothers in the U.S. are significantly more likely to report symptoms of anxiety and depression. The societal stigma surrounding teenage pregnancy often exacerbates these feelings, leading to heightened stress and poor mental health outcomes. These emotional

challenges are compounded by the need to balance the demands of motherhood with the pursuit of education, social development, and personal growth.

A study conducted by Public Health England (2021) supports this notion, revealing that a significant percentage of teenage mothers report feeling socially isolated during pregnancy. This isolation can contribute to heightened anxiety, depression, and feelings of inadequacy as they face the challenges of motherhood without sufficient social support.

One of the most persistent psychological experiences for teenage mothers is the societal stigma that surrounds teenage pregnancy. This stigma can lead to feelings of shame, guilt, and low self-esteem, which have been found to contribute to mental health issues such as depression and anxiety. In a study by Silva et al. (2021) in Brazil, teenage mothers reported experiencing intense stigma, which led to feelings of low self-worth and emotional distress. Furthermore, studies have shown that teenage mothers often experience social isolation due to the stigma surrounding their pregnancies. In a 2020 study in Australia by Johnson et al., teenage mothers reported elevated levels of fear and uncertainty about their future, partly due to the lack of social connections. The inability to connect with peers and the fear of being judged by others can significantly affect their mental health during pregnancy and postpartum.

The emotional challenges faced by teenage mothers are also exacerbated by a lack of access to proper prenatal education and social support networks. Haugen & Nilsen (2020) in Norway found that teenage mothers are often unprepared for the physical and emotional toll of childbirth. Many teenage mothers report feeling overwhelmed and anxious about the birth process, leading to traumatic birth experiences. Inadequate prenatal education on childbirth, combined with the lack

of emotional support, leads to heightened anxiety and fear during labor. This lack of support often extends into the postpartum period as well. Teenage mothers frequently report having insufficient knowledge and skills to care for their newborns, which can further contribute to stress and anxiety. According to UNICEF (2020), teenage mothers globally face increased levels of anxiety due to inadequate knowledge of newborn care, which can have a profound effect on both their mental health and the well-being of the child.

The psychological experiences of teenage mothers vary by region and are often influenced by cultural and socio-economic factors. In Sub-Saharan Africa, for instance, a study in Tanzania by Mwita et al. (2020) found that teenage mothers face severe stress due to inadequate healthcare and limited social support. In Ethiopia, 80% of teenage mothers reported feelings of depression and anxiety during pregnancy, driven by socio-economic challenges, including poverty and limited access to education (Tadesse et al., 2021). In Nigeria, Adeyemo & Williams (2021) found that societal expectations and economic hardship significantly contribute to emotional distress among teenage mothers. The pressure to meet societal expectations, coupled with the lack of financial support, can lead to high levels of stress, anxiety, and feelings of hopelessness. The role of social support cannot be understated when discussing the psychological experiences of teenage mothers.

A study by Nabunya et al. (2021) found that access to community-based support programs, such as counseling services and educational workshops on newborn care, helped teenage mothers manage stress and reduce anxiety. These programs provided crucial emotional and practical support, which alleviated some of the burdens of teenage motherhood. However, the reach of such programs is often

limited, leaving many teenage mothers without the necessary support. In Uganda, research by Nsubuga & Nsimire (2021) found that 65% of teenage mothers experienced high levels of stress and anxiety due to the lack of family and community support. Studies have shown that community-based interventions can provide much-needed emotional support, improving the well-being of teenage mothers (Nabunya et al., 2021).

To mitigate the psychological challenges faced by teenage mothers, recent studies emphasize the importance of comprehensive support systems. Increased access to mental health services, community-based programs, and targeted educational initiatives can significantly improve outcomes for teenage mothers (WHO, 2021). For instance, programs offering prenatal and postnatal care education alongside psychological counseling have demonstrated promising results in alleviating emotional distress (UNICEF, 2020). By addressing both emotional and practical needs, such interventions can improve the overall well-being of teenage mothers and their children (Stewart & Vigod, 2021).

CHAPTER THREE: METHODOLOGY

3.0 Research Methods

3.1 Study Design

A descriptive phenomenological approach was used to explore the lived experiences of postpartum teenage mothers before, during, and after their first pregnancy through focus group discussions. The study employed qualitative methods focused on understanding how teenage mothers navigate the difficult stages of pregnancy and childbirth within a healthcare facility setting.

3.2 Study area

The study was carried out at Itojo Hospital, a government-run district hospital situated in Ntungamo district along Mbarara Highway. It serves the Ntungamo district and parts of nearby Northern Tanzania and Northeastern Rwanda. The hospital has 120 beds, but during busy periods, patients often surpass this capacity, with some sleeping on the floor. The hospital's catchment area includes approximately 191,200 people, both inpatients and outpatients.

3.3 Study population

The study population consisted of teenagers (aged 13 to 19 years) who had become pregnant and given birth, and those who were still pregnant

3.4 Study unit

Teenage mothers aged 13–19 years receiving care at Itojo Hospital, a government health care facility in Ntungamo District.

3.5 Inclusion and exclusion criteria

3.5.1 Inclusion criteria

Only teenage mothers who had given birth and attended the postnatal unit, along with pregnant mothers attending the antenatal clinic who consented, were enrolled in the study.

3.5.2 Exclusion criteria

Teenage mothers with sick children and those with more than one child were disqualified from the research study.

3.6 Sample size determination.

Being qualitative data, teenage mothers were interviewed until the saturation point was reached.

3.7 Sampling technique and procedure

The study employed purposive sampling. The researcher chose only teenage mothers who attended a postnatal and antenatal clinic and had given their consent.

Recruitment was carried out through various entry points. Health facilities, including antenatal and postnatal clinics and maternity wards, served as the main contact points where healthcare workers and facility managers introduced the study to eligible participants.

Eligibility was determined using a brief screening checklist. Inclusion criteria required participants to be female adolescents aged 13–19 years, currently pregnant or having recently given birth, and residing in the study area. Participants were excluded if they had severe medical conditions or other issues that prevented participation. All eligible participants received an information sheet, and informed consent was obtained from those aged 18 and older. For those

under 18, parental or guardian consent was obtained according to ethical guidelines until a sample size of 19 was reached.

3.8 Variables

Socio-demographic factors- These included age, birth order, residence, marital status, religion, level of education, and wealth status. These were measured as proportions of questionnaire responses.

Socioeconomic factors—such as income level and knowledge about contraceptives—were assessed as proportions derived from questionnaire responses.

Individual factors — These variables include respondents' age, education level, number of children, experience, marital status, occupation, and monthly income.

Socio-cultural factors—such as parental influence, community support, alcohol use, and initiation ceremonies—were measured as proportions of questionnaire responses.

Health system factors: These included the distance to health facilities, the hospitality of health workers, and their attitudes towards patients, and were measured as proportions of questionnaire responses.

3.9 Data collection tools and methods

Data was collected through in-depth interviews with first-time teenage mothers at postnatal and antenatal units. Each focus group discussion consisted of five teenage mothers and lasted approximately 30 minutes. To ensure openness and confidentiality, the research assistant was not an employee of the clinic and had training in qualitative data collection. The research assistant received training before beginning data collection. Ten guiding questions were used during the

interviews. These questions were initially developed in English, but due to the participants' level and the local area, they were translated into Runyankole for this research.

The data collection tool was pretested with teenage mothers who visited the hospital for services. The focus group discussions were conducted in convenient locations for participants, such as open spaces at the health facility after clinic hours.

At each focus group discussion, notes and recordings were primarily in the local languages of Runyankole/Rukiga. Some participants communicated in English. After each discussion, the recordings were fully transcribed and translated verbatim into English. Each transcript was analyzed independently by two researchers to minimize bias. Coding was performed manually based on keywords and phrases derived from the data. The codes were then grouped into themes and sub-themes. The themes were categorized according to experiences related to pregnancy and childbirth, parental views, and reactions. The data was sorted thematically by clustering similar content to identify meaningful categories.

3.10 Data entry, analysis, and presentation.

Data were analyzed thematically using identified themes. Audio recordings were transcribed verbatim in the local language and then translated into English for analysis. The researcher randomly checked samples of transcripts against the recordings to ensure accuracy.

3.11 Quality controls

Selection and training of research assistants

The researcher selected qualified research assistants and trained them on the data collection tools. Meetings with the research assistants were held daily before and after returning from the field. The data collection tool was pretested for appropriateness before the actual data gathering.

Pretesting of data collection tools

The pretesting of data collection tools was carried out at a nearby health facility in Ntungamo to evaluate their appropriateness. Any needed corrections were made to the updated tool after fixing inconsistencies. The data collection instruments were translated from English into the local language (Runyankore/Rukiga).

Field supervision

The researcher supervised the research assistants at all times to ensure that all the data collected were complete.

Field editing of data collected

The editing of data collection tools was properly done to ensure that all relevant information related to the study's objectives was collected. Daily review meetings were held to ensure consistency in data collection.

3.12 Ethical considerations

Permission was sought from the Uganda Christian University Research Ethics Committee. Permission was also sought from the administration of Itojo Hospital and the District Health Officer (DHO). Individual study respondents were also approached to obtain their consent to carry out the study. All information provided by the respondents was kept confidential.

3.13 Study limitations

Since this is a qualitative study, the cause-and-effect relationship was not established. Information and selection bias were likely to occur because some questions required recalling past events, and only women were interviewed.

3.14 Plan for dissemination.

The report was shared with the Uganda Christian University Research Ethics Committee and the District Local Government administration. Findings were also disseminated in Ntungamo District and at different conferences and workshops.

THEMES	SUB THEMES	RESPONSES
Individual challenges	Health-related issues	I was feeling weak and vomiting almost every time, then I went to the hospital and they tested and told me it's the pregnancy causing such. (*Participant number 1)* I fell sick when I was four months pregnant, and even during delivery time, I wasn't sick. *(Participant number 7)* I got severe abdominal pain, then went to the hospital and tested pregnancy positive, and they also told me that I had an infection, and they treated me. *(Participant number 10)* l was weak, lacked energy and appetite, and failed to eat food. *(Participant number 3)* I fell sick, got serious malaria and anemia. *(Participant number 13)* I fell sick while pregnant, and they admitted me and put me on a drip. *(Participant number 5*) I lacked appetite and vomited a lot, and l kept vomiting until I gave birth. *(Participant number 8)* I went to the hospital while feeling abdominal pain and vomiting. They tested me and said I was pregnant. *(Participant number 15)* I experienced a lot of pain during labor. *(Participant number 19)* The problem I got delivered when it was not yet 9 months *(Participant number 14)*
	Interrupted education and lost dreams	I got so stressed and wanted to abort, because I wanted to continue with my studies. *(Participant number 1)* It affected my studies, l wanted to become a nurse, but l stopped studying when I became pregnant. *(Participant number 4)*

		I got married when I was 16, but l wasn't ready. My friend tricked me, she told me to accompany her to go and visit someone, and when we reached, she escaped and left me alone. The man closed the door. That's how I got pregnant. I felt bad and got stressed because I wasn't ready. I wanted to study and get a good job or become a doctor. *(Participant number 9)* It affected me because I was still learning hair dressing, and it could have helped me in the future if l had learnt the skill. *(Participant number 13)* Disturbs every day now, like today, I have missed classes to bring this child for immunization. *(Participant number 16)*
	Financial burdens	I didn't prepare well for my baby because my husband and I were not financially okay, my husband is an orphan no one to support him. *(Participant number 7)* I was mistreated by my husband, he did not give me enough Money, even when the time of giving birth reached, I didn't have all the requirements and money for transport to come to the hospital. (*Participant number 8)*
Social cultural experience	Good family and partner support	I got support from my parents; they cared for me through the whole pregnancy period. (Participant number 1) I got support from both my parents and my husband. (*Participant number 4)* My uncle supported me throughout. *(Participant number 6)* The man cared for me, and my family supported me. (*Participant number 9)*

		It didn't affect my relationships with family; they became happier because it was their first grandchild. (*Participant number 2).* Mum supported me throughout, she taught me how to behave and what not to do, and gave me herbs to use. (*Participant number 5)* Parents became happy since l had not become pregnant while still at home, l was already married. (*Participant number 11).* Husband cared for me, bought everything l wanted, took care of me while in the hospital, and paid all the bills. (*Participant number 14)*
	Parents' and partners' reaction	My parents became angry after knowing where I was, but after they had nothing to do, they accepted and cared for me. *(Participant number 9)* My mother first became tough on me, and after she allowed me to stay home, and stopped me from going to the garden and told me to stay at home. *(Participant number 10)* My mother never wanted me to get pregnant because l was still a child, and they all became angry with me. (*Participant number 12)* My parents got angry because I got married young, and I have not yet learnt hair dressing, yet they had paid for me. *(Participant number 13)* I have been supporting myself alone, with the occasional help from my brother, who sometimes assists me when I'm short on money. (*Participant number 18)* My husband kept abusing me, saying it's not his pregnancy and that I got it from other men, claiming I came with it. I became so stressed that I felt a lot of pain, but his mother kept supporting me. (Participant

		number 15) The man's family refused the pregnancy, claiming it's not theirs, but my man stood by my side, asserting it's his. However, family members kept insisting it's not theirs, and they almost left me alone in the hospital. (Participant number 1).
	community reaction	Oh, they really talked about me, saying I became pregnant while still young and at home, but I just kept quiet. (Participant number 4) people talked that l have married at a young age and that l have defiled myself. (*Participant number 13)* Community people have something to always say, they talked that l was still young and not married officially, that l have produced from home, which is seen as an abomination in the community. *(Participant number 12)*
	Healthy workers attitude	Healthy workers cared for me during ANC and delivery time; they talked to me in a good well. (*Participant number 1)* In the hospital, they cared for me during ANC visits and labour time. *(Participant number 2)* Healthy workers asked me why are you pregnant at this age? l felt bad because I also didn't want to be pregnant by that time but l had nothing to do about it. *(Participant number 12)* The problem I got, l delivered when it was not yet 9 months, and while at the hospital, the health worker pushed me with a box of drugs that l should go away, "l will see in the morning' the health worker said. yet l was feeling the baby coming, l almost fell on a mental, and they refused

		to work on me afterwards and we left that hospital and went to a village hospital where I gave birth from. I really felt a lot of pain. The health worker pushed me shouted at me abused me, he was shouting at everyone but me l was following him because I was feeling the baby was almost coming. (*Participant number 14)*
Psychological experience	Joy and happiness	I became happy because I was already married and wanted to produce. (*Participant number 2)* I became happy because I wanted to the pregnant, after I told my parents and they allowed me to go and stay with my husband. *(Participant number 3)* I became happy because people were saying that l will never get pregnant (*Participant number 5)* I became happy, and my man wanted a child, and my parents became happy too because I became pregnant after being married. (*Participant number 7)*
	Worry and stress	When they told me that I was pregnant, l felt bad, l got so worried because I was staying with my uncle, and l was still young, l wasn't sure what was next. (*Participant Number 6*) I got married when I was 16, but l wasn't ready. My friend tricked me; she told me to accompany her to go and visit someone, and when we reached, she escaped and left me alone, and the man closed the door. I really felt bad and got stressed. *(Participant number 9)* I got so scared because I knew at home, they were going to punish me, but when I told the one who had impregnated me and he took me to his place. (*Participant number 17)* I felt bad and stressed when I found out that I'm pregnant. I wanted to

		abort, but my mother told me to keep it and produce because I could die in the process of aborting. (Participant *number 18*) I started feeling weak and vomiting, l thought I was just sick, then I went to the hospital and they tested and told me I'm pregnant. I got so stressed and l wanted to abort, because I wanted to continue with my studies. *(Participant number 1)*
	Fear, anxiety, and denial	When they told me that I was pregnant, l felt bad. l got so scared because I was staying with my uncle, and l was still young. l wasn't sure what was next, but the doctor in the hospital told me to be strong. (*Participant Number* 6) I first refused that l am pregnant, it was like a lie, but later it started growing. I accepted but kept hiding; to tell you the truth, I didn't even go for antenatal and l also delivered from home. *(Participant number 16)* I wanted to abort because I was still young and had no money no work. l didn't know what to do, but luckily the man supported me and told me not to abort. *(Participant number 19)*
	shame and guilt	I can't even talk about it. L became pregnant at that young age because l still feel ashamed. *(Participant number 1)* It's hard for me to go home now because my parents don't want me there, when they see me, they don't become happy because they think I am ashamed of them. *(Participant number 8)* I became pregnant while at school, but l continued studying, l gave birth during the third term holiday after I resumed studying when another term started

		My family and friends, no one knew that l was pregnant l kept studying while hiding my pregnancy, and l didn't even go for ANC. *(Participant number 16)* Silence, it disturbs, but I wish l was at home, but they don't want me there, they don't want me to produce from home. *(Participant number 17)*
	Suicidal thoughts and hopelessness	I had thoughts of killing my baby myself and even killing my husband because of the situation. I think it's because I'm young, maybe if l were old l couldn't have thought that way. (*Participant number 7*)

CHAPTER FOUR: STUDY FINDINGS

4.0 Introduction

This chapter presents findings from respondents who were interviewed during the study of the lived experiences of teenage mothers attending Itozo Hospital in Ntugoma district. Data and emerging themes were analyzed and organized so that the themes and sub-themes would accurately and meaningfully reflect the respondents' experiences. Themes emerged include

THEMES	SUB THEMES
Individual challenges	Healthy challenges
	Interrupted education and lost dreams
	Financial burdens
Social cultural experience	Good family and partner support
	Community reaction
	Health workers attitude
	Joy and happiness
Psychological experience	Worry and stress
	Fear, anxiety and denial
	Shame and guilt
	Suicidal thoughts and hopelessness

Profile of participants

This phenomenological research study encompasses 19 respondents who were tape-recorded. All participants are aged between 13 – 19 years. 14 stopped studying at the primary level, five stopped at the secondary level, only nine are married, ten are single mothers staying at their parents' home, 12 have one child, and only two had two, and five were pregnant for the first time. Only three participants reported having casual jobs, while 17 are peasant farmers at their homes.

Theme One: Personal Challenge

Healthy challenges. Ten participants reported having serious illnesses such as malaria, anemia, excessive vomiting, infections, and severe abdominal pain during pregnancy, which affected their health and pregnancy outcomes. Some reported lacking energy and appetite for food; some were admitted, while others were treated as outpatients during antenatal visits. One participant reported contracting serious malaria and delivering before completing nine months of pregnancy.

I fell sick several times with serious malaria and anemia. mother number 13

l fell seriously ill and I ended up delivering when it was not yet nine months. Participant number 18.

I lacked appetite and vomited a lot, and l kept vomiting until I gave birth. Mother number 8.

Interrupted education and lost dreams.

Four mothers reported that they lost their dreams of becoming important people in the future because of pregnancy. Some mothers reported that they couldn't finish their training skills school when they became pregnant due to the high demands that come with caring for an unborn child and frequent illnesses that disturb them. However, one of the mothers reported that sometimes she misses classes because she has to bring her child for immunization, which interrupts and lowers her academic performance at school.

I got so stressed and l wanted to abort, because I wanted to continue with my studies participant 1.

It really affected my studies. I wanted to become a nurse, but l stopped studying when I became pregnant. Participant number 4

It affected me because I was still learning hair dressing, and it could have helped me in the future if l had learnt the skill. Participant. number 13

It disturbs every day, now, like today, I have missed classes to bring this child for immunization. participant number 16

Financial burdens

Some mothers reported the inability to meet the financial responsibility that comes with pregnancy and child care, like buying things to use during delivery time, transport, and other essentials. Nine of these mothers have no formal jobs. Most depend on casual farming for food, and some are single mothers, and their partners are not supporting them.

I didn't prepare well for my baby's birth because my husband and I were not well financially, and my husband is an orphan with no one to support him. Mother number 7

I was mistreated by my husband, he did not give me enough Money, even when the time of giving birth reached, I didn't have all the requirements and money for transport to come to the hospital. Mother number 8

Theme Two: Social and Cultural Experience

Community Reaction. Some Mothers reported that they were judged by the community because they gave birth at a young age, and they were not married officially, and they had been produced from their parents' home, which was seen as an abomination and not allowed in the community.

Oh, they really talked about me, that l have become pregnant while still young and at home, but me l just kept quiet. Participant number 4.
Yes, people talked that l have married at a young age and l have defiled myself. Participant number 13.

Community people have something to always say, they talked that l was still young and not married officially, that l have produced from my parents' home. Participant number 12.

Sub-themes: family and partner reaction

Eight participants reported that their parents became so angry and disappointed on hearing that they were pregnant, which caused some parents to withhold support during pregnancy. Other mothers reported having been rejected and neglected by their partners, and some got false accusations from their partners claiming that they were not the owner of the pregnancy, which affected their support and care through the whole process, and two participants were quoted as saying how partners mistreated them and kept accusing them, and one denied the pregnancy.

It has affected my relationships with my family; my mum became angry when she got to know that l was pregnant. Participant Number 4.

My mother never wanted me to get pregnant because l was still a child, they all became angry with Participant number 12.

My parents got angry because I got married young, and l have not yet learnt hair dressing, yet they had paid for me. Participant number 13.

My husband kept abusing me, saying it's not his pregnancy that l got it from other men that l came with it, l became so stressed I felt a lot of pain, but his mother kept supporting me. Participant number 15

The man's family refused the pregnancy because it's not their's but my man stood by my side, that it's his, but family members kept saying it's not theirs, and they almost left me in the hospital alone. Participant number 14.

Good family and partner support. However, some teenagers reported good family and partner support from the time of pregnancy to delivery and child care. The support included financial help, emotional support, motherly teaching about pregnancy and care for the child, and some mentioned their partners who held onto them and took them in when they couldn't go back to their parents' homes.

Yeah, I got support from my parents; they cared for me throughout the whole pregnancy period. participant number 1

It didn't really affect my relationships with family; in fact, they became happier because it was their first grandchild. participant number 2

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Mum supported me throughout, she taught me how to behave and what not to do, and gave me herbs to use. Participant number 5

Theme: Psychological experience

Joy and happiness. Despite the dangers that come with teenage pregnancy, five participants were quoted narrating how they felt happy holding their first baby, and some said they were married and their husbands wanted children, so pregnancy came at the right time to fulfill and strengthen their marriage.

I became happy because I was already married and l wanted to produce. Participant 2.

I became happy because I wanted to the pregnant, after I told my parents and they allowed me to go and stay with my husband. Participant number 3.

I became happy because people were saying that l will never get pregnant number 5.

I became happy, and my man wanted a child, and my parents became happy too because I became pregnant after being married. Participant number 7

Sub Theme: Worry and Stress. Seven mothers reported that they got so stressed after knowing that there are pregnant. One of the mothers mentioned that she was worried because she was staying with her uncle, and she didn't know how to tell him. Others mentioned that they wanted to abort because they felt unready to be mothers, while others were still studying and they wanted to continue with their dreams.

When they told me that I was pregnant, l felt bad, l got so worried because I was staying with my uncle, and l was still young, l wasn't sure what was next. Participant Number 6

I felt bad and stressed when I found out that I'm pregnant. I wanted to abort, but my mum told me to keep it and produce because I could die in the process of aborting. Participant number 18

I started feeling weak and vomiting, l thought I was just sick, then I went to the hospital and they tested and told me I'm pregnant. I got so stressed and l wanted to abort, because I wanted to continue with my studies. Participant number 1

Sub Theme Fear, Anxiety, and Denial

One of the teenage mothers reported that she felt anxious when she tested positive, but she first refused to accept it, thinking it was a lie, until she stopped seeing her periods and the growing stomach, and she was quoted as saying how she didn't even go to the hospital for a checkup.

I first refused that l am pregnant, it was like a lie, but later it started growing. I accepted but kept hiding; to tell you the truth, I didn't even go for antenatal and l also delivered from home. Participant number 16

I wanted to abort because I was still young and had no money, no work. l didn't know what to do, but good enough, the man supported me and told me not to abort. Participant number 19

Shame and guilt

Some of the teenagers reported that they still feel the shame even after giving birth, and one was quoted saying she can't even tell someone that she gave birth at such a young age, and another said they wish to go back home, but they can't because they still feel guilty and shameful, especially in front of their parents and the community.

I can't even talk about it. L became pregnant at that young age because l still feel ashamed. Participant number 12.

It's hard for me to go home now because my parents don't want me there; when they see me, they don't become happy. I would be ashamed of them because I became pregnant at a young age and was not married officially. Mother number 8.

Silence, it disturbs, but I wish l was at home, but they don't want me there, they don't want me to produce from home. Participant number 17

Suicidal thoughts and hopelessness

One of the mothers said that at one point she felt like killing herself, her child, and her husband because the expectations were overwhelming — motherhood, parenting, pressure from the child and husband — and she didn't know how to handle it. She was quoted as saying, "Maybe if she were a bit older, she could have managed better."

I thought of killing my baby myself and even killing my husband because of the situation, I think it's because I'm young, maybe if l were old l couldn't have thought that way. Mother Number 7.

CHAPTER FIVE: DISCUSSION OF RESULTS

Introduction

Becoming a mother at a young age brings various emotions and challenges, putting significant responsibilities on teenagers early in life. Studies have shown that these difficulties affect not only the young mothers themselves but also the generations they raise (S. Mariwah et al., 2022).

A study by Mohammed Ali et al (2019) reported that adolescent girls often have greater emotional, psychological, and social needs compared to older women. Giving birth at a young age can also pose increased risks for both the mother and her newborn. Pregnancy at this age is linked to a higher risk of mental health issues. According to the WHO 2020, first-time teenage mothers are more likely to experience anxiety, depression, and other psychological challenges. Depression is the most common issue during the postpartum period among teenagers compared to older mothers.

In this study, despite the challenges that come with teenage pregnancy, some participants reported mixed feelings about becoming a mother. Several adolescents expressed positive feelings about the experience, such as the joy of holding their first baby, and some were happy because they felt fulfilled since they were already married and their husbands wanted a child. These findings are similar to a study conducted in Mbale, Uganda, which reported that some adolescents shared positive emotions about becoming mothers. They felt a sense of pride, recognition as mature individuals in their communities, and a sense of achievement in accomplishing something others had struggled to attain. Motherhood gave them a good feeling (Chemutai Violet et al, 2020).

In this study, many teenage mothers reported receiving support from their parents, such as care and help during pregnancy, as well as from their partners, who supported them throughout the pregnancy and paid the necessary bills. This aligns with findings from a study in Ghana (Smith et al., 2020), where young mothers shared that they were supported by their mothers, siblings, and close friends.

However, some participants in this study reported feeling neglected by their parents after becoming pregnant. Others mentioned that their partners mistreated them, rejected the pregnancy, and accused them of infidelity. These findings are similar to those of (Smith et al. 2020), which showed that some teenage mothers received little or no support from the fathers of their children or the wider community. Another study by Amiwa et al. (2022) indicated that many young mothers experienced mistreatment from their families, especially from parents who felt disappointed by their daughters' pregnancies. They were no longer treated the same as before and often faced exclusion or differential treatment within their households. This led some teenagers to feel isolated and rejected by their parents. Such emotional experiences can lead to serious psychological issues, including depression (Jacinta Torres Pueyo et al., 2022). Other studies have also found that becoming a mother often brings stress, fear of childbirth, concerns about potential harm to the reproductive system, and anxiety about caring for a newborn. These challenges are intensified when there is no support from the partner and when young mothers face criticism from family, the community, and even peers who had previously dropped out of school for unrelated reasons. (Agnes M. Kotoh et al., 2022)

In this study, some teenagers reported that, even though they had given birth, they couldn't tell or discuss it with anyone—that they had children or that they gave birth at such a young age. Similar to the results of a study conducted in Eastern Uganda, which showed that teenage mothers are often judged negatively by community members, leading to feelings of shame and embarrassment, despite feeling a sense of achievement in becoming mothers. (Chemutai Violet et al, 2020)

In this study, the adolescents further explained that, according to cultural expectations, a girl is expected to get married before having children and should not give birth in her parents' home. Any departure from this norm is considered unacceptable and often leads to negative judgments towards the adolescent and her pregnancy. Such negative community perceptions are not limited to Africa; similar experiences have been reported in studies from other parts of the world, like Asia, which found that societal judgment and strict social expectations—particularly in rural communities—are often harsh and unforgiving. In many Asian countries, straying from accepted social norms is viewed as an unpardonable offense. The emotional burden of teenage pregnancy is largely driven by the shame and guilt imposed by societal attitudes. (Marris R. et el 2022).

In this study, participants reported frequent illnesses during pregnancy, such as malaria, anemia, excessive vomiting, and infections. These could be linked to the physiology of pregnancy and other health challenges that come with being pregnant. This is consistent with the study conducted by Agnes et al. (2022), where they reported that nearly half of adolescent girls experience malaria and anemia during pregnancy.

The study also emphasized that financial difficulties significantly contribute to these health problems, as many young mothers cannot afford nutritious meals, food supplements, or transportation to access healthcare services like ANC. Additionally, another study found that pregnancy often limits job opportunities, raising the risk of poverty and making it harder to meet nutritional needs (Z. Amod et al., 2019). These challenges frequently result in negative pregnancy and birth outcomes, such as stillbirth, premature delivery, neonatal death, birth defects, and low birth weight (Jacinta Torres Pueyo et al, 2022).

In the current study, several participants shared that pregnancy disrupted their education. Some girls reported dropping out of school entirely, while others mentioned missing school days to take their children for immunizations. A few were unable to complete vocational training due to the demands of early motherhood. These findings align with those of Chemutai Violet et al. (2020), who reported that teenage pregnancy often leads to interrupted education, unemployment, and emotional challenges. Similarly, Mohammed Ali Kiani et al. (2019) noted that many teenage mothers leave school to take on their parenting responsibilities. Among young parents, it is the mothers who bear the heavier burden, experiencing setbacks in education, health concerns, emotional turmoil, and family pressure. The accounts from participants in this study further support the idea that early motherhood not only hinders personal educational goals but also adds responsibilities that make school attendance difficult. This underscores the broader concern that teenage pregnancy has long-term implications for both the mother's and child’s well-being.

In the current study, participants reported experiencing intense emotional distress upon discovering their pregnancies. Many described feelings of anxiety, denial, and fear—especially fear of being punished by their parents. Some even considered abortion as a possible option, driven by panic and a lack of support. These emotional reactions were rooted in fear of social judgment and the sudden change in their life circumstances. These findings agree with those of Agnes et al. 2022), who reported that teenage mothers often face psychosocial challenges such as denial, sadness, and shame. In their study, some participants also considered abortion or even suicide. Initially, most were in denial, but they eventually came to accept their situation—often due to a lack of awareness about pregnancy symptoms or fear of mistreatment. Both studies highlight the emotional burden that teenage mothers carry, especially in the early stages of pregnancy, emphasizing the need for psychological and social support.

4.1 Conclusion

The study found that becoming a mother at a young age is risky and challenging, involving physical issues like frequent illnesses, such as malaria, anemia, and excessive vomiting during pregnancy, as well as psychological challenges like stress, anxiety, fear, and suicidal thoughts. It also includes increased pressures of motherhood, social and cultural experiences such as community judgment, lost dreams, and interrupted education. Efforts to support these young mothers during antenatal care with special adolescent ANC clinics and ongoing counseling, together with their partners, should be prioritized to improve outcomes not only during pregnancy but also in the postpartum period. Further research is needed to

be carried out on the lived experiences of teenage disabled girls during pregnancy, childbirth, and child upbringing.

4.2 Recommendations

Continued Support and Orientation of Teenage Girls. Teenage girls require consistent guidance and mentorship both at school and within their homes. The emotional and psychological struggles shared by participants in this study—ranging from fear, shame, denial, to suicidal thoughts—indicate the critical need for early support systems. Schools and families must work together to provide accurate sexual and reproductive health information and emotional support to empower young girls in making informed life choices.

Introduction of adolescent antenatal clinics. Many teenage mothers in this study expressed fear about sharing their pregnancy with others. Therefore, scheduling their own antenatal clinic days will help them openly express their feelings and challenges with health workers.

Parental Involvement in Girls' Education. Schools should actively engage and motivate parents to discuss the importance of girls' education and the dangers of teenage pregnancy. Many teenage mothers in this study shared how their parents either abandoned or mistreated them after discovering their pregnancy. Strengthening parent-school partnerships can help reduce stigma, encourage early prevention, and support young mothers in re-entering the education system.

Additional support for the families of pregnant and teenage mothers should be offered, as this study showed that these adolescents' families often do not know how to handle the news of their pregnancies, struggle to involve their teenage

partners for support, or are already in crisis and need outside help. Family therapy group sessions could significantly benefit these family units.

Adolescent parents also expressed concern about the negative effects of stigmatization. Therefore, providing psycho-education on adolescent pregnancy and its circumstances could be offered in schools and to clinic and hospital staff to foster acceptance, support, and reduce stigma.

Further research needs to be conducted on the lived experiences of teenage disabled girls during pregnancy, childbirth, and raising children.

4.3. Study Limitations

Since it was a purely qualitative study, it did not quantify the number of patients affected or their specific associated factors. Language barriers limited participants' ability to fully express their thoughts and experiences, which may have reduced the richness of the narratives. Fear and reluctance to open up due to concerns about judgment, stigma, or mistrust caused many participants to hesitate in sharing their personal experiences. This could have led to underreporting or withholding important information, impacting the overall findings.

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APPENDICES

APPENDIX I: INFORMED CONSENT FORM FOR PARTICIPANT INTERVIEW

Participant ID number ----------

Title: A STUDY EXPLORED THE LIVED EXPERIENCES OF TEENAGE MOTHERS DURING PREGNANCY AND CHILDBIRTH AT ITOJO HOSPITAL

Principal investigator: Atim Grace

Supervisor: Rev Canon Evatt M. Mugarura

Study site: Itojo Hospital, Ntungamo District

Part I: Information Sheet

Introduction and purpose of this study

Good day. My name is Atim Grace, and I am a student of Uganda Christian University pursuing a Master of Public Health Leadership. I am conducting a study to explore the lived experiences of teenage mothers during pregnancy and childbirth. the purpose of this study is to: Identify the individual challenges faced by teenage mothers in accessing healthcare services at Itojo Hospital, investigate the socio-cultural experience influencing the lived experiences of teenage mothers in the context of maternal and child health services, and explore the psychological experiences of teenage mothers during pregnancy and childbirth at Itojo Hospital.

What will happen if you take part in this study?

We are asking you to participate in an interview today. The questions will be about:

- The individual challenges faced by teenage mothers
- Social cultural experience influencing the lived experiences of teenage mothers
- The psychological experiences of teenage mothers

The questions we will ask are only about what you think. There are no right or wrong answers to the questions we will ask. This is not a test. If you agree to take part in the study, you will be asked to complete the interview. The interview will take about 15-20 minutes.

Why are you being asked to take part in this research?

We are asking you to participate in this study because you are a member of itojo community and you have been randomly selected to participate.

Are there any possible risks to you?

We think that there are few risks to you if you participate in this interview. We will not tell anyone about your participation in this interview. We are conducting this interview in a private place to minimize this risk.

There is a chance that you may feel embarrassed or uncomfortable by some of the questions in the interview. You can decide the information you would like to share with us. You can skip any question you do not want to answer. You can stop the interview at any time. We will not tell anyone that you were in the study or what you told us, but there is a chance that other people might find out that you were in the study.

Are there any possible benefits to you?

There are no direct benefits to you for being in this study. However, the information you tell us may help to improve service provision among all the teenage mothers.

What if you decide you do not want to join this study?

You are free to refuse to be in this research study. You are free to stop taking part in the research at any time. There will be no penalty to you if you choose not to take part in the research. You may leave the research study at any time even after

providing consent. There will be no penalty to you if you choose to stop participating in the research. Participation in the study will not affect any services you receive.

Confidentiality

We will do our best to protect information about you and your participation. We will interview you in private. We will use a participant number for the interview, instead of your name. We will remove any reference to your name. We will not use your name in any reports. We will ensure that any information we include in reports does not identify you. The data collection tools may be reviewed by other researcher, and the ethics review committees. I may share the information you provide with other people, but I will not share your name or anything that identifies you.

Compensation

There are no costs to you for participating in this study other than the time you will spend in the interview. All participants will be found in their communities to avoid the participant incurring travel costs

What if you have a problem or have questions?

If you have questions about the research, contact: (0774085722)

What are your rights as a participant?

This proposal has been reviewed and approved by Uganda Christian University REC, which is a committee whose task it is to make sure that research participants are protected from harm.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked, have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

[Participant should tick appropriate boxes below]

I consent voluntarily to be a participant in this study Yes □ No □

I consent voluntarily to have the interview audio-recorded. Yes □ No □

_____ _____

Printed Name of participant Date

Thumbprint/Signature of participant

_____

If participant cannot read the form herself, a witness must sign below:

I was present while the informed consent form was presented to the volunteer. All the volunteer's questions were answered.

_____

_____

Printed Name of Witness

Date

_____

Signature of Witness

Statement by the researcher/person taking consent

I certify that the nature and purpose, the procedures, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual, and she has provided verbal consent to take part in the interview.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

The translated version of the consent form (In Runyankore/ Rukiga)

EKYOKWONGYERWAHO I: EKIHANDIKO KY'OKWEKIRIZA KY'OKUBUUZA EBIBUUZO

Omutwe: OKUCONDOOZA KUKARREEBA EBI ABAKAZI ABAKIIRI OMU MYAKA YOMUSHOGOYO BARIKURABAMU BABA BIINE ENDA NANA OKUZARA AHARI ITOOJO HOSPITAL

Omuchondoza: Atim Grace

Omureberezi: Rev canon Evatt M. Mugarura

Omwanya: ITOOJO hospital ntungamo district

Ekichweka 1 : Ebyokumanywa

Entandikwa n'ekigyendererwa ky'okucondooza oku.

Eiziina ryangye ni Atim Grace, kandi ndi omwegi aha Yunivasite ya Uganda Christian University ndikushoma diguri ya kabiri omu by'amagara g'abantu. Ndiyo ninkora okucondooza okushwijuma ebirikugwera abaishiki abakiri bato omubwire bw'okutwara enda hamwe n'okuzaara. ekigyendererwa ky'okucondooza oku n'okumanya oburemeezi obu abakazi eminyeeto barikutunga omukutunga obuheereza bw'eby'amagara omu irwariro rya Itojo.

Niki ekireije kubaho waaba ori omu kucondooza oku?

Nitukushaba kwejumba omu kubuuzibwa ebibuuzo erizooba. Ebibuuzo nibiija kuba nibikwata ahari:

Oburemeezi oburikushangwa abakazi abakiri bato, eby'obuhangwa ebirikukwata aha magara g'abakazi abakiri bato, ebirikukwata aha miteekateekyere y'abakazi abakiri bato, ebibuuzo ebi turikuza kubuuza n'ebirikukwata aha ku orikuteekateeka. Tihariho eby'okugarukamu ebihikire nainga ebitahikire ahabibuuzo ebi turikuza kubuuza. Eki ti kigyezo. Ku oraikirize kwejumba omu kucondooza, noija kushabwa kumaririza okubuuzibwa. Okubuuzibwa nikwija kutwara edakiika nka 15 nari 20.

Ahabwenki nooshabwa kwejumba omu kucondooza oku? Nitukushaba kwejumba omu kucondooza oku ahabwokuba ori memba w'ekicweka ky'e itojo kandi otoorainwe kwejumba omu kucondooza oku.

Hariho akabi koona akarikubaasa kubaho ahariiwe?

Nituteekateeka ngu hariho akabi kakye ahariiwe waaba ori omu kubuuzibwa oku. Titurikwija kugambira omuntu weena ebirikukwata aha kwejumba kwawe omu kubuuzibwa oku. Nitukora okubuuzibwa oku omu mwanya gw'ekihama okubaasa kukyendeeza akabi aka. Hariho oburemeezi ngu noobaasa kuhurira enshoni nainga otarikushemererwa ahabw'ebibuuzo ebimwe omu kubuuzibwa. Noobaasa kusharamu amakuru agu orikwenda kutugambira. Noobaasa kwehuzya ekibuuzo kyona eki otarikwenda kugarukamu. Noobaasa kurekyeraho okubuuzibwa eshaaha yoona. Titurikwija kugambira omuntu weena ngu okaba

ori omu kucondooza nainga eki watugambiire, kwonka hariho omugisha ngu abantu abandi nibabaasa kumanya ngu okaba ori omu kucondooza.

Hariho emigasho yoona erikubaasa kukugasira? Tihariho migasho y'omutaano ahariiwe ahabw'okwejumba omu kucondooza oku. Kwonka, amakuru agu orikutugambira nigabaasa kuhwera omu kutunguura obuheereza omu bakazi abato boona.

Nookora ki waacwamu ngu torikwenda kwegaita aha kucondooza oku?
Oine obugabe kwanga kwejumba omu kucondooza oku. Oine obugabe kureka kwejumba omu kucondooza eshaaha yoona. Tihariho kibonerezo ekirikwija kukuheebwa waaba otarikwejumba omu kucondooza. Noobaasa kuruga omu kucondooza eshaaha yoona, nobu waakuba oikiriize. Tihariho kibonerezo kyona ekirikwija kukuheebwa waacwamu kurekyeraaho kwejumba omu kucondooza. Okwejumba omu kucondooza tikirikwija kuteganisa obuheereza bwona obu orikutunga.

Eby'ekihama
Nituza kukora kyona ekirikubaasika okurinda ebirikukukwataho n'okwejumba kwawe. Nitwija kukubuuza omu kihama. Nitwija kukoresa enamba y'omuntu omu kubuuzibwa, omu mwanya gw'eiziina ryawe. Nitwija kwihaho byona ebirikugamba aha iziina ryawe. Titurikwija kukoresa eiziina ryawe omu ripoota yoona. Nitwija kureeba ngu amakuru goona agu turikuza kuta omu ripoota, tigarikukumanya. Ebikwato by'okurundaana ebihandiiko nibibaasa kushwijumwa abakyondoozi abandi, hamwe n'akakiiko k'emitwarize. Nimbaasa kugabana

amakuru agu orikuheereza n'abantu abandi, kwonka tindikuza kugabana eiziina ryawe nainga ekintu kyona ekirikukumanya.

Okushumbuusibwa, tihaine esente ezi orikushashura okwejumba omu kucondooza oku, okwihaho obwire obu orikumara omu kubuuzibwa. Abeejumbemu boona nibaija kushangwa omu byaro byabo okubaasa kwetantara okushashura esente z'engyenda.

Ku oraabe oine ekizibu nainga ebibuuzo? Ku oraabe oine ebibuuzo ebirikukwata aha kucondooza, tera ahari: (0774085722)

Obugabe bwawe nk'okwetabamu nibuuha?

Ekiteiso eki kyashwijumwa kandi kikaikirizibwa akakiiko k'eby'obutegyeki aka Uganda Christian University REC, omurimo gwaako n'okureeba ngu abarikwejumba omu kucondooza barindwa akabi. Noobaasa kumpereza ebibuuzo ebindi byona ebirikukwata aha kucondooza, waaba noyenda. Oine ekibuuzo kyona?

Ekicweka kya kabiri: Satifiketi y'okwikiriza

Nshomire ebihandiiko ebiri ahaiguru, nainga byanshomirwe. Ntungire omugisha gw'okubuuza ebibuuzo ebirikukwata ahari kyo, kandi ebibuuzo byona ebi naabuurize, bikagarukwamu kurungi. Ninyikiriza okwejumba omu kucondooza oku nk'oku ndikwenda.

[Oyejumbiremu ashemereire kuta akabokisi ahaiguru]

Ninyikiriza n'omutima gwangye kwejumba omu kucondooza oku. Eego / Ngaaha /

Ninyikiriza n'omutima gwangye gwona ngu okubuuzibwa kwangye kukwatibwe. Eego □ Ngaaha □

Eiziina ry'omwejumbu, eizooba .....

omukono gw'omwejumbi.....

Omwegi ku araabe atarikubaasa kushoma foomu ye, omujurizi ashemereire kuta omukono ahansi: Nkaba ndiho obu foomu y'okwikiriza ehairwe omukozi. Ebibuuzo by'abaheekyera boona bikagarukwamu.

_____

Amaziina gwomujuruzi _____ ebiro

_____

Date_____

Omukono gwomujuruzi _____

Ekihandiiko ky'omucondooza/omuntu orikwikiriza, nikworeka ngu omuringo n'ekigyendererwa, engyenderwaho, emigasho, hamwe n'oburemeezi oburikubaasa kureetwa okwejumba omu kucondooza oku, bishoboroirwe omuntu ori ahaiguru, kandi yaikiriza kwejumba omu kubuuzibwa.

eiziina ry'omucondoozi/omuntu orikwikiriza.....

Omukono gwomuchondozi, ...

Ebiro.....

APPENDIX II: IN-DEPTH INTERVIEW GUIDE ON LIVED EXPERIENCE OF TEENAGE MOTHERS DURING PREGNANCY AND CHILDBIRTH

Section A: Demographic information of the respondent

1. How old are you?.....
2. What is your current level of Education? …….
3. Are you currently married? Yes/No?.....
4. Do you currently have any employment?.....
5. How many children do you have?.....

Section B: main study questions

1. Please describe your initial reactions when you found out you were pregnant?.....
2. What kind of support did you receive during your family friends and community during your pregnancy?.....
3. What challenges did you face during pregnancy as a teenager?

   .....
4. Please describe your experience with healthcare providers during your pregnancy and childbirth.....

5. How did your pregnancy and childbirth experience affect your education or carrier plans?.....
6. What was your experience like during child birth?

   .....
7. How did you prepare for the arrival of your baby?

   .....
8. How has becoming a mother as a teenager affected your relationships with your family and friends?.....
9. What are your thoughts on the societal perception of teenage mothers?

   .....
10. What advice would you give to other teenage mothers based on your own experiences?.....
11. Is there anything else you would like to share about your experience as a teenage mother during pregnancy and childbirth? Why or why not?.....

A translated version of the In-depth Interview Guide (In Runyankore/ Rukiga).

1. Shoborora okuwahurire waheza kumanya ku oine enda?.....
2. Okaboona obuyambi bwamuringo ki kuruga omubantu baawe nabataahi banyu omurugyendo rwenda yaawe?.....
3. Okakira kugumirwa ki omukugira enda haza ori muto?.....
4. Shoborora oku abashaho bakutwariize nk'omishki muto atwiire enda?.....

5. Nibuzibu ki obu washangire omukugira enda nokuzaara bikakuretera aha kushoma n'ebiroto byawe byomumaisho?.....
6. Okuzaara kwawe kubaba kuta?.....
7. Oketekatekyera ota okuzaara?.....
8. Okuba omuzeire wemyaka egyi kikuteganise kita aha kukwatanisa kwawe nabeeka nabanywani baawe?.....
9. Hereza ebitekateko byawe aha ntekateka yabataka ahakugira enda okiri muto?.....
10. Nohereza buhabuzi ki eminyeto ahakugira enda batakahikire kurugir'ra ebyorabiremu?.....
11. Nikikwanguhira kugaanira nabandi bantu ahabyorabiremu oine enda n'omukuzaara otakahikize myaka?..... Ahabwenki? …….

UGANDA CHRISTIAN UNIVERSITY
A Centre of Excellence in the Heart of Africa

18th March, 2025

The District Health Officer
Ntungamo District
P.O. Box, Ntungamo

Permission granted to Conduct the research
Advised to adhere to the REC. Good luck
for

DISTRICT HEALTH OFFICER
31 MAR 2025
NTUNGAMO DISTRICT

The Medical Superintendent
Itojo hospital
P.O. Box 046, Ntungamo

forwarded
31/3/2025.

MEDICAL SUPERINTENDENT
ITOJO HOSPITAL

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT ITOJO HOSPITAL

Greetings from Uganda Christian University!

This is to introduce to you Atim Grace **(Access number B23589 & Reg. No. RM23M07/013)** who is doing her research study for the award of the degree in Master of Public Health, Leadership (Save the Mothers) at Uganda Christian University.

The student's topic is ***"A study to explore the lived experience of teenage mothers during pregnancy and childbirth at Itojo Hospital Ntungamo District"***.

Any assistance given to her will be highly appreciated.

Thanking you for your cooperation.

Yours Sincerely,

UGANDA CHRISTIAN UNIVERSITY
18 MAR 2025
FACULTY OF PUBLIC HEALTH NURSING & MIDWIFERY

Ayebare Andrew
Assistant Academic Registrar, Faculty of Public Health, Nursing & Midwifery
Uganda Christian University

UGANDA CHRISTIAN UNIVERSITY
A Centre of Excellence in the Heart of Africa

Office of the Vice Chancellor
Research Ethics Committee UG-026

12th March, 2025

ATIM GRACE
Uganda Christian University
0774085722
Email: atimgrace8@gmail.com

UG-REC-026 APPROVAL NOTICE

To: **Atim Grace**, Principal Investigator

Re: UCU-REC Application titled: *A Study to Explore Lived Experience of Teenage Mothers during Pregnancy and Childbirth.*

Application Number: **UCUREC-2025-794**

UGANDA CHRISTIAN UNIVERSITY
APPROVED
UNTIL
12 MAR 2026
RESEARCH ETHICS COMMITTEE

Version: 4.1
Type: [ ] **INITIAL REVIEW**
[ ] Protocol Amendment
[ ] Letter of Amendment (Loa)
[ ] Continuing Review
[ ] Material Transfer Agreement
[ ] Other, Specify:

I am pleased to inform you that the **UG-REC-026**; UCUREC approved the above referenced application.
Approval of the research is for the period from **12th March, 2025**, to **12th March, 2026**
This research is considered minimal risk category.
As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and additions to the protocol or the consent form must be submitted to the REC for re-review and approval prior to the activation of the changes. The REC application number assigned to the research should be cited in any correspondence.

3. Reports of unanticipated problems involving risks to participants or other must be submitted to the REC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for REC review.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the REC eight weeks prior to the above expiration date of 12th March, 2026 in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. Your research details have been shared with the Executive secretary of Uganda National Council for Science and Technology (UNCST) and you are **not** required to get clearance since you are a Master's Degree research. Refer to UNCST Research registration and clearance Policy and guidelines (July 2016) in Uganda section 6(e).

The following is the list of all documents approved in this application by **UG-REC _026:**

	Document Title	Language	Version	Version Date
1.	Protocol	English	1.0	2025-02-01
2.	Informed Consent form	English	1.0	2025-02-01
3	Interview guide	English	1.0	2025-02-01
4	Interview guide	Runyankole	1.0	2025-02-01

Signed and Stamped

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Prof. Peter Waiswa.
UCUREC Chairperson,
pwaiswa@musph.ac.ug

UGANDA CHRISTIAN UNIVERSITY
APPROVED
12 MAR 2026
RESEARCH ETHICS COMMITTEE

Research and Ethics
P.O. Box 4. Mukono. Uganda. Plot 67-173. Bishop Tucker Road. Mukono Hill

APPENDIX III: TIME SCHEDULE (GANTT CHART) IN WEEKS (TWO MONTHS, FEB-MARCH)

TASK	WEEK 1-2	WEEK 3-4	WEEK 5-6	WEEK 7-8	WEEK 9-10	WEEK 11-12
LITERATURE REVIEW						
RESEARCH DESIGN AND METHOLOGY						
PARTICIPANT RECRUITMENT						
DATA COLLECTION						
DATA ANALYSIS						
WRITING AND DISSEMINATION						

APPENDIX IV: BUDGET

SN	Activity	Amount (Ugx)	Rate (Ugx)	Total (Ugx)
Proposal development and approval				
1	Ethical review and approval	1,500,000		1,500,000
	Sub-Total **1,500,000**			
Data collection costs				
1	Research assistants' facilitation	30,000	3*20 days	1,800,000
Sub-Total **1,800,000**				
Travel				
2	During ethical approval (Private means)	500,000	Lump sum	500,000
3	During data collection (Private means)	100,000 per week	weekly *8	800,000
4	During dissemination (Private means)	500,000	Lump sum	500,000
Sub-Total **1,800,000**				
Supplies and services				
Internet services		10,000 per week	12 weeks	120,000
Photocopying		200,000	Lump sum	200,000

Books and pens	50,000	Lump sum	50,000
Data analysis	1,000,000	Lump sum	1,000,000
Sub-Total **1,370,000**			
Dissemination			
Conference fee	1,000,000	Lump sum	1,000,000
Grand total			**7,170,000**