EXPERIENCES OF MEDICAL NEGLIGENCE DURING CHILDBIRTH AMONG RURAL WOMEN IN NTENJERU SUB-COUNTY, MUKONO DISTRICT

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DECLARATION

I, NAMARA SARAH GOLDEN, declare that this piece of work is my original work; it has never been presented anywhere for any award in any University or higher institution of learning in Uganda. However, where necessary, due acknowledgments have been made.

Registration Number.IRS19M07/135

Signature ....

Date.......... 18/02/2025 ....

APPROVAL

I hereby approve that this proposal was done by Sarah Golden Namara under my supervision. It is now ready for submission for examination.

Name. Kobusingye Jacqueline

Signature ……………………………………………………………………………..

Date……………………………………18/02/2025…………………………………………….

DEDICATION

I dedicate this work to my family members particularly my Husband, your enduring support has enabled me to get this far. My sister Namara Rebecca Loi for believing in me and starting this great journey. Am further grateful to my sponsors, Scott and Carol Aubuchon for their generous financial and spiritual support to see that this study comes to a conclusion.

ACKNOWLEDGMENT

I acknowledge the role of my supervisor whose guidance has brought me this far. Am forever grateful to you Madam Kobusingye Jacqueline. You made sure I never gave up.

ABSTRACT

The study set out to research on the topic,"lived experiences of medical negligence during childbirth among rural women in Ntenjeru sub-county, Mukono district" (i) The research topic was guided by three research objectives which were; To explore the mothers' perceptions of medical negligence during childbirth among rural women.(ii)To understand the challenges faced by rural mothers who experience medical negligence during childbirth.(iii)To identify coping mechanisms which can handle challenges faced by rural mothers who experience medical negligence during childbirth. The study employed a phenomenological research design, utilizing a qualitative research approach. A total of 25 mothers who had experienced medical negligence constituted the participants for the study. Interviews were conducted with the 25 participants. Data was entered in NVivo version 14, coding was undertaken and themes were formed to make meaning out of the data. The data was analyzed thematically and presented verbatim.

On objective one, the study concluded that mothers in the rural areas perceive health workers to be rude and not caring to pregnant mothers, perceived loss of trust in the government health facilities, perception on medical negligence included the cause of death for both the mother and the baby, mothers were not knowledgeable on long term effects of medical negligence, and mothers perceived medical negligence to cause trauma and anxiety. On objective two, the study concluded that, mothers received inadequate care, travelled long distances to access medical services, limited knowledge on medical negligence and financial difficulties were some of the challenges faced by the mothers. On objective three, the study concluded that, mothers coped with medical negligence by seeking second opinion of medical officers from personnel who they considered superior or more advanced in the medical field, made use of the support from family members, they utilised the help of village health teams, mothers consulted spiritual leaders to help them heal, and other mothers who could afford visited professional counsellors to help them heal. The study recommends that more sensitization is done to educate mothers on

medical negligence. More recruitment of skilled health workers in government health centres.

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LIST OF ABBREVIATIONS AND ACRONYMS

World Health Organization……………………………………………………………………………………. WHO

Ministry of Gender Labour and social development………………………………………………MGLSD

CHAPTER ONE: INTRODUCTION

1.1 Introduction

This chapter includes the introduction, background, problem statement, general research objective, specific research objective, research questions, scope, justification, significance, theoretical framework.

1.2 Background of the study

Childbirth, according to the observations made by Dweck et al. (2022), is considered one of the major and important events in the course of women's lives. These events are associated with huge anxiety but always bring very joyous and lifetime memory. However, the picture may change into trauma due to medical negligence. Birth injuries in medical negligence will involve a health professional failing to act at the standard of care, causing injury to either the mother or the baby. This is especially more common in rural areas (Iyio,2016).

While maternal health inequities gain momentum, with increased calls to raise the level of obstetric care a notch higher in a rural setup, few studies have been done regarding research into the lived experiences of women who suffered medical negligence during childbirth. These would have helped in formulating policy interventions and health care practices through which mechanisms may be rendered to avoid occurrence and consequences of further incidents of medical negligence.

Studies carried out in different parts of the world have pointed out that maternal health outcomes and experiences differ. Medical negligence issues are more pronounced in vulnerable populations and among women of lesser means (McCloskey et al., 2021). The statement above is supported by the fact that in 2023 alone, an estimated 260,000 women around the world lost their lives due to complications related to pregnancy and childbirth. That means, heartbreakingly, a mother dies somewhere in the world every two minutes—lives that could often be saved with timely and quality care.

The region also has the highest maternal mortality ratio (MMR) in the world, based on the most recent statistics. The MMR in the region during 2020 was projected at 545 deaths per 100,000 live births, which was significantly higher than the global

average of 223 deaths per 100,000 live births. What this means is that nearly 70% of all the maternal deaths that were accounted for globally occurred in Sub-Saharan Africa during the year 2020.

The major challenge is that most of the low-income countries and those still developing face enormous challenges in offering equitable, safe maternal health care. The country has been historically burdened with a high MMR, currently standing at 368 deaths per 100,000 in 2021, according to Uganda Bureau of Statistics, 2021, though on the decline for some time. However, the maternal deaths are still worrying, and birth medical negligence is suspected to be one of the causative factors leading to such unplanned events (Ruder et al., 2018).

The Ugandan health infrastructures depict a mix of both public and private health providers that offer varying levels of care with varied accessibility to services. This may raise some issues of proper access to quality maternity care, though not in most cases, since only a few health facilities may be in the rural areas. The country has a total number of 6,937 health facilities according to the Ministry of Health, 2023, comprising those from the public, private, and non-profit sectors.

Government owned are 45.16% 3,133, private and not for profit 1,002, private for profit 2,795 and community owned facilities 0.10% 7. Currently Uganda has a population of over 45 million which is served by the above facilities which points to a disparity in health service provision. As Nabaweesi et al. (2021) explicate, the doctor-to-patient ratio currently stands at 1: 24000 in Uganda, which points to the argument that it is easy for medical negligence to occur to a woman giving birth owing to the above doctor-to-patient ratio standing below the recommended ratio of the World Health Organization, which is 1: 1000.

Socioeconomic inequities have cropped up as one of the major determinants of maternal health care outcomes. Women from rural and poor areas face much larger barriers to accessing health services, which raises the chances of medical malpractice.

While the government is working hard to make as many qualified midwives such as midwives and nurses available, shortfalls of such personnel, along with

discrepancies in training and competence, lead to medical malpractice. The ratio of midwives to patients in Uganda is 1: 9000, and nurses to patients stands at 1: 1700; this indicates the gap within the Ugandan healthcare system (Kakyo & Xiao, 2019). This kind of care for pregnant women may be compromised since facilities are understaffed and overcrowding is at a high. Timely utilization of emergency obstetric care forms the effort toward the prevention of maternal mortality and management of complications. This however often becomes not accessible in most rural areas hence leading to promoting medical negligence. Such facilities are however limited as described by Dowhaniak (2021).

The discussions above place the relevant field of interest in context in seeking to understand experiences around birth injury and medical negligence in Ugandan women. These discussions secondly instigate debates on considerations toward country environments within specific healthcare challenges, correctly crafting interventions and policy formulation aimed at managing these challenges while ensuring safer health care for mothers.

1.3 Problem statements

The World health organization (2023), notes that significant strides have been made in regard to maternal health care globally. The statistics show that between 2000 and 2020, the global maternity ratio reduced by 34%, from 339 to 223 deaths per 100,000 live births. However, despite the above progress, challenges persist. In 2020, over 287,000 women died during pregnancy and at child birth (WHO, 2023), indicating that although progress has been registered, the numbers remain unacceptably high, which points to a gap in maternal health. As of the 2023 WHO report, the estimated worldwide MMR is 197 deaths per 100,000 live births. This is approximately one death per two minutes, and an estimated 260,000 deaths in 2023 globally.

Sub-Saharan Africa remains the region with the highest MMR, accounting for 70% of global maternal deaths. The regional MMR is about 545 deaths per 100,000 live births.

In Uganda, the health sector is bedevilled by challenges which affect maternal health. The Uganda maternal mortality ratio is reported at approximately 189 deaths per 100,000 live births by national estimates and the WHO (2023).

These challenges are intensified by systemic failures such as a shortage of healthcare staff, lack of essential medical resources, and poor communication between patients and healthcare providers (Kakyo & Xiao, 2019). These deficiencies contribute to disturbingly high rates of maternal complications and deaths, with many women experiencing delays in receiving critical care or inadequate attention during childbirth (Nambatya et al., 2019).

According to Byamugisha (2018), the absence of a reliable health care system, coupled with limited access to trained medical officers during childbirth are drivers of the prevalence of medical negligence in rural areas. Uganda falls short of the world health organization doctor patient ratio of 1:1000, as its ratio stands at 1:25725 (International society for Quality in health care, 2023).

While the above is true for some parts of Uganda, the personal experiences of the women affected by medical negligence, particularly those in Ntenjeru Sub-County, remain under-explored as there is no documented study that has been carried out in Ntenjeru Sub County regarding medical negligence of mothers. A rigorous search on different search engines has proved so. Undertaking research into these women's experiences in regard to medical negligence is necessary in improving maternal healthcare (Kiwanuka et al., 2020).

1.4 Purpose of the study

The purpose of the study was to explore the experiences of women who have experienced medical negligence during childbirth in Ntenjeru Sub-County, Mukono Municipality.

1.5 Specific Objectives

i. To explore the mothers' perceptions of medical negligence during childbirth among rural women.

ii. To understand the challenges faced by rural mothers who experience medical negligence during childbirth.

iii. To identify coping mechanisms which can handle challenges faced by rural mothers who experience medical negligence during childbirth.

1.6 Research Questions

i. What are the mother's perceptions of medical negligence during childbirth among rural women?

ii. What are the challenges faced by rural mothers who experience medical negligence during childbirth?

iii. What are the coping mechanisms that can handle the challenges faced by rural mothers who experience medical negligence during childbirth?

1.7 scope

1.7.1 Content scope

The study concentrated on the content which is contained in the research variables which were identified in line with the research topic. The research topic is *"experiences of medical negligence during childbirth among rural women in Ntenjeru sub-county, Mukono district"*.

Guided by the socioecological model, variables were also identified for the study and these concerned themselves with the experiences of women who faced medical negligence.

1.7.2 Time scope

The study considered the time period of 14years as this was sufficient to inform the study on the evolution of medical services in Ntenjeru sub county in relation to medical negligence. That is from 2010 to 2024.

1.7.3 Geographical scope.

The study was carried out in Ntenjeru sub county, in Mukono district. This because Sabano (2023) notes that Ntenjeru sub county health centers do not have the essential health machines like the ultra sound machine, which forces mothers to walk long distances in search of equipped health units thereby contributing to medical negligence.

1.8 Justification

The research is justified in the light of a few key reasons discussed below.

The lives and health of women in labour are priceless enough to be foreborne in the name of safety. Medical negligence in such cases can cause severe harm, trauma, and sometimes death to such women. In this context, research studies help in making an estimation of the magnitude of the problem, finding out its cause, and determining effective means to prevent this negligence from causing lives and health of the women and new-born babies.

The topic is very relevant and important for public health. Excellent maternal care can avoid maternal and infant mortality. Addressing negligence in childbirth can contribute to the necessary fundamental step to that important aspiration of public health.

This may bring in some accountability within the health care system. Finding the incidents of negligence and studying their roots may bring improvement in the quality, safety, and accountability of providers in health care in order to avoid further incidents.

It means that each one has the right to be treated in a health care setting, having no harm caused and being treated respectfully. Broader issues of patient rights and consent among others are what this research bases on. The women's experiences about medical negligence at child delivery would thus provide information toward the formulation of policies and practices which place first such rights while keeping the woman informed and empowered through her healthcare journey.

Past Research also revealed health disparities in medical negligence. These were common among the most vulnerable, including poor women and those from marginalized groups. That such disparities should be identified is important if equitable health care is to be developed.

1.9 Significance

This present study shall give women a chance to be enlightened with regards to their rights since birth and options just in case negligence has taken place. By doing so, women will be their own advocate in their health thus allowing improvement in their relationship with the provider.

Birth traumas due to medical negligence can cause serious traumas in women, both of an emotional and psychic nature. The depth ensured by research may lead to the elaboration of interventions and supports in mental health and resilience for individuals who go through such trauma.

1.10 Theoretical Framework

Social ecological model

The social ecological model by Boukaya (2018), explains the way in which different societal factors shape each person's behaviors and experiences. This also encompasses medical malpractice at birth. The factors operating at individual, interpersonal, community, institutional, and societal levels contribute to the experiences of women. Personal factors involve knowledge, attitude, and belief about childbirth and health care. Interpersonal factors involve relationships of members of the family, friends, and relationships with health providers. Community factors will involve access to quality health care services and appropriate cultural norms that enable the giving of proper care. Added to these, the institutional factors contributing to the quality of care include staffing shortages and a lack of appropriate training among professionals. Other sociocultural factors that may contribute to the rise in risk include socioeconomic disparities and gender inequality.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviewed literature that is related to the topic under study. The literature is in a similar study area which is mothers facing medical negligence. The literature is organized according to the research objectives.

2.2 Mothers' perceptions of medical negligence during child birth amongst rural women

According to Downe et al. (2018) and Larson et al. (2019), agree that feelings of mistrust are common in mothers who, during labour, have been mistreated by the officers in government health centers. Childbirth presents a critical life-threatening moment to the mother because it presents a moment of life or death either to the baby or the mother.

Usually when the mother and the baby emerge out alive, they usually have some minor complications that need immediate attention, while sometimes the needed intervention is major in nature. Statistics from sub-Saharan Africa show that 20% of the women iexperienced mistreatment or disrespectful care during child birth, which is a form of medical negligence (Bohren et al.,2019).

The lack of skilled labour has been identified as one of the leading causes of medical negligence in rural areas in Africa (WHO,2022; Kruk et al.,2018). According to UNICE (2019), only 50% of women in Africa have access to skilled care during child birth. This means that the remaining 50% who don't have access to skilled care have a high possibility of facing medical negligence.

Data from the developed countries suggests that there are better policies and the health indicators attest to the above and this means that these policies are attuned to the needs of maternal health thereby ensuring that the health rights of mothers are observed (WHO,2017).

Ossei-Tutu (2022) argues that mothers in both rural and urban settings have different levels of awareness on medical negligence as more awareness of mothers in urban areas is attributed to more exposure. He adds that Most Rural mothers are unaware of the long-term impacts of medical negligence. Campell (2021) differs with Ossei-Tutu (2022) as he argues that some rural mothers are knowledgeable on

the long-term consequences of medical negligence and can therefore make decisions on maternal health more so when they are due for delivery, they usually go to urban areas to utilize the medical services which are presumed to be better equipped and have highly qualified medical officers. This can reduce the possibility of the occurrence of medical negligence.

Women's right to maternity care is provided for in the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Article 12 of the convention provides for the right for women to access maternal health services.

Another instrument which provides for the right to maternity care which is respectful is the World Health Organization which provides that all women have the right to access maternity care which protects their right to privacy, dignity, and confidentiality and free from harm, and allows them to make informed decisions during Labour and delivery. (CEDAW Committee,2010). Medical negligence is an issue which is affecting both the developed and developing countries and therefore needs a pronged approach. The multi pronged approaches include;

(i)Legal and Regulatory Reforms

Legal reforms are needed to limit medical negligence. Countries like Nigeria are seeking legal reforms in legislation that can bring accountability and transparency into the healthcare sector. Implementing stringent legislation on the accountability of medicine, like has been implemented by the United States' and the United Kingdom's legislations, can bring patient safety along with patient confidence in the healthcare sector (Premium Times, 2025).

(ii) Clinical Governance and Institutional Policies

There should be an effective governance system within healthcare institutions that wards off negligence. In Uganda, increasing levels of negligence, particularly by private hospitals, have been described by Uganda Medical and Dental Practitioners Council as a reason for strict supervisions and adherence to clinic standards where warrants calls (Monitor, 2024).

(iii) Alternative Dispute Resolution (ADR) Mechanisms

ADR processes, such as mediation, are more conciliatory methods of addressing medical negligence claims. Mediation has been viewed as the proper process to avoid the complexity of medical negligence cases by being a platform where the two parties engage in negotiations cordial to each other without the burden of litigation (Mokhtar, 2022).

(iv) Health Information Systems and Technology Innovations

Application of sophisticated technology in medicine can reduce negligence mistakes to a large degree. Use of Electronic Health Records (EHRs) and Clinical Decision Support Systems (CDSS) can improve the accuracy of treatment for a patient. In addition, Explainable AI (XAI) of diagnosis of a disease provides transparency and credibility in machine judgment (Prentzas et al., 2023).

(v) Patient Empowerment and Public Awareness

Patient education and awareness also avert medical negligence. Specialist medico-legal units in South Africa have been called upon to help develop units that can handle complaints suitably and inform patients about their rights in a move to increase accountability (Percept, 2023).

Data from south east Asia shows that one third of maternal deaths are due to violations of fundamental rights during Labour, with 90% of these deaths occurring in poor countries (WHO,2015; Filipi et al.,2015). This is underscored by a survey from India which revealed that 71.31% of the maternal deaths were attributed to medical negligence (Sharma et al.,2022). Cases such as disrespectful maternity care and violation of women's rights were reported.

Some studies reveal that some indirect and direct drivers of medical negligence include age, migrant status, wealth, caste, education, social group, religion, partners, occupation, media exposure, parity, referral status, admission, admission day, and the health care sector (Zaed,2020).

According to Mira et al. (2018), abuse and disrespect during child Labour discourages women who have experienced such mistreatment from recommending

other women to such facilities. In such circumstance, mothers are referred to health facilities where mothers believe are free from cases of medical negligence.

The plight of mothers is highly influenced by their experiences during labour. For example, mothers who have postpartum depression as a result of medical negligence tend to have mental health issues which need immediate attention. such mothers have feelings that make them feel bad about themselves and their own babies (Zaed et al.,2020). Anxiety is also highly linked to medical negligence during child labour and this anxiety has negative effects on the life of mothers. Averting medical negligence can be one way of avoiding postpartum cases that can be dangerous to mothers (Vismara et.,2017).

It is also argued that the perception of medical negligence by mothers is not only affected by their mental health but also by the environment in which they inhabit. Trumnel et al. (2018), argues that the perception of the mother and her environment can affect how the mother views her infant and how sensitive she can be towards the baby. If the mother experienced medical negligence that gravely affected her health, she is more likely to have negative feelings towards the baby because she will keep in her mind that the baby is responsible for her fate/situation. Such a mother is likely to find it difficult to have another baby because of her earlier experiences which were not good. One must argue that the baby is not its own creation but that it is a product of human activity which is natural. Such mothers need help to review their perception on medical negligence.

2.3 Challenges faced by rural mothers who experience medical negligence during childbirth

High maternal mortality rates in Uganda have been attributed to social economic and political instability which includes the destruction of health facilities and reduced the number of health workers. This created a dearth in the number of health workers which meant that there were to be less qualified health workers attending to mothers in rural parts of Uganda (Kalule -Sabiti et al.,2014). Parts of Northern Uganda, Eastern, Central and Western Uganda have all faced the challenge of limited health facilities and medical officers, thereby contributing to cases of medical negligence.

Mothers have received inadequate care from non-qualified or less qualified personnel which has contributed to medical complications which have in many cases claimed the lives of mothers and their babies (Kruk et al.,2018). These outcomes are considered avoidable if the right policies are in place to ensure that mothers receive the needed health attention during child birth. Uganda still faces a critical shortage of medical personnel. In 2023, the ratio of doctors to population is approximately 1.8 doctors per 10,000 or one doctor per every 5,555 individuals, which is less than the World Health Organization standard of one doctor for every 1,000 citizens (Daily Monitor, 2024). Uganda has approximately 7,793 doctors for a population of over 45 million people, an enormous shortage in health provision (Uganda Broadcasting Corporation, 2023).

Despite ongoing endeavors by the government of Uganda to bridge this shortage e.g. training 1,747 medical interns in 2023, including 911 medical doctors and dentists the density of the overall health workforce remains merely 23 health workers per 10,000 population (UBC, 2023). This is also less than half of the WHO benchmark of 45 health workers per 10,000 population.

The challenge of medical negligence is exacerbated by the problem of transport which affects the already wanting health sector as mothers have move long distances to access medical care and yet sometimes the situation is of emergency nature which calls for immediate attention. The lack of immediate response leads or contributes to medical negligence (Ajari & Ajilong,2020).

Women who lived 5km away from a health Centre were three times more likely to die due to maternal deaths as opposed to those who lived close to a health facility (Lacet Global Health,2016; Ngoma et al.,2019).

Research by Kruk et al. (2018), shows that financial constraints complicate the access to quality health care for most mothers in rural areas of Uganda. Financial challenges force mothers to consider low-cost health centres which endanger the lives of mothers by increasing the possibility of mothers experiencing medical negligence which may lead to their death.

From the Uganda National Household Survey (UNHS) 2019/2020 conducted by the Uganda Bureau of Statistics (UBOS), rural poverty stood at 32.8% and extreme poverty at 8.4% of the rural population. These figures indicate the wide poverty gap between the rural and urban residents in Uganda.

Furthermore, over 56% of rural Ugandans face difficulties accessing healthcare services (Uganda Ministry of Health Report,2022).

Rural mothers find it difficult to advocate for their health needs because partly their education levels are very low with statistics showing that 27.2% being illiterate (Uganda National Household Survey, 2021/2022). The educated 71.3% for women, are mostly concentrated in urban centres where there is better health care while the 60% of rural women in Uganda are illiterate and all these are in rural areas where health care is very wanting.

Some of the reasons which prevent mothers from speaking out about medical negligence in health centers and their own experiences is because of cultural norms.

In societies which are considered patriarchal like Uganda where Ntenjeru is found, it is likely that patriarchy dominates and that women speaking out to raise awareness and also to seek justice is unusual. By not speaking out against such practices promotes medical negligence in one way or the other unchallenged.

2.4 Coping mechanism to handle the challenges faced by rural mothers who experience medical negligence during childbirth

Laurenzi (2018) argues that mothers in rural settings use different coping mechanisms when managing medical negligence and such include education and community engagement. This is through the use of village health teams that help them receive more learning on medical negligence and how to handle the situation. Some mothers persist and accept the situation the way it is and never make efforts to intervention from professionals. This is due to different reasons like poverty which doesn't enable mothers to afford fees for counselling or consulting with professionals.

Some mothers seek prayer to seek solace after experiencing medical negligence. Fasting and prayer are largely utilised by many rural mothers as this is the cheapest and most known approach. Prayers are known to provide solace to mothers during difficult times when mothers are desperate and can't understand the situation (Vitorino et al.,2018). Finding peace and a sense of purpose if important to mother s and this can only come through prayer and fasting. Since most religious teachings emphasize forgiveness, mothers are able to forgive the medical doctors and whoever participated in the events that led her to experience medical negligence. Forgiveness is seen to help people to let go but also release the offender form their hearts. This can be seen to supplement other efforts or approaches such as medical treatment and community support (Swinton, 2022; Williams, 2023).

Mothers with premature babies often seek help from advanced hospitals which can provide equipment that accommodate a premature baby. Mothers of this nature are trained on how to care for the baby and also how to care for themselves (Singh, Haider & Gupta, 2021). Seeking medical attention from a referral hospital usually means that the referring hospital has less or no capacity to handle cases which are considered to be of an advanced nature.

Mesenburg et al. (2018) argue that one of the ways of coping with medical negligence is by mothers undertaking antenatal education, which is considered to play a major role in in equipping women with information on pain management techniques, obstetric interventions and strategies that help in reducing the fear and anxiety associated with childbirth.

Duncan et al. (2017) posits that mindfulness training is as part of the training that helps in preparing women for child birth. This enables women to cope with the challenges they may face during and after child birth. It is known to reduce anxiety and fear.

According to Adara et al. (2020), community initiatives and traditional coping mechanisms are approaches that help mothers to cope with medical negligence. Communities supporting a mother who has experienced medical negligence gives a sense of acceptance and hope which she hangs on as she recuperates. During such

hard times, it is good for mothers to be visited and encouraged by community members.

Mothers easily cope with medical negligence when they receive attention from professional counsellors. These help the mother to engage their feelings and emotions which helps them to gently absorb the pain of medical negligence. Enabling acceptance of the situation helps to prevent long term psychosocial issues which may manifest like depression and anxiety (Shea, 2021; Nicholas & Davis,2020).

Furthermore, counsellors are known to bring to the understanding of mothers' resilience techniques like mindfulness, stress management and cognitive behavior techniques, to manage the emotional burden of medical negligence (Neria & Gross, 2020). It is also known that prolonged distress can result from medical negligence which if not managed well may lead to mental health issues (Shea,2021). Counsellors can prevent this by counselling mothers on the different approaches that can be used to avert the situation.

Family being the first unit in society plays a very important role in attending to the problems of its members. When mothers are experiencing medical negligence, the family is the first unit that can support her both financially and socially, and emotionally (Smith & Brown,2020). Such support can only come from stable family members who are economically viable and are willing to support such a mother. It is argued that support of that nature is contingent on family unity and cooperation. families with conflicts may find it difficult to support a mother who is experiencing medical negligence (Mazanderani & Paparini,2022; Goldsmith & Thomas,2021).

Mothers are known to seek a second opinion in the event of experiencing medical negligence. This is done to either confirm or refute their concerns and suspicions (Pradha,2018). This helps mothers to know if their suspicions are true or false. If true then they can seek medical treatment from a more qualified medical facility with more advanced instruments and personnel for treatment. This is usually done by mothers who are financially sound or have strong financial support from family members (Smith,2022). Seeking second opinion reduces anxiety and fear which

negatively affects the mother's mental health. If the suspicions are found to be true, the medical doctor can make professional referrals which can help the mother to manage the situation of medical negligence.

Second opinion provides clarity on the medical status of the mother and this can aid in times when there is need for litigation in courts of law (Jones & Brown,2017).

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter will discuss the research design, target population, sample, sampling techniques sources of data, and data collection procedures used in obtaining the required data.

3.2 Research design

The study used a phenomenological research design which was used to explore and understand the lived experiences of individuals regarding a particular phenomenon. The research approach was qualitative in nature (Cresswell,2019). Phenomenology, as a philosophical framework, focuses on describing and interpreting the essence of human experiences as they are subjectively lived and perceived by individuals, utilizing a qualitative research approach.

According to Kalu and Bwalya (2017), the research design that is to be used in a research study should be appropriate to answer the research questions. Phenomenological research offers several advantages, as highlighted in a number of studies. Girogi,(2020) emphasizes the need for a more rigorous consideration of the women's lived experience, which can be achieved through phenomenological research. Frost (2014) discusses the method's ability to capture the details of participants' lived experiences, particularly in the psychological study of human experiences. Furthermore, long-held beliefs about mental health have also been questioned by phenomenological techniques, which have shown intricate subjective aspects that quantitative methodologies are unable to fully represent (Kang, 2020).

3.3 Area of study

The study was carried out at Ntenjeru Sub County in Mukono district. Ntenjeru was the study area for this study because it had a high percentage of women from disadvantaged backgrounds that faced limited access to healthcare facilities, leading to delayed or inadequate prenatal care (Uganda Demographic health survey,2022). They also received care from overworked, under-resourced, or inadequately trained healthcare providers, increasing the risk of medical negligence. Communication barriers, such as language barriers and low health

literacy, can hinder effective communication between women and healthcare providers.

3.4 Sources of data

The study used both secondary and primary sources of data. The secondary sources included journal articles, dissertations and other credible sources of secondary data.

Primary sources included the mothers who had individual experiences with medical negligence and these ably articulated their individual experiences which formed a basis for the presentation of data in chapter four and discussion of study findings in chapter five (smith,2020).

The use of both secondary and primary data enabled data triangulation more so when it came to literature review, writing chapter one where the problem statement is needed, the discussion of study findings in chapter five (Bryman, 2016).

3.5 study population

The study population included: Rural women who had experienced medical negligence during childbirth, in Ntenjeru Sub County, Mukono district. These were important participants for the study since they belonged to the population that provided the needed data for the study. The participants for the study were identified using snowball approach as they were relevant to the study. They were accessed using the snowball approach were by a woman who had experienced medical negligence referred the researcher to another woman who had an experience of medical negligence. Village health team members were key in helping the researcher to identify the research participants.

Table 3. 1: **sample size determination for the population of study**

Category of participants	Population of study	sample	Sampling techniques
Rural women who have experienced medical negligence during childbirth	30	25	Snowball

Total	30	25	Snowball

Source: Ntenjeru Sub County records 2023.

3.6 Sampling

Snowball sampling was used as a non-probability sampling technique in which research participants who are already engaged assisted in finding potential study subjects in the future. It was especially helpful when researching delicate subjects or when it was challenging to find the members of a population. A small initial group of participants (seeds) was used to begin the procedure. These first participants then suggested to the researcher other members of the target demographic who they knew could be prospective participants. The researcher was then referred to others by those participants, and so on. This enabled the researcher to get the needed participants for the study.

The point of saturation was attained after the researcher realized that there were no new themes being generated to enrich the study.

3.7 Data Collection method

3.7.1 Interview method

The interview method was used to collect data from the study participants. This was because interviews allowed the researcher to explore in-depth aspects of the research topic which needed confidentiality and trust of the participant to be won over by the interviewer. Interview enabled the mothers to freely open up to the researcher and thereby providing data which if not for individual interviews would not have been collected. Interview method proved resourceful in terms of data collection.

3.7.1.1 In depth interviews

The Researcher used in-depth interviews, participant observation, document analysis, and creative methods like storytelling to explore the lived experiences of medical negligence during childbirth among women. In-depth interviews provided detailed accounts of the experiences. Participant observation allowed for firsthand insights into care practices and interactions, while document analysis provided context and validation of narratives.

3.7.2 Documentary Review

Documentary review involved reviewing government health reports at Ntenjeru sub county, as this contained information on maternal health, cases on medical negligence and policy guidelines concerning to maternal health. These methods therefore, assisted the researchers to acquire data regarding women and their experiences.

3.8 Data collection instruments

3.8.1 Interview guide

The study used an interview guide which was designed to explore the research questions to enable mothers to engage in an in depth discussion. The interview guide enabled the researcher to collect the needed data. The interview guide enabled the exploration of different thematic areas that concerned the topic of study.

3.9 Data Analysis

3.9.1 Thematic analysis

Thematic data analysis was done, and the findings presented verbatim. efforts were made to make meaning of big tracts of data through themes development. This process included transcription, familiarization, open coding, axial coding, selective coding, constant comparison, theoretical sampling, thick description, reflexivity, member checking, and reporting findings. First of all, the researcher transcribes the audio recordings and then gets familiar with the data through reading and rereading.

3.9.2 Free coding

It involves line-by-line identification of meaningful segments relating to experiences of medical negligence in childbirth. In axial coding, the codes are taken further into broader categories or themes. These obtained themes would be taken forward for refinement and consolidation at the selective coding level. Constant comparison assures the reliability and validity of the obtained themes.

3.10 Reliability in qualitative research

The study adopted the criteria recommended by Lincoln and Guba (1985). The criteria recommend observing transferability, trustworthiness, dependability and confirmability.

The researcher undertook thick description which helped to observe credibility and trustworthiness of the findings as recommended by Lincoln and Guba (1985). Assurance of integrity within the analysis was achieved through reflexivity and member checking. Findings The presentation of findings were made clear and coherent, setting them in context against existing literature and a theoretical framework.

3.11 Ethical Considerations

Research into the lived experience of medical negligence during childbirth for women was an ethical requirement. Free informed consent of participants; Privacy; Confidence, respect for participant's autonomy; No more than Minimal risk of harm; Beneficence; Justice; Ethics reviewed and approved by the Research Ethics Committee at Uganda Christian University.

Transparent reporting

Every respondent was fully free to ask all his/her questions and to make every other kind of decision anytime during this research process. Stopped data are kept in access-restricted areas. Participants were permitted to withdraw from this study at any time for any reason without penalty.

The results of this study were available and the purpose, procedure, risks, and benefits that may relate to this study were completely explained. Given these ethical considerations, researchers have been able to do research with respect for participants' dignity, autonomy, and welfare while contributing to improvements in health care practice and policy.

CHAPTER FOUR: PRESENTATION AND INTERPRETATION

4.1 Introduction

Results presented from this study were reviewed for interpretation. Information retrieved was from mothers whose lives in their childbirth periods were negligent.

The current chapter represents the presentation of experiences lived by rural women about medical negligence at childbirth in the Ntenjeru Sub-County, Mukono District. Analysis of data thematically captured the experiences, perceptions, and emotional impacts that participants expressed about medical negligence. Interest in this chapter lies in making an appropriate, authentic recording of these experiences through key themes that have been presented from the in-depth interviews.

The themes that organize this chapter represent emergent insights from the data analysis process. Each of them represents another dimension of participants' experiences in relation to medical negligence at childbirth. Quotations from direct responses allowed the experiences of women to be presented so that their voices were truly reflected.

Data was presented in a way that it corresponded to the thematic trend of this chapter, reflecting its complexity. Medical negligence and consequences for women's health, emotional states, and view of healthcare have been discussed.

This was achieved through the setting of scenery by describing demographic background information of participants, narrating experiences shared and unique to women in regard to each identified theme. It would then set the ground for Chapter Five, where findings from the study were interpreted in the context of existing literature and discussed in light of implications for healthcare practice and policy in general.

It was evident that all participants were aged between 25 to 50 years. These were women who had experiences with medical neglect during childbirth.

The study explored the following themes in line with the three research objectives as seen in the table.

Table 4. 1: **Themes**

Themes	**subthemes**	**Description**
Understanding Medical Negligence	Delayed Response	This explains mothers' experiences regarding delayed response to medical negligence
	Vulgarities	Vulgarities are explored by the researcher as medical negligence practice
Impact on Trust in Healthcare	Avoiding government health centers	This explains why mothers' perception shaped avoidance of government health centers
	Corruption	Corruption as a practice that contributes to medical negligence is explained
Consequences of Perceived Negligence	Occurrence of Death	Death as a result of medical negligence is explained
	Trauma and Anxiety	Trauma as a consequence of medical negligence is explained
Physical and	Long-term Health	Examines physical injuries or lasting health

Health-Related Challenges	Complications	issues due to negligence, such as infection, chronic pain, or disability affecting mothers post-childbirth.
	Lack of Adequate Postpartum Care	Highlights the insufficient follow-up care and support received by mothers, leading to unresolved health problems and difficulty in recovery.
	Impact on Future Pregnancies	Explores fears or physical complications that mothers face when considering future pregnancies due to past negligent experiences.
Emotional and Psychological Challenges	Trauma and Anxiety Resulting from Negligence	Describes the emotional trauma, stress, or anxiety experienced by mothers as a result of perceived negligence during childbirth.
	Loss of Trust in Healthcare Providers	Addresses the emotional toll and hesitancy mothers feel toward seeking healthcare services due to mistrust created by past negative experiences.
	Feelings of Isolation and Shame	Explores feelings of isolation, stigma, or shame that mothers may experience, especially when negligence affects their health or the baby's well-being.
Distance and Transportation Barriers		This explains how distance and transportation contribute to medical negligence
Lack of Awareness and Education		This explains how the lack of awareness and education affects mothers.
Cultural and		This explains how mothers experience medical

Social Pressures		negligence are affected by culture and social pressure
Family Support		Explains how family support enabled mothers to cope with medical negligence
Professional Counselling		The role of professional counselling enabling mothes cope with medical negligence is explained
Seeking Second Opinions		The role of second opinion seeking in coping with medical negligence is explored
Engaging in Spiritual or Religious Practices		The role of spirituality in coping with medical negligence is explored
Community Health Workers		The role of community health workers in medical negligence is explored

4.2 What are the mother's perceptions of medical negligence during childbirth among rural women?

The study explored this objective, and themes were developed to explain the findings. The in-depth interviews captured mothers' perceptions.

Theme 1. Understanding Medical Negligence

The study explored the experiences of rural women regarding medical negligence as the failure of healthcare providers to provide the standard care expected during childbirth. This included delayed or inadequate response to complications, lack of attention or respect from medical staff, and failure to provide necessary medical interventions.

Subtheme. Delayed Response

The study explored this subtheme and found that mothers had experienced delayed responses from the health workers/doctors at the health centre where they had gone to give birth. The mothers therefore understood medical negligence in the context of doctors and other health workers taking their time to attend to them and yet their need for medical attention was urgent. This delay caused some mothers to lose their babies in the process of labour.

Table 4. 2: **responses to in-depth interviews with mothers on delayed response**

Observation	**Counts**
Delayed response from the doctors caused the death of my baby	10
Delayed response from the doctors caused me health complications	5
Delayed response from the doctors caused me to experience psychological trauma	5
Delayed response from the doctors caused me birth injuries	5
Total	25

Source: *Research data 2024*

A mother who shared her view during an in-depth interview revealed as seen below;

“Most medical officers/doctors delay to attend to mothers who are due for labour and yet that is a critical moment where the attention of the medical officer is needed. During this moment many mothers more so the inexperienced mothers tend to panic and usually, things go wrong if the doctors delay, I have experienced delayed attention from doctors and this led to the death of my baby two months ago. I have not recovered from that loss. Am still grieving” (**Participant 13, personal communication, July 23,2024).**

The researcher proved that the above mother had lost her baby two months due to medical negligence and the above was corroborated by neighbors who supported her emotionally and financially during the difficult moment.

The above view was shared with other mothers who like the above-quoted mother experienced the loss of their babies, experienced psychological traumas, birth injuries, and other health complications that have been experienced. The above experiences caused the mothers to perceive delayed responses from the doctors and health workers as medical negligence.

Subtheme 2. Vulgarities

The above subtheme was explored and the findings showed that 15 of the 25 mothers who participated in the in-depth interview revealed that they had experienced vulgar language used on them by health workers during labour. To the mothers, vulgar language was undesirable and was not welcome because they claimed that vulgar language caused them increased stress and anxiety, emotional trauma, and erosion of trust in the medical officers. One of the mothers who was quoted verbatim had this to say as quoted below;

“The use of vulgarities on mothers during childbirth is bad as it caused me to have less trust in the doctor/health worker. I felt ignored and not cared for by the health worker who was working on me. She shouted at me while mentioning vulgarities and yet during such moments the doctor needs to handle the emotions of the mother professionally. I have since never returned to seek medical attention from that health facility because I still feel the trauma and the bad memories keep flashing” (**Participant 13, personal communication, July 23,2024).**

The above shows that mother’s perception of medical negligence was shaped by their experiences like the above.

This means that many mothers in rural areas perceive health workers to be rude and not caring to pregnant mothers.

However, on the contrary some mothers believed that the health workers were trained to handle mothers in Labour in a tough manner so that they can accelerate the Labour process and mentioning vulgarities to the mothers is one way of forceful motivation that can be used to cause the mothers to deliver the babies.

A mother argued contrary to the above as seen below,

“Some medical officers don’t care about mothers but the majority care about mothers and being tough on mothers can cause them to give birth. And vulgarities can sometimes cause the mothers to know that they are delivering life of a human being and must therefore be intentional on giving birth. For example, sometimes a mother can be reluctant to open her legs wide for the birth canal to open and it takes the wisdom of a health worker to invoke vulgarities for the mother to open her legs wide and thereby increase the chances of delivering the baby” (**Participant 14, personal communication, July 22,2024).**

The above submission was the only differing voice from the others who believed that most health workers mistreated mothers during labour which led to medical negligence.

From the study findings, it is evident that most mothers reported that they experienced different forms of medical negligence and it is the reason they perceived and understood medical negligence in the way the study findings were captured and reported.

Theme 2. Impact on Trust in Healthcare

The study explored the above theme which concerns mothers' perception of medical negligence. The erosion of trust in the government health centres was driven by earlier experiences which compelled many mothers to develop mistrust in government health centres.

Subtheme 1. Avoiding government health centres

Most rural mothers who had experienced medical negligence in Ntenjeru developed a mistrust of healthcare systems due to perceived or experienced negligence. This mistrust led to reluctance to seek medical help for future pregnancies.

One of the mothers revealed that ever since she lost her baby in Koja health centre IV Ntenjeru, she has made it a point to avoid that health center and that she has had all her babies born with the help of a traditional birth attendant.

"I decided to deliver all my babies from my home with the help of a traditional birth attendant and I don't regret it. The birth attendant is more humane than the trained health workers who act like they are not trained when attending to expectant mothers and yet the traditional mothers treated me with respect and care when I was giving birth. The belief in traditional birth attendants was reinforced when I witnessed many of my friends in Ntenjeru give birth with the help of traditional birth attendants. Traditional birth attendants helped me and am forever grateful to them" (**Participant 17, personal communication, July 23,2024).**

The above is one of the cases where mothers have developed negative attitudes towards medical officers to the extent that they believe that most medical officers are bad and that they would rather seek attention elsewhere during Labour times other than risk going through the same ordeal of abuse that may lead to medical negligence.

The above observation was supported by one of the health workers who argued that the number of mothers who give birth at Koja Health Centre IV, Ntenjeru had reduced in the last two years, and yet the number of mothers who come for antenatal health care was higher. She attributed this to the many mothers who are giving birth at their homes with the help of traditional birth attendants and some Village health team members since these have been empowered by the government to offer first aid but the mothers utilize their services due to ignorance. More so, the mothers who are not educated enough to know that the qualified healthcare workers at Koja Health Centre IV, Ntenjeru can do a better job. It was found that the fear of having health workers mistreat the mothers created mistrust which has had far-reaching consequences of discouraging mothers from giving birth at government health center four in Ntenjeru.

Subtheme 2. Corruption

However, some mothers believed that the mistreatment of mothers by medical officers was largely influenced by the less pay that the government pays medical officers. This caused some mothers to prefer private medical centres/clinics where they believed that medical officers were paid a better salary and therefore offered a better service to the mothers during labour thereby limiting the occurrence of cases of medical negligence. It was because the medical officers were paid less salary/wage by the government.

On the contrary, the result highlighted that health workers employed by the government are in the category of some of the best-paid civil servants as per the government science policy. A Ugandan medical doctor employed by the government earned a gross salary of 5 million ($1,362 US Dollars) to 6 million Ugandan shillings, ($1,633.82 US Dollars). This is one of the best in the region (Independent Uganda,2024).

From a scholarly point of view, what would be the driver of corruption in the health sector when health personnel are paid better than other professionals?

“I have had all my three children born in a private health facility ever since I lost my baby due to medical negligence in a government health center in Mukono district. The doctor wanted me to pay some money which I didn’t have. Because I was new to the whole experience, the nurse used the word which when interpreted in the English language means that you pay some money before a doctor can attend to you. The doctor asked me “oze nensawo yo” which when interpreted means have you come with your bag of money for the doctor? Not having the doctor's money and yet this was a government hospital rendered me helpless and yet I was in labour and my baby died in the process.” (**Participant 18, personal communication, July 22,2024).**

This means that the mother’s perceptions were shaped by how health workers treated them in regard to soliciting for bribes and other monies before they could attend to them.

Furthermore, upon questioning the mother regarding the economic cost of giving birth in a private health setting and how she managed to meet the bills, she replied say;

“I start saving for my treatment in a private health facility the moment I realize that I have conceived a baby. I make sure to save money every week from my expenditure. This helps to cater for the expenses and also my husband is supportive as he makes sure that I have resources when heading to a private clinic” (**Participant 18, personal communication, July 22,2024).**

Theme 3. Consequences of Perceived Negligence

The above theme looked at the perceived consequences and below are subthemes that emerged

Subtheme 1. Occurrence of Death

Through the study, it was established that mothers perceived medical negligence during child birth to cause death of either the mother or the baby. The mothers revealed to the study that as a result of women avoiding health facilities due to earlier experiences of medical neglect, there was increased maternal and infant mortality. The mothers mentioned cases of women who had died as a result of avoiding giving birth from the nearby health centres. Although the cases were not at a high scale as there were only three cases mentioned in Ntenjeru sub county, they shade light on the fears that the mothers have.

“Due to earlier experiences of medical negligence, some women in my community lost trust in the health centers and the health workers and opted for traditional methods of giving birth by way of seeking the services of the traditional birth attendants. This led to some mothers losing life at the hands of the traditional birth attendants during labour” (**participant 20, personal communication, July 24,2024).**

This means that once, mothers feel threatened by the earlier experiences of medical neglect during child birth, they chose other alternatives safe as they may not be.

Subtheme 2. Trauma and Anxiety

Mothers perceived medical negligence to cause trauma and anxiety

Some mothers revealed that they silently suffered from trauma and anxiety as a result of losing babies due to medical negligence.

"Since the loss of my baby to medical negligence at the health center, the doctors never gave me an explanation. I went and buried my baby and this has left me traumatized" ***(participant15, personal communication, July23,2024)***.

The researcher noticed that this mother had just lost her baby three weeks ago as there was evidence alluding to this claim. She was emotionally traumatized, stigmatized and had lost hope at the time of conducting this interview with her. She described the baby to have been big in size and looked healthy, only to be declared dead two hours after birth.

Trauma and anxiety are wide spread among women who face medical negligence during child birth. There were other mothers who also claimed to have suffered trauma and anxiety as a result of medical negligence during child birth.

4.3 What are the challenges faced by rural mothers who experience medical negligence during childbirth?

The themes and subthemes based on the challenges faced by rural mothers who experienced medical negligence during childbirth. This format presents qualitative findings in a structured and accessible way.

Theme 1. Physical and Health-related challenges

Subtheme 1. Long-term health complications

The study found that some mothers experienced long-term health complications. For example, medical negligence during delivery, such as improper handling of prolonged labour, caused damage to the pelvic floor muscles, leading to urinary or fecal incontinence. A mother who suffered the above explained as seen below;

"I suffered damage to my pelvic floor muscles due to the medical negligence that I experienced while in labour five years ago. This caused me fecal incontinence

which happened for a period of one month until I was helped by an NGO which supported and sponsored an operation which stopped the fecal incontinence. I was supported by African Medical and Research Foundation (AMREF), which sponsored my operation. The quality of my life has improved greatly and I no longer experience fecal incontinence, although I still experience back pain which comes occasionally when I do heavy work like lifting items which weigh ten kilograms" (**participant 25, personal communication, July 24,2024).**

While the mother acknowledges that the operation saved her life, she stresses that she still experiences back pain as a result of the medical negligence despite the lifesaving operation.

Some mothers also explained experiencing long-term health complications resulting from medical negligence which included Mental Health Issues (Post Traumatic Stress Disorder). The trauma of experiencing medical negligence led to long-term mental health issues, including post-traumatic stress disorder (Post Traumatic Stress Disorder), postpartum depression, and anxiety, which persisted long after childbirth. A mother revealed as follows;

"I have never fully recovered from the trauma of experiencing medical negligence when in labour leading to the loss of my baby. I still suffer Post-Traumatic Stress Disorder (PTSD) due to the psychological trauma associated with the traumatic birth experience. Due to PTSD, I avoid places, people, or activities that remind me of the traumatic event. To me this means avoiding medical settings and birth-related conversations as they echo sad memories of medical negligence" (**Participant 24, personal communication, July23,2024)**

Subtheme 1. Lack of adequate postpartum care.

The study found that due to a lack of enough skilled healthcare professionals, there was inadequate care during childbirth. When negligence occurs, the consequences can be more severe due to the unavailability of immediate and advanced medical interventions. This causes mothers to suffer from complications that could have been prevented with timely and appropriate care, leading to long-term health issues or even mortality.

This was revealed by some mothers in the interviews conducted and this was quoted as seen below.

“I was attended to by a health worker who was not skilled enough due to the lack of enough qualified medical officers at the time when I gave birth to my first-born child five years ago. As a result, I was not given adequate care and I developed complications resulting from the operation, and the death of my baby. The effects have affected me up to today. I developed obstetric fistulas which have continued to affect me even after I was operated on to solve the fistula problem. This has resulted in chronic pain, incontinence, and severe long-term health issues” (**participant 01, personal communication, July 23,2024).**

The aspect of mothers experiencing the lack of adequate postpartum care was shared by many mothers who argued that upon being discharged from the health center where they have experienced medical negligence, there is no follow-up from the medical officers and yet during that period is when they need attention from the medical officers.

Sub theme 2. Impact on future pregnancies

Some mothers expressed the fear of getting pregnant shortly due to their unfortunate experience of medical negligence. This was quoted verbatim from a mother as seen below;

“I don’t have any intentions of getting pregnant again considering the fear that I have regarding experiencing medical negligence again. I have bad memories which can’t allow me to think of going to the labour room again. I want to avoid the labour room as much as I can. The medical officers neglected me a big deal and I still feel the consequences” (**participant 22, personal communication, July24,2024).**

The above submission came from a mother who was still in the reproductive age as she was 35 years of age and had one kid, and yet she claimed that her husband wanted her to give birth to more kids which conflicted with her experience of medical negligence. This explains that the mother’s mental health was affected.

Other mothers argued that one may have the feeling of not giving birth again considering the trying moment of medical negligence. However, their submission was that one needed to go through healing to be able to again conceive and embrace motherhood. They argued that such servic4es that could enable mothers to heal were not readily available.

Theme 2. Emotional and Psychological Challenges

This theme explores the emotional and psychological challenges that constitute challenges faced by rural mothers who experience medical negligence during childbirth. Below are three subthemes that emerge from the above theme.

Subtheme 1. Trauma and Anxiety Resulting from Negligence

The effects of trauma and anxiety were felt by mothers who had experienced medical negligence during childbirth. Anxiety and trauma often led to insomnia, disrupted sleep patterns, or nightmares, which exacerbated fatigue and stress. Sleep deprivation worsened emotional regulation and increased feelings of helplessness. These mothers struggled with ongoing emotional and psychological effects, which included symptoms of Post-Traumatic Stress Disorder (PTSD) and heightened anxiety in their day-to-day lives. This was revealed by mothers as seen below;

"I can't shake the feeling that something went wrong. Every time I think about the birth, I relive the panic, the pain. I'm always on edge now, scared of something happening to me or my baby. I can't sleep properly, and I keep thinking about what went wrong."(**Participant 23, personal communication, July 23,2024).**

This was the experience with the many mothers who participated in this study. Of the 25 mothers, all the mothers revealed that they had an experience of trauma and anxiety after they had experienced medical negligence.

Subtheme 2. Loss of Trust in Healthcare Providers

This sub theme explored and found that mothers who had experienced medical negligence—such as poor treatment, lack of informed consent, or failure to address complications—felt betrayed by the very system that was meant to care for them.

This sense of betrayal left lasting emotional scars, as mothers feel abandoned or mistreated at their most vulnerable. For example, a healthcare provider who failed to identify a life-threatening issue like postpartum hemorrhage or neglected a complication from childbirth injuries, compelled the mother to question the competency and intentions of healthcare professionals. The mothers who came in touch with this experience had this to say;

"I wondered what was going in the mind of the health worker who declined to attend to me on time and yet I felt my waters had broken and the baby was coming out. He instead was telling me to wait, and I couldn't believe what was happening to the medical officer as he couldn't respond to my situation. It is no wonder I lost the baby through such negligence. From that time, I started to question the competence of medical officers in government health centers. I have never gone to a government health center for medical attention as I now prefer private health centers and I have given birth to all my babies in private health centers" (**Participant 19, personal communication, July 23,2024*)***.

Subtheme 3. Feelings of Isolation and Shame

This theme explored how mothers felt isolation and shame resulting from medical negligence. Mothers found it hard to discuss their traumatic experience with friends, family, or other mothers, fearing they won't be understood or that others will downplay their experience. This led to emotional isolation, as mothers felt that they needed to navigate their trauma alone, disconnected from support networks that might otherwise offer comfort.

"As a mother who has experienced medical negligence, sometimes the people around you and the community may misunderstand you during the difficult time you are going through. This forces the mother to isolate herself so that she is not judged by the community and made to feel shame as a result of experiencing medical negligence which in most cases the society largely attributes to the mother. For example, two months ago when I lost my third baby to medical negligence at the health center three, the community blamed so much for the

death of the baby and yet it wasn't my problem as it was the problem of the medical officer. Because of that I have kept indoors for the last one month to isolate myself as I don't talk to my neighbors but only my husband.my husband understands me" **participant 18/23/07/2024**

Theme 3. Financial Constraints

The study explored this theme and highlighted that many rural families faced financial difficulties, making it hard to afford quality healthcare, legal redress, or follow-up treatment after experiencing negligence. Financial barriers led to a reliance on substandard care, and when negligence occurred, the cost of managing the aftermath was overwhelming. This was recorded from the mothers who were interviewed and this is represented as seen below.

"As rural families we are always incapacitated financially and therefore managing the consequences of maternal negligence can be costly both in terms of time and financial resources. It is one of the reasons I personally never sought legal redress for my baby who I lost as a result of negligence by the health care providers at Koja health centre IV Ntenjeru" (**participant 06, personal communication, July 23,2024).**

Theme 4. Distance and Transportation Barriers

The study revealed that mothers had to travel long distances to access health Centres where they could access doctors and other healthcare providers. The physical distance from healthcare facilities was a significant barrier for rural mothers. During emergencies or in the event of negligence, the time taken to reach the health center four in Ntenjeru was critical. The delays in receiving care worsened outcomes, increasing the risk of complications for both the mother and the baby.

This was revealed by a mother who lost a baby due to the long distance which made it impossible for her to reach Koja Health Centre IV, Ntenjeruon time to be attended to by qualified health workers.

“I lost my baby due to the long distance from my village to Ntenjeru Health Centre IV as there was no emergency transport to transport me to the health Centre four. It was night time and the means of transport were not readily available to help me reach the health Centre on time. Despite overcoming the transportation obstacles, there were no health workers to attend to me” **(participant 02, personal communication, July 22,2024).**

The above description by a mother revealed how distance and transport affected or contributed to the case of medical negligence, but also stressing that there were no health workers to attend to her situation.

Theme 5. Lack of Awareness and Education

Through this study, it was established that many rural mothers had limited knowledge about their rights and what constitutes medical negligence. This lack of awareness prevented them from recognizing negligence or advocating for better care. Without knowledge of their rights, mothers are less likely to seek legal or medical recourse, leaving cases of negligence unaddressed.

“Many mothers like me are unaware of their rights and this has caused us to ignore many cases of medical negligence which we experience. For example, I didn’t sue the health workers who caused the loss of my baby at Ntenjeru Health Centre four in 2017” (**Participant 08, personal communication, July 22,2024)**

This was also supported by another woman who lost a baby through medical negligence. She was quoted verbatim as seen below.

“The fact that we are not educated makes us unable to identify medical neglect, and so we usually just ignore the cases and we don’t do anything serious about the cases like seeking some remedies or cautioning the medical officers so that they don’t continue perpetuating cases of medical negligence. However, it is different as health workers do whatever they wish as they are slow and unbothered when dealing with life threatening issues concerning the lives of mothers in Ntenjeru” (**Participant 10, personal communication, July 22,2024).**

The above experiences show that the lack of awareness on the part of mothers has continued to promote systemic reoccurrence of such cases of medical negligence.

Theme 6. Cultural and Social Pressures

The study established that Cultural norms and social pressures discouraged rural mothers from speaking out about their experiences with medical negligence, particularly in patriarchal societies where women's voices are often marginalized.

Silence and stigma prevented mothers from seeking justice or sharing their experiences, perpetuating a cycle of poor care and negligence.

"Because of the stigma which comes with experiencing medical negligence, our culture tends to suppress us women not to speak up. For example, when I lost my baby due to medical negligence, the members of my village accused me of killing my baby, and yet they didn't know that it was medical negligence. I felt stigmatized as a result of these accusations and I have never spoken out publicly about my situation. Many mothers are experiencing the same situation as mine" **participant 15, personal communication, July 23,2024).**

This means that mothers continue to experience such similar cases without seeking any form of intervention to address the problem of medical negligence.

4.4 What are the coping mechanisms that can handle the challenges faced by rural mothers who experience medical negligence during childbirth?

This research question explored the coping mechanisms that were used by mothers to manage challenges emerging from medical negligence during child birth.

Theme 1. Family Support

Most mothers who were interviewed regarding how they coped with medical negligence revealed that they relied on family members for emotional comfort and practical assistance.

"My family was very supportive during the trying moment when I had lost my baby during labour. My husband, my sisters, brothers, and cousins ensured that my medical bills were settled and that the baby was buried. This helped me to quickly

go through that tough moment of grief and loss” ***(Participant 21, personal communication, July 23,2024).***

Other mothers who had a similar experience of medical neglect also attested in support of having close family members support them during the trying moment of medical negligence, more so when it came to comforting the mothers and showing support financially. This means that family support was a pillar in supporting mothers at this point of need.

Although a family is considered a unit in the community, some community members were critical of some mothers who had experienced medical negligence. These were mostly family members who held on to cultural norms which vilified a woman who lost a baby at birth. The blame was put on the woman without the critics clearly taking time to study and understand the circumstances under which the baby died during birth.

“Some community members have continuously blamed me for the loss of the baby during birth, and yet I am not responsible as I did my best to push the baby, only to be told that the baby was dead. The fact is that the doctors first told me not to push when the Labour pains had come, and later told me to push. This was contradictory as I was following the doctors’ instructions” ***(Participant 03, personal communication, July 22,2024).***

The above underscores the role of family members who not informed well on matters regarding medical negligence.

Theme 2. Professional Counselling

The study established that some few mothers with the help of family members were able to access professional counselling from a qualified psychologist/counsellor. The mother submitted that the professional counsellor helped her to process trauma, manage stress, and develop coping strategies for dealing with the emotional aftermath of medical negligence.

“I was taken to a professional counsellor by my sister. the counsellor helped to go through the tough moment of medical negligence. I felt better after meeting the

counsellor for the first meeting, and I kept meeting her. The sessions were very fulfilling emotionally" ***Participant 22, personal communication, July 24,2024).***

The study found that few mothers had accessed a professional counsellor while most mothers were unable to use access a professional counsellor due to ignorance about the role of a counsellor, and also the mothers did not have money to afford a counsellor.

"I have no idea who a counsellor is, am just hearing from you. Even if a counsellor was to exist, I did not have money at that time to seek the services of a counsellor. The moment I lost my baby through medical negligence, I just decided to go back home and burry my baby. I didn't go anywhere apart from staying at home and taking some medication until I healed" ***(participant 23, personal communication, July 24,2024).***

Theme 3. Seeking Second Opinions

Some mothers (few) sought medical advice or treatment from alternative healthcare providers especially those who lost trust in the local healthcare system. This included traditional healers while others traveled to urban areas for more reliable care. This was used as a coping mechanism for some mothers.

"After the loss of my baby through medical negligence, I decided to travel to Kampala International Hospital for medical consultation. The doctors were good to me. During my baby's birth, my sisters could pay for me at Kampala International hospital to avoid a similar scenario at Ntenjeru Health Centre. The doctors were so good to me and my birth there was a very successful one" (**Participant 04, personal communication, July 23,2024)**

This was the case of a mother who had support from her family members and that these family members were willing to pay for her health bills at one of the top health facilities in Kampala.

However, some mothers attested to having had to consult the services of a traditional healer regarding their situation of medical negligence.

"I had to consult a traditional healer as a way of coping with the tough situation of medical negligence which had befallen me to the extent of causing me to lose a baby which had never happened in my family" **(participant 11, personal communication, July 24,2024).**

Theme 4. Engaging in Spiritual or Religious Practices

When interviewed on the above theme, most mothers agreed to have consulted their spiritual or religious leaders on this misfortune of medical negligence. Many mothers turned to spiritual or religious practices to find solace, cope with grief, and seek healing after experiencing medical negligence. This is because religious communities provide emotional and spiritual support during difficult times.

"I had to go and see my pastor regarding the unfortunate event of medical negligence which happened to me. The pastor read me the scriptures and helped me to pray more and trust the God of Abraham, Jacob, and Isaac. My faith was strengthened. This increased my sense of hope and resilience" (**Participant 23, personal communication, July 23,2024).**

The above represents the many mothers who highlighted that through prayer, and engaging in religious practices, they found comfort and solace to overcome the depressive moments that came as a result of experiencing medical negligence. This underscored the importance of spiritual practices in enabling mothers to manage the emotional and psychological challenges that they experienced.

Theme 4. Community Health Workers

Some mothers revealed that Community health workers like the village health teams who trusted figures are offered guidance and support, particularly in the aftermath of medical negligence. They helped mothers navigate the healthcare system and access available resources.

"Some village health team members were so helpful as they often followed up on my situation, and also, they kept the doctors aware of my recuperation process. At one moment, the village health team member brought here a doctor to confirm if

indeed I was progressing well. This humbled me" (**Participant 04, personal communication, July 22,2024).**

Although some mothers made use of village health team members to help them cope with the case of medical negligence, some mothers didn't use the services of village health team members as they believed that these were part of the failed health system and therefore, they couldn't trust them. The mother was quoted as seen "I can't trust village health team members. they are part of the failed health system" *(***participant 24, personal communication, July 23,2024).**

The above coping mechanisms helped rural mothers to navigate the challenges they faced after experiencing medical negligence during child birth.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter discusses the findings of this study, which examined the lived experiences of medical negligence during childbirth among rural women in Ntenjeru Sub-County, Mukono District. The chapter reflects on experiences of these women in a broader socioeconomic and cultural framework and contributes useful lessons that can help address the problem of medical negligence in health care at large, as well as in the rural context.

5.2 Mothers' perceptions of medical negligence during childbirth among rural women.

On this objective, the study explored themes and these are discussed as seen below.

Theme 1. Understanding Medical Negligence

The study showed that mothers' perceptions of medical negligence during child-birth were influenced by the limited understanding of what constitutes medical negligence, compounded by the inaccessibility of information. Most of the rural mothers experienced delays and poor care as part of the challenges from the under-resourced healthcare setup; thus, they could not realize this as a form of negligence. This agrees with the socioecological model which posits that mothers lack of knowledge on the subject of medical negligence creates the impression that medical negligence is absent and yet mothers actively experience, and can’t speak about it (Cruz et al,2023). This further supports the finding of Smith et al. (2020) that the community accepts poor experiences of healthcare services as normal in a rural context. This theme signifies the place of education and awareness in the lives of women for identification and response to medical negligence.

Additionally, according to Mbekengaet al. (2019), the lack of awareness about healthcare rights and medical standards in rural areas directly impacts maternal health outcomes. This agrees with the findings in the study wherein participants indeed expressed being unsure about how to advocate for themselves; thus, many did not pursue further medical help or reporting of cases of negligence. This

therefore calls for education campaigns and community mobilization geared at equipping rural women with knowledge about their rights, hence making more informed choices regarding their health.

Impact on Trust in HealthCare

According to the mothers who were interviewed in chapter four, perceived medical negligence was an act that made them lose trust in the health care system operated by the government of Uganda. This was because most had lost trust in the health system, having experienced medical negligence in government health centres like Ntenjeru Health centre four. Such mothers preferred seeking medical treatment from alternative areas health providers, more so the private health providers. Medical negligence during childbirth can greatly dent experiences that reduce rural mothers' trust in healthcare systems. This lack of confidence in turn becomes the cause for avoidance of the treatment, suspicion regarding the health professionals, and even a lesser sense of safety inside health facilities themselves (Cheng et al., 2020; Downe et al., 2018; Larson et al., 2019).

Communication and its role in trust

Some mothers were complaining about the health worker's style of communicating. For example, a mother who felt that she did everything humanly possible to have her baby delivered safely was let down by the health worker who told her not to push the baby and yet she was already feeling the labour pains. She felt that communication from the health worker went contrary to what was happening to her, yet still felt that if she had pushed the baby at this time, she would have saved her baby who died just after delivery, thus making this mother lose trust in the health workers at Ntenjeru health centre four hence attributing this death to the baby's tiredness. As noted by the socioecological model, poor communication between the mother and the medical caregiver can lead to a lapse in the management of health situations which have far reaching consequences on the health of the mother (Mabetha et al.,2022). The above observation is supported by Smith and Taylor (2021), who argue that, good communication between health workers and mothers in labour can only serve to sustain the faith of people in them. As Smith and Taylor's (2021) study cited, poor communication at every level

in healthcare accelerates feelings of being let down, snowballing into miscommunication that might undermine belief in the whole system. In an instance when there is a feeling that problems are not solved or that adequate information has not been provided, it may lower confidence levels in both healthcare services and providers (Smith & Taylor, 2021).

Consequences of perceived negligence

The study highlighted that the mothers were aware of the consequences of medical negligence on a mother.

The consequences according to the mothers were short term such as death of the baby and the mother. However, most of the mothers were not aware of the long-term consequences such as chronic pain, infection or conditions like fistula. It was only one mother who reported to have experienced chronic back pain ever since she experienced medical negligence five years ago. She disclosed to the researcher that the medical diagnosis showed that the pain was as a result of the medical negligence which she experienced some five years ago. Whatever the case, this agrees with Brown and Smith (2021), who note that perceived negligence, most especially around child-birth maternal health, creates long-term or permanent scarring effects in individual individuals and in the greater health care system as a whole. These detriments may be to the child birth ranging from post-traumatic psychological trauma to very long-term psychological trauma and distress, even resulting in generalized mistrust of healthcare facilities.

Furthermore, the consequences of perceived negligence are most severe regarding understanding how the individuals deal with their experiences and how healthcare systems may react to avoid such negative consequences.

Trauma

In the research, trauma was inflicted on mothers due to medical negligence.

Trauma is one of the significant severe psychological impacts brought about by medical negligence during and after birth, as stated by Watson and Henderson, (2022).

Trauma after such experiences often manifests in post-traumatic stress disorder, which includes symptoms such as intrusive memories, hyper vigilance, and avoidance behaviours (Lindfors et al., 2020). Many of the mothers interviewed in this study described reliving the trauma of their childbirth experience through vivid flashbacks, nightmares, and constant fear of similar occurrences. This trauma was further compounded by feelings of abandonment and helplessness in cases where mothers perceived negligence or abandonment on the part of healthcare providers. Feelings of failure that a mother may be experiencing can result in significant, long-lasting emotional and psychological burdens. According to Watson and Henderson (2022), traumatic birth experiences can have long-lasting mental health consequences when the mother feels unsupported or betrayed during the process.

Anxiety and Fear of Future Healthcare Experiences

Anxiety is another common response to perceived negligence at birth.

Mothers described anxiety at the time of and subsequent to medical negligence.

The fear of future medical care, related to or unrelated to childbirth or general health care, was a source of ongoing duress. Many mothers reported feeling continually apprehensive or fearful when approaching health care, and for this reason often avoided medical facilities altogether. This more characterized rural areas where health care options were limited and accessing medical care was not easy. The foregoing agrees with Foster and Mitchell (2021), who argue that anxiety is the shared experience of mothers who have had medical negligence.

On the other hand, Vismara et. (2017) support the argument that unmanaged anxiety leads mothers to avoid future pregnancies, but also medical centres where they suffered medical negligence. Current studies establish that the mothers who had medical negligence have a kind of reluctance in future pregnancy care or general health issues due to the emotional impact caused by those experiences (Foster & Mitchell, 2021).

This in turn has its negative consequences in that early and timely medical intervention can be either denied or delayed in such cases.

However, the trauma and anxiety that mothers have been through do not remain within the ambit of individual emotional turmoil. This spills over into maternal mental health and further trickles down into disturbing family dynamics. It was what the mothers confessed to still blaming themselves for their babies' deaths due to medical negligence, but it is totally nothing they would have done to restore the babies to life.

This is in agreement with Snyder et al. (2021), who explain that mothers suffering traumatic childbirth usually experience depression, feelings of guilt, and anxiety.

Due to a shortage of mental health resources, especially in rural areas, this results in increased emotional burden whereby one is unable to process the trauma and impairs the mother's usual ability to bond with and normally care for her baby. This may lead further to an emotional inability of attachment that can have long-lasting consequences on both the mother and child psychologically.

Larson and Anderson (2023), indicated that in early childhood development, maternal mental health is very important while trauma hinders effective mother-child attachment with resultant effects on the child's emotional wellbeing into a lifetime.

5.3 Challenges faced by Rural Mothers Who Experience Medical Negligence during Childbirth

Theme 1. Physical and Health-related challenges

Long-term health complications

Some of the mothers had long-term health complications. For example, medical negligence at birth such as poor management of the labour complication of prolonged labour caused damage to muscles of pelvic floor and led to either urinary or faecal incontinence.

Physical Health Complications

Medical negligence during childbirth may result in many long-term physical health complications, especially when there is a failure to provide timely interventions. Many participants in this study reported still experiencing physical problems from the childbirth, such as chronic pain, prolapse, and incontinence, which they attributed to inadequate or late medical care.

Such complications in health could affect the quality of life of a mother and daily activities, and for some, even the care of her children or completing usual tasks.

This is a reflection of how perceived negligence has long-term consequences that can be rather physical. McGowan et al. (2020) commented that poor medical attention during and after childbirth might lead to postpartum infections, untreated tears or lacerations, and other maternal morbidities extended over very long periods. These complications further reduce the mother's capability for any further pregnancies and possibly lead to disabilities.

Other long-term health issues that participants normally reported to include pelvic organ prolapse. This resulted from prolonged labour, poor medical interventions, and neglect at birth. Beeson et al. (2021) assert that poorly treated birth trauma or that which was not well managed enhance chances for prolapse, hence needing surgical management and follow-up. Such conditions mostly go undiagnosed or untreated, hence long suffering, in rural settings where specialized care is unavailable.

Psychological Health Complications

Besides the physical health complications, medical negligence also brings long-term consequences on the psychological health of the victims. Trauma and anxiety from perceived negligence heightens mental health conditions such as depression and PTSD, leading to a vicious circle of poor health outcomes.

Lang et al. (2021) add that there will always be low reporting and treatment of mental disorders within the rural setups since the health professionals might lack either the resources or even the necessary training in attending to the mothers' psychological needs. Among the participants, some of the mothers indicated that

they felt chronically sad, having guilty feelings and anxiety since their experience with childbirth for a long period of time.

The mental trauma denotes that a perceived negligence occurs and will stay while, at the same time, emphasizing how important it is that psychological support is available to a mother who suffered trauma during birth. According to the explanation of Gant et al. (2022), non-treated depression and anxiety reduce the bonding process of mothers and result in poor health outcomes for the family as a whole. Often this results in further chronic mental problems which require long period time treatment.

Inaccessibility to Care and Deterioration of Health Outcomes

Some mothers were found to have had experiences of being unable to access health care during medical negligence. These health complications caused by medical negligence further deteriorated by inaccessibility of health services in rural areas. However, several multiplicative factors relating to the extent of distance of access routes to the facilities, lack of means of transports, and unable to afford such costs involved prohibited rural mothers to seek health care as shown by denying treatment for continuous ill health. The above study findings are in the same line of argument with Tully and Stuebe (2021), who argue that among the poor settings, the hindrance to use of health care is quite strongly felt in cases where health facilities are under-resourced and often suffer from staff scarcity, which makes it difficult for mothers to get the desired attention from health workers.

The above statement reflects the real struggles of rural area mothers who continue to live with health complications that have never been treated due to logistical and financial issues. Henning Smith and Kohzimannil (2020) posit that if these long-term health complications are not treated in time, they could exacerbate into more serious and life-threatening conditions.

Impact on Future Pregnancies

In some cases, medical negligence at the time of delivery affected a women's future pregnancies. According to Parry et al. (2021), traumatic deliveries or

physical injuries of the mother are bound to increase the likelihood of complications during subsequent pregnancies, preterm birth, low birth weight, or maternal morbidity. Such sequences of complications tend to perpetuate medical negligence-with the mother's history likely to make them more skeptical of care (Trumnel et al., 2018).

Lack of postpartum care

One major issue this paper identified which most mothers experienced after birth was the lack of proper postpartum care. Generally, the postpartum period was considered to commence with delivery and continued to six weeks. This period was considered the critical period of both physical and emotional recovery for mothers. On the other hand, for most rural women, it was a time of least care, little or no treatment, and loss of due follow-up. In addition to making such recovery slower than expected, postpartum conditions exacerbated the chronic sequalae which mothers had to endure over their lifetime during deliveries.

The above contradicts with Kaseje and Mungala-Odera (2020), who argue that most mothers in rural settings can be able to access postpartum care provided they remain within the reach of health workers. They argue that most mothers in rural areas may lack postpartum care due to their ignorance to adhere to the guidance of health workers to seek professional health care since many mothers in rural areas usually have faith in using traditional remedies to treat postpartum issues and yet these are not medically tested by international regulating agencies like the World Health Organization.

Physical Health Complications Due to Inadequate Care

The most distressing feature is that inappropriate postpartum care occurred with the mothers who reported medical negligence in childbirth. Many of the participants mentioned continued physical complications which would have been cured or treated at an early stage if the required follow-up care had been given. Conditions such as infections and prolapse of the pelvic organ were not treated owing to the non-availability of any post-delivery medical consultation. This assertion therefore establishes that a poor postpartum care leads to implications

related to long-term physical health of a mother. Beeson et al. (2022) confirm that Post-partum care offers implications for the managing complications such as infection, abnormalities in the uterus as well as a myriad of another condition that threatens the long run health of the mother. Thus, condition may not have been diagnosed, hence not taken, resulting in serious chronic health challenges if not appropriately.

Consequences to Mental Health

Besides the complication involving physical health, poor postpartum care had serious implications concerning mother's mental health. The period of postpartum was really very vulnerable, and without appropriate care and support, many mothers felt isolated, anxious, and depressed. The emotional burden of childbirth and recovery, combined with a lack of proper care, further exacerbated these conditions. Without follow-up, many rural mothers had their mental health needs left unmet and putting themselves at risk for longstanding psychological distress.

This emotional isolation and lack of mental health support have long-lasting consequences for the mother's well-being (Slomian et al., 2019). The failure to address mental health problems during the postpartum period leads to the development of chronic conditions, including depression, PTSD, and chronic anxiety, all of which lead to further deterioration in the relationship between mother and child and overall family dynamics (Lang et al., 2021).

Barriers to Receiving Postpartum Care

Amongst several reasons identified as obstacles for postpartum care to be accessed in rural mothers include: economic status, culture, and ignorance about the essence of the follow-up cares. Most of the mothers in rural areas may not afford making a trip to healthcare facilities for postpartum check-ups, especially if they have other children whom they have to take care of, or if they are in very remote areas with limited means of transportation. This is compounded by a lack of financial capability, let alone the low availability of healthcare providers and facilities in rural regions, making mothers less able to get the care they require.

Besides, cultural factors can be a barrier to post-partum care for mothers. Traditional practices and beliefs related to childbirth and post-delivery recovery may not favor formal medical consultation after birth in some rural communities. According to Gant et al. (2022), in some rural areas, healthcare providers may also fail to make postpartum care a priority because of their lack of training and/or resources to do so, thus aggravating the problem.

Emotional and Psychological Challenges

Trauma and anxiety due to medical negligence at childbirth were fresh in mothers' minds. Anxiety and trauma mostly resulted in insomnia, disturbed sleep, and nightmares that further aggravated their fatigue and stress. Sleep deprivation aggravated emotional regulation and further enhanced feelings of helplessness. Other residual emotional and psychic impacts suffered by these mothers included symptoms of PTSD and heightened anxiety in daily life.

Similar studies like Dewan et al (2023), argue that trauma and anxiety is a common occurrence among mothers who have experienced medical negligence with the consequences manifesting in terms of loss of sleep which if not attended to can graduate to depression.

Financial Constraints

Medical negligence at birth time resulted in long-lasting impacts on mothers and have economic devastation as noted in chapter four. When health care services and resources are scanty, this economic devastation cripples the mothers in rural settings. This theme, therefore, details how financial constraints arise as a direct consequence of medical negligence and affect not only the mothers but also their families and communities. The study also shows that mothers who experience negligence have immediate and long-term financial burdens, which are increased by the lack of access to financial resources and support systems in rural areas.

Immediate Financial Consequences

The immediate financial consequence of medical negligence at birth is multifaceted. For many rural mothers, the cost of seeking medical care after

negligence occurs is a major barrier. In case of complications, such as infections, haemorrhage, or injury during child birth, mothers are often rushed for emergency medical care and this mostly involves being taken to distant health centres. It is here that direct and indirect costs start being incurred as a result of the emergency medical care. Whereas some examples of direct costs might include hospital costs, medicine, and operations, indirect costs more often have to do with losing income because time must be taken from paid work, as in many settings studied the women are bringing in a big portion of income or the whole amount.

Long-term Economic Burden

Medical negligence, therefore, does not stop at the level of immediate treatment in terms of financial consequences. In the long term, many mothers have to bear continued medical expenses for chronic health conditions arising from the negligence-such as incontinence, pelvic organ prolapse, or psychological problems-most of which require continuous medical treatment or rehabilitation and are beyond the financial capacity of rural families already struggling to meet basic needs (Millers & Belizan,2015).

These complications may, in turn, require long-term medical attention, thus continuously burrowing into the finances of families. In most instances, these mothers are not able to receive proper care because of lack of funds; thus, their suffering prolongs and perpetuates the worsening of their health status.

Loss of Livelihood and Economic Stability

Apart from the direct health care costs, mothers who experience medical negligence may also incur a loss of livelihood. For instance, most women in rural areas are involved in physical subsistence farming. Medical negligence leading to a physical disability-for example, a long-term injury or debilitating health conditions-can render women unable to work any longer and, therefore, deplete them of their source of livelihood. This affects their lives and that of the families, especially wives.

It also talks about the distance and transportation barriers: how these concerns are linked with accessing quality health care at birth within a rural setup and, particularly, most parts of sub-Saharan Africa (Abu-Dahab & Sakellariou,2020).

Distance and Transportation Barriers

The theme Distance and Transportation Barriers highlights how physical distance from health facilities and lack of transport have brought negative impacts on the experience of mothers, especially about medical negligence during childbirth. This theme has been developed to show how these challenges further exacerbate health outcomes and contribute to the persistence of healthcare disparities, particularly in rural areas such as Ntenjeru Sub-County, Mukono District.

Geographic Distance to Health Facilities

Distance from health facilities remains one of the main barriers that limits timely and efficient access to health care in rural settings. The results indicated that most mothers who were interviewed in Ntenjeru Sub-County had to travel several kilometres to get to nearby healthcare centres, such as Ntenjeru Health Centre IV. This distance was among the many challenges in accessing appropriate prenatal and postnatal care, including emergency care during childbirth. This is so in cases of medical emergencies, as the long journeys often delayed critical care and thus had worse health outcomes for both mothers and babies. Indeed, this finding is supported by Lacet Global Health (2016), and Ngoma et al. (2019), who affirm that women who lived 5km away from a health centre were three times more likely to die due to maternal deaths as opposed to those who lived close to a health facility.

Financial Cost of Transportation and Distance Barriers

The cost of transportation probably presents another vital aspect of the theme of distance and transport barriers.

In most of the rural families studied, the transport to healthcare facilities proved too expensive, especially since, as often happens with prenatal and postnatal care, several journeys may be needed. This overstretched the finances to the extent that mothers have either been discouraged from seeking care or show delays in

seeking of care, elements which only increase the likelihood of medical negligence. The challenge of transport is documented in Ajilong and Ajari (2016) and Kruk et al. (2018), who argue that inability of immediate response due to barrier presented by transport leads or contributes to medical negligence. That means, the transport barrier is the collective problem that this rural mother is facing as put forward by these scholars.

Lack of Awareness and Education

In line with the socioecological model as advanced by Rautara et al. (2021), there emerged the theme of Lack of Awareness and Education as a contributory factor to how rural women felt when they fell victim to medical negligence during childbirth in Ntenjeru Sub County. The rural woman in Ntenjeru Sub-County in Mukono District-suffers a lot due to a lack of understanding in respect of medical procedures, rights, and what constitutes medical negligence. This needs to go and prove that lack of awareness makes the victim unable to identify negligence, assert health rights, or seek redress, adding to perpetuation of poor maternal health outcomes. Agreeing with Abu-Dahab and Sakellariou (2021), the implications of very limited education and awareness about maternal health rights, how such ignorance shaped the healthcare-seeking behavior, and that there was an urgent need for educational interventions which would considerably help in empowering the mothers.

Other studies have noted that mothers in urban areas suffered less in regard to medical negligence owing to their exhibition of higher levels of medical literacy as discussed by Ay and Boztepe (2021).

Limited Understanding of Rights and Negligence

The core issue, as revealed in the responses by participants in this study, is the level of knowledge concerning the rights in regard to the health system and medical negligence. A number of mothers from the rural area do not have information concerning the standard of care to be expected from the providers or means of going through the court if exposed to inadequate levels of health

provision. Cases and claims cannot be reported since women are unaware of how such critical matters are addressed.

The consequence of not being knowledgeable regarding rights and negligent conduct engendered feelings of powerlessness among mothers. Failure to recognize negligence on the part of professionals translated into the reality that no form of malpractice was going to be reported and that health workers continued with bad practice and went scot-free. The situation in this regard led to poor performance in maternal health, further eroding trust in care, especially in mothers who felt mistreated and whose neglect then felt similarly well-deserved without knowing anything different.

Accordingly, in agreement with the socioecological model, mothers' limited understanding of medical negligence contributes to the occurrence of medical negligence (Memon et.,2019)

The authenticity of the above study is validated by the similar assertion expressed by Ouyang and Yilmaz (2019) where they say that people may not be aware of their rights or the standards of medical care, therefore they might not recognize whether the care which they got was low quality or some sort of negligence happened. Such acts like delaying the diagnosis or failure to prescribe the necessary medication or not taking informed consent might be missed. This is recorded to lead to the under-reporting of incidents, hence allowing negligent practices to go unchecked and further compromise the quality of care.

Poor Health Literacy

The fact that the study revealed that some mothers in Ntenjeru had poor health literacy indicated that they couldn't make sure health decisions using health information.

Health literacy is the ability of the individual to obtain, read, understand, and use basic health information to make appropriate decisions concerning their health (Centre for Disease Control and Prevention, 2020). In agreement, Moniz and Davis (2020) add that in rural settings, many mothers have low health literacy, hence limiting their ability to participate in appropriate health care. They are further

unable to fathom the signs of early complications and timely seekers of care amid uninformed choices concerning child deliveries. This goes contrary to those in urban centres where the enlightened folk congregate with the ability to point out at a glance such cases of professional negligence for an overhaul as desirable (Wolf et al., 2019).

The findings revealed that cultural norms and the social pressures in the rural settings discouraged the rural mothers from speaking out in cases where they were experiencing medical negligence amid societal settings where the female gender's voice is suppressed.

Pressures of Culture and Society

One would observe that through cultural and social pressures, medical negligence to these pregnant rural mothers has posed a big role. Besides the physical barriers, such as those brought forth by child delivery, the struggles faced by mothers in a rural setup-for instance, Ntenjeru Sub-County, Mukono District-relate to those that pitch one against the complex topography of cultural norms, social expectations, and community pressures impinging on the choices made about health care. These pressures might be influencing their capabilities or intentions of seeking proper medical care, reporting instances of medical negligence, or even advocating for health and wellness. This theme now addresses how cultural beliefs, social stigmas, and traditional practices have an impact on the maternal health-seeking behavior of rural women and sometimes make them vulnerable to medical neglect.

Cultural Norms and Beliefs

It was also noted during the study that at Ntenjeru, it was the cultural norms that predetermined women's attitude towards giving birth. In fact, in most rural communities, the attitude of women towards pregnancy and delivery is influenced by the traditional beliefs and customs surrounding childbirth. Traditional birth attendants may, in fact, be central in maternal care in many places of the world where modern health services are not accessible. These practices, as helpful as they are to the mothers, may put them at risk too, in-cluding medical negligence if health care is not provided according to accepted medical standards. For example,

childbirth may be viewed as some private family matter to which medical practitioners are merely summoned with a minimum amount of interference (Kumbeni et al.,2023). This includes delivering at home or with the assistance of TBAs where the situation calls for skilled medical attention. Social Expectations and Family Dynamics

Social expectations also played an important role that molded decisions for rural mothers. This also established that pressure was strongly applied to make women confirm idealized ideals of motherhood and femininity that include having children in a "proper" way, having social expectations of healthy babies without complication, and all these pressures pressed them to insufficiency anytime things went wrong. Many times, this pressure gets internalized, and women are afraid to raise their voices against experiences of medical negligence lest a finger of accusation is pointed towards them. A similar submission in the research undertaken by Geleto, Mohammad & Makonnen (2021) postulate that it is this fear of social stigma that makes mothers shy away from reporting medical negligence or seeking an account over mistreatment by health professionals. Victims of this fear, they remain silent about negligence that has dire consequences on their health and contributes to the general culture of unaddressed medical malpractices.

Leaving that aside, the social pressure for harmony in the family and society at large may compel mothers to suppress or hide traumas gone through.

5.4 Coping mechanisms which can handle challenges faced by rural mothers who face medical negligence at child delivery Family Support

Smith & Brown (2020) found out that family support is necessary in as much as persons who validate experience are needed, comforting and reassuring persons from the stress and emotional turmoil wrought by medical negligence lessen loneliness and powerlessness.

Indeed, in agreement with the findings of Smith & Brown (2020), most of the mothers exposed that indeed their families have been so supportive emotionally and even materially. Mazanderani & Paparini, (2022) argue that a stable family would always try to render financial assistance to any one of their members who may require them. This they say forms the wider responsibility which a member of

a family is bound to incur, but then this comes when people live in cooperation and in agreement. wrangling and constant fighting would lead to not supporting fully even the mother who was subjected to medical negligence. In fact, some of the mothers interviewed in this study claimed that some of their family members were unsupportive. They blamed the mother as being among those people in the community who blamed her for the death of the baby during birth due to the negligence she committed.

Goldsmith & Thomas (2021) further opine that once there is some conflict within family, this could cause disunion and in conditions of extreme severity, tear asunder to such a degree as it loses even that sense which, if anything was to be expected of the members to be supportive of one another at the least on grounds of a member getting victimized over some issue relating to medical negligence. Professional Counselling Some of the mothers received professional counsellors as they had family members who could enable them access the service.

This made them go through the process of recuperating from the medical negligence quickly than those who didn't have. Those who could not seek professional advice had to either source from family members, church leaders and some community members More so the elderly provided a listening ear to the mothers.

Most had no idea who the professional counsellors were, not to mention a position to afford access. Counselling may avail an avenue through which the mothers are able to work through processing a wide range of emotions-anger, grief, frustration, and many others (Shea, 2021). This works with professional counselling placed on them in such a way that it diffuses feelings of anxiety so these situations may not cause psychological problems such as depression or anxiety.

Nicholas & Davis (2020) add that counsellors teach mothers coping strategies and building techniques of resilience due to the impact caused by medical negligence. These may include but are not limited to mindfulness, stress management, and cognitive behavior techniques.

Furthermore, considering that long-term medical negligence-induced distress can lead to chronic mental health conditions, professional counsellors can provide long-term support that can prevent long-term psychological trauma and promote general well-being (Neria & Gross, 2020). From the discussion above, one can observe that seeking professional counselling can enable mothers to deal constructively with medical negligence.

Seeking a second opinion

Others sought consultations or treatments elsewhere by other care providers after they lost their confidence in the said Ntenjeru health centre particularly those who had already lost faith in the local health care systems.

These results are corroborated by Gupta & Padha, (2018) as when suspicion of medical negligence occur mothers seek second opinion with a view to dislodging or confirming that suspicion.

Such validation allows them to assess whether the primary diagnosis had been the best, thus minimizing or giving them hope for the future of a course of action.

This view after a second opinion helps mothers' regain trust in the medical advice which is very critical in emotionally and mentally restoring a mother. This same view point has also been pointed out by Smith, (2022). Second opinions on legal issues have also been identified to provide the courts with necessary evidence that they require in undertaking legal redress of disputes. Furthermore, a second is ethical in ensuring the mother makes an informed decision concerning her child welfare based on understanding the medical situation of her child, Jones & Brown, (2023).

Participation in Spiritual or Religious Practices

In this context, all the interviewed mothers participated in religious activities that helped them cope with such events of medical negligence. Among those spiritual leaders who were identified to have played major roles during these trying moments of managing death and grief include pastors, reverends, priests, and Imams. My findings agrees with that of the study by Vitorino et al., (2018) stating

that religious practices, especially prayer, emotionally comfort and spiritually support people when in distress.

While it may seem so, prayer, meditation, and even religious services would work to stabilize the mothers on their journey toward healing after being made to feel neglected. Of course, on such a journey comes encouragement, hope, and resilience that will no doubt be fundamentally necessary in confronting this negligent trauma. While general religious teaching has laid much emphasis on forgiveness, the engagement of mothers in these practices aids in better digestion of feelings that help a person move on rather than harbor bitterness from negligence experienced. This is especially when mothers develop anger towards the medical officers who were to handle the birth, and in return, the babies' death through medical negligence and the physical harm that a mother may be feeling, in her opinion was allowed. That it is time to let go and remember; compose themselves is according to the writings of Swinton (2022) and Williams (2023).

The Role of Village health teams and medical negligence.

The study examined the role of village health teams in enabling the mothers to cope with the situation caused by medical negligence. It showed that is within the village health teams, some of the mothers reported that identification and guidance from figures whom they trusted-after events concerning medical negligence-opened up a way for the mothers both in the system and in the available resources. Ahemd, Mbayo, and Nsubuga (2023) add weight to the above submission when they say that village health teams also act as counsellors and confidants of mothers who face trauma because of negligence in the care given to their babies.

Several mothers can be traumatized after bad treatment and experience depression characterized by sorrow, guilt feelings, or anxious sensations that come after their experience with bad healthcare. These teams at the Health Villages are trained in sensitive listening, validation of mothers' feelings, and basic psychosocial first aid. For example, it may be support groups where mothers share experiences with others who have survived similar difficulties. It is this social network among mothers themselves that works out sad feelings and avoids

stigmatization or isolation that some of them may go through. Recent literature reviews revolve around the efficacy of the psychological interventions at the community level. For instance, Smith and Johnson, 2022 established that the CHWs were effective in reducing postpartum depression among the rural mothers as a result of constant emotional support.

More so, the mothers indicated that the village health teams taught them how to avoid future incidences of medical negligence.

This agrees with Ahmed, Mbayo, and Nansubuga, (2023), who stated that the village health teams further train the mothers on how to avoid the occurrence of medical negligence in the future by teaching the mothers the warning signs that appear during pregnancy and delivery after which a pregnant mother requires immediate medical attention.

Health-promoting initiatives in the education sector have also been able to give voices and options to mothers concerning their health. For instance, Otieno and Mwangi, (2021), related a Kenyan initiative that indicated that mothers who had participated in education sessions by the CHW team had a higher demand for better care and could even report negligence.

5. Provision of Holistic Postpartum Care

Some of the mothers reported that village health teams attend to them at the critical moments of postpartum. Otieno and Mwangi (2022) reiterate this, adding that negligence from the medical profession has left mothers with physical complications and unserved needs during the postpartum period, which are bridged by the village health teams through conducting visits at the home level to check on the status of health concerning the mother and her baby.

Village health teams play an important role of referring mothers to specialized care when necessary, such as counselling services, physical therapy, or nutritional sup-port.

Ensuring that mothers receive appropriate vaccinations and postnatal checkups (Smith & Johnson, 2022).

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter deals with the conclusion and recommendations of the study in line with the study objectives.

The purpose of this chapter is to present recommendations based on findings from the study undertaken into the experiences of medical negligence during childbirth lived by rural women in Ntenjeru Sub-County, Mukono District. This has been guided, so far, by the following objectives: identification of mothers' perceptions in regard to medical negligence; establishing the difficulties faced by the rural mothers when experiences of such a nature occur surrounding medical negligence; and establishment of a coping mechanism through which most challenges can be softened.

This chapter synthesizes the key findings from the thematic analysis done in the previous chapters into an all-round understanding of how medical negligence impinges on the rural mother during childbirth.

It further avails recommendations that can be acted upon regarding systemic gaps and challenges identified toward the aim of better maternal health experiences and outcomes.

It is, therefore, in presenting the conclusions and recommendations that this study shall contribute to the formulation and improvement of policies relevant to health,

especially for rural mothers, by setting out evidence in a way to enhance their rights and well-being.

6.2 Mothers' perceptions of medical negligence during childbirth among rural women.

On objective one, I conclude as follows;

Many mothers interviewed perceive health workers to be rude and not caring to pregnant mothers.

Most rural mothers interviewed who had experienced medical negligence in Ntenjeru developed a mistrust of healthcare systems due to perceived or prior experienced of medical negligence.

Mothers were aware of the consequences of medical negligence, which amongst included the causing the death of the mother and the baby. However, the mothers were not so knowledgeable on the long-term effects of medical negligence.

Mothers perceived medical negligence to cause trauma and anxiety as a result of losing babies due to medical negligence.

6.3 Challenges faced by rural mothers who experience medical negligence during childbirth.

On objective two, I conclude as follows;

Mothers in Ntenjeru received inadequate care during childbirth and after childbirth due to lack of enough skilled healthcare professionals. This contravenes the both the patients charter of Uganda 2009,and the World Health Organization patient safety charter (1994),and the Global Patient Safety Action Plan 2021–2030.

Mothers had to travel long distances to access health centers where they could access doctors and other healthcare providers. During emergencies or in the event of negligence, the time taken to reach the health center IV in Ntenjeru was critical. The delays in receiving care worsened outcomes, increasing the risk of complications for both the mother and the baby.

Many rural participants interviewed reported that they faced financial difficulties, making it hard to afford quality healthcare, legal redress, or follow-up treatment

after experiencing negligence. Financial barriers led to a reliance on substandard care, and when negligence occurred, the cost of managing the aftermath was overwhelming.

Many rural mothers interviewed had limited knowledge about their rights and what constitutes medical negligence. This lack of awareness prevented them from recognizing negligence or advocating for better care. Without knowledge of their rights, mothers are less likely to seek legal or medical recourse, leaving cases of negligence unaddressed.

6.4 Coping mechanisms that can handle the challenges faced by rural mothers who experience medical negligence during childbirth

On objective three, the study looked at how the mothers coped with medical negligence. I conclude as follows on objective three;

Mothers coped with medical negligence by relying on family members for emotional comfort and practical assistance.

Few mothers with the help of family members were able to access professional counselling from a qualified psychologist. This is how they coped with medical negligence. Most mothers did not have access to a professional counsellor.

Some mothers (few in number) coped with medical negligence by seeking medical advice or treatment from alternative healthcare providers especially those who lost trust in the local healthcare system. These included high end hospitals that were considered superior in terms of the quality of health services provided.

Being ignorant and constrained financially, most mothers didn’t seek second opinion. They considered the medical report from Ntenjeru health centre to be authoritative enough for them not to consider any form of action against the health centre. They just buried the babies who died and let the matter to rest.

Mothers coped with medical negligence by consulting their spiritual or religious leaders on the misfortune of medical negligence. Many mothers turned to spiritual or religious practices to find solace, cope with grief, and seek healing after experiencing medical negligence.

Mothers also coped with medical negligence by using the help of Community health workers like the village health teams who were trusted figures. These offered guidance and support, particularly in the aftermath of medical negligence. They helped mothers navigate the healthcare system and access available resources.

6.5 RECOMMENDATIONS

Drawing from the study findings, I recommend as follows;

Educating mothers on their rights.

I recommend that mothers in rural areas like Ntenjeru sub county be educated on their rights regarding medical negligence so that they can be civically aware but also increase health literacy so that they can make informed decisions regarding their lives more so regarding child birth. This can be done by government partnering with non-government organizations that focus on reproductive rights for women so that the mothers are trained to increase their knowledge on medical negligence.

The government should consider using NGOs to train the mothers on medical negligence because the mothers have less trust in government medical facilities and medical officers. Using NGOs will increase the attendance rate to achieve the above idea.

The above can help mothers to know more about the consequences of medical negligence as the study revealed that most mothers were not aware of the long term effects of medical negligence to mothers.

The education program on medical negligence should consider all other community members so that medical negligence can be made clear to the communities. This can address the stigma that mothers suffer as a result of community members accusing them of being responsible for the death of their babies. Mothers suffering

from stigma from the community is because the community members are also ignorant about medical negligence.

Recruiting counsellors

I recommend that government considers recruiting counsellors at every health center IV so that the mothers can feel free to talk to the counsellor more so those who can't afford the services of a private counsellor. This can help the mothers to cope easily and well with the situations like medical negligence and others that are related.

Still on capacity building, the government should recruit more skilled medical officers at Ntenjeru Health center IV to cater for the needs of the growing population in Ntenjeru sub county since most cases of medical negligence were as a result of mothers being attended to by medical officers who they considered less qualified to handle their situation which caused the death of their babies.

Improving infrastructure

The government should consider improving infrastructure so as to facilitate transport and improve mobility. This can help mothers to easily transport themselves to the health Center without delay due to the bumpy roads.

Alternatively, due to the high numbers of patients at Ntenjeru Health center IV, the government can consider constructing another health facility in the deep rural areas of Ntenjeru sub county to cater for the needs of the increasing population growth, while also addressing the issue of women having to walk long distances to access Ntenjeru health Center IV.

The government can as well consider increasing the capacity of Ntenjeru health center four so that it can be able to cater for the growing population.

Rebuilding trusted-after

The government being a lead actor and having a social contract with the electorate can undertake efforts to rebuild trust amongst the population in regard to offering services in the health sector more so when it comes to accountability.

Doctors and other health workers should be provided with the health equipment needed to work in the health sector more so the rural areas.

The health workers should also be held to account for the cases of medical negligence. This can rebuild trust if the citizens see to it that the government cares about providing services to the rural population, but also holds medical workers to account for their misdeeds.

6.6 Areas for Further Research

Research should be carried out on drivers of eroding trust in government health centres in rural parts of Uganda.

A study of a similar nature covering a wider geographical scope should be carried out utilizing a pragmatic approach so that the results can be used for comparative analysis.

Finally, research should be conducted on drivers of medical negligence in government owned health facilities. This can help to reveal the reasons behind this aspect of medical negligence

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APPENDICES

Appendix A. Consent Form

Title of Study: EXPERIENCES OF MEDICAL NEGLIGENCE DURING CHILDBIRTH AMONG RURAL WOMEN IN NTENJERU SUB-COUNTY, MUKONO DISTRICT

No.	Name of Investigator	Designation	Address/Telephone/Email	Institution of Affiliation
1.	Namara Sarah Golden	Principal Investigator	0773450730	Uganda Christian University
2.		Co-investigator/ Academic supervisor		
3.		Co-investigator		

1. Introduction and rationale of the Study

(Briefly introduce what the study is all about and its rationale in one or two brief paragraph(s))

The study concerns itself with medical negligence and its effect on mothers in rural parts of Uganda taking a case study of Ntenjeru subcounty

2. Description of the Research

Briefly describe how the study/research is designed e.g. This is a phenomenological research design, employing a qualitative research design. Through this design, in-depth individual experiences shall be captured by the researcher so as to be able to analyze the data in chapter four and then discuss the findings in chapter five

3. Participation

Briefly mention who the participants are and why they are chosen to take part. E.g. Participants will be Head of Health facilities, In-Charges of Palliative care units where they exist, selected district Health Officers, and Ministry of Health Officials.

The participants shall be mothers who have experienced medical negligence and village health teams.

4. Potential Risks and Discomforts

Every study/research has a potential of being risky or some degree of discomfort or inconvenience. Mention any possible risk or discomfort as a result of one's participation. They could be minimal or otherwise, explain to the participant how they will be mitigated. This study has no risks associated to the health or physical and psychological well-being of all participants, whether parents, students or parents. All confidential information from the participants shall be kept confidential and shall not be disclosed to a third party unless with the permission of the participants.

5. Potential Benefits

Mention the potential benefits that will be as a result of the research. The benefits can be directly or indirectly to the participants, their wider society, or for general good not necessarily to the participants. Mention all possible benefits. The study shall present no tangible benefits in terms of economic gains to the participants, but the information shall culminate in a dissertation which shall enable the researcher to graduate with a master's degree in public health.

6. Confidentiality

The information you give us, will be confidential and only used for purposes of this study. In the process of report writing, your name will never be used and so everything you tell us will remain anonymous. We shall interview you on parenting practices. If you do not want to respond to a particular question, you can simply say so, and we will not insist. Every participant will be asked to sign a written study informed consent form before participating in the study as this ensures voluntarism and acceptability to participate in the study.

7. Procedure

Inform the participant(s) how the study/research will be carried out. Will it involve injecting, questioning, and how long will the engagement be? Approximately 30 minutes to 2 hours?

The interview shall take 45 minutes.

8. Voluntary Participation

Your decision to participate in this study is completely voluntary. If you decide to not participate in this study, it will not affect your work in any way.

9. Withdrawal from the Study and/or Withdrawal of Authorization

As a participant in this study, you can withdraw at any point if you choose not to continue. Give the participant confidence that they have rights and freedom on any decision they want regarding the study. Participants can even choose particular questions/engagements in the process not the entire time.

10. Reimbursements

Reimbursement which is equivalent to 10,000 for you. This can be in transport, time compensation, drinks and food/snacks. Put a figure/an amount of what it will cost on a particular individual.

11. Whom to contact in case of ethical related concerns.

a) Prior Ethical approvals and permissions.

If the study has acquired any other foreign Research Ethics approvals, indicate the institutions details and contact people who can attest to that.

b) Local authorities and approvals.

This study was Approved by Uganda Christian University Research Ethics Committee (UCU-REC) and cleared by Uganda national Council for Science and Technology (UNCST), In case of any Ethical or your rights related concerns or inquiries, please contact UCUREC

Chairperson; Prof. Peter Waiswa, 0772405357, pwaiswa@musph.ac.ug or UCUREC Manager, Mr. Osborn Ahimbisibwe, 0775737627 or oahimbisibwe@ucu.ac.ug. UNCST: Tel; +256 414 705500, info@uncst.go.ug

STATEMENT OF CONSENT

Do you accept to be recorded?

Yes **No**

I voluntarily agree to participate in this research program; to tick appropriately

Yes **No.**

I understand that I will be given a copy of this signed Consent Form.

Name of Participant: ……………………………

Signature: ……………………… Date: ………………………….

Name of Researcher/designee: Namara Sarah Golden

Signature: …………………. Date: June 10th 2024.

NOTE: Depending on the nature of participants, witnesses or guardians (for minors & other vulnerable groups) will be required.

APPENDIX 1**: INFORMED CONSENT FORM (LUGANDA VERSION)**

Omulamwa gwo kunonyereza: Abakyala byebayitamu mukulagajalirwa mu kuzaala

Akuliddemu okunoonyereza NAMARA SARAH GOLDEN Essimu 0773450730

Wamu ne Uganda Christian University, ekiruyi kyendwadde ezalukale akasansanduke 4 Mukono- Uganda.

i. **Enyanjula nomulamwa gwokunoonyereza**

Amanya NAMARA SARAH GOLDEN omuyinzi wa university Uganda Christian University, Mukono baali mukunoonyereza ku bakyaala byebayitamu nga balagajalidwa mukuzaala. Omulamwa ogukulembedde mu kunoonyereza kuno kwekuzuula abakyaala byebayitamu nga balagajaliidwa mukuzaala.Ebilowoozo byemutuwa bijja kukumibwa nga byaama era bijja kozesebwa mu kunoonyereza kuno. Mu kiseera kyokuwandiika ebivuddemu elinyalyo telijja kwasangazibwa ne byonotuwa bijja kukuumibwa. Tuuja kubuuza ebibuuzo ebikwata kunkola yobujjanjabi mu dwaliro lino. Bwoba toyagala kudamu ebimu kubibuuzo binno osobola okudamu nedda era tetujja gaana.

2. **Okunyonyola kwo kunoonyeereza**

Okunoonyereza kugenda kukolebwa mu mitendera okuzuula abakyala byebayitamu nga balagajalidwa mukuzaala.

3. **Omulamwa gwokwenyigira mu kunoonyereza**

Abaneetaba mu kunoonyereza bajja kuba ku bakyaaala bomubyaalo abalina obumanyiliivu mu byebayitamu nga balagajalidwa mukuzaala.

4. **Ebiyinza okulemesa okunoonyereza**

Okunoonyereza kujja kwetabwaamu abanoonyereza nabanadamu ebibuuzo ku bikwaaata ku bakyaala byebayitamu nga balagajaalidwa mukuzaala. Ebilemesa bisuubilwa bitono.

5. **Ebyokuganyulwamu**

Ebinavaamu bijja ku yamba okumanya abakyaala byebayitamu nga balagajaliidwa mukuzaala, okulaba wa wetuyinza okwongeramu amaanyi awamu nokendeeza obulagajavu mu byokuzaala.

6. **Okukuuma ebyaama**

Ebilowoozo byemunatuwa bijja kumiibwa nga byaama era biija kozeesebwa mu ku noonyereza. Elinya lyo terijja kwasangazibwa era nebyojja okutubuulira bijja kuumibwa nga byaama. Tuuja okubuuza ebibuuzo ebikwata ku kulagajalira abakyala mukuzaala. Bwoba toyagala kuddamu oli wadembe obutadamu tetujja kukaka.

7. **Okutukiliza**

Bwokiliza okusaako omukono, oja kuba otukiliza okukozesa birowoozo byo okuva mubivudemu okugeza ebyokusoma nokulaba kyetuyinza okukola okwongera kumutindo gwobujanjabi mu bakyaala nga tebalagajalidwa.

8. **Okwenyigiramu**

Okusalawo kwo okenyigira mu kunoonyereza Kwa kwagala. Bwosalawo obutenyigiramu tetujja Kukukaka.

9. **Okuva mu kunoonyereza**

Yadde wenyigidde mukunoonyereza oliwadenbe okuvaamu oba okuwanduuka

10. **Okukudiza**

Sente ekumi taano (Shs 5000/=) ejja kudizibwa

11. **Abantu bokwebuuzaako nga wemulugunya**

Bwoba olina kyona ekyo kwemulugunya kubila chair person ucu.REC

Kakensa Peter Waiswa ku 0772405357, pwaiswa@musph.ac.ug oba UCU-REC secretariat.Mwaami Osborn Ahimbisibwe Ku 0775737627 oba oahimbisibwe@ucu.ac.ug

Nzikiliza okwenyigira mu kunoonyereza kuno.

i). Yee

ii). Nedda

Ntegedde nti bajja kumpa ku copi yokukiliza okwenyigira mukunoonyereza

Elinya lye yenyigiddemu…………………………………………………………..……….

Omukono…………………………………….. Date……………………………………..

Appendix B. Interview guide for women who have experienced medical negligence

Name…………………………..

Age…………………………….

Level of education………………………..

Place of residence……………………….

Name of health Center where you gave birth from…………………………………….

Have you experienced medical negligence?..................................

Name the case of medical negligence which you experienced?......................

What do you think caused this case of medical negligence?

Mothers perceptions of medical negligence during child birth among rural women

i). Can you please share your childbirth experience(s) in detail, including any interactions you had with healthcare providers during the prenatal, delivery, and postnatal stages?

ii). Were there any aspects of your childbirth experience that you found particularly challenging or concerning? If so, please describe these challenges and how they impacted your experience.

iii). In your opinion, what constitutes medical negligence during childbirth? Can you recall any specific instances or behaviors by healthcare providers that you perceived as negligent?

iv). How did you feel about the quality of care you received during childbirth? Did you feel that your concerns and preferences were adequately addressed by healthcare providers?

v). Can you describe any barriers or challenges you encountered in accessing maternal healthcare services in your rural community? How did these barriers impact your childbirth experience?

v). How would you describe your overall satisfaction with the maternity care services available in your rural area? What improvements, if any, would you suggest to enhance the quality and safety of these services?

vii). Did you feel adequately informed and involved in decision-making processes related to your childbirth? Please share any experiences you had with informed consent and shared decision-making during your maternity care journey.

viii). How do you perceive the role of healthcare providers, healthcare facilities, and the healthcare system in ensuring safe and respectful childbirth experiences for rural women? What changes, if any, do you believe are needed to improve maternal healthcare in rural areas?

ix). Can you discuss any emotional or psychological affects you experienced as a result of your childbirth experience, particularly if you felt that medical negligence was involved? How did these experiences impact your well-being and maternal health?

x). Is there anything else you would like to share about your experiences with childbirth and maternal healthcare in a rural setting, particularly regarding perceptions of medical negligence?

2. Challenges faced by rural mothers who experience medical negligence during childbirth

i). Can you describe your experience of childbirth in a rural setting?

ii). What were your expectations going into childbirth, and how did they compare to your actual experience?

iii). Did you face any challenges or difficulties during your pregnancy or childbirth that you feel could have been prevented or addressed differently?

iv). How do you feel about the level of medical care and support you received during your pregnancy and childbirth?

v). Were there any specific instances of medical negligence or mistakes that you encountered during childbirth?

vi). How did any instances of medical negligence impact you physically, emotionally, and financially?

vii). what barriers or obstacles did you face in seeking recourse or justice for any medical negligence you experienced?

viii). In your opinion, what improvements could be made to healthcare services in rural areas to better support mothers during childbirth and prevent instances of medical negligence?

ix). How do you think the broader community, including healthcare providers and policymakers, could better support rural mothers who have experienced medical negligence during childbirth?

x). Is there anything else you would like to share about your experience or the challenges faced by rural mothers in similar situations?

3. Coping mechanism to handle the challenges faced by rural mothers who experience medical negligence during child birth

i). Can you describe some of the challenges you faced after experiencing medical negligence during childbirth?

ii). How did you initially cope with the emotional and physical effects of the medical negligence you experienced?
iii). Did you seek support from family, friends, or community members? If so, how did they support you during this time

iv). Were there any specific coping strategies or techniques that helped you navigate the challenges you faced?
v). How did you maintain your resilience and hope during difficult times following medical negligence?

vi). Did you encounter any barriers in accessing mental health support or counselling services? If so, what were they?
vii). How did your experience of medical negligence impact your relationships with healthcare providers and the healthcare system as a whole?

viii). Did you engage in any advocacy or activism efforts to address the issues of medical negligence in rural childbirth? If so, what actions did you take?

ix). what advice would you give to other rural mothers who may be facing similar challenges after experiencing medical negligence during childbirth?

x). Is there anything else you would like to share about your journey of coping with the challenges of medical negligence during childbirth in a rural setting?

THANK YOU

Appendix C. Letter from the Research Ethics committee

UG-REC-026 Approval Version 4.0

02nd July, 2024

02nd July, 2024

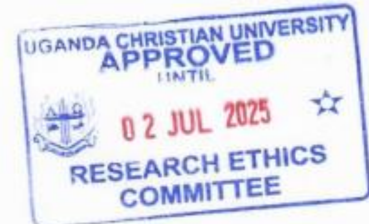
Namara Sarah Golden
Uganda Christian University
07723450730
Email: golden.namara@gmail.com

UG-REC-026 APPROVAL NOTICE

To: Namara Sarah Golden, Principal Investigator

Re: UCU-REC Application titled: **Lived Experiences of Medical Negligence during Childbirth among Rural Women In Ntenjeru Sub-County, Mukono District**

Application Number: **UCUREC-2024-911**
Version: 4.0



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 **02ND July, 2024**, to **02ND July, 2025**

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.

1 of 2

A Centre of Excellence in the Heart of Africa

P.O. Box 4, Mukono, Uganda (East Africa), Plot 67-173, Bishop Tucker Road, Mukono Hill, Tel: +256 (0) 31 235 0800, www.ucu.ac.ug
Ugandachristianuniversity @UCUniversity, Founded by the Pronvice of Church of Uganda, Chartered by the Government of Uganda.

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 02nd July, 2025 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 Masters Degree research. Refer to UNCST Research registration and clearance Policy and guidelines (July 2016) in Uganda section 6(e).

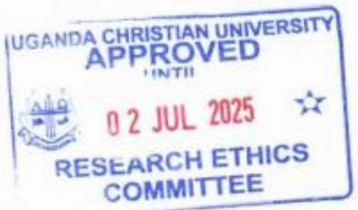
The following is the list of all documents approved in this application by **UG-REC _026:**

	Document Title	Language	Version	Version Date
1.	Protocol	English	1.0	2024-05-28
2.	Data collection tools	English	1.0	2024-05-28
3.	Informed consent form	English	1.0	2024-05-28
4.	Focus group interview guide	English	1.0	2024-05-28

Signed and Stamped

....

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



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Appendix D. Letter from the Chief Administrative Officer of Mukono district

TELEPHONE: 0414697450

IN ANY CORRESPONDENCE ON THIS SUBJECT, PLEASE QUOTE

Our Ref: ***ADM/MKN/220/01***
Your Ref: ....

THE REPUBLIC OF UGANDA

OFFICE OF THE
CHIEF ADMINISTRATIVE OFFICER
MUKONO DISTRICT
P. O. BOX 110
MUKONO
Email: caomukono@yahoo.com

Date: ***July 18, 2024***

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

LETTER OF INTRODUCTION

This office is in receipt of your letter dated **17th July, 2024**, of the above subject matter.

The purpose of this communication is to grant **Ms. Namara Sarah Golden** permission to conduct research a topic; ***"Lived Experience of Medical Negligence during Childbirth among Rural Women in Ntenjeru Kisoga Town Council"***

For: CHIEF ADMINISTRATIVE OFFICER
MUKONO DISTRICT

Tekisooka Margaret Nkata
For. CHIEF ADMINISTRATIVE OFFICER
MUKONO DISTRICT

Copies to:-

- *The District Chairperson,* ***Mukono***
- *The Resident District Commissioner,* ***Mukono***

Mission:

To provide coordinated services for poverty reduction and attainment of sustainable economic development to the community by focusing on the National Policies and local priorities.

UGANDA CHRISTIAN UNIVERSITY

SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: 24th April 2025

Name of Candidate: …NAMARA SARAH GOLDEN   Reg. No: ….. IRS19M07/135

Title of Dissertation .EXPERIENCES OF MEDICAL NEGLIGENCE DURING CHILDBIRTH AMONG RURAL WOMEN IN NTENJERU SUB-COUNTY, MUKONO DISTRICT

SN	COMMENTS PUT IN THE DISSERTATION	ACTION TAKEN	INDICATOR
1	Dissertation should be signed.	The dissertation has been signed by both the student and the supervisor	Pages i and ii
2	Background should quote the most recent literature.	The background has been updated with the most recent literature	Page 1,2,and 3
3	Correct the grammar in the problem statement.	The grammar has been corrected	Page 3

4	Rephrase the significance	The significance has been rephrased	Page 6
5	Edit grammar on beginning sentence on objective two	Grammar has been edited	Page 8
	Please describe the multi-pronged approaches	Multi-pronged approaches have been described	Page 8
	What is the current picture? 2018 is over 8 years ago, the situation must have changed since then	The current picture has been provided	Page 12
	Provide the latest MMR statistics	These have been indicated in the problem statement	Page 4
	Indicate the year	Year has been indicated	Page 13
	How were these women identified?	This has been indicated	Page 20
	How was this sample determined?	This been indicated	Page 20
	Point of data saturation should be indicated	The point at which saturation was attained has been indicated	Page 18
	Relate the patient charter with the WHO Negligence in the conclusion	This has been included	Page 63
	The candidate needs to realign and refine all the sections of the dissertation	The sections of the dissertation have been realigned	All Page of the dissertation
	Correct all the grammar in chapter three	All grammar in chapter three has been corrected	Page 20
	What tool was used during the interview?	The tool has been indicated	Page 20
	What were the ages of the remaining 5 participants?	The age has been indicated	Page 21
	Didn't these have sub-themes? If so, put a footnote to provide information on why some cells are blank.	Footnotes have been included	Page 25-38
	Thu use of the word "great" is subject since	This has been addressed	Page 50

	the study method was qualitative.		
	Should read, “most of the mothers interviewed” … The sample is not representative of all mothers in Ntenjeru.	This has been addressed.	Page 54
	This is not correct. The sample was not representative of all mothers in Ntenjeru Subcounty. Instead, the sentence should read “….most mothers who were interviewed..”	This has been addressed	Page 54
	Was this part of the study?	This has been addressed	Page 60
	mother is not a medical workers and therefore cannot cause medical negligence	This has been addressed	Page 62
	Please think of a recommendation for rebuilding trust in using public health facilities.	This has been addressed	Page 65
	Include a recommendation for rebuilding trust	This has been included	Page 66

SN	COMMENTS BY VIVA VOCE	ACTION TAKEN	INDICATOR
1	Candidate needs to update some statistics like the MMR	The MMR have been updated in the background and the problem statement	Pages 3 and 4
2	Include the point of saturation as a rationale for the sample size	This has been included in chapter three	Page 18
3	Relate the patients charter with the WHO Negligence in the conclusion	This has been included in the conclusion	Page 68
4	The candidate needs to realign and refine all the sections of the thesis	The sections of the thesis have been realigned	All pages

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	Please think of a recommendation for rebuilding trust in using public health facilities.	Typos have been corrected	Page 1,2,and 3
2	Literature citation: Overall, literature citation was done well. However, there are very many typos including spelling errors and unclear sentences that require rephrasing.	Typos have been corrected	Page 12,13,and 14
3	Questionnaire for data collection: Although the methods section of the report does mention the tools used, an interview guide is appended to the report. The methods section should be revised to include the interview tool used.	The interview guide has been included	Page 20
4	Sample size: 25 mothers who had	This has been addressed	Page 21

	experienced medical negligence constituted the participants for the study. However, there is no explanation of how this sample was determined. Furthermore, there is no description of how the seed population of size 30 from which the sample of 25 came was obtained.		
	Data Analysis, Presentation and Interpretation of Results Data analysis: The data was analyzed thematically and presented verbatim following data entry in NVivo version 14 and coding. The data analysis involved multiple actions, namely; • transcription • familiarization • open coding • axial coding • selective coding • constant comparison • theoretical sampling • thick description • reflexivity • member checking, and • reporting findings. Gap in data analysis: No mention of the ages of 5 participants. Also, no information was provided on the marital status of the participants and yet family support was considered.	This has been addressed	Page 21
	Data presentation: The data was well presented and in a manner that clearly speaks to the study objectives and research questions. The presentation followed well thought through thematic areas. These made the report reader-friendly and the reading very interesting.	All typos have been corrected	Page 25,26,27,28,29,30,31, 32,33,34,35,36,37
	Discussion of Results Quality of discussion: The quality of		Page 45,46,47,48,49,50,51,

	discussion is good; the results were well discussed relating them to what is in literature and bringing out programme and policy implications. Gap in the discussion: There were some circumstances when the results were taken as representative of all mothers in Ntenjeru Subcounty. Generalizing the results to apply to all mothers in Ntenjeru Subcounty is inappropriate. Also, in a number of cases, references were made to “most mothers”, “many mothers”, etc, instead of saying x mothers out of y mothers interviewed. Numbers could have been appended because the figures are there.	The gaps have been addressed	52,53,54,55,56,57,58.
	Conclusions and Recommendations Conclusions and recommendations have been made: Conclusions were drawn based on the results. By and large, the conclusions were supported by adequate data. The only drawback is that the conclusions extended beyond the study population to all mothers 3 | P a g e in Ntenjeru Sub-County. Also, some of conclusions were weak leading to weak recommendations. Significance of the conclusions drawn: The study provided insightful information on medical negligence during childbirth. The	The conclusions have been strengthened to improve the recommendations	Page 64,65,66,and 67

	findings have some programme and policy implications. Hence, the study has made good contributions on the subject matter.		
	List of References/Bibliography The references/bibliography have been listed in an ascending alphabetical order. The list is well presented.	The list has been updated although it was already good	Page 73
5		The luganda version has been included	Appendix 1

NAMARA SARAH GOLDEN	....	**KOBUSIGYE JACQUELINE**	....
Candidate's Name	Signature	Supervisor's Name	Signature