Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

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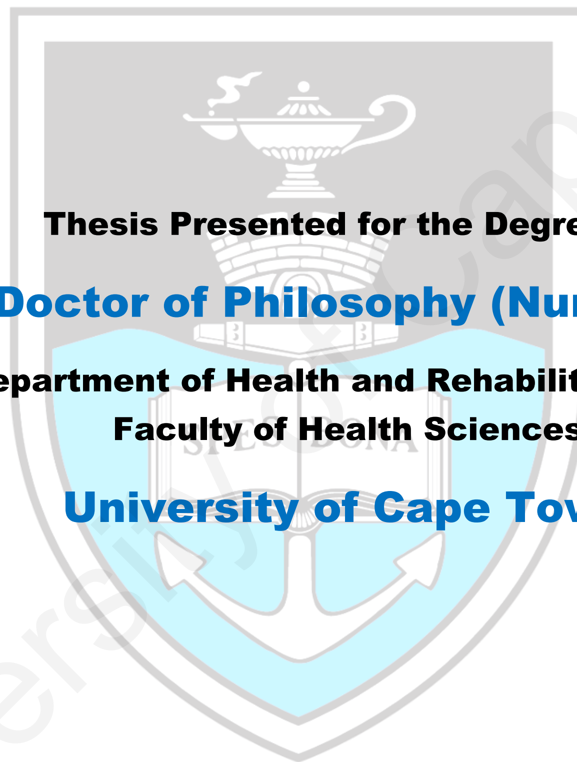

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DECLARATION

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DEDICATION

To my beloved parents, Mr. Christopher Okumu and Mrs. Santa Okumu. I am indebted to you for shaping me into the person I am today through your unwavering sacrifices. Your determination to provide education for your children while managing financial constraints has been a great source of inspiration for me to achieve greatness.

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ACRONYMS / ABBREVIATIONS

ANC	Antenatal Clinic
ANOVA	Analysis of Variance
AOR	Adjusted Odds Ratio
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Cultural Health Capital
CI	Confidence Interval
COR	Crude Odds Ratio
COREQ	COnsolidated criteria for REporting Qualitative research
COVID-19	Coronavirus Disease 2019
CST	Community Survey Tool
DA	Disrespect and Abuse
ENAP	Every Newborn Action Plan
EPMM	Ending Preventable Maternal Mortality
GUREC	Gulu University Research and Ethics Committee
H/C	Health Centre
HREC	Human Research Ethics Committee
IDI	In-depth Interview
IQR	Inter-Quartile Range
MDG	Millennium Development Goal
MMR	Mixed-Methods Research
MVS	Maximum Variation Sampling
NRH	National Referral Hospital
PCCRHE	Person-Centered Care Reproductive Health Equity
PCMC	Person-Centered Maternity Care
PFP	Private For Profit
PNFP	Private Not For Profit
QDR	Qualitative Descriptive Research
QoC	Quality of Care
RA	Research Assistant

REF	Reference
RRH	Regional Referral Hospital
SD	Standard Deviation
SDG	Sustainable Development Goal
SHP	Skilled Health Personnel
SSQ	Six Simple Questions
STROBE	Strengthening the Reporting of OBservational studies in Epidemiology
SVB	Spontaneous Vaginal Birth
TA	Thematic Analysis
UBOS	Uganda Bureau Of Statistics
UCT	University of Cape Town
UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shillings
UNCST	Uganda National Council of Science and Technology
VIF	Variance Inflation Factor
WHO	World Health Organization
WRA	White Ribbon Alliance
ZAR	(Zuid-Afrikaanse) South African Rand

ABSTRACT

Background: Despite the importance of care experience during childbirth, there is a dearth of literature on adolescents' experiences of care during childbirth and how their experiences influence their satisfaction with care and future utilization of healthcare facilities. This study examined adolescents' perceptions of PCMC during childbirth in health facilities in rural northern Uganda and how their perceptions influenced their satisfaction with care and future childbearing intentions (intentions to give birth, give birth in the same facility, and recommend the same facility to a sister or friend), and explored the drivers of adolescents' experiences of care during childbirth.

Methods: A mixed-methods study was conducted among 570 adolescents aged 14 to 19 years who gave birth in public health facilities in northern Uganda. Adolescents' perceptions of PCMC were measured using the PCMC tool, satisfaction with care was measured using the Six Simple Questions tool, and future childbearing intention was measured using questions from the Community Survey tool. Qualitative data was collected from 14 purposively sampled participants using in-depth interviews. Quantitative data were analysed using descriptive and regression analyses, while qualitative data were analysed thematically and integrated with quantitative data.

Results: The PCMC percentage mean score out of 100% was 62% (SD ± 10.12), and percentage mean scores for sub-scales of dignity and respect was 60% (SD ± 12.05), 59% (SD ± 17.12) for communication and autonomy, and 63% (SD ± 9.92) for supportive care. Adolescents' perceptions of moderate/high PCMC during childbirth were positively associated with being married (AOR = 2.61, 95% CI: [1.01, 6.76]), doing casual labour (AOR = 3.18, 95% CI: [1.52, 6.68]), and having an episiotomy (AOR = 1.88, 95% CI: [1.05, 3.36]). Conversely, five to seven antenatal visits (AOR = 0.52, 95% CI: [0.33, 0.83]), birth companionship (AOR = 0.34, 95% CI: [0.19, 0.60]) and having a newborn with complications (AOR = 0.25, 95% CI: [0.09, 0.68]) were negatively associated.

The mean satisfaction with the care score was 30.12/42 (SD ± 4.10). Adolescents perceived moderate and high levels of PCMC during childbirth were positively associated with satisfaction with care ($\beta = 4.01$, 95% CI [3.14, 4.88], $p < 0.001$and $\beta = 4.38$, 95% CI [2.91, 5.86], $p < 0.001$ respectively).

Most adolescents expressed intentions to have another child (82%), return to the same facility for future childbirth (83%), and recommend the same facility to a sister or friend (85%). Adolescents perceived moderate and high levels of PCMC during childbirth were positively associated with intentions to choose the

same facility for the next childbirth (AOR=2.84, 95% CI [1.61, 5.00] and AOR=5.60, 95% CI [1.19, 26.43] respectively) and recommend the facility to a sister or friend (AOR=4.31, 95% CI [2.46, 7.54]).

Adolescents had mixed experiences during childbirth, ranging from positive experiences of effective communication, dignity and respect, supportive care, and health facility hygiene to negative experiences of disrespect and abuse, and health facility constraints. Negative experiences were associated with lack of birthing necessities, younger age, and perceived low social status while positive experiences were driven by passive compliance, calm demeanor, relational skills, possession of birthing necessities, cleanliness, and smartness.

Conclusion: Adolescents' varied experiences of care during childbirth, influenced by various individual-level factors, resulted in perceptions of moderate PCMC during childbirth. PCMC has the potential to enhance childbirth experience for adolescent mothers, as well as influence their satisfaction with care and future childbearing intentions.

Keywords: Adolescents, Experiences, Childbirth, “Person-Centred Maternity Care”, Satisfaction, Childbearing, and Intention.

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CHAPTER ONE: FOUNDATION OF THE STUDY

1. Introduction

"*Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care*" (World Health Organization, 2014c, p. 1). Adolescence is a crucial and transformative stage of human development and the unique physiological, cognitive, social, emotional, and sexual changes that occur during this period require particular focus during childbirth (World Health Organization, 2023a).

The World Health Organization (WHO) quality-of-care dimension recognises experience of care, besides provision of care, as pillars for the improvement of quality of maternity services in health facilities (World Health Organization, 2019a). This chapter introduces and defines the key concepts (person-centred maternity care, experience of care, satisfaction with care, future childbearing intentions, and adolescence) underpinning this study and describes the context in which the study was conducted. The problem statement, study rationale, and significance of the study are presented at the end of the chapter.

1.1 Background

Every day in 2020, almost 800 women died globally from preventable causes related to pregnancy and childbirth, and a maternal death occurred almost every two minutes in 2020 (World Health Organization, 2023b). The global maternal mortality ratio is estimated at 216 deaths per 100,000 livebirths with low and middle-income countries (LMICs) disproportionately affected (Alkema et al., 2016). Almost all maternal deaths (99%) occur in LMICs with more than half of these deaths in Sub-Saharan Africa (Alkema et al., 2016; World Health Organization, 2015c). Despite significant progress in the reduction of maternal mortality, we still have unacceptably high numbers of maternal mortality partly because of poor quality of care within healthcare facilities (Tunçalp et al., 2015).

Improving the quality of care in health facilities is increasingly recognised as an important focus in the quest to end preventable mortality and morbidity among mothers and newborns (World Health Organization, 2014a, 2015a). It has been estimated that high-quality maternal and newborn health systems could prevent one million newborn deaths and half of all maternal deaths each year (World Health Organization, 2020b). Quality of maternal and newborn care is the extent to which health services provided to mothers and newborns improve the desired health outcomes by providing care that is safe, effective, timely, efficient, equitable, and people-centred (Tunçalp et al., 2015). The quality of maternal and newborn care can be assessed based on (i) the provision and (ii) the woman's experience of care (World Health Organization, 2016a, 2019a).

Research has shown that maximising the utilisation of maternal healthcare services is insufficient to reduce maternal and neonatal mortality and morbidity (Carvajal–Aguirre et al., 2017).

Efforts to improve the quality of maternal and newborn care focused on the provision of care at the expense of the experience of care and subsequently research focused on measuring the provision of essential interventions and availability of essential toolkits (Choi & Ametepi, 2013; Diamond-Smith et al., 2016; Khatri et al., 2021). However, there is a complex interplay between experience of care and maternal and newborn outcomes that needs attention (World Health Organization, 2019a). Sudhinaraset et al. (2017) reconceptualised the quality of maternal and newborn care to include the experience of care and called it PCMC based on the evidence about the limitations of coverage of care in averting maternal and newborn mortality. PCMC refers to a healthcare approach which prioritises provision of care that is respectful of and responsive to individual women and their families' preferences, needs, and values during pregnancy and childbirth (Sudhinaraset et al., 2017).

Previous research on PCMC during childbirth examined the psychometrics of PCMC (Afulani et al., 2022; Afulani, Diamond-Smith, et al., 2017; Afulani, Diamond-Smith, et al., 2018). Studies have also explored the perceptions of women, providers, and communities regarding the implementation of PCMC (Afulani et al., 2019; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Sudhinaraset et al., 2019), as well as predictors of PCMC (Afulani, Sayi, et al., 2018; Dagnaw et al., 2020; Tarekegne et al., 2022). Other research investigated the association between PCMC and maternal and newborn health outcomes and complications, as well as women's satisfaction (Rishard et al., 2021; Sudhinaraset et al., 2020; Sudhinaraset et al., 2021).

However, there is little information on PCMC and associated factors during childbirth among adolescents who give birth in fragile settings like rural northern Uganda. There is also a dearth of literature on how PCMC during childbirth influences adolescents' experiences of care, satisfaction with care, and future childbearing intentions. Rural northern Uganda was plagued by the Lord's Resistance Army war (LRA), which lasted for over two decades (Allen, 2023; Atkinson, 2009; David & Ayegba, 2021; Lindemann, 2011). As a post-war area characterised by the secondary effects of conflict, such as high teenage pregnancy, poverty, and weak healthcare systems (Bendavid et al., 2021; Chi et al., 2015a; Jawad et al., 2021), adolescents who give birth in public health facilities in this region may experience poor quality of care.

Assessing the quality of care during facility-based childbirth for adolescents, especially in regions with limited healthcare resources like rural northern Uganda, can be used to design interventions that strengthen the quality of intrapartum care, ultimately contributing to the reduction of maternal and newborn mortality in the

country. Therefore, this study examined PCMC during facility-based childbirth among adolescents in rural northern Uganda, its influence on satisfaction with care and future childbearing intentions and explored the drivers of adolescents' experiences of care during childbirth.

1.2 Study Concepts

The key concepts underpinning this study are PCMC, experience of care, satisfaction with care, future childbearing intentions, and adolescence.

1.2.1 Person-Centred Maternity Care

PCMC has its roots in the concept, Person-Centred Care (PCC) which is sometimes referred to as patient-centred care, client-centred care, or resident-centred care (Morgan & Yoder, 2012). The concept of PCC has a long history and tradition in health care and it can be traced back to the work of Florence Nightingale, who differentiated nursing from medicine by its focus on the patient rather than the disease. Contemporary work in this field has been done by The Picker-Commonwealth Programme (Morgan & Yoder, 2012).

The Picker-Commonwealth Programme for PCC was formed in the United States in 1987 to mainstream PCC into a comprehensive health care system as a way to delivering better health care services (Beach et al., 2006). The programme focused on patients' needs, and seven dimensions of PCC were identified (Beach et al., 2006). These dimensions are (a) respect for patients' values, preferences, and expressed needs, (b) coordination and integration of are, (c) information, communication, and education, (d) physical comfort, (e) emotional support and alleviation of fear and anxiety, (f) involvement of friends and family, and (g) transition and continuity (Beach et al., 2006).

The Institute of Medicine (IOM) in the United States published a report, ''*Crossing the Quality Chasm*" and defined PCC as care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions (Corrigan, 2005, p. 49). A concept analysis by Morgan and Yoder (2012, p. 8) redefined PCC as "*a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualised, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care*".

Sudhinaraset et al. (2017) contextualised PCC to maternity care and defined it as care that is respectful of and responsive to individual women and their families' preferences, needs, and values during pregnancy and childbirth hence the concept PCMC. It is defined by 10 attributes which are (i) dignity and respect, (ii) autonomy, (iii) privacy and confidentiality, (iv) communication, (v) social support, (vi) supportive care,

(vii) predictability and transparency of payments, (viii) trust, (xi) stigma & discrimination, and (x) health facility environment (Sudhinaraset et al., 2017). When the tool to measure PCMC was developed and validated, the ten attributes of PCMC were regrouped into three sub-domains namely, dignity and respect, communication and autonomy, and supportive care (Afulani, Diamond-Smith, et al., 2017; Afulani, Diamond-Smith, et al., 2018).

The level of PCMC during childbirth is a process measure of quality of maternal and neonatal care in health facilities (World Health Organization, 2016a, 2019a). The degree of implementation of PCMC determines the extent of realisation of person-centred outcomes (World Health Organization, 2016a, 2019a). The level of PCMC during facility-based childbirth influences women's experience of care, satisfaction with care, and future childbearing intentions or health-seeking behaviours (Sudhinaraset et al., 2017).

1.2.2 Experience of Care

According to the Beryl Institute of patient care headquartered in Southlake, Texas, United States, a patient's experience of care can be generally defined as, "*the sum of all interactions that patients have with the health care system, shaped by an organisation's culture, that influence patient perceptions, across the continuum of care*" (Wolf & Jason, 2014). The patient experience of care reflects occurrences and events that happen independently and collectively across the continuum of care (Wolf & Jason, 2014). It also reflects the patient's expectation of care and if those expectations were positively realised (LaVela & Gallan, 2014; Wolf & Jason, 2014).These expectations go beyond the clinical outcomes and the health status of the patient (LaVela & Gallan, 2014).

Experience of care is one of the four process domains of quality of care for mothers and newborns besides access to care, provision of care, and management and organisation of care (Tunçalp et al., 2015; World Health Organization, 2019a). It is a process indicator for measuring the quality of care for mothers and newborns (Tunçalp et al., 2015; World Health Organization, 2019a). It is measured by three core parameters of care namely, effective communication, respect and preservation of dignity, and emotional support (Tunçalp et al., 2015; World Health Organization, 2019a). Its measurement may also entail health facility infrastructure and the competence and motivation of the skilled health personnel (Tunçalp et al., 2015; World Health Organization, 2019a).

1.2.3 Satisfaction with Care

Satisfaction with care is a measure of the extent to which a patient is content with the health care they received from their health care provider (Ng & Luk, 2019; Wagner & Bear, 2009). It is an important and

commonly used outcome indicator for measuring the quality of maternal and newborn care (Tunçalp et al., 2015; World Health Organization, 2019a). Satisfaction with care is becoming the basis of quality improvement of maternal and newborn care because it is the actual evidence of the effectiveness of the healthcare services being provided in a health facility (Ng & Luk, 2019). Increased satisfaction with care in a healthcare setting generally improves patient compliance, clinical outcomes, loyalty, and referrals (Ng & Luk, 2019; Wagner & Bear, 2009). Hence, the evaluation of satisfaction with care during childbirth from the perspectives of vulnerable adolescents serves as a valuable indicator to measure the experience of care, especially in public health facilities with limited resources (Orte et al., 2020).

1.2.4 Future Childbearing Intentions

Future childbearing intentions refer to an individual or couple's plans, desires, or intentions regarding having children in the future (Duvander et al., 2020). It is a complex concept that entails intentions to give birth in the future, intentions to give birth in the same facility in the future, and intentions to recommend the same facility to a sister or a friend following previous childbirth experiences (Bohren et al., 2018; Sudhinaraset et al., 2017).

According to the theory of planned behavior by Ajzen (1991), behaviors are influenced by intentions, which are determined by multiple prevailing factors. Childbearing decision-making is a complex process influenced by social, economic, political, individual, and health systems factors (Araban et al., 2020; Baki-Hashemi et al., 2018; Kariman et al., 2016). This current study postulated that the level of PCMC during facility-based childbirth influences adolescents' future childbearing intentions.

1.2.5 Adolescence

Adolescence is a period of transition between childhood and adulthood that is characterised by physical, cognitive, emotional, and social changes (Sanders, 2013; World Health Organization, 2014b). Scholars have conceptualised the age bracket of adolescence differently owing to the variability of the onset of puberty and the complexity in defining the onset of adulthood (Lee & Styne, 2013; Orenstein & Lewis, 2020; Sanders, 2013; Sawyer et al., 2018). For instance, Sawyer et al. (2018) argued that the age category for adolescents should stretch from 10-24 years because the current age category is outdated and does not represent the contemporary transition to adulthood in developing countries.

The WHO and UNICEF define adolescents as persons from the age of 10 to 19 years (UNICEF, 2021; World Health Organization, 2014b). They further classify adolescence as early adolescence (ages 10-14 years), middle adolescence (ages 15-17 years), and late adolescence (ages 18-19 years) accordingly. This study

conceptualised an adolescent as persons between 10 and 19 years because this is the age bracket adopted by Uganda as recommended by WHO and UNICEF (Ministry of Health, 2004, 2011). Adopting the age category of 10-19 years aligned this study with the policy framework for adolescents in Uganda, and hence the results of this study are suitable for advocacy, galvanising, and informing actions to improve the quality of maternal and newborn care among this special age group.

According to Erikson's stages of psychosocial development, the hallmark of adolescence is identity confusion because of the burden of identity definition and personality development (Orenstein & Lewis, 2020; Sanders, 2013). Psychosocial changes during adolescence include abstract thinking, the formation of new relationships away from family, increased self-involvement, and an increased drive for independence (Özdemir et al., 2016; Sanders, 2013). Adolescents also begin to take up roles and responsibilities commensurate to their gender, social, and professional identities (Özdemir et al., 2016; Sanders, 2013). These developmental changes impact how adolescents behave during maternity care and how they are treated while seeking care (Crooks et al., 2022; Mangeli et al., 2017; World Health Organization, 2023a).

1.3. Study Context

The study concepts were examined in the context of adolescents who gave birth in public health facilities in Lira District, northern Uganda. This sub-section describes Lira District's location, size, administrative unit, population, and history of armed conflict. The trends in teenage pregnancy, health service delivery, and maternal and neonatal health indicators in the broader Uganda context are presented at the end of the section.

1.3.1 Study Location, Size, and Administrative Unit

Lira district is located 342 kilometres (212 miles) from Kampala, the capital city of Uganda. It covers a total area 1 326 square kilometres of which 1 286 square kilometres is land area and the rest of the area covered by water and swamps (Uganda Bureau of Statistics, 2017) (Figure 1.1).

Figure 1.1: Map of Uganda Showing Lira District with Its Sub-Counties

Note. Adapted from National Population and Housing Census 2014 Area Specific Profiles-Lira District, by Uganda Bureau of Statistics, 2017, *Uganda Bureau of Statistics*, p. 7 & 9. (https://www.ubos.org/wp-content/uploads/publications/2014CensusProfiles/LIRA.pdf).

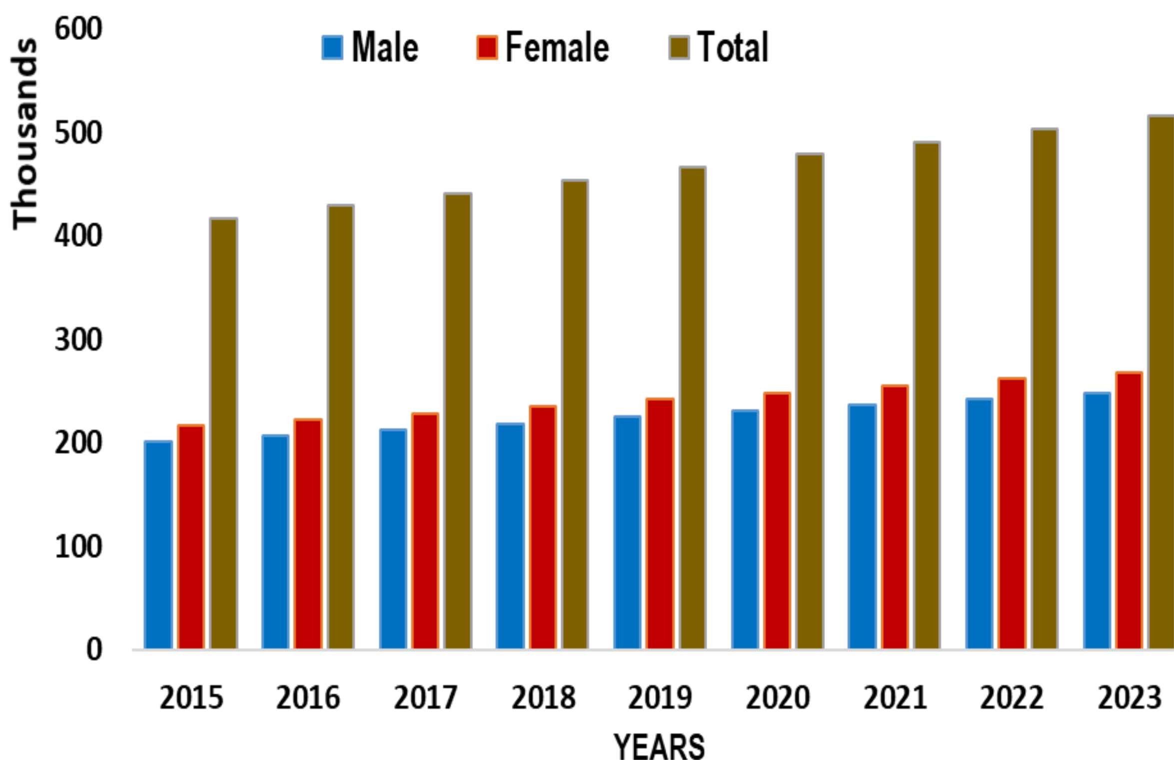
Lira District consists of two counties namely, Erute North and Erute South separated by Lira City (Uganda Bureau of Statistics, 2017). Erute North is comprised of Aromo, Agweng, and Ogur sub-county while Erute South is comprised of Barr, Agali, and Amach sub-county. These sub-counties have a total of 49 parishes (Uganda Bureau of Statistics (UBOS), 2019a).

1.3.2 Population

1.3.2.1 Population Trend

The 2014 national population census estimated the district's human population at 408,043 with females constituting 51.8% of the population (Uganda Bureau of Statistics, 2017). The human population projection of Lira District has steadily increased from 417,000 in 2015 to 516,000 in 2023 which represents an increase of 25% (Uganda Bureau of Statistics, 2019) (Figure 1.2 below).

Figure 1.2: Projected Trends in Population, Lira District, 2015-2023

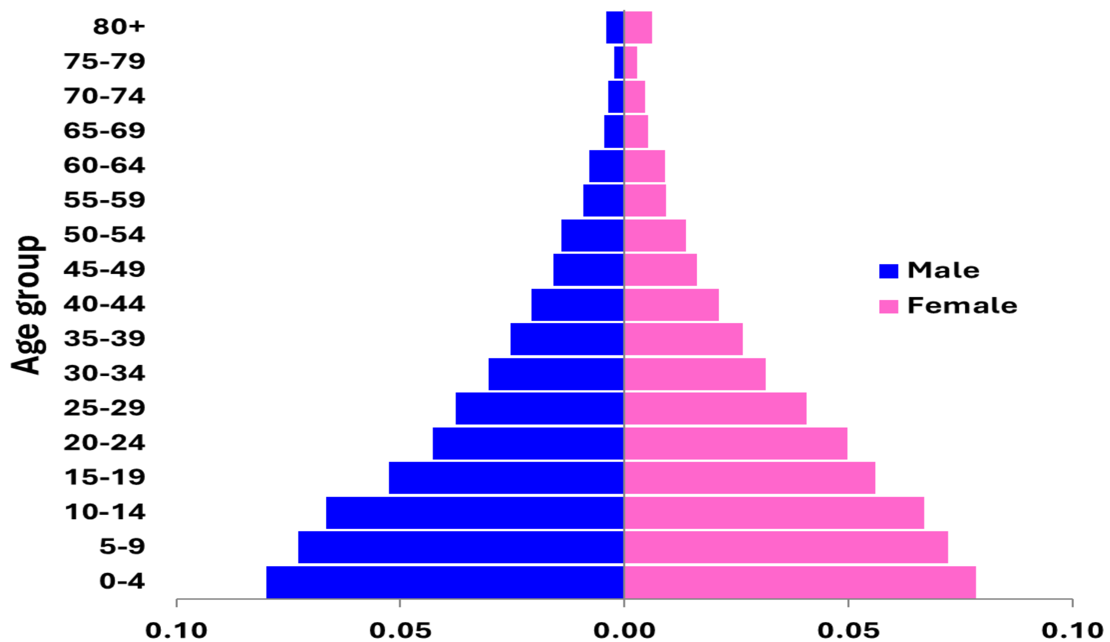


Note. Adapted from Population Projections By District, 2015 to 2023 by Uganda Bureau of Statistics (UBOS) (2019b)

1.3.2.2 Population Distribution by Age and Sex

Females constitute 52% of Lira District's population as of 2023 (Uganda Bureau of Statistics, 2019). The population of teenagers and young adults in Lira District as of 2023 was estimated at 85,656 (44,541-Females and 41,115-Males) and 178,020 (92,570-Females and 85,450-Males) respectively. Figure 1.3 below presents the population pyramid of Lira District.

Figure 1.3: Population Pyramid of Lira District



Note. Adapted from National 5-Year Age Group Population Projections by (Uganda Bureau of Statistics, 2019)

1.3.2.3 Language and Economic Activity

The dominant tribe in Lira District is the Lango tribe who speak the *Lango* language, although the official language of the country is English (Uganda Bureau of Statistics, 2017). The main economic activity in the district is subsistence farming with beans, cassava, maize, and potatoes as the most commonly grown crops (Uganda Bureau of Statistics, 2017). The main administrative and commercial centre in the district is Lira City (Uganda Bureau of Statistics, 2017).

1.3.3 Armed Conflict in Northern Uganda

Northern Uganda and the development trajectory, which includes the provision of maternal and neonatal health services, cannot be disassociated from the history of the Lord's Resistance Army (LRA).

1.3.3.1 Overview of the Lord's Resistance Army (LRA) War

The Lord's Resistance Army (LRA) was founded in northern Uganda in 1987 by Joseph Kony to drive President Yoweri Museveni[1] out of office and establish a Christian theocracy (Allen, 2023; David & Ayegba, 2021). This rebel group followed a spiritual-led resistance called the Holy Spirit Movement led by Alice

[1] President Yoweri Museveni overthrew President Milton Obote and was sworn in as president of the Republic of Uganda on the 26th January 1986.

Lakwena. Although Lakwena did not believe in gun war, the well-intentioned movement was soon highjacked by Joseph Kony to become a full-blown rebel group that used standard military tactics, as opposed to previous methods of depending on oil or holy water to ward off bullets and use of evil spirits as methods of protection and attack (Allen, 2023).

The LRA strategy was to use terror to disrupt life and normal social function, spread fear and insecurity, and cause the national government to appear weak and unable to protect its citizens. The conflict-affected sub-regions were Acholi, Lango, and Teso. These sub-regions constitute the original districts of Gulu, Kitgum, Pader, Lira, Apac, Soroti, Katakwi, and Kumi although the first three districts where the rebellion started were the most affected. The LRA insurgency moved into Lira district in 2002, almost 21 years ago.

On July 14, 2006, peace talks, named, "The Juba Peace Talk" began between the government of Uganda and the rebel LRA to end the Northern Uganda war (Atkinson, 2009; David & Ayegba, 2021). The LRA was then given a deadline of 30th September 2007 to sign the peace agreement. Unfortunately, the peace talks broke down owing to divisions within the LRA group and complaints of government manipulation including secret cash payments to certain LRA members that both divided the rebels and undermined the peace process (Atkinson, 2009; David & Ayegba, 2021).

After the failed peace talk, the Uganda government together with her allies launched a new operation codenamed, "Operation Lightning Thunder" in December 2008 (Atkinson, 2009; David & Ayegba, 2021). This operation marked the end of the LRA war in Uganda in 2009 (Atkinson, 2009; David & Ayegba, 2021). The people of Acholi, Lango, and Teso sub-regions who had been internally displaced in camps began to return to their homes to begin a journey of recovery from the effects of the war. Although this rebel activity ended, the different sectors including the health sector of the affected district are still in a state of recovery.

1.3.3.2 Armed Conflict and Maternal and Neonatal Health

Armed conflicts cause major health problems with direct and indirect impacts on maternal and neonatal health (Bendavid et al., 2021; Jawad et al., 2021). Armed conflicts are associated with sustained high maternal and neonatal deaths because they destabilise health systems and foster negative socioeconomic conditions which undermine efforts to reduce maternal and neonatal mortality (Bendavid et al., 2021; Jawad et al., 2021). Also, the capacity to deliver services may be undermined due to the loss or diversion of healthcare personnel and the disruption of supply chains, referral networks, communication, and supervision thus reducing access to quality of services to maternal and newborn (Chi et al., 2015a).

Research evidence from post-conflict areas of Uganda and neighbouring Burundi shows that utilisation of maternal and neonatal services remains low which is associated with poor maternal and neonatal outcomes (Chi et al., 2015b). According to the Uganda Demographic and Health Survey, between 2000/01 and 2016, northern Uganda has consistently lagged in respect of antenatal care provided by skilled providers, birth in health facilities, and birth by skilled birth attendants. This can be largely attributed to the weak healthcare systems and high poverty rates in the region as a result of the LRA armed conflict (Chi et al., 2015a; Uganda Bureau of Statistics (UBOS) and ICF, 2016). The 2021 poverty report for Uganda indicates that the poverty rate for Acholi, Lango (where Lira District belongs), and Teso sub-regions, northern Uganda stands at 63.6%, 57%, and 55.6% respectively above the national average of 42.1% (Ministry of Finance, 2023). By region, northern Uganda has the highest rate of poverty at 36% (which translates to 3.1 million people) compared to 8.7%, 29.2%, and 14.4% in central, eastern, and western Uganda (Ministry of Finance, 2023).

The measurement of indirect and longer-term effects of armed conflict on maternal and neonatal health in sub-Saharan Africa including Uganda has received limited attention (Boerma et al., 2019), and yet the impact is considered to be much larger than the direct effects (Bendavid et al., 2021). Limited studies have documented the quality of maternal and neonatal care since the end of the conflict in 2008 (Arach et al., 2021; Mukunya et al., 2021; Odongkara et al., 2022). Being a post-war area, characterised by secondary effects of conflict such as trauma, moral decay, poverty, and weak healthcare systems, the quality of maternal and neonatal care may be poor especially during childbirth when women are most vulnerable. These factors accentuated the need to examine how adolescents are cared for during childbirth in this context.

1.3.4 Teenage Pregnancy

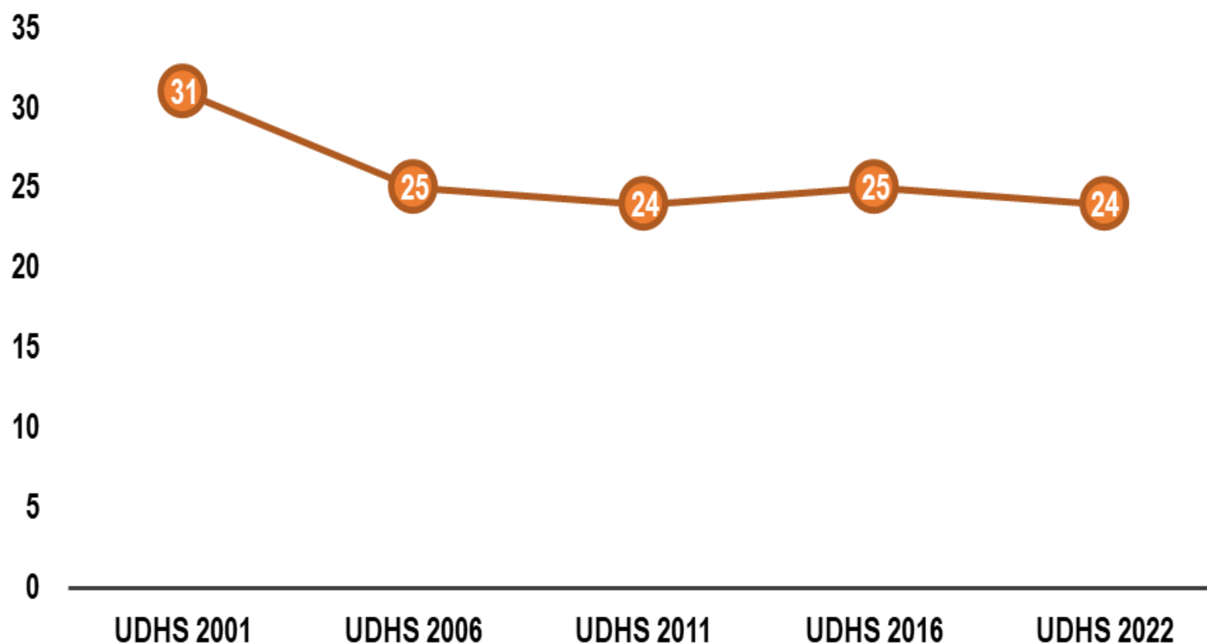
Teenage pregnancy refers to girls aged 10-19 years who are either currently pregnant or have had a birth (The Ministry of Finance, 2021). Teenage pregnancy remains a significant public health challenge in Uganda, with profound implications for the health, education, and socio-economic status of young mothers and their children (The Ministry of Finance, 2021).

1.3.4.1 National Trends in Teenage Pregnancy

The rate of teenage pregnancy in Uganda declined from 31% in 2000/2001 to 25% in 2006 (Uganda Bureau of Statistics (UBOS) and ICF, 2022). Since then, the rate of teenage pregnancy has stagnated at around 25% (Uganda Bureau of Statistics (UBOS) and ICF, 2022). Teenage pregnancy is more common in rural areas (25%) than in urban areas (21%) (Uganda Bureau of Statistics (UBOS) and ICF, 2022). Nearly two-thirds of the adolescents (63.3%) who have begun childbearing have either no formal education or only

attained primary-level of education while more than one-third of them (34%) are in the lowest wealth quantile (Uganda Bureau of Statistics (UBOS) and ICF, 2016).

Figure 1.4: Trends in Teenage Pregnancy in Uganda

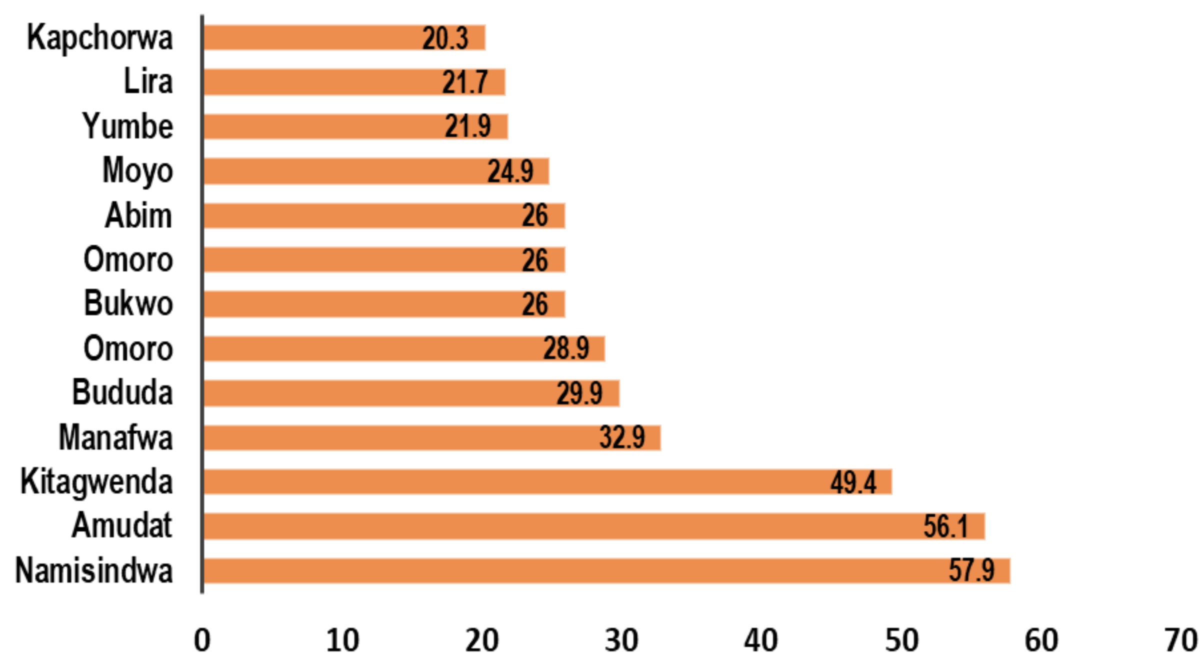


Note. Adapted from Adapted from Uganda Demographic and Health Survey: Key Indicators Report by Uganda Bureau of Statistics (UBOS) and ICF (2022, p. 10).

1.3.4.3 Districts Most Affected by Teenage Pregnancies

Given the disruption to sexual and reproductive health service delivery with the advent of Covid-19 in 2020, districts like Namisindwa and Amudat in the Eastern and Northern region respectively registered over 50% increase in teenage pregnancy while districts such as Lira registered more than 20% increase in teenage pregnancy the following year (United Nations Population Fund (UNFPA) Uganda, 2022a). With Uganda still recovering from the effects on Covid-19 pandemic on the health systems, the burden of teenage pregnancies in these districts may not be very different in 2024. The districts most affected by teenage pregnancy in Uganda in 2021 are presented in Figure 1.5 below:

Figure 1.5: Districts Most Affected by Teenage Pregnancies, 2021



Note. Adapted from The Magnitude of Teenage Pregnancy in Uganda by United Nations Population Fund (UNFPA) Uganda (2022a, p. 3).

1.3.5 Health Service Delivery System in Uganda

Health services in Uganda are delivered through the public, private for-profit (PFP), and private not-for-profit (PNFP) health facilities through a decentralised system of health service delivery (Ministry of Health, 2016, 2018). Uganda's health facilities are classified into seven levels based on the services they provide and the catchment area they serve. The health facilities are designated as health centre level one (Clinic) to health centre level four (H/C II-IV); general hospital (GH), regional referral hospital (RRH), and national referral hospital (NRH) (Ministry of Health, 2016, 2018). Provision of maternity care services starts at H/C III and above and it is provided largely by midwives although nurses, clinicians, and medical doctors including the specialists also form part of the core team (Ministry of Health, 2016, 2018) as shown in Table 1.1.

Table 1.1: Overview of Maternity Service Delivery by Level of Health Facility in Uganda

#	LEVEL	POPULATION	SERVICES PROVIDED
1	Health Centre III	20 000	Offers antenatal, intrapartum, and postnatal care services. It also offers laboratory services and Basic Emergency Obstetric and Newborn Care (BEmONC).
2	Health Centre IV	100 000	Offers antenatal, intrapartum, and postnatal care services. It also offers laboratory services and Comprehensive Emergency Obstetric and Newborn Care (CEmONC).
3	General Hospital	500 000	In addition to services offered at H/C IV, it also provides in-service training, consultation and research.
4	Referral Hospital	1 000 000	In addition to maternity services offered at the General Hospital, Referral Hospitals offer a package of specialized services and training with advanced diagnostic and treatment facilities.
5	Regional Referral Hospital (RRH)	2 000 000	In addition to services offered at the Referral Hospital, RRH act as a regional hub for training, mentorship, and supervision of lower-level facilities. It also handles more advanced surgical services
6	National Referral Hospital (NRH)	10 000 000	The NRH offer National-level teaching, research, and policy development for maternity care. They also handle specialized consultations for the entire country.

Note. Adapted from National Health Facility Master Facility List by Ministry of Health (2018, p. 7).

Northern Uganda has 1 061 health facilities of which 733 (69.1%) are public facilities, 176 (16.6%) are PFP, and 152 (14.3%) are PNFP health facilities (Ministry of Health, 2018). Meanwhile, Lira has a total of 57 health facilities of which 25 (43.8%) are public facilities, 23 (40.4%) are PFP, and 9 (15.8%) are PNFP health facilities (Ministry of Health, 2018). Lira District alone has only seven public health facilities with capacity to offer maternity services, namely Ogur H/C IV, Amach H/C IV, Aromo H/C III, Barr H/C III, Agali H/C III, Alik H/C III, and Agweng H/C III (Ministry of Health, 2018).

1.3.6 Maternal and Neonatal Health Indicators in Uganda

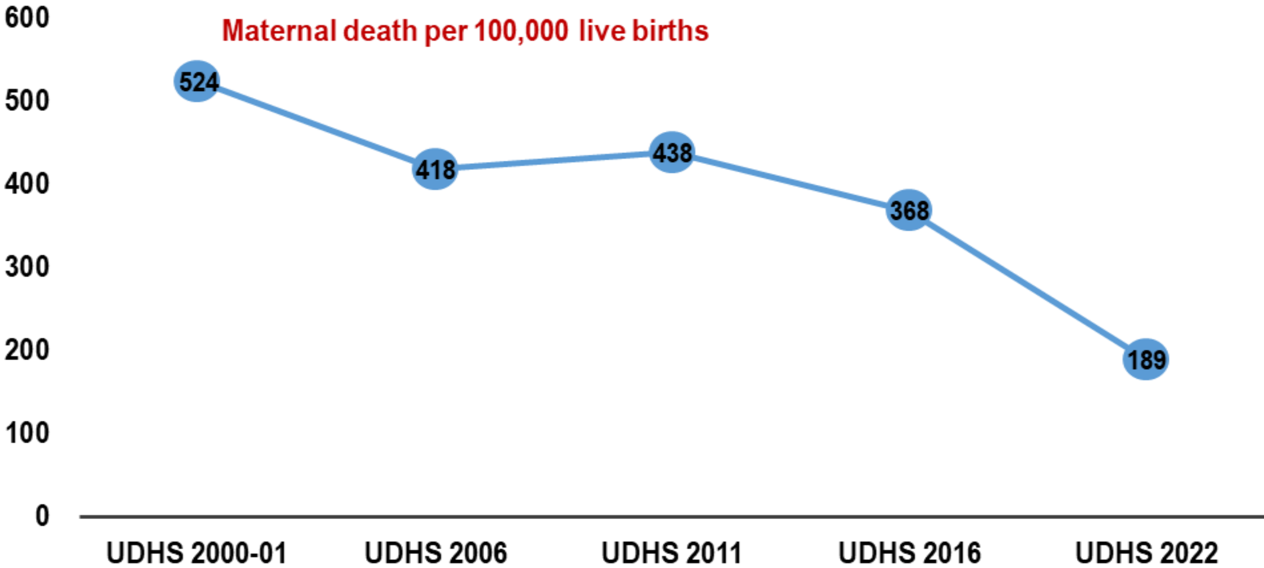
Maternal mortality ratio, neonatal mortality rate, and utilisation of maternal and neonatal care services are key indicators of a country's effort to improve maternal and neonatal outcomes. In this section, Uganda's progress in relation to these indicators are presented.

1.3.6.1 Maternal Mortality Ratio

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes per 100 000 livebirths (World Health Organization, 2021a). Maternal mortality ratio is a key performance indicator for efforts to improve the health and safety of mothers before, during, and after childbirth (World Health Organization, 2019b).

The current maternal mortality ratio (MMR) in Uganda is estimated at 189/100 000 live births (Uganda Bureau of Statistics (UBOS) and ICF, 2022) and 28% of maternal deaths occur in adolescents (United Nations Population Fund (UNFPA) Uganda, 2022b). Although the MMR in Uganda is still high, the country has made steady progress in the reduction of MMR since 1990 (World Health Organization, 2019b). The trend in MMR in Uganda has been one of decline from the year 2000/2001 to 2022 partly due to improved utilisation and quality of maternal and neonatal care services (Figure 1.6).

Figure 1.6: Trends in Maternal Mortality Ratio (MMR) in Uganda, 2000-01-2022



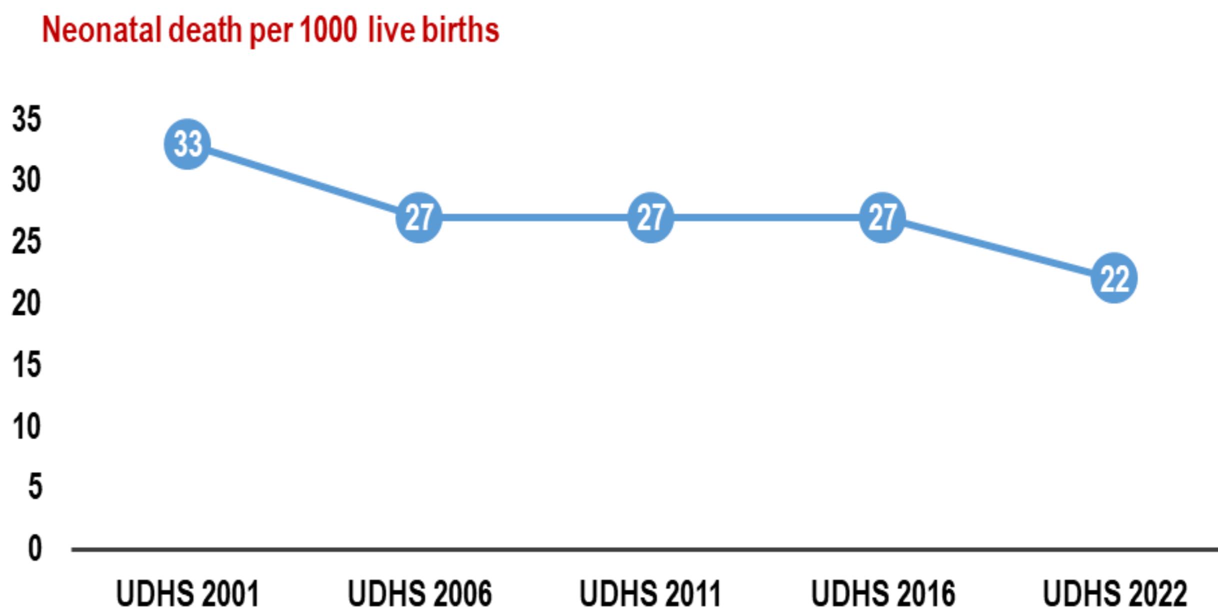
Note. Adapted from Adapted from Uganda Demographic and Health Survey: Key Indicators Report by Uganda Bureau of Statistics (UBOS) and ICF (2022, p. 42).

1.3.6.2 Neonatal Mortality Rate

The neonatal mortality rate is the number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period (World Health Organization, 2021b). Neonatal deaths may be

subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before the 28 completed day of life (World Health Organization, 2021b). The current national demographic and health survey report indicates that the neonatal mortality rate in Uganda stands at 22 deaths per 1000 live births (Uganda Bureau of Statistics (UBOS) and ICF, 2022). It is estimated that teenage pregnancy contributes to 20% of infant deaths in Uganda (United Nations Population Fund (UNFPA) Uganda, 2022b). Uganda made a substantial decrease in neonatal mortality rate between the year 2001 and 2022 due to improved utilisation and quality of maternal and neonatal care services (Asiimwe et al., 2019; Uganda Bureau of Statistics (UBOS) and ICF, 2016, 2022) as summarised in Figure 1.7.

Figure 1.7: Trends in Neonatal Mortality Rate in Uganda, 2000-01-2022

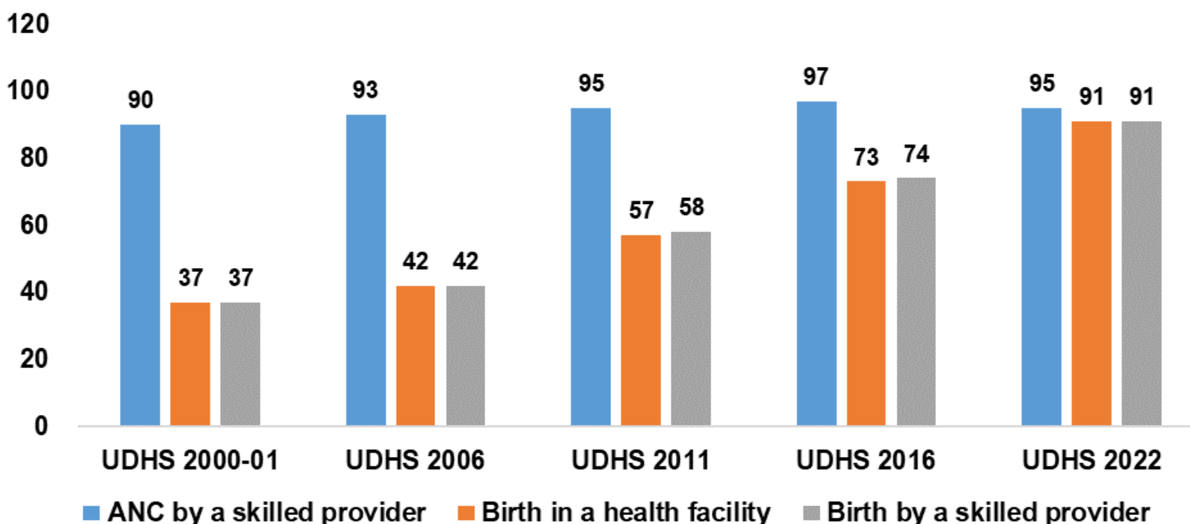


Note. Adapted from Adapted from Uganda Demographic and Health Survey: Key Indicators Report by Uganda Bureau of Statistics (UBOS) and ICF (2022, p. 17).

1.3.6.3 Utilisation of Maternal Healthcare Services in Uganda

Among women of reproductive age, the proportion of antenatal care (ANC) provided by a skilled provider increased from 90% in the year 2000-01 to 95% in 2022 while the proportion of births in healthcare facilities increased from 37% to 91% within the same period (Uganda Bureau of Statistics (UBOS) and ICF, 2022). The proportion of births attended by a skilled provider increased from 37% in 2000-01 to 91% in 2022 (Uganda Bureau of Statistics (UBOS) and ICF, 2022).

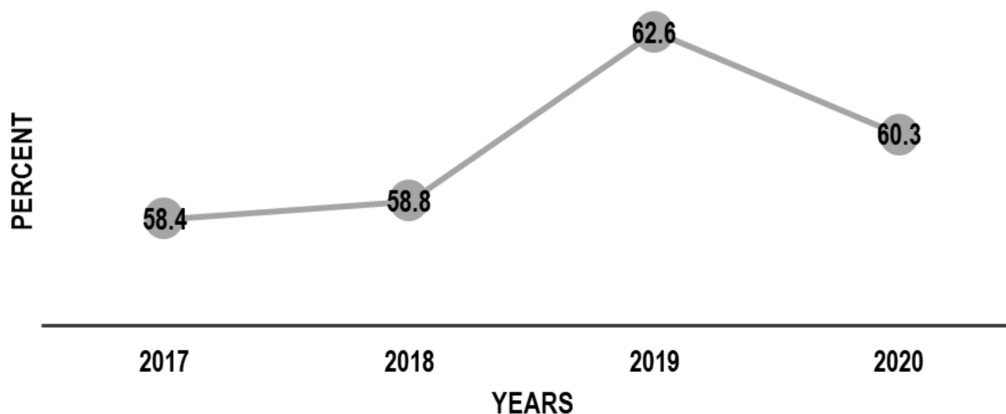
Figure 1.8: Trends in Utilisation of Maternal Healthcare Services in Uganda



Note. Adapted from Uganda Demographic and Health Survey: Key Indicators Report by Uganda Bureau of Statistics (UBOS) and ICF (2022, p. 30).

However, the utilisation of maternal healthcare services in the country has been generally lower among adolescents compared to older women. For instance, only 6 in 10 (60.3%) of childbirths among teenagers were attended by a skilled provider in 2020, lower than the 74% of childbirths attended by a skilled provider among all women of reproductive age between 2017 and 2020 (United Nations Population Fund (UNFPA) Uganda, 2021).

Figure 1.9: Trends in Childbirth Under Skilled Birth Attendant Among Adolescents



Noted. Adapted from Facts on Teenage Pregnancy, 2021 by United Nations Population Fund (UNFPA) Uganda (2021, p. 2)

1.4 Problem Statement

There is a discrepancy between the use of maternal and newborn services and the rates of maternal and newborn deaths in Uganda. Although 91% of births occur in healthcare facilities or are attended by a skilled provider, the national maternal mortality ratio is still at 189 deaths per 100 000 live births and the newborn mortality rate is at 22 deaths per 1000 live births (Uganda Bureau of Statistics (UBOS) and ICF, 2022). In Northern Uganda, the maternal mortality ratio (288/100,000 live births) and newborn mortality rate (23/1000 live births) are higher than the national average (Alobo et al., 2022; Arach et al., 2021). Adolescent pregnancy is associated with 20% of the newborn deaths and 28% of the maternal deaths (United Nations Population Fund (UNFPA) Uganda, 2022b).

Research has shown that simply increasing the utilisation of maternal healthcare services without improving the quality of care is not enough to reduce maternal and neonatal mortality and morbidity (Carvajal–Aguirre et al., 2017). An estimated 1 in 3 women experience poor quality of care during childbirth in the form of disrespectful and abusive care, unsupported care, poor communication, or subjugated care (Bohren et al., 2019; Kmietowicz, 2019). Poor experience of care influences women's decisions to seek care at a health facility during childbirth which ultimately affects maternal and neonatal mortality rates (Bowser & Hill, 2010). Previous studies have shown that adolescents are at heightened risk of experiencing poor quality of care during childbirth (Bohren et al., 2019; Füzy et al., 2020; Irinyenikan et al., 2022).

Unfortunately, there is a lack of reliable generalisable data on PCMC and associated factors during childbirth among adolescents who give birth in fragile settings like rural northern Uganda. Sudhinaraset et al. (2017) presupposed that there is a bi-directional relationship between PCMC and women's experience of care, satisfaction with care, and future childbearing intentions. This hypothesis has not been tested among adolescents. This lack of high-quality data makes it challenging to plan, evaluate, and design interventions to improve the quality of maternal and newborn care in health facilities like rural northern Uganda.

Shim (2010) argued that the mistreatment of vulnerable groups such as adolescents during healthcare interactions is produced by the interplay of economic, social, and cultural capital. Limited studies have examined whether the treatment of adolescents during childbirth could be explained by their economic, social, and cultural capital.

1.5 Rationale for Study

SDG 3.1 and 3.2 targets are to reduce Maternal Mortality Ratios to 70 per every 100 000 live births and newborn deaths to 12 per 1 000 live births by 2030. To achieve these targets and move towards the elimination of preventable causes of maternal and newborn death, increased coverage should be accompanied by improved quality throughout the continuum of care (World Health Organization, 2014a, 2015a). One of the strategic objectives in the Every Newborn Action Plan (ENAP) and the Ending Preventable Maternal Mortality (EPMM) guidelines is to measure processes and outcomes of quality of maternal and newborn care (World Health Organization, 2014a, 2015b). Undertaking this study was a step towards contributing to literature on quality of maternal and neonatal care among a group that is under-researched. To achieve SDG 3.1 and 3.2 there is need to generate context-specific data on PCMC during childbirth among adolescents and how it influences adolescents' experience of care, satisfaction with care, and future childbearing intentions to drive accountability and quality improvement projects.

Quality of maternal and neonatal health care represents the unfinished agenda of the Millennium Development Goal (MDG), especially MDG 4 and 5 where emphasis was placed on coverage of maternal and neonatal care while neglecting the quality of care (World Health Organization, 2023c). The Sustainable Development Goal (SDG) 3.7 urges countries to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. SDG 3.8 advocates for Universal Health Coverage (UHC) in which quality of health care services is a key element (World Health Organization, 2023c). Efforts have since shifted towards experience of care besides access to care in the SDG era based on the evidence that high coverage alone is not enough to reduce maternal and newborn mortality (World Health Organization, 2016a).

This study aligns with Uganda's Health Sector Strategic Plan 2020/21-2024/25, which prioritises the improvement of maternal and neonatal health services (Ministry of Health, 2020a). Specifically, the plan aims to reduce the maternal mortality ratio to less than 70 per 100 000 live births and the neonatal mortality rate to less than 12 per 1 000 live births by 2030 (Ministry of Health, 2020a). By focusing on the quality of care during childbirth, this study will contribute to achieving these ambitious targets by providing actionable data for change on the quality of maternal and neonatal care thus making the services more acceptable to the population in the study area. Moreover, the study seamlessly aligns with the goals stated in the National Development Plan III (2020/21-2024/25) (National Planning Authority, 2020a). This national plan emphasises the enhancement of household incomes and overall quality of life (National Planning Authority, 2020a). By

investigating adolescents' childbirth experiences and their perceptions of care, the study directly supports the broader socioeconomic objectives outlined in the plan.

Finally, Uganda's Vision 2040 provides a long-term perspective for sustainable development of the country (National Planning Authority, 2020b). As part of this vision, Uganda aims to reduce maternal mortality ratio to 15 per 100 000 live births and the neonatal mortality rate to 4 per 1 000 live births by the year 2040, a goal that seems unobtainable (National Planning Authority, 2020b). This goal relies on ensuring equitable access to high-quality healthcare services for all Ugandans. Investigating the impact of PCMC during childbirth on adolescents' experience of care, satisfaction with care, and future childbearing intentions may generate actionable data which may lead to the realisation of Uganda's Vision 2040 and Health Sector Strategic Plan 2020/21-2024/25.

1.6 Conclusion

The quality of maternal and neonatal care in health facilities is an important topic that should be examined in various contexts to inform the development of interventions aimed at improving maternal and neonatal outcomes. Lira District in Northern Uganda presents a distinct context due to its high rate of teenage pregnancy, weak health systems, low socio-economic status, and a history of recent war. These factors have the potential to hinder the provision and experience of care, particularly among adolescents. Understanding the concepts and contexts that underpin this study serves as the basis for this research investigation.

CHAPTER TWO: LITERATURE REVIEW

2. Introduction

A literature review is an integral part of the research process as it helps the researcher identify patterns and trends in the literature, highlighting gaps or inconsistencies in existing knowledge. In this study, a traditional or narrative approach was used to review the literature (Booth et al., 2021; Pautasso, 2019). This approach involves a comprehensive, critical, and objective analysis of the current knowledge on a specific topic (Booth et al., 2021; Pautasso, 2019). The study's specific objectives were to (i) assess the level of Person-Centred Maternity Care (PCMC) during childbirth and associated factors, (ii) examine the association between PCMC and satisfaction with care, (iii) examine the association between PCMC and future childbearing intentions, (iv) explore adolescents' experiences of childbirth, and (v) identify the drivers of adolescents' experiences of care during childbirth. This chapter presents the search strategy used to source literature and the review of literature based on the study objectives. The review focused on women of childbearing age since a scoping review showed a paucity of literature specific to adolescents in these research areas (Udho & Clow, 2024).

2.1 Search Strategy

Systematic review of literature is essential for finding the best evidence. The success of any review depends on the search strategy used to identify relevant literature. This section presents the databases searched, key words used, search criteria, eligibility criteria, and risk of bias assessment statement.

2.1.1 Databases

The databases searched included PubMed (MEDLINE), EBSCOhost (Africa Wide Information, CINAHL, PsycINFO, and SocINDEX), Web of Science (SciELO Citation Index and Web of Science Core Collection), Scopus, and Google Scholar. Hand searching of references was also used to examine sources beyond electronic databases to capture studies that may not have been indexed but were relevant to the literature review such government reports, theses, and guidelines.

2.1.2 Keywords

A search strategy was developed using Boolean Logic Operators of 'AND' and 'OR' and adapted for the selected databases. The MESH terms associated with these words were also added to the search strategy to avoid missing any key references. The keywords and the associated MESH terms were applied in line with the study objectives as shown below:

a) Person-centred OR person-centered AND maternal OR maternity AND childbirth OR delivery OR birth, AND associated OR determinants AND factors.

b) Person-centred OR person-centered AND Maternal OR maternity AND childbirth OR delivery OR birth AND satisfaction AND care.
c) Person-centred OR person-centered AND Maternal OR maternity AND childbirth OR delivery OR birth AND fertility AND recommendation OR recommend AND intentions OR intention.
d) Experiences AND childbirth OR delivery OR birth AND drivers OR determinants OR factors

Initially, all the search strategies had adolescents as a key term, but due to the paucity of literature, the literature search had to be expanded to include women of childbearing age. The search was also not limited to any country(ies).

2.1.3 Search Criteria

Literature from the last 10 years (2014 to 2024) was searched for retrieval and review. However, earlier seminal studies were included in the review. The search was restricted to peer-reviewed articles published in the English language (abstract only or abstract and full-text). Qualitative, quantitative, and mixed-methods studies were included.

2.1.4 Eligibility Criteria for Literature Selection

When the articles were retrieved, an inclusion and exclusion criteria were set to select the most suitable articles as presented below:

2.1.4.1 Inclusion Criteria

The review included studies conducted among women which presented evidence on (i) PCMC and associated factors, (ii) satisfaction with care and association with PCMC, (iii) future childbearing intentions and association with PCMC, (iv) experiences of care, and (v) drivers of experiences of care. Because of the paucity of literature, all studies which presented these evidences were included in the study.

2.1.4.2 Exclusion Criteria

The literature review excluded studies that did not report on the main outcomes of the study. Studies conducted among women who gave birth at home were also excluded.

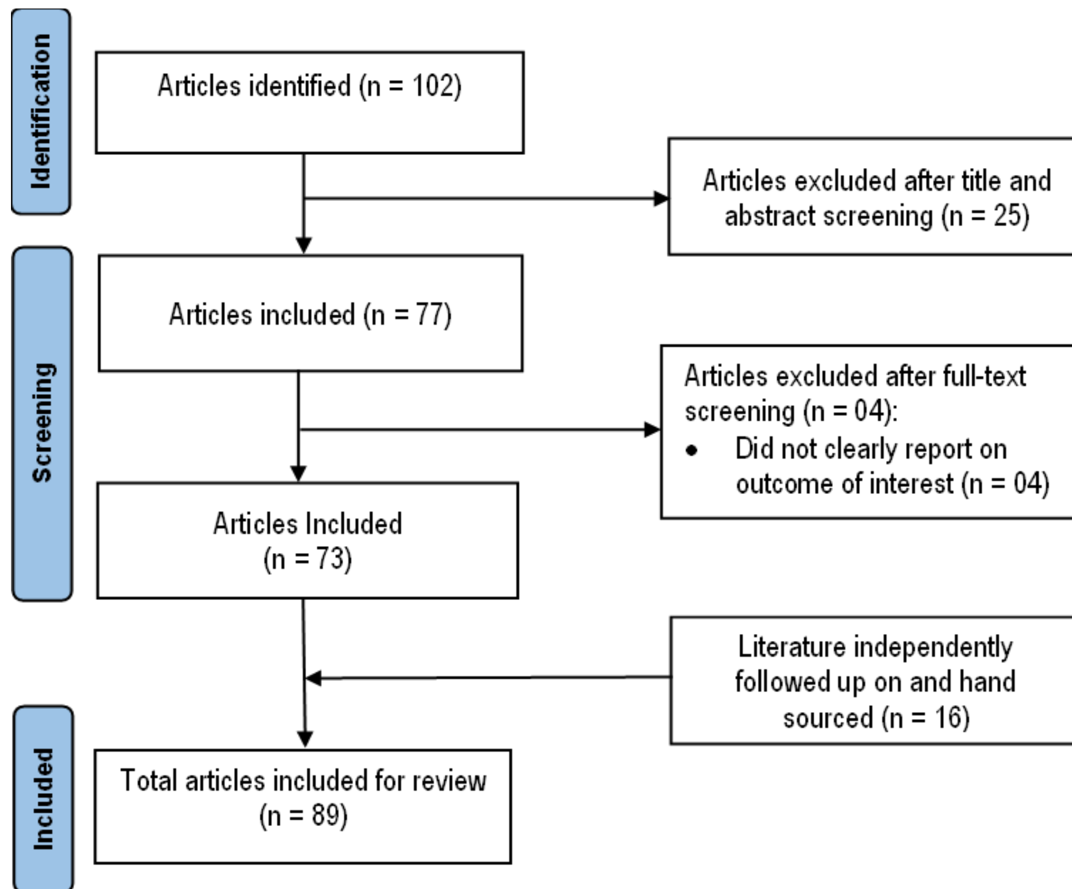
2.1.5 Risks of Bias Assessment

Although conducting a risk of bias assessment would have improved the quality of the reviewed literature, it was not performed due to the limited availability of literature and the choice of approach to literature review. However, all the articles included in the review were peer-reviewed.

2.1.6 Search Outcome

The search outcome is presented in Figure 2.1 below:

Figure 2.1: Literature Search Outcome



2.2 Person-Centred Maternity Care During Childbirth

PCMC during childbirth is the measure of how care during childbirth prioritises provision of care that is respectful of and responsive to individual women and their families' preferences, needs, and values during pregnancy and childbirth (Sudhinaraset et al., 2017). PCMC has three sub-domains of dignity and respect, supportive care, and communication and autonomy (Afulani et al., 2019). The level of PCMC during childbirth are categorised into percentage means scores of low, moderate, and high scores while some researchers use the actual mean scores (Afulani et al., 2019). Low scores are defined as scores in the lower 25th percentile and scores in the top 75th percentile are defined as high (Afulani et al., 2019).

2.2.1 PCMC

Cross-sectional studies conducted in Ethiopia have found that women's overall mean percentage score for overall PCMC during childbirth ranged from 48.7% to 65.8% (Dagnaw et al., 2022; Dagnaw et al., 2020;

Getahun et al., 2022; Tarekegne et al., 2022). Similar findings have been reported in studies conducted in Kenya (Kiti et al., 2022; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Sudhinaraset et al., 2019), India (Montagu et al., 2020), Pakistan (Hameed et al., 2023b), and Nepal (Tomita et al., 2023), where women's overall mean percentage score for overall PCMC during childbirth ranged from 61% to 73.6%. However, there were marked variations in the mean percentage scores for PCMC sub-scales of dignity and respect, communication and autonomy, and supportive care across these studies.

2.2.2 Dignity and Respect

Respectful and dignified maternity care is a key factor for a positive experience during intrapartum care (World Health Organization, 2018). Studies conducted in Ethiopia (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Tarekegne et al., 2022), Kenya (Kiti et al., 2022; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Sudhinaraset et al., 2019), and India (Montagu et al., 2020), and Nepal (Tomita et al., 2023), found that the average percentage score for dignity and respect during childbirth was generally high (74% to 87%. However, a study conducted in in Pakistan found a lower mean percentage score of 55% (Hameed et al., 2023b).

2.2.3 Communication and Autonomy

Effective communication and respect for autonomy during childbirth are essential for ensuring a positive birthing experience and promoting maternal and newborn well-being (World Health Organization, 2018). A community-based cross-sectional study conducted in Dessie town, Northeastern, Ethiopia among 310 postnatal mothers aged 17 to 48 years found that the mean percentage score for communication and autonomy during childbirth was 57% (Dagnaw et al., 2020). Dagnaw et al. (2022) reported similar findings (56.4%) when he conducted an institution-based cross-sectional study among 369 postnatal women in South Wollo Zone, Northeastern, Ethiopia.

Similar findings were reported by other researchers regarding the mean percentage score of communication and autonomy during childbirth among postnatal mothers in Pakistan, India, Nepal, Kenya, and other parts of Ethiopia (Getahun et al., 2022; Hameed et al., 2023a; Montagu et al., 2020; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tarekegne et al., 2022; Tomita et al., 2023). Across these studies, the mean percentage score for communication and autonomy during childbirth was generally moderate and it ranged from 53% to 68%.

2.2.4 Supportive Care

Supportive care during childbirth in the form of labour and birth companions, as well as a conducive birthing environment, is crucial for enhancing maternal comfort, reducing stress, and improving overall birth outcomes (World Health Organization, 2018). The mean percentage scores for supportive care during childbirth was also generally moderate and it ranged from 51% to 75% for studies conducted in Ethiopia, Kenya, Nepal, India, and Pakistan (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Hameed et al., 2023b; Montagu et al., 2020; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tarekegne et al., 2022).

2.2.5 Factors Associated with Person-Centred Maternity Care During Childbirth

Several factors are associated with PCMC during childbirth. These include socio-demographic characteristics such as age, marital status, level of education, employment status, and socioeconomic status; as well as obstetric factors such as gravidity, parity, number of ANC visits, place of birth, mode and time of birth, number of babies, sex of baby, companionship during birth, complications during birth, and newborn outcome.

A cross-sectional survey conducted among 1575 women in six regions of Ethiopia found that women under 20 years of age were treated with less respect during childbirth compared to older women (Stierman et al., 2023). This finding is consistent with a Lancet publication of a cross-sectional study conducted in the low- and middle-income countries of Ghana, Guinea, Myanmar, and Nigeria, which found that younger women aged 15-19 years were twice as likely to report mistreatment compared to older women (Bohren et al., 2019). However, other studies did not find any association between age and PCMC during childbirth (Afulani, Sayi, et al., 2018; Dagnaw et al., 2020; Getahun et al., 2022; Hameed et al., 2023b; Kiti et al., 2022; Odiase et al., 2021; Tarekegne et al., 2022).

Married women report higher PCMC scores compared to their unmarried counterparts (Afulani, Sayi, et al., 2018; Kiti et al., 2022). Afulani, Sayi, et al. (2018) found that an increase in the marriage mean score resulted in a 3.3 times higher increase in PCMC scores (Afulani, Sayi, et al., 2018). Adolescent girls are often in transitional or unstable marriages, which confers weak support systems (Bantebya et al., 2014; Watson et al., 2018). They also experience physical changes that cause flaring of hormones and emtions which makes them have intense but short love relationships leaving many pregnant adolescent girls without social support (Chemutai et al., 2020; Chulani & Gordon, 2014; Özdemir et al., 2016).

Across different contexts, individuals with limited or no formal education consistently reported lower PCMC scores compared to those with higher levels of education (Getahun et al., 2022; Kiti et al., 2022; Stierman et

al., 2023). Consistent with the previous statement, literate women reported higher PCMC scores compared to their illiterate counterparts (Afulani, Sayi, et al., 2018; Odiase et al., 2021). For example, a study conducted in Kenya (Odiase et al., 2021) showed that an increase in literacy (reading) resulted in a 10-fold perception of improved care. Paradoxically, other studies have shown that women with less education are likely to report perception of higher PCMC and higher levels of satisfaction with care during childbirth due to their low cultural health capital[2] (Dey et al., 2017; Duysburgh et al., 2013).

Studies conducted in Kenya revealed that employed women had higher PCMC scores than unemployed women (Afulani, Sayi, et al., 2018; Kiti et al., 2022; Odiase et al., 2021). However, some studies conducted in Ethiopia and Pakistan did not find any association between PCMC and employment status of women (Hameed et al., 2023b; Stierman et al., 2023).

A community-based cross-sectional study conducted in Ethiopia among 310 mothers found that women with lower monthly income (≤Birr 3000 = ≤USD 54) had statistically significantly lower PCMC scores compared to those with higher income (Dagnaw et al., 2020). Similarly, women with higher wealth reported statistically significantly higher PCMC scores compared to their counterparts (Afulani, Sayi, et al., 2018; Kiti et al., 2022; Stierman et al., 2023). However, most of these studies used money as the sole proxy for income/wealth, disregarding the physical assets that the women possessed. Therefore, their estimation of wealth or income may be misleading.

Shim (2010) argues that repeated interactions with healthcare systems, which can be perpetuated by high gravidity and parity, lead to the development of skill sets needed to navigate the healthcare systems, thus improving the birth experience. Adolescents often have low gravidity and parity, and therefore, have limited experience with the maternity care setting, fostering a low PCMC during childbirth. Studies conducted among women of reproductive age (15-49 years) did not report an association between PCMC and gravidity, parity, and the number of children (Kiti et al., 2022; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tomita et al., 2023).

A facility-based cross-sectional study conducted in Ethiopia among 384 women aged 18 to 40 years found that women who attended fewer ANC visits (< 4 visits) had statistically significantly lower PCMC scores (ß=

[2] Cultural health capital is defined as *"specialised set of cultural skills, behaviours, and interactional styles that are valued and leveraged as assets by both patients and providers in clinical encounters"* Shim, J. K. (2010). Cultural health capital: a theoretical approach to understanding health care interactions and the dynamics of unequal treatment. *Journal of health and social behavior*, *51*(1), 1-15. The details are presented in Chapter III.

- 4.0) compared to those who had more visits (Tarekegne et al., 2022). Getahun et al. (2022) found that childbirth attended by a care provider after providing antenatal care for mothers increased women's perception of improved care during childbirth. Adolescents are likely to initiate antenatal care late for reasons beyond the scope of this review, thus making fewer visits (Teshale & Tesema, 2020; Tola et al., 2021; Warri & George, 2020).

The literature consistently demonstrates that women who give birth in private health facilities generally receive superior treatment compared to those who give birth in public health facilities. Studies on PCMC indicate that women who gave birth in private health facilities report higher PCMC scores than those who gave birth in public health facilities (Afulani, Sayi, et al., 2018; Dagnaw et al., 2020; Getahun et al., 2022).

Night-time birth has been identified as one of the contributing factors to the mistreatment of women by skilled health personnel during childbirth due to limited staffing at night and other factors (Bowser & Hill, 2010). Studies conducted in Ethiopia (Dagnaw et al., 2020; Tarekegne et al., 2022) revealed that women who gave birth at night reported lower PCMC scores compared to those who gave birth during the day or evening shifts. Regarding the mode of childbirth (vaginal versus caesarean section versus instrument delivery), studies conducted in Nepal and Ethiopia did not find any statistically significant association between the mode of birth and PCMC during childbirth (Stierman et al., 2023; Tomita et al., 2023).

The World Health Organization (WHO) recommends intrapartum care to ensure a positive childbirth experience. One key recommendation is a companion's presence during childbirth (World Health Organization, 2018). Research from Sri Lanka and Kenya has shown that having a companion during childbirth is statistically associated with higher PCMC scores. Specifically, studies by Kiti et al. (2022) and Rishard et al. (2021) found this positive association. However, it is important to note that these studies were conducted among women of reproductive age (15 to 49 years) and the analyses for the association between birth companionship and PCMC were not stratified by age.

Adolescent mothers have a higher incidence of adverse pregnancy outcomes compared to older pregnant women (Akseer et al., 2022; de la Calle et al., 2021; Wong et al., 2020). Women who experienced complications during childbirth or had stillborn babies had lower PCMC scores compared to those who had few or no complications and whose babies survived (Dagnaw et al., 2020; Getahun et al., 2022; Sudhinaraset et al., 2020; Tarekegne et al., 2022). A study by Tarekegne et al. (2022), found that a unit increase in the maternal complication mean score resulted in a 3.2-point decrease in PCMC scores.

Although many studies assessed the number and sex of the baby(ies) (Getahun et al., 2022; Hameed et al., 2023a; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tomita et al., 2023), none reported any statistically significant association between the number and sex of the baby(ies) and PCMC during childbirth. Therefore, it remains to be seen whether the number and sex of baby(ies) produced by adolescents influence their perceptions of PCMC during childbirth.

2.3 Satisfaction with Care During Childbirth

Women's satisfaction with intrapartum care is a frequently utilised measure of the quality of maternal and newborn care (Tunçalp et al., 2015; World Health Organization, 2019a). This measure encompasses various aspects of care, including the technical proficiency of the healthcare providers, the emotional support provided, the physical environment of the facility, and the overall experience of the mother during labour and delivery. High levels of satisfaction are often associated with better health outcomes for both mother and child, as well as increased trust in the healthcare system (Tunçalp et al., 2015; World Health Organization, 2019a). Assessing the satisfaction of adolescents with childbirth care is a valuable indicator of service effectiveness, particularly in public health facilities with limited resources (Orte et al., 2020).

A multi-country study conducted in Ghana, Guinea, Myanmar, and Nigeria included 2 672 women who gave birth in public health facilities. The study found that women's satisfaction with care during labour and childbirth was generally high (88.4%) (Maung et al., 2022). This finding is similar to a study conducted in Mozambique (92.5%) (Mocumbi et al., 2019). However, these findings are different from the results of several studies conducted in Ethiopia where the level of satisfaction during childbirth ranged from 28% to 74.8% (Hailemariam et al., 2020; Karoni et al., 2020; Silesh & Lemma, 2021; Tadele et al., 2020). These findings suggest disparities exist in women's satisfaction with intrapartum care in different countries.

European countries such as Italy, Norway, and Slovakia have reported higher levels of women's satisfaction with care during labour and childbirth, with some studies showing satisfaction rates as high as 80% (Bains et al., 2021; Lazzerini et al., 2020; Mazúchová et al., 2020). However, studies conducted in Turkey and The Netherlands have reported lower satisfaction with intrapartum care (Demirel et al., 2022; Peters et al., 2019). Considering the high-income status of these countries, these results show that more resources do not guarantee satisfaction with care.

North and South America generally experienced mixed results in terms of satisfaction with childbirth care (Gregory et al., 2019; Lopes et al., 2021; Pantoja et al., 2020; Passarelli et al., 2019; Ramos et al., 2022). For example, studies conducted in the USA, Chile, and Brazil reported satisfaction rates of 60%, 49.4%, and

88% respectively (Gregory et al., 2019; Pantoja et al., 2020; Passarelli et al., 2019). This variation in findings is also evident when comparing studies conducted in China, Iran, and Sri Lanka (Liu et al., 2021; Rishard et al., 2021; Shamoradifar et al., 2022). These findings underscore the need for further research within and across countries to establish global evidence and enhance the quality of maternal and newborn care.

2.3.1 Association Between Person-Centred Maternity Care During Childbirth and Satisfaction with Care

According to the Person-Centered Care for Reproductive Health Equity framework (PCCRHE)[3], there is a two-way relationship between person-centred outcomes and satisfaction with care (Sudhinaraset et al., 2017). This section presents the literature examining the association between PCMC and satisfaction with care (2.3.1.1). The association between the sub-domains of dignity and respect, communication and autonomy, and support care and satisfaction with care is also reviewed (2.3.1.2-2.3.1.4).

2.3.1.1 Overall PCMC and Satisfaction with Care

A cross-sectional survey conducted in Sri Lanka among women aged 15 to 45 years (n = 400) found a moderate correlation between PCMC and satisfaction with care during childbirth (Spearman, $r = 0.58$, $p<0.001$) (Rishard et al., 2021). However, the study did not categorise the PCMC scores into low, moderate, and high. This raises the question of whether low, moderate, and high levels of PCMC scores have the same impact on women's satisfaction.

2.3.1.2 Dignity and Respect and Satisfaction with Care

In 2014, the WHO called for the prevention and elimination of disrespect and abuse during facility-based childbirth, as well as greater action, dialogue, research, and advocacy on this matter (World Health Organization, 2014c). This statement was made in response to a series of studies documenting the disrespect and abuse of women during childbirth (Bohren et al., 2014; Bowser & Hill, 2010; Freedman & Kruk, 2014; Silal et al., 2012; White Ribbon Alliance, 2011)

Studies conducted in high-income countries such as Italy, The Netherlands, and the USA found that women who were perceivably treated with dignity and respect were more likely to be satisfied with the care they received during childbirth (Gregory et al., 2019; Lazzerini et al., 2020; Peters et al., 2019). Similar findings were reported in low-middle-income countries including Chile, Ghana, Guinea, Myanmar, Nigeria, Mozambique, and Ethiopia, where women who were treated with dignity and respect were more likely to be satisfied with the care they received during childbirth (Bulto et al., 2020; Hailemariam et al., 2020; Maung et

[3] The details of the PCCRHE framework are presented in Chapter III.

al., 2022; Mocumbi et al., 2019; Pantoja et al., 2020). However, some studies did not find any association between dignity and respect and satisfaction with care during childbirth (Alemu et al., 2024; Tadele et al., 2020). The reasons for the lack of observed association are beyond the scope of this review. Nonetheless, most of the literature reported that when women are treated with dignity and respect, they are more likely to be satisfied with the care they receive during childbirth.

2.3.1.3 Communication and Autonomy and Satisfaction with Care

Effective communication and respect for women's autonomy are critical components of PCMC (Sudhinaraset et al., 2017). Some parameters of respect for women's autonomy were reported to be consistently associated with satisfaction during childbirth include control and participation in labour and childbirth, as well as freedom of positioning during labour (Demirel et al., 2022; Liu et al., 2021; Mazúchová et al., 2020; Peters et al., 2019). A cross-sectional study conducted among 1 244 Italian women reported a tenfold increase in satisfaction with care during childbirth among women who had effective communication with their healthcare providers compared to those who did not (Lazzerini et al., 2020). Studies conducted in Iran, The Netherlands, and The USA also showed that effective communication between facility staff and women during childbirth is positively associated with women's satisfaction with care (Gregory et al., 2019; Peters et al., 2019; Rishard et al., 2021; Shamoradifar et al., 2022).

2.3.1.4 Supportive Care and Satisfaction with Care

Companionship and the physical environment are important aspects of support for women during childbirth (World Health Organization, 2016a, 2019a). Studies conducted in Sri Lanka (Rishard et al., 2021), China (Liu et al., 2021), Slovakia (Mazúchová et al., 2020), Mozambique (Mocumbi et al., 2019), Ethiopia (Bulto et al., 2020), Turkey (Demirel et al., 2022), and Brazil (Lopes et al., 2021) have all found a positive association between psychosocial support from friends, relatives, and healthcare providers during childbirth, and satisfaction with care.

Another important factor that affects women's satisfaction with childbirth care is the condition of the physical infrastructure of health facilities (Bulto et al., 2020; Lazzerini et al., 2020; Pantoja et al., 2020). This encompasses various elements such as the cleanliness and maintenance of the floor in the labour suite, the availability and hygiene of bathroom and toilet facilities, and the overall environment and amenities provided by the healthcare facility. A clean, well-maintained, and adequately equipped facility can significantly enhance a woman's experience during childbirth by ensuring comfort, privacy, and a sense of safety. For instance, a study conducted in Italy found that the physical infrastructure was associated with a six-fold increase in women's satisfaction with childbirth care (Lazzerini et al., 2020).

2.4 Future Childbearing Intentions

Women's future childbearing intentions are conceptualised as outcome measures for the quality of maternal and newborn care (World Health Organization, 2019a). Future childbearing intentions range from fertility intentions (desire to give birth in the future), return to the same provider/facility in the future and recommendation of facility to others.

2.4.1 Intention to Give Birth in Future

Childbearing intentions are not always voluntary and can be influenced by various circumstances, both actual and perceived (Bernardi et al., 2014). Women who give birth in medical facilities generally have high fertility intentions (Preis et al., 2020; Zeng et al., 2023). A large longitudinal study conducted in Israel among 1 163 pregnant women found that their fertility intentions increased from 88.3% during pregnancy to 91.7% after giving birth in a medical facility (Preis et al., 2020). Adolescent pregnancies are often unplanned and the childbirth experiences associated with them are typically negative (Füzy et al., 2020; Lusambili et al., 2020). These factors can greatly influence their fertility intentions, making it important to investigate how these intentions change after giving birth in a health facility.

2.4.2 Intentions to Choose the Same Facility in Future

Studies have also generally reported that a high percent of women would return to the same facility for their next childbirth where they previously gave birth (Lazzerini et al., 2020; Sudhinaraset et al., 2020). For example, a cross-sectional study conducted among 531 women (15-49 years) who gave birth in seven government facilities in Kenya found that 85% of the women would return to the same provider/facility for the next childbirth (Sudhinaraset et al., 2020).

2.4.3 Intentions to Recommend Facility to a Sister of Relative

A multi-country study conducted in Ghana, Guinea, Myanmar, and Nigeria among 2 672 women during facility-based childbirth found that 90% of the women would recommend where they gave birth to others (friend/family) (Maung et al., 2022). In Italy, a study reported that 79.3% of women would recommend the facility where they gave birth. Although lower than the multi-country average, this still indicates that the majority of women expressing satisfaction with their childbirth experience (Lazzerini et al., 2020). Another study conducted in Mozambique found that 94.2% of women would recommend the facility where they gave birth (Mocumbi et al., 2019). In Guatemala, 85% of women expressed their intention to recommend the facility where they gave birth (Peca & Sandberg, 2018).

2.4.4 Association Between Person-Centred Maternity Care and Future Childbearing Intentions

Studies have shown that PCMC and its sub-domains of dignity and respect, communication and autonomy, and supportive care are statistically significantly associated with future childbearing intentions among women who had facility-based childbirths (Lazzerini et al., 2020; Maung et al., 2022; Peca & Sandberg, 2018; Preis et al., 2020; Sudhinaraset et al., 2020; Zeng et al., 2023).

2.4.4.1 Overall PCMC and Future Childbearing Intentions

A cross-sectional study conducted in Kenya among 531 women of reproductive age revealed that women who had higher overall PCMC scores had higher odds of reporting a willingness to return to the same facility for the next childbirth (AOR=12.72) compared to those with low PCMC scores (Sudhinaraset et al., 2020). However, the study did not report the association between PCMC and fertility intentions and intentions to recommend the facility to others.

2.4.4.2 Dignity and Respect and Future Childbearing Intentions

Dignity and respect during childbirth generally increase women's odds of returning to the same facility for the next childbirth (Peca & Sandberg, 2018; Sudhinaraset et al., 2020; Wassihun & Zeleke, 2018) and recommending the facility to others (Maung et al., 2022). A multi-country study conducted in Ghana, Guinea, Myanmar, and Nigeria among 2 672 women found that women who did not experience any verbal or physical abuse or discrimination during facility-based childbirth were more likely to recommend the facility to others (AOR=3.89) (Maung et al., 2022). A cross-sectional study conducted in Ethiopia among 284 women found that women who were treated with dignity and respect were 3.6 times more likely to use the health facility in the future compared to those who were disrespected and abused (Wassihun & Zeleke, 2018).

Studies where respondents were victims of abuse, discrimination, and aggressiveness, were less likely to recommend the facility to others or return to the same facility for the next childbirth (AOR=0.35) (Lazzerini et al., 2020). Studies that examined the association between disrespect and abuse during childbirth and women's future childbearing intentions found that disrespect and abuse generally reduce the odds of women using skilled health personnel or giving birth in a health facility on subsequent occasions (Bowser & Hill, 2010).

A study done among 1 163 women in Israel largely reported that negative childbirth experience adversely affects women's fertility intention (Preis et al., 2020). However, the study did not specify which aspect of negative childbirth experience is associated with fertility intentions.

2.4.4.3 Communication and Autonomy and Future Childbearing Intentions

Moderate to high scores of communication and autonomy have been reported to be associated with higher odds of returning to the same facility for the next childbirth (AOR=2.16 and AOR=3.71 respectively), albeit it was not associated with fertility intentions or recommendation of the facility to others (Sudhinaraset et al., 2020). Negative childbirth experiences in the form of poor communication between the client and provider are also associated with women's future fertility intentions (Preis et al., 2020).

2.4.4.4 Supportive Care and Future Childbearing Intentions

In a Kenyan study, moderate to high scores of supportive care during childbirth were reported to be associated with statistically significantly higher odds of a willingness to return to the same facility for the next childbirth (Sudhinaraset et al., 2020). Similarly, a study conducted in seven provinces of China among 1 119 women aged 16 to 53 years found that social support during childbirth was associated with fertility intentions (Zeng et al., 2023).

2.5 Adolescents' Experiences of Care During Childbirth

Although research specific to adolescents' experiences of childbirth remains limited, there is a plethora of studies documenting general women's childbirth experiences. Childbirth is a subjective experience that varies across contexts. These childbirth experiences are either positive or negative depending on how the woman perceives the care received. This section starts by reviewing literature on positive childbirth experiences (2.5.1) followed by the negative childbirth experiences (2.5.2).

2.5.1 Positive Childbirth Experiences

Afulani studied what makes or mars the facility-based childbirth experience among 58 mothers (15-49 years) in a rural county in western Kenya and found that women had a positive experience when they were received well at the health facility, treated with kindness and respect, and given sufficient information about their care (Afulani, Kirumbi, et al., 2017). These findings were similar to those reported by Oluoch-Aridi and Hajizadeh who found that a positive childbirth experience is engendered by women's perceptions of responsiveness of facility or providers to their needs, dignified treatment, support during childbirth of companionship, and respectful communication between the mother and the care provider (Hajizadeh et al., 2020; Oluoch-Aridi, Afulani, Guzman, et al., 2021).

Research on childbirth experiences is not limited to the provision of care related to childbirth but extends to the effect of positive birth experiences on women's psychological well-being. A systematic review that reviewed eight articles involving 94 women found that self-confidence, empowerment, and uniqueness of the

birth experiences are some of the things that make childbirth a positive experience (Olza et al., 2018). Women narrated how they were empowered to have self-esteem and self-efficacy in their ability to push the baby normally. Sharing labour pain with a birth companion and accepting labour pain as a process leading to a glorious ending made some women feel good about their experiences. These accounts of positive birth experiences were similar to those reported by a study that explored the meaning of a positive childbirth experience expressed among 10 Iranian women (Hosseini Tabaghdehi, Keramat, et al., 2020).

On the continuum of maternal health care, two extreme situations exist: too little, too late, and too much, too soon (Miller et al., 2016). Too much too soon includes unnecessary use of non-evidence-based interventions, as well as the use of interventions that can be lifesaving when used appropriately, but harmful when applied routinely or overused (Miller et al., 2016). In a study conducted among 12 primigravid women in urban Turkey, positive childbirth experiences were synonymous with non-intervention care which required women to be empowered and supported to transition to motherhood (Demirci et al., 2019).

2.5.2 Negative Childbirth Experiences

A systematic review that examined 18 studies globally on the prevalence of negative childbirth experiences globally found that the prevalence of negative childbirth ranges from 6.8 to 44% (Hosseini Tabaghdehi, Kolahdozan, et al., 2020). These prevalence ranges are higher than that reported by a cohort study conducted among Finnish women aged 15 to 49 years in 2020 which reported a 4.5% prevalence of negative childbirth experience (Adler et al., 2020).

A qualitative meta-synthesis conducted in sub-Saharan Africa (SSA) that included 30 articles reported numerous forms of negative childbirth experiences (Ahmed et al., 2023). Negative childbirth experiences were in the form of verbal abuse, physical abuse, poor communication, non-consented care, non-involvement in decision-making, and denial of companionship (Ahmed et al., 2023). Other forms of negative birth experiences reported across SSA included poor reception and long waiting time, lack of privacy and confidentiality, lack of respectful communication, neglect and abandonment, poor facility environment, lack of information, feeling excluded, discrimination in care, and feelings of fear, anxiety, sorrow, and anger associated with childbirth (Abdollahpour & Motaghi, 2019; Koster et al., 2020; Oluoch-Aridi, Afulani, Guzman, et al., 2021).

Another qualitative meta-synthesis that examined 51 articles on the lived pregnancy and childbirth experiences of migrant women found that these women experienced language barriers (poor communication), difficulty in navigating the health systems, and mistreatment during childbirth (Fair et al.,

2020). The study also found that these women felt that the care providers only focused on childbirth and ignored other vital aspects of their care such as the opportunity to ask other health-related questions (Fair et al., 2020).

One of the few studies that exclusively explored adolescents' (14 to 17 years) lived experiences of childbirth in the context of South Africa found that adolescents' experiences of childbirth are overwhelmingly negative (Füzy et al., 2020). The study reported issues of poor pain management during labour, dehumanised care characterised by disrespect, being ignored by providers, being victimised, and being left feeling unimportant. The study further explored the mental anguish related to these negative experiences and issues of fear related to childbirth became apparent. These findings align with those reported by Lusambili et al. (2020) who also found physical and verbal abuse as the dominant form of abuse experienced by adolescents during childbirth.

2.6 Drivers of Experience of Care During Childbirth

Drivers of women's childbirth experiences vary depending on whether they had a positive or negative birth experience.

2.6.1 Drivers of Positive Childbirth Experiences

A cross-sectional study conducted among 287 Brazilian women found that satisfaction with childbirth, understanding the information provided by the care provider, respectful and dignified care, and immediate initiation of breastfeeding were associated with increased positive childbirth experiences (Martins et al., 2021). Hajizadeh in his study among Iranian women also found that respectful maternity care was associated with positive childbirth experiences (Hajizadeh et al., 2020).

Meanwhile, a community-based study conducted among 2 138 American women found that vaginal births, community births, midwife-led care, being older than 30 years, and being a multiparous woman were associated with a positive childbirth experience (Vedam et al., 2019). The study by Zamani et al. (2019) also supported the finding that vaginal birth increases the odds of positive childbirth experiences.

A systematic review that explored and identified risk and protective factors for women's subjective childbirth experience and birth satisfaction found that women's level of support during childbirth and their perceptions of control during labour and childbirth increased women's positive childbirth experiences (Chabbert et al., 2021). This is supported by another study that examined the correlation between perceived social support in pregnant women and their childbirth experience (Zamani et al., 2019). The World Health Organization in their

intrapartum guidelines for a positive childbirth experience strongly recommended companionship during labour and childbirth to increase satisfaction with care and minimise adverse maternal and newborn outcomes (World Health Organization, 2018).

2.6.2 Drivers of Negative Childbirth Experiences

Negative childbirth experiences are associated with sociodemographic, obstetric, and psychological factors (Adler et al., 2020; Chabbert et al., 2021; Fenaroli et al., 2019; Hosseini Tabaghdehi, Kolahdozan, et al., 2020; Vedam et al., 2019). These studies found that negative childbirth experiences were associated with being young, low parity, labour pain, caesarean section, operative vaginal deliveries, low Apgar score, use of epidural analgesia, labour induction, labour complications, prolonged labour, lack of companionship or support during labour, long duration of the second stage of labour, fear of labour/birth, and transfer to neonatal intensive care unit (NICU) (Adler et al., 2020; Chabbert et al., 2021; Fenaroli et al., 2019; Hosseini Tabaghdehi, Kolahdozan, et al., 2020; Vedam et al., 2019).

According to a landmark review report by Bowser and Hill (2010), women's negative experiences during childbirth are often rooted in complex interplays of socio-cultural, institutional, and individual factors. At the societal level, entrenched gender norms and power differentials perpetuate a culture where women's voices and autonomy are often undermined, contributing to a sense of entitlement among healthcare providers (Bowser & Hill, 2010). Institutionally, resource constraints, overcrowding, and hierarchical structures within healthcare systems can lead to rushed, dehumanising care, where providers may prioritise efficiency over patient dignity (Bowser & Hill, 2010). At the individual level, factors such as implicit biases, lack of empathy, and burnout among healthcare professionals can further exacerbate disrespectful behaviours.

A study conducted in Kenya among 49 maternity care providers found that the work environment, including factors like perceived lack of time, language barriers, stress and burnout, and facility culture negatively impacts women's childbirth experiences (Afulani et al., 2020). This perception of insufficient time may affect the quality of care provided to women during childbirth while the presence of language barriers can hinder effective communication between care providers and women. On the other hand, workplace stress and burnout can impact care providers' emotional well-being and their interactions with patients. Also, language barriers have been implicated as one of the workplace drivers of the mistreatment of women during childbirth (Afulani et al., 2020). Mobility of skilled health personnel means that they may end up in places where they don't speak the language and that lack of effective communication fuels mistreatment of women during facility-based childbirth. Also, women's inability to demand or command effective communication and respect

for their autonomy has been documented as key drivers of women’s negative childbirth experiences (Afulani et al., 2020).

Providers' knowledge, bias, and assumptions about how women should be treated have been reported as key drivers of women’s negative birth experiences (Afulani et al., 2020). Inadequate providers’ knowledge and skills may be compensated by being overly aggressive with women to cover up their knowledge and skills gaps. In addition, providers' bias toward another category of women especially those who are young and of low socioeconomic status drives these care providers to mistreat these women because they seem incapable of seeking any legal redress (Afulani et al., 2020; Dubbin et al., 2013; Shim, 2010).

2.7 Summary of Literature Review

The literature review on PCMC during childbirth found moderate scores with variations in sub-scale scores. The factors associated with PCMC included age, marital status, education, employment, socioeconomic status, gravidity, parity, antenatal care visits, place and time of birth, companionship during birth, complications, and newborn outcomes. However, the review highlighted some gaps in the literature regarding PCMC during childbirth and the associated factors.

The review highlighted the differences in satisfaction levels, both in African nations and globally, highlighting the need for further research, particularly in low and middle-income countries. The review noted the lack of specific research on adolescent populations. It also underscored the positive effect of dignity and respect, effective communication, autonomy, and supportive care on women's satisfaction. However, it acknowledged that the relationship between these factors and satisfaction can vary depending on the context.

This review found a generally positive trend in fertility intentions, facility recommendations, and return rates. However, the limited geographic and population scope and potential recall bias in previous studies underlined the importance of further research. It also noted that dignity and respect, communication and autonomy, and supportive care sub-domains have links with women's willingness to return to the same facility for future childbirth and recommend the facility to others. Nevertheless, there is a need for further research, particularly among adolescents, to address gaps in the literature regarding the comprehensive impact of PCMC and its sub-scales on fertility intentions.

This review noted both positive and negative experiences of childbirth and found that positive childbirth experiences are less frequently studied and reported. The review also found most of the studies were not underpinned by any theory to allow systematic exploration of the phenomena. The review identified various

factors linked to negative childbirth experiences, such as young age, low parity, medical interventions, workplace stress, and the influence of healthcare culture, provider knowledge, and biases.

2.8 Gaps and Limitations in Literature

The gaps and limitations in literature are structured based the review objectives:

2.8.1 PCMC During Childbirth and Associated Factors

Findings regarding women's experience of PCMC during childbirth indicate that the overall rating is moderate, as well as the PCMC sub-scales of communication, autonomy, and supportive care. Women generally had high dignity and respect scores. However, most of these studies were conducted while women were not yet discharged from health facilities, except the study by Dagnaw et al. (2020), which means that women might have been reluctant to share their negative childbirth experiences due to fear of being denied future services. Some of the interviews were conducted up to 12 months postpartum increasing the risk of recall bias (Stierman et al., 2023; Tomita et al., 2023).

Notably, studies on PCMC have limited geographical representation, with the majority of studies coming from Ethiopia (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Tarekegne et al., 2022) and Kenya (Kiti et al., 2022; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Sudhinaraset et al., 2019), and none from Uganda.

Most of the studies (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Hameed et al., 2023b; Kiti et al., 2022; Montagu et al., 2020; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tarekegne et al., 2022; Tomita et al., 2023) focused on women of reproductive age (15-49) and did not specifically address age groups such as adolescents, who are more susceptible to mistreatment during childbirth (Bohren et al., 2019; Füzy et al., 2020; Lusambili et al., 2020). The lack of focus on adolescents undermines the statistical analysis of determinants of PCMC in this age group, as they are typically underrepresented in the overall sample size of studies conducted among the general population (15-49) (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Hameed et al., 2023b; Kiti et al., 2022; Montagu et al., 2020; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tarekegne et al., 2022; Tomita et al., 2023).

There were mixed findings on the association between employment and PCMC during childbirth. Some studies did not find any association between PCMC and employment status of women (Hameed et al., 2023b; Stierman et al., 2023) while others found association between employment and PCMC during childbirth

(Afulani, Sayi, et al., 2018; Kiti et al., 2022; Odiase et al., 2021). Therefore, it was important to examine this association among adolescent population to see if employed adolescents receive preferential treatment during childbirth compared to their age peers.

2.8.2 Association Between PCMC During Childbirth and Satisfaction with Care

Women's satisfaction with childbirth care varies greatly between countries, and yet there is a lack of literature specifically focused on adolescents in Uganda. Moreover, most of the studies (Lazzerini et al., 2020; Mazúchová et al., 2020; Mocumbi et al., 2019; Passarelli et al., 2019) were conducted among women who gave birth about a year previously, which could introduce recall bias, while others measured satisfaction without using validated tools (Mazúchová et al., 2020; Peters et al., 2019).

There is a bi-directional relationship between PCMC during childbirth and women' satisfaction with care (Sudhinaraset et al., 2017). However, the relationship between the overall PCMC and satisfaction with care is still under-researched. A study that examined the association between PCMC and satisfaction with care (Rishard et al., 2021) did not categorise PCMC scores before examining the relationship with satisfaction with care. This raises the question of whether low, moderate, and high levels of PCMC scores have the same impact on women's satisfaction with care. Also, the association between the sub-domains of dignity and respect, communication and autonomy and supportive care remains largely unstudied.

2.8.3 Association Between PCMC During Childbirth and Future Childbearing Intentions

Literature is still limited geographically on women's future childbearing intentions after facility-based childbirth. Most of the studies on future childbearing intentions were conducted in developed countries with well-developed health systems (Lazzerini et al., 2020; Preis et al., 2020; Zeng et al., 2023), therefore their findings cannot be generalisable to contexts such as Uganda.

There is a lack of research on the connection between PCMC and its sub-domains during childbirth and women's future childbearing and PCMC, particularly the relationship between PCMC and women's fertility intentions. Furthermore, there is limited documentation on how the impact of the overall PCMC scale and its sub-scales vary, making it challenging to determine if the overall domain and sub-domains of PCMC have the same effect on women's future childbearing intentions.

2.8.4 Adolescents' Experiences of Care During Childbirth

Positive childbirth experiences are rarely studied and reported (McKelvin et al., 2021). The majority of research on women's experiences of care focuses on negative birth experiences (McKelvin et al., 2021). The literature also shows that childbirth experiences among adolescents are often overlooked, as most studies

concentrate on older women or women of reproductive age in general. When adolescents are included in the study population, their experiences are typically not analysed separately. These situations undermine the perspectives of adolescents regarding their birth experiences, highlighting the need for more qualitative studies on this topic.

Some studies exploring women's childbirth experiences conducted interviews within the health facility (Abdollahpour & Motaghi, 2019; Füzy et al., 2020), which could have prevented the participants from expressing their experiences freely. Importantly, most of these studies (Abdollahpour & Motaghi, 2019; Füzy et al., 2020; Koster et al., 2020; Lusambili et al., 2020) were not underpinned by a theoretical framework, which made it easy for them to overlook crucial aspects of negative birth experiences, such as bribery, which is seldom reported in the literature. Finally, most of the studies (Abdollahpour & Motaghi, 2019; Adler et al., 2020; Füzy et al., 2020; Koster et al., 2020; Lusambili et al., 2020; Oluoch-Aridi, Afulani, Guzman, et al., 2021) relied on a single approach (either qualitative or quantitative), thus being limited by the constraints of that approach.

2.8.5 Drivers of Adolescents' Experiences of Care During Childbirth

The review of drivers of women's childbirth experiences has shown that various factors influence women's childbirth experiences and that drivers of adolescents' childbirth experiences are largely unknown. Given the fact that most of the reviewed studies were quantitative, their findings ended at identifying the factors influencing childbirth experiences but how these factors combine to perpetuate positive or negative childbirth experiences remain enigmatic. None of the studies identified used a recognised theory to explore the drivers of adolescents' experiences of care during childbirth.

These gaps justified my research on adolescents' childbirth experiences in rural northern Uganda using a well-theorised mixed-methods approach to better understand how PCMC during childbirth influenced adolescents' experience of care, satisfaction with care, and future childbearing intention to guide future efforts to improve quality, equity, and dignity of intrapartum care among adolescents. These gaps and limitations in literature had the following implications for this study:

2.9 Implications for this Study

2.9.1 Research Questions

This study sought to answer the following research questions:

1. How do adolescents who give birth in health facilities in rural northern Uganda experience childbirth?

2. What factors determine how adolescents perceive how they are treated during childbirth in health facilities in rural northern Uganda?

3. How do adolescents' experiences of care during childbirth in health facilities in rural northern Uganda influence their perceptions of PCMC?

4. What is the relationship between adolescents' perceptions of PCMC during childbirth in health facilities in rural northern Uganda and their satisfaction with care, and future childbearing intentions?

2.9.2 Research Aim

This study examined adolescents' perceptions of PCMC during facility-based childbirth in rural northern Uganda and how their perceptions influenced their satisfaction with care and future childbearing intentions (intentions to give birth, give birth in the same facility, and recommend the same facility to a sister or friend), and explored the drivers of adolescents' experiences of care during childbirth.

2.9.3 Specific Objectives

The specific objectives of the study were to:

1. Assess perceived PCMC during childbirth and associated factors among adolescents who gave birth in health facilities in rural northern Uganda.

2. Examine the association between perceived PCMC during childbirth and satisfaction with care adolescents who gave birth in health facilities in rural northern Uganda.

3. Examine the association between perceived PCMC during childbirth and future childbearing intentions among adolescents who gave birth in health facilities in rural northern Uganda.
4. Explore experiences of care during childbirth among adolescents who gave birth in health facilities in rural northern Uganda.

5. Explore the drivers of experiences of care during childbirth among adolescents who gave birth in health facilities in rural northern Uganda.

CHAPTER THREE: PHILOSOPHICAL AND THEORETICAL UNDERPINNINGS

3. Introduction

The philosophical and theoretical underpinnings refer to the foundational beliefs and assumptions that guide a research study and these underpinnings provides the framework for understanding the nature of reality, knowledge, and the relationship between the researcher and the subject of study (Saunders et al., 2009). This chapter begins by examining the researcher's philosophical stance including the researcher's positionality as relates to mixed-methods approaches to research. The chapters end by presenting the WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities, Person-Centred Care for Reproductive Health Equity (PCCRHE) Framework, and the Cultural Health Capital (CHC) theory underpinnings of the study.

3.1 Philosophical Underpinnings

The philosophical worldview or paradigm of a researcher can influence how research is conducted, its outcomes, and results (Holmes, 2020). In a mixed-methods study, the researcher can use different approaches to choose their worldviews for a given study. Creswell and Clark (2017) recommend that mixed-methods researchers should choose their worldviews based on the study context and type of mixed-methods design. In this instance, the selection of the worldviews informs and possibly is informed by the type of mixed-methods design (Creswell & Clark, 2017).

This study used the explanatory sequential mixed-method design where quantitative data was collected in Phase I and qualitative data in Phase II. Although this design lends itself to a post-positivist paradigm, the researcher used different assumptions within each phase of the study. The study adopted a post-positivist philosophical worldview for Phase I (quantitative phase) and a constructivist philosophical worldview for Phase II (qualitative phase). The post-positivist worldview relates to the philosophical stance of natural scientists and entails working with an observable social reality to produce law-like generalisations (Saunders et al., 2009). The constructivist worldview on the other hand emphasises the interactions that human beings have with different physical phenomena and contexts to create a new, richer understanding, and interpretation of the physical phenomena and contexts (Saunders et al., 2009).

The choices of these worldviews, especially for Phase II were underpinned by the researcher's positionality as stated in his ontological, epistemological, and methodological positions. Positionality refers to the researcher's worldview and the positions that s/he adopts while carrying out research and how that position

influences the conduct of research (Holmes, 2020). It's a description of a researcher's reflexive thought processes about how s/he interacts with the subject matter, research participants, and the study context. Creswell and Clark (2017) encourage mixed-methods researchers to explicitly state their positionality. The positionality of the researcher is briefly described below in sections 3.1.1 to 3.1.3:

3.1.1 Ontological Position

Ontology refers to the nature of reality (Saunders et al., 2009). The two ontological positions used in this study were realism and social constructivism. Realism presupposes that social entities are like physical entities and they exist independently of how we think, frame, and embrace them (Saunders et al., 2009). Social constructivism on the other hand presupposes that reality is constructed through social interactions in which social actors create partially shared meanings and realities (Saunders et al., 2009). Below, I present my subjective ontological position on adolescents' experiences of childbirth in rural northern Uganda and the ways this position influenced my conduct of research (or how I conducted the research).

I am a nurse-midwife practicing since 2015. In my practice, I have had the privilege of serving people of all age groups, including adolescents, across the antenatal, intrapartum, and postpartum continuum of care. During my service, I witnessed incidents that I now recognise as experiences of poor care during childbirth. Regrettably, I had little information or understanding on how experience of care influences one's overall perception of quality maternal and newborn care.

My ontological confrontation with adolescents' experiences of care during childbirth in rural northern Uganda came during my internship in a public health facility. I vividly remember an adolescent girl who walked into the maternity ward and reported feeling labour-like pain although she did not show any signs of being in labour. She was ignored and abandoned partly because of her young age, poor socioeconomic status, lack of companionship, and inability to appropriately express her experience of being in labour. She only drew the attention of the skilled health personnel when she was almost giving birth. The memory of her neglect in childbirth continues to haunt me and this motivated me to be a better midwife. Although I have witnessed adolescents' experiences of poor care during childbirth, I haven't had any in-depth conversations with any about their experiences. This increased my desire to have intentional conversations with adolescents who might have experienced poor quality maternal and newborn care.

Additionally, as a midwife educator, I have listened to different accounts of experience of poor care during childbirth from the perspectives of my students. Most of the narrative accounts were blatant forms of mistreatment during childbirth. These conversations could have desensitised me from probing covert forms

of experience of poor care such as lack of confidentiality which may go unnoticed. However, the generated themes on adolescents' experiences of childbirth in this study were compared to the experience of care dimensions of the WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities which kept in check.

Finally, I adopted both an etic and emic perspective on the adolescents' experiences of care during childbirth. In Phase I, I adopted an etic position by using a validated tool to screen for PCMC during childbirth among adolescents and PCMC impact on their satisfaction with care and future childbearing intentions. By adopting this etic position, I was able to make an accurate estimation of these variables. It also enabled me to document these variables in a language that is understandable and appropriate to the wider community of scientific scholars rather than only those within the study context. Meanwhile, in Phase II, I adopted an emic perspective that allowed these adolescents to fundamentally express their experiences of care during childbirth in a socially and culturally specific terminologies or references that were meaningful to them. My dual perspectives enhanced the richness of the study findings in a way that was meaningful to both the scientific community and the adolescents.

3.1.2 Epistemological Position

Epistemology refers to what constitutes acceptable, valid, and legitimate knowledge and how we communicate that knowledge to others (Saunders et al., 2009). The two epistemological positions used in this study are objective and subjective measures of social phenomena. Epistemologically, objectivists seek to discover the truth about a social phenomenon through observation and measurement to generalise the findings (Saunders et al., 2009). Accordingly, in this study, PCMC during childbirth and its impact on satisfaction with care and future childbearing intentions were assessed using validated tools to capture true and accurate results that could be generalised. Conversely, social constructionists believe that social phenomena are in a state of flux, and knowledge is best obtained through exploring the unique experiences of the actors to understand how realities are being experienced (Saunders et al., 2009). My subjective epistemological position on adolescents' experiences of care during childbirth and how it influenced my conduct of research is explicated below:

My first encounter with the concept of PCMC was in 2017 when I was chatting with a colleague. In our conversation, I was introduced to the work of White Ribbon Alliance (WRA) and I was fascinated by how WRA had delineated dignity and respect as a form of PCMC in childbirth using the human rights-based approach. Later in 2019, I had the privilege of attending a ''Respect workshop'' organised by the International

Confederation of Midwives (ICM) during the ICM Africa Regional Conference in Windhoek, Namibia. During that conference, I was fully immersed in the concept of Respectful Maternity Care. Since then, I have read widely about the concept from journal articles to web page publications and I have also participated in webinars as a panelist to discuss the subject.

It's my conviction that the knowledge and experience that I accumulated about Respectful Maternity Care enabled me to explore how the concept fits into various frameworks that examine quality of maternal and neonatal care (Renfrew et al., 2014; Sudhinaraset et al., 2017; World Health Organization, 2016a). It also enabled me to judge my credibility as a researcher in terms of intellectual rigour, professional integrity, and methodological competence to implement the current study. Despite my adequate knowledge base, I was wary that I may easily be biased during the interviews in a manner that may stop me from hearing about other emerging forms of experience of poor care during facility-based childbirth in the context of the study area.

Nonetheless, I was still amazed by how there is limited literature on adolescents' perceptions of PCMC during facility-based childbirth in Uganda and how their perceptions impact their satisfaction with care, future childbearing intentions, and overall experience of care.

3.1.3 Methodological Position

Methodological position relates to the approaches to theory development in research (Saunders et al., 2009). This study used both the deductive and inductive approaches to theory development. Deductive reasoning is where a research strategy is designed to test an already existing theory and / or framework (Saunders et al., 2009). The deductive reasoning was used in Phase I of the study where a framework was used to guide the design of the study, data collection, and data analysis. By contrast, inductive reasoning is where data is collected and theoretical conceptualisation is formed as a result of the data analysis (Saunders et al., 2009). The inductive reasoning was used in the qualitative arm of the study where adolescents' experiences of care during childbirth was explored.

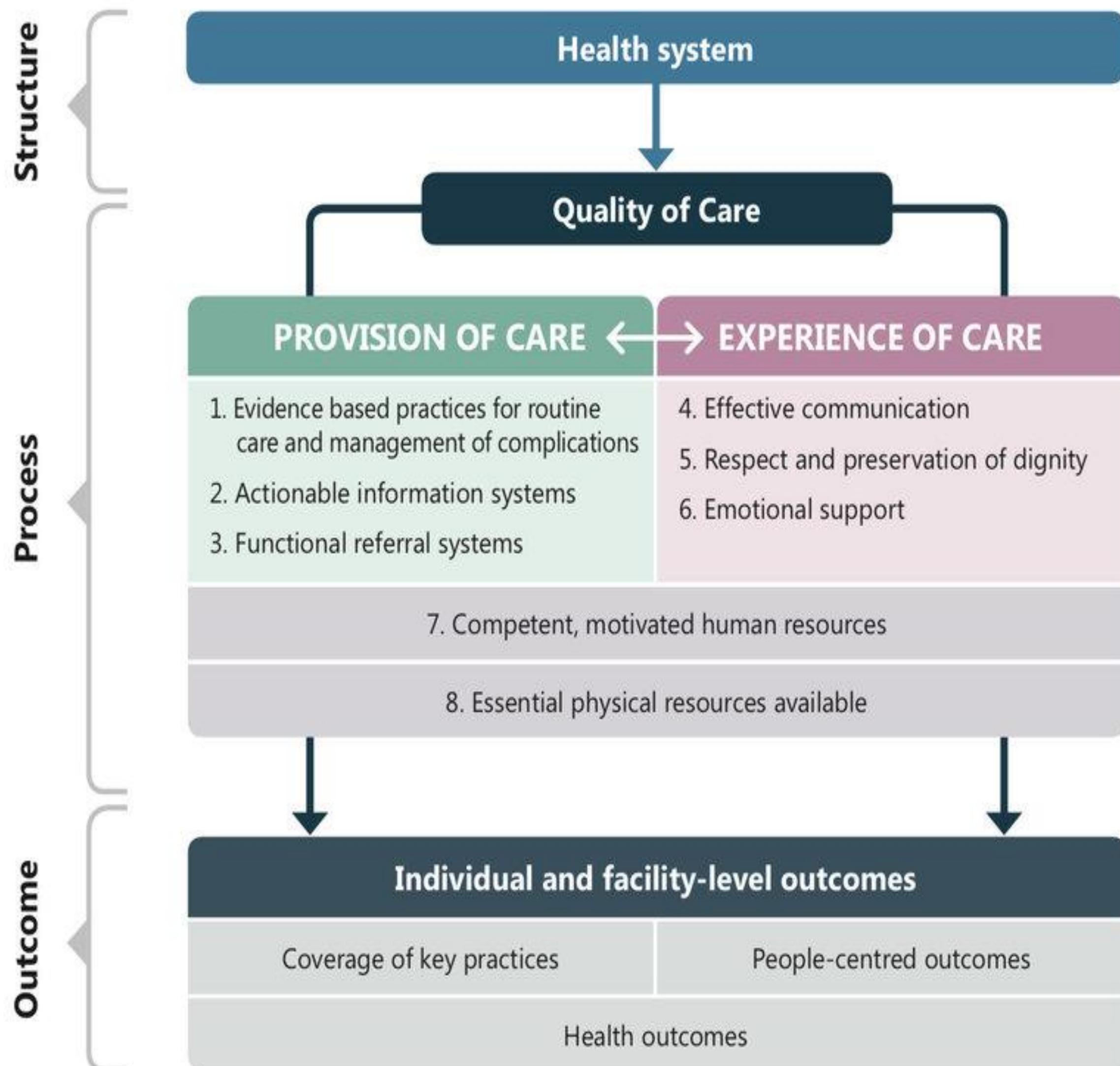
3.2 Theoretical Underpinnings

The theories that underpinned this study are the WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities, Person-Centred Care for Reproductive Health Equity (PCCRHE) Framework, and the Cultural Health Capital (CHC) theory.

3.2.1 WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities

The conceptualisation of this study was partly informed by the WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities (World Health Organization, 2016a) in Figure 3.1.

Figure 3.1: WHO Quality of Care Framework for Maternal and Newborn Care in Health Facilities



Note. Adapted from Standards for Improving Quality of Maternal and Newborn Care in Health Facilities by (World Health Organization, 2016a, p. 16)

Quality of care is the extent to which health services provided to individuals and populations improve the desired health outcomes by providing care that is safe, effective, timely, efficient, equitable, and people-centred (Tunçalp et al., 2015; World Health Organization, 2016a). Therefore, the quality of care reflects how well maternal and newborn health services ensure timely and appropriate care to achieve desired outcomes that align with current professional knowledge and consider the preferences and aspirations of individual women and their families (World Health Organization, 2016a). The WHO quality of care framework is a robust tool for examining the structure/inputs, process, and outcomes of care for women and newborns.

The framework has two main domains which are provision of care and experience of care (World Health Organization, 2016a). Provision of care represents safety and effectiveness of care, and experience of care represents the person-centredness of care. Each of the domains has at least one standard for quality of care (World Health Organization, 2016a).

A standard of quality of care within each domain is a description of what is expected to be provided to achieve high-quality care around the time of childbirth (World Health Organization, 2016a). The provision of care domain has three standards of evidence-based practices (S1), actionable information system (S2), and functional referral system (S3). Experience of care also has three standards of effective communication (S4), respect and dignity (S5), and emotional support (S6). Meanwhile, competent, motivated human resources (S7) and essential physical infrastructure (S8) are cross-cutting standards.

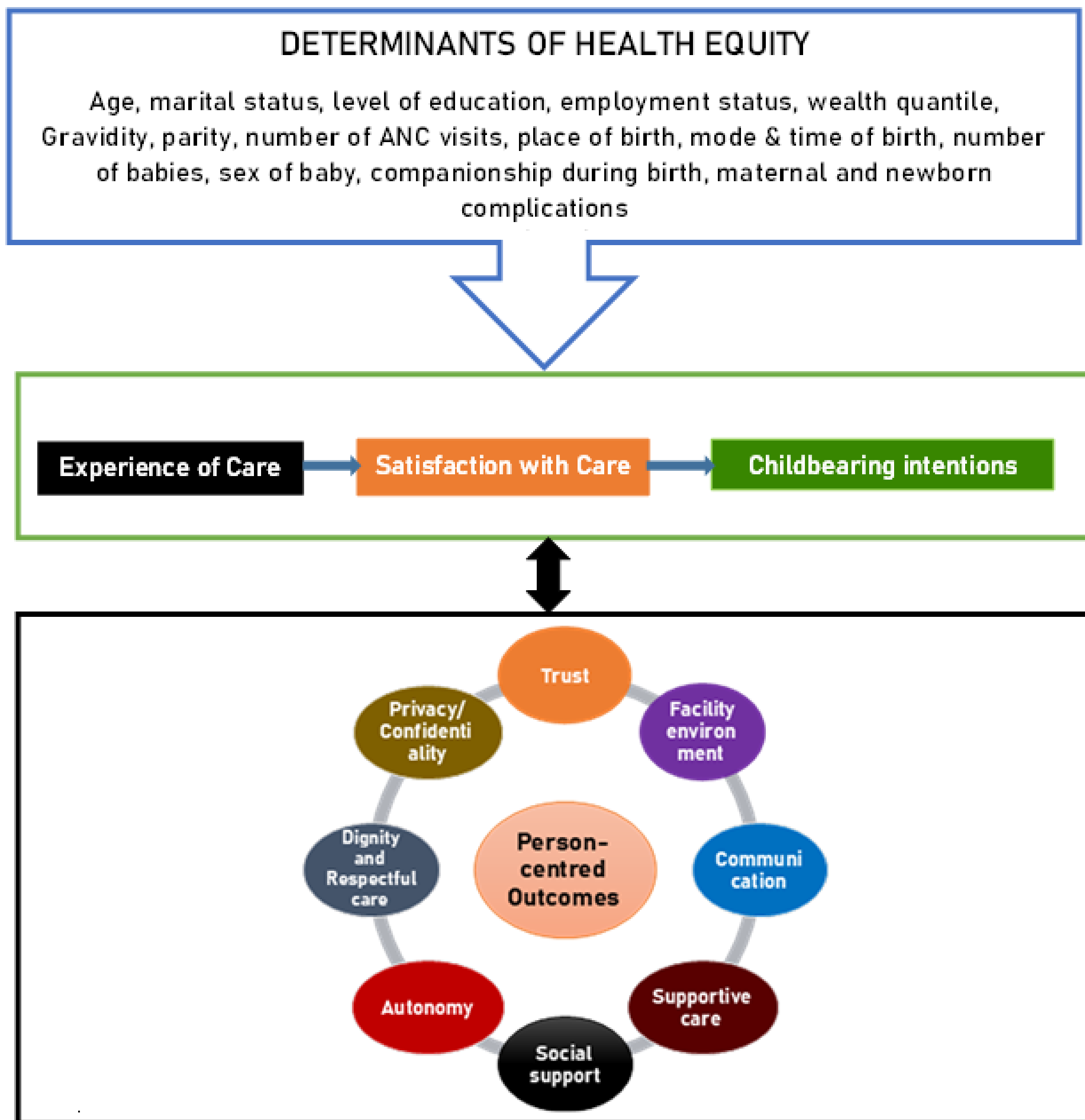
The framework presupposes that improved provision and experience of care increases the likelihood of increased coverage of key practices, person-centred outcomes, and the overall health outcomes of mothers and newborns (World Health Organization, 2016a). Specifically, improved provision of care increases the likelihood of coverage of key practices while improved experience of care increases the likelihood of person-centred outcomes.

The WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities has some limitations from my review and analysis. One of the major criticisms of this framework is that the framework suggests that only health systems' factors determine the quality of maternal and newborn care in health facilities, without considering individual and social determinants of quality of maternal and newborn health care. The framework postulates that improved experience of care influences the likelihood of person-centred outcomes but does not spell out these outcomes. Relatedly, the framework does not make any predictions of outcomes of person-centred care. Against these limitations, a second framework, the Person-Centred Care for Reproductive Health Equity Framework was adopted to expand on the WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities.

3.2.2 Person-Centred Care for Reproductive Health Equity Framework

The PCCRHE framework illustrated in Figure 3.2 presents the quality of reproductive health (Sudhinaraset et al., 2017).

Figure 3.2: Adapted from the Person-Centred Care for Reproductive Health Equity Framework



Note. Adapted from Advancing a Conceptual Model to Improve Maternal Health Quality: The Person-Centred Care Framework for Reproductive Health Equity by Sudhinaraset et al. (2017, p. 5)

The PCCRHE framework has four major presuppositions:

1) There is a unidirectional relationship between determinants of health equity and experience of care, satisfaction with care, and future childbearing intentions.
2) Women's experience of care influences their satisfaction with care.
3) Women's satisfaction with care influences their future childbearing intentions.

4) There is a bi-directional relationship between person-centred outcomes and women's experience of care, satisfaction with care, and future childbearing intentions.

The PCCRHE framework expands the WHO Framework in the following ways:

1) The framework expands the determinants of quality of maternal and newborn care in health facilities to include sociodemographic characteristics (age, marital status, level of education, employment status, and socioeconomic status) and obstetric history of women (gravidity, parity, number of ANC visits, place of birth, mode & time of birth, number of babies, sex of baby, companionship during birth, complications during birth, newborn outcome).
2) It expands the influence of women's experience of care to include satisfaction with care and future childbearing intentions (intentions to give birth, give birth in the same facility, and recommend the same facility to a sister or a friend).
3) It also suggests that PCMC has a relationship with women's experience of care, satisfaction with care and future childbearing intentions.
4) Finally, the framework identified eight mutually inclusive person-centred outcomes, namely (i) dignity and respect, (ii) autonomy, (iii) privacy and confidentiality, (iv) communication, (v) social support, (vi) supportive care (vii) trust, and (viii) health facility environment.

The PCCHRE framework was chosen because it provides a visual illustration of the concepts and constructs which are clear and researchable. It is also an extension of the WHO Framework for Quality of Maternal and Newborn Care in Health Facilities which is a key framework underpinning the conceptualisation of this study. Furthermore, it is also linked to the Cultural Health Capital (CHC) theory which is also applied in this study.

3.2.3 Cultural Health Capital Theory

The Cultural Health Capital (CHC) theory was proposed by Shim (2010) as a theoretical approach to understanding healthcare interactions and the dynamics of unequal treatment. This theory was chosen because it helps to account for several issues significant to explaining and understanding the drivers of experience of care during childbirth among vulnerable groups such as adolescents (Shim, 2010).

The CHC theory has its roots in the concepts of cultural capital and habitus of Bourdieu (1986) in which he describes how inequality can be reproduced by the interplay of economic, social, and cultural capital. According to Bourdieu (1986), **cultural capital** can be viewed as people's symbolic and information resources for action and those resources/capital may take many forms. The identified forms of cultural capital

include a) objectivised (artefacts, expensive clothes, blankets, paintings), b) institutionalised (education, job title), and c) the incorporated/embodied (values, skills, knowledge, robust vocabulary) forms.

Shim (2010) coined all health-relevant cultural capital as cultural health capital and she viewed it as the total of all culture-based resources that are available for people to enhance their health and wellbeing during healthcare. She defined CHC as, a *"specialised set of cultural skills, behaviours, and interactional styles that are valued and leveraged as assets by both patients and providers in clinical encounters"* (Shim, 2010, p. 4). Specific elements of CHC may include a proactive attitude towards the accumulation of knowledge, knowledge of medication and health conditions, ability to communicate and use that knowledge effectively, and ability to adjust one's interactional styles, organisational skills, and cues of favourable social and economic status (Dubbin et al., 2013; Shim, 2010).

These attributes are viewed as resources and / or skills that multiply and develop with repeated experiences with healthcare institutions and during interactions between the client and the provider in a healthcare setting (Shim, 2010). Therefore, women who are less educated, unmarried, unemployed, and poor may lack the resources and the personal agency to access healthcare. Additionally, younger women who are often of low gravidity and parity may also have less experience with maternity settings. The socio-economic characteristics of such women amount to low CHC in being able to navigate the healthcare system thus increasing the risk of mistreatment and deriving less satisfaction from care (Dubbin et al., 2013; Srivastava et al., 2015; Vedam et al., 2019). Paradoxically, women of lower socioeconomic status report perceptions of higher PCMC and higher levels of satisfaction with care during childbirth (Dey et al., 2017; Duysburgh et al., 2013). However, such women experience poor PCMC during childbirth compared to what they report, and they receive a lower quality of care (Dey et al., 2017; Duysburgh et al., 2013; Sharma et al., 2017). This inconsistency can be explained by the concept of *'habitus'* as conceptualised later by Bourdieu (1986).

Habitus are dispositions that are rooted in one's past experiences, schemes of thoughts and perceptions, and one's sensibilities about how the world works (Shim, 2010). Women of low socioeconomic status are likely to respond to healthcare providers in a manner that underscore their underprivileged positions in society as informed by their past social interactions with formal institutions including healthcare settings. Additionally, their expectations of the providers may be lower compared to their privileged counterparts because of past experiences and negative feedback from counterparts in the same social class. On the other hand, women of high socioeconomic status are likely to command attention from healthcare providers and have high

expectations of care based on experiences of their counterparts and habitual thoughts and perceptions that people of a higher class or privilege should be treated better.

Furthermore, the CHC theory posits that the CHC competencies are not innate and can be developed with repeated exposure to healthcare and that it can be deployed to enhance one's healthcare interactions hence reducing mistreatment (Shim, 2010). However, some individuals lack the agency to develop and deploy their CHC because of larger social inequalities, age, marital status, education, literacy levels, social support networks, and the general class designation. Moreover, the development and deployment of CHC are known to be driven by relationships and institutional power dynamics (Dubbin et al., 2013). As such, the exchange of CHC resources between the healthcare provider and the client largely depends on the repertoire of specialised cultural resources that the client brings to the healthcare encounter, in combination with the provider's fostering of and receptiveness to those resources (Shim, 2010).

The patient-provider interactions are not always jointly determined (Dubbin et al., 2013). The care provider plays a significant role in how CHC is activated and deployed especially when interacting with vulnerable groups (Dubbin et al., 2013; Madden, 2015). For example, a provider may assert power and control during clinical interactions thus inhibiting a patient from deploying their CHC during care. On the other hand, a provider may politely ask a patient a question thus activating the patient's CHC. Therefore, in the interactions between the healthcare provider and vulnerable clients, the healthcare provider can be seen as the custodian of the client's CHC, and their ability to harness the client's CHC is vital during the healthcare interactions. Although the CHC theory is relatively new and its use and application in research are still limited and nuanced, the theory's explanatory power makes it highly relevant for this study.

3.3 Conclusion

The two philosophical approaches used in this study were post-positivism and constructivism. In terms of positionality, my ontological standpoint was rooted in realism and social constructivism. Epistemologically, I employed both objective and subjective measures of social phenomena. Methodologically, I embraced both emic and etic positions. The utilisation of the WHO Quality of Care Framework for Maternal and Newborn Health in Health Facilities, Person-Centred Care for Reproductive Health Equity Framework, and the Cultural Health Capital theory enhanced the conceptualisation and design of the study.

CHAPTER FOUR: METHODOLOGY AND METHODS

4. Introduction

This chapter incorporates the study design, study population, eligibility criteria, sample size and sampling, recruitment of participants, study variables, data collection, data analysis, quality control, integration, mixed-methods legitimation, and ethical considerations.

4.1 Overview of Study Design

This study used an explanatory sequential mixed-method research (MMR) design (Creswell & Clark, 2017; Wium & Louw, 2018) as illustrated in Figure 4.1 below.

Figure 4.1: Explanatory Sequential Mixed-Methods Design

Phases	Procedure	Product
Quantitative Data Collection	Cross-sectional survey	Numerical data
Quantitative Data Analysis	Use of descriptive and inferential statistics	Meaningful measures
Connecting Quantitative and Qualitative Phase	Selection of qualitative participants purposefully	Qualitative samples
Qualitative Data Collection	In-depth interviews	Textual data
Qualitative Data Analysis	Coding and thematic analysis Theme development Cross theme analysis	Codes, categories, and themes Cross thematic matrix
Integration of the Quantitative and Qualitative Results	Interpretation and explanation of quantitative and qualitative results	Discussion Implications Future research

Note. Adapted from Explanatory Sequential Mixed Method Design as the Third Research Community of Knowledge Claim by Subedi (2016, pp. 570-577).

This design is a quantitative dominant MMR design represented by the notation, QUANT → qual. It is a two-phase model that begins with quantitative data collection and proceeds with qualitative data collection to explore the phenomenon under investigation.

4.2 Phase I: Quantitative Component of the Study

4.2.1 Research Design

A cross-sectional survey was used to assess the level of PCMC during childbirth and associated factors among adolescents in public health facilities in Lira District, northern Uganda between March and October 2023. This design was chosen because it allows simultaneous measurement of exposure and outcome (Polit & Beck, 2008).

4.2.2 Study Population

- Female adolescents aged 14 to 19 years[4], who gave birth within the previous two to six weeks in public health facilities in Lira District, northern Uganda.

4.2.3 Inclusion Criteria

- Female adolescents aged 14 to 19 years, who were admitted for childbirth in public health facilities in Lira District, northern Uganda.
- Lived within the catchment area of the public health facilities offering maternity services in Lira District, northern Uganda.
- Willingness to participate in the survey at two to six weeks postpartum.
- Could speak *Lango* or English language.

4.2.4 Exclusion Criteria

- A staff member in a public health facility offering maternity services in Lira District, northern Uganda.
- A first-degree relative (mother, sister, cousin) to a staff member in a public health facility offering maternity services in Lira District, northern Uganda.
- Adolescents with postnatal depression at the time of data collection (based on a three-point Edinburgh Postnatal Depression Scale, EPDS by Kabir et al. (2008)).

[4] Adolescents aged 14 to 17 years who wished to participate in the study without parental/legal guardian consent were treated as emancipated minors capable of self-determination Uganda National Council for Science and Technology [UNCST]. (2014). National Guidelines for Research involving Humans as Research Participants. In. Kampala, Uganda: UNCST.

- Adolescents who had health issues/problems and were in an unstable condition at the time of data collection.

4.2.5 Sampling and Sample Size

The sample size and sampling section outlines the methods and rationale used to determine the number of participants in the survey and the sampling technique employed.

4.2.5.1 Sampling Method

A cluster sampling technique was used to sample the study participants. This is a probability sampling technique in which the entire population is divided into clusters or groups (Acharya et al., 2013; Etikan & Bala, 2017). Lira District was divided into seven clusters based on the seven sub-counties of the district. Each of these sub-counties has at least a level III or IV health facility (H/C). These health facilities include Amach H/C IV, Ogur H/C IV, Barr H/C III, Aromo H/C III, Agali H/C III, Agweng H/C III, and Alik H/C III.

Census sampling was applied to select all the clusters for the study because of the large sample size and the limited number of adolescents giving birth in public health facilities in the Lira District. All participants who met the inclusion criteria were selected to participate in the study.

4.2.5.2 Sample Size Determination

The sample size, *n* for this study was calculated using the Kish (1965) formula:

$$\mathbf{n} = \frac{\mathbf{Z^2pq}}{\mathbf{e^2}}$$

The prevalence, *p*=0.603 (estimated childbirth by a skilled provider among adolescents in Uganda (United Nations Population Fund (UNFPA) Uganda, 2021)); z-score, *z*=1.96; margin of error, *e*=0.05 at 95% level of precision, and q= (1-*p*). The calculated sample size was *n*=367. To improve representation because of cluster sampling, the sample size was multiplied by the design effect, estimated at 1.5. Thus, the sample size, *n* = 367X1.5 = 551. Considering a 10% non-response rate, the final estimated sample size was *n*=551 + 55 = 606 participants. The final sample size was rounded off to 610 participants.

4.2.6 Recruitment of Participants

Upon obtaining necessary ethical and administrative clearances (Appendices 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8), information about the study (Appendix 4.9a&b) was displayed in poster format in the postnatal wards and clinics. This aimed to provide prospective participants with information about the study. Research assistants used a screening tool (Appendix 4.10a&b) to screen interested prospective participants from the

postnatal clinics or wards. Eligible participants were then approached and invited to voluntarily participate in the study. The research assistant explained the purpose, risks, and benefits of participating in the study, and obtained written informed consent from prospective participants aged 18 to 19 years (Appendix 4.11a&b) at the postnatal clinic or ward. For adolescents aged 14 to 17 years, both parental/legal guardian consent (Appendix 4.12a&b) and participants' assent were sought (Appendix 4.13a&b). However, adolescents in this age group who wished to participate without parental/legal guardian consent were considered emancipated minors, per Uganda's policy on responsible conduct of research (Uganda National Council for Science and Technology [UNCST], 2014) (Appendix 4.14a&b). Contact details of participants who consented to participate in the study were collected from the health facility for the survey at two to six weeks postpartum in the community. It was anticipated that within this timeframe, participants would have had sufficient time to reflect on their childbirth experiences and would be in a setting separate from the facility where they received maternity care (Sando et al., 2017). The surveys were conducted in the community at the participants' convenience. To assess participants' and parental/legal guardians' understanding of the information sheet, they were asked to retell what they had heard/understood and asked a few questions related to the information sheet.

4.2.7 Study Variables

This section identifies the key dependent and independent variables investigated in the quantitative arm of the study.

4.2.7.1 Dependent Variable

- Primary dependent variable: Person-Centred Maternity Care (PCMC) during childbirth.
- Secondary dependent variables: Adolescents' satisfaction with care during childbirth and future childbearing intentions after childbirth.

4.2.7.2 Independent Variables

- Socio-demographics (age, marital status, level of education, employment status, and socioeconomic status).
- Obstetric history (gravidity, parity, number of ANC visits, place of birth, mode & time of birth, number of babies, sex of baby, companionship during birth, complications during birth, newborn outcome).

4.2.8 Data Collection

Data collection is arguably one of the most important phases in research. This section encompasses data collection method, procedure, and tools and presented below:

4.2.8.1 Method

Data were collected using a researcher-administered questionnaire involving a face-to-face survey between the interviewer and the study participant.

4.2.8.2 Procedures

Upon ethical and administrative clearances, three research assistants were recruited and trained on responsible conduct of research, data collection tools, and administration of the tools. The research assistants who were social workers, counsellors, and youth workers collected data under the supervision of the researcher (Samson Udho) and his academic supervisor (A/Prof. Sheila Clow). The surveys were conducted in either *Lango* (the local dialect) or English language depending on the preference of the participant. The survey lasted on average 30 minutes per participant.

4.2.8.3 Tools and Measurements

Data were collected using a paper-based structured questionnaire with closed-ended questions (Appendix 4.15a&b). The questionnaire consisted of five sections, namely, socio-demographic characteristics, obstetric history, person-centred maternity care, satisfaction with care, and future childbearing intentions.

4.2.8.3.1 Socioeconomic Status

The socio-economic status of participants was assessed using the Principal Components Analysis on ownership of durable assets (radio, television, car, motorcycle, bicycle, and telephone), source of drinking water (piped water, open well, borehole, and rivers/swamps), and type of house floor material (sand/cow dung, cement, tiles, and terrazzo (Appendix 4.15a&b, Section I). Principal Components Analysis has been validated as a method to describe socioeconomic differentiation within a population (Vyas & Kumaranayake, 2006). The socioeconomic status was then classified into three wealth quantiles (lowest, middle, and highest) (Vyas & Kumaranayake, 2006).

4.2.8.3.2 Person-Centred Maternity Care

PCMC during facility-based childbirth was assessed using the PCMC tool (Appendix 4.15a&b, Section III). The validity and reliability test of the tool in this study using Cronbach Alpha showed that the overall PCMC tool was valid and reliable (r=0.86) as well as the sub-scales of dignity and respect (r=0.74), supportive care (r=0.78), and communication and autonomy (r=0.80). The overall PCMC tool was a 30-item scale with a total score range of 0 to 90 where each item has a four-point response scale i.e. 0 (“no, never”), 1(“yes, a few times”), 2 (“yes, most of the time”) and 3 (“yes, all the time”) (Afulani et al., 2019). The PCMC tool was divided

into three sub-scales, namely dignity & respect, communication & autonomy, and supportive care. The dignity and respect sub-scale was measured on a six-item sub-scale with a total score ranging from 0 to 18. Communication and autonomy sub-scale was measured on a nine-item sub-scale with a total score ranging from 0 to 27. The supportive care sub-scale was measured on a 15-item subscale with a total score ranging from 0 to 45. The overall PCMC and sub-scale scores were categorized into "low, moderate, and high". Low was defined as scores in the lower 25th percentile and scores in the top 75th percentile was defined as high.

4.2.8.3.3 Satisfaction with Care

Satisfaction with care during childbirth was assessed using the Six Simple Questions (SSQ) tool (Appendix 4.15a&b, Section IV) which is a brief, easily administered questionnaire (Harvey et al., 2002). The tool had been previously used to measure satisfaction with childbirth at 48 hours, two weeks, and six weeks postpartum (Harvey et al., 2002). The Cronbach Alpha test of the tool in this study showed that the tool was valid and reliable (r= 0.70). Satisfaction with care was measured on a 7-point Likert scale where 1=strongly disagree and 7=strongly agree. The scores for the SSQ tool ranged from 6 to 42. Satisfaction scores were classified as low scores (<28 score), moderate scores (28-33 score), and high scores (>33 score).

4.2.8.3.4 Future Childbearing Intentions

These were assessed using three items on the community survey tool (CST) (Appendix 4.15a&b, Section V) (Bohren et al., 2018). The CST is a valid and reliable tool for measuring future childbearing intentions in low-income settings like Uganda (Bohren et al., 2018). Participants were asked if they had intentions to give birth in the future after their latest childbirth, use the same health facility for future childbirth, and recommend the same health facility to a sister or friend. Future fertility intention was recorded as "No", "Yes", or "Don't Know". Future intention to give birth in the same facility was as recorded as "Same health facility", Different health facility", "At my home", "At someone else's home", or "Don't Know". Meanwhile, future intention to recommend the same facility to a sister or friend was measured on a 5-point Likert scale (0=strongly disagree, 1= Agree, 2= Neutral, 3=Disagree, and 4=strongly disagree) based on response to the statement, "I would recommend this health facility to a sister or friend".

4.2.9 Quality Control

Ensuring quality during conduct of research is an important aspect of ensuring the validity and reliability of the study findings. This section presents strategies used to ensure quality control.

4.2.9.1 Translation

Data collection tools were translated from English to the native Lango language and back-translated to English by two independent translators and compared to ensure the accuracy of the translated tools.

4.2.9.2 Pre-Testing

The tools were pretested at Aboke Health Centre IV in Kole District to ensure the correctness and suitability of the tool and adjustments were made accordingly. The tool was pre-tested on 15 participants whose results were excluded from the final dataset used for analysis.

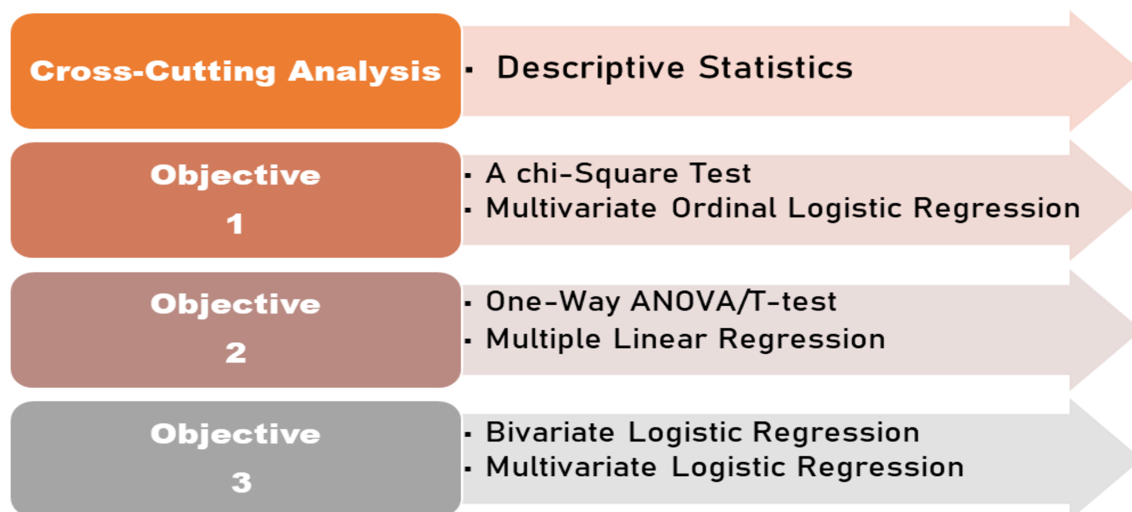
4.2.9.3 Other Strategies

This study used data collection tools that were valid and reliable for measuring PCMC during childbirth, satisfaction with care, and future childbearing intentions. Trained research assistants who were non-healthcare providers, conversant with the social norms, and fluent in both *Lango* (local dialect) and English language were used for data collection. This was done to ensure the correct administration of the questionnaire and to reduce bias.

4.2.10 Data Management and Analysis

Every questionnaire was checked for completeness at the end of data collection. A data entry screen was created in SPSS version 23 and the dataset was exported into STATA version 17 for analysis (Stata Corp, College Station, TX, SA) (Stata Corp, 2017). Data were checked for out-of-range entries and missing values. Quantitative data analysis followed the pathway below (Figure 4.2):

Figure 4.2: Pathway of Quantitative Data Analysis



Variables were analysed using descriptive and inferential statistics. Continuous variables were tested for normal distribution with the Shapiro-Wilk test. Normally distributed variables were reported as mean and standard deviation while non-normally distributed variables were reported as median and interquartile range (IQR).

A chi-square test was done to test the association between socio-demographic characteristics, obstetric characteristics, and PCMC during childbirth. Variables with a *p*-value <0.05 were included in a multivariate ordinal logistic regression model to determine the factors associated with moderate/high PCMC during childbirth. Statistical significance was set at 95% and the corresponding adjusted odds ratio (AOR) and *p*-value were reported. All the variables in the final model were assessed for multi-collinearity using the Variance Inflation Factor (VIF) and variables with VIF>10 were removed from the model (Dormann et al., 2013).

A one-way ANOVA test was done to test the association between PCMC during childbirth and satisfaction with care. Meanwhile, a t-test/one-way ANOVA was done to test the association between socio-demographic characteristics, obstetric characteristics, and satisfaction with care. A multiple linear regression was run to examine the association between PCMC and satisfaction with care while controlling for the influence of socio-demographic and obstetric characteristics. Variables with a *p*-value <0.05 were included in the model and the level of statistical significance was set at 95%. All the variables in the model were assessed for multi-collinearity using the VIF and variables with VIF>10 were removed from the model (Dormann et al., 2013).

A bivariate and multivariate logistic regression was performed to test the association between the PCMC and adolescents' future childbearing intentions while controlling for the influence of socio-demographic and obstetric characteristics. Variables with a p-value <0.05 in the bivariate analyses were included in the multivariate model. The analysis was conducted at a 95% level of significance, and the corresponding adjusted odds ratio (AOR) was reported. All the variables in the model were assessed for multi-collinearity using the VIF and variables with VIF>10 were removed from the model (Dormann et al., 2013).

4.3 Phase II: Qualitative Component of the Study

4.3.1 Research Design

A qualitative descriptive research (QDR) design was used to explore adolescents' experiences of childbirth and the factors influencing how they are treated during childbirth (Doyle et al., 2020; Holly, 2013). QDR is an exploratory approach that aims to comprehensively describe and summarise specific events experienced by individuals or groups of individuals in everyday terms (Doyle et al., 2020; Holly, 2013; Lambert & Lambert,

2012). The design draws inspiration from the phenomenology of Edmund Husserl (2019), particularly the concept of bracketing (Doyle et al., 2020; Holly, 2013). Bracketing involves the researcher setting aside their prior opinions, sentiments, knowledge, and experiences about the phenomenon and subject during data collection and analysis, thereby revealing their positionality within their ontological, epistemological, and methodological positions (Doyle et al., 2020; Holly, 2013). Positionality is a description of a researcher's reflexive thought processes about how s/he interacts with the subject matter, research participants, and the study context (Holmes, 2020). Ontologically, the study adopted realism and social constructivism, while epistemologically, it utilised objective and subjective measures of the social phenomenon. Methodologically, the study employed both inductive and deductive approaches to reasoning[5]. The QDR design was chosen for its frequent use within explanatory sequential MMR, its ability to provide a rich description of a phenomenon, and its lack of theoretical assumptions compared to other qualitative methodologies, such as phenomenology (Doyle et al., 2020; Holly, 2013).

4.3.2 Study Population

- Female adolescents aged 14 to19 years, who gave birth two to six weeks ago in public health facilities in Lira District, northern Uganda.

4.3.3 Inclusion Criteria

- Female adolescents aged 14 to 19 years, who participated in the community survey.
- Those who agreed to be approached to participate in the in-depth interview after the survey two to six weeks postpartum.

4.3.4 Exclusion Criteria

- Those who could not express their childbirth experiences, based on survey responses.
- Those who developed postpartum depression after the survey.

4.3.5 Sampling and Sample Size

The sample size and sampling section outlines the methods and rationale used to determine the number of participants in the interview and the sampling technique employed.

4.3.5.1 Sampling Methods

Nested sampling was utilised in the implementation of MMR (Creswell & Clark, 2017; Wium & Louw, 2018). Nested sampling involves selecting some participants from Phase I to participate in Phase II of an explanatory

[5] This is presented in more details in Chapter III, page 46

sequential MMR (Creswell & Clark, 2017; Wium & Louw, 2018). For phase II of the study, Maximum Variation Sampling (MVS) was employed to sample the participants (Mujere, 2016; Palinkas et al., 2015). MVS is a type of purposive sampling where participants with diverse backgrounds are sampled to have participants with a wide range of opinions or experiences (Mujere, 2016; Palinkas et al., 2015). In this study, the sampling involved deliberately selecting participants that represent diverse characteristics such as age, parity, marital status, and socioeconomic status. The use of MVS by the researcher allowed for a diverse and comprehensive narrative of childbirth experiences and their determinants for adolescents (Palinkas et al., 2015).

4.3.5.2 Sample Size Determination

The principle of information power was used to estimate the sample size (Malterud et al., 2016). Information power states that the more information the sample holds, relevant to the actual study, the lower the number of participants needed (Malterud et al., 2016). Malterud et al. (2016) recommend that a study that has a narrow aim, with participants holding characteristics specific to the study, in which a theory is applied based on strong dialogue, and case analysis is done, requires a smaller sample size and *vice versa*. In this study a theory was applied, a quality in-depth interview with the researcher was done, the sample was relatively restricted because of MVS, the aim was relatively narrow, and a cross-case analysis was conducted. Therefore, a trade-off of a sufficient sample size for this study was estimated at 15 to 20 in-depth interviews. Seventeen prospective study participants were sampled to participate in the study. Of these, one participant declined to give consent and two were lost to follow-up. However, data saturation was reached during the 14th interview, whereafter data collection was halted.

4.3.6 Recruitment of Participants

Participants who consented to be approached for phase II of the study were contacted by the researcher via phone calls. Attempts were made to visit their homes to obtain written informed consent/assent. Once the participants signed the consent/assent form, they were enrolled in phase II of the study. To assess participants and their parents/legal guardians' understanding of the information sheet, they were asked to summarise what they had heard/understood and were also asked a few questions related to the information sheet.

4.3.7 Data Collection

This section encompasses data collection method, procedure, and tools and presented below:

4.3.7.1 Method

Data were collected using face-to-face in-depth interviews (IDI). The face-to-face approach allowed the researcher to collect both the verbal and nonverbal messages related to adolescents' experiences during childbirth and the drivers of how they were treated. It also allowed the researcher to probe the participants to elicit a richer account of the meaning of their experiences.

4.3.7.2 Procedures

Upon completion of data collection and preliminary analysis of Phase I, the researcher embarked on the collection of qualitative data. The researcher is a 33-year-old male nurse-midwife by profession who works as a midwife educator at a public university in Uganda. He has five years of experience in conducting qualitative research. The researcher received training on responsible conduct of research, protection of human research subjects, and conducting in-depth interviews. The researcher had no prior relationship with any of the study participants but established rapport with the study participants during the actual period of data collection. All the data were collected in the *Lango* language based on the preference of the study participants. All the interviews were audio-recorded with permission from the participants using a smartphone. The interviews were conducted in participants' homes, and they lasted for a maximum of 45 minutes. Field notes were taken focusing on the body language, mood, and behaviours of the participants during the interviews. The interviewer summarised the interview to the participants and asked them to confirm if it was a true reflection of the interview. A full-time qualified counsellor not affiliated with any health facility was on standby to provide counselling where needed. Participants were also allowed to have companions of their choice if they wished so during their interviews.

4.3.7.3 Tool

Data were collected using the IDI guide (Appendix 4.16a&b). The IDI guide had closed-ended questions that captured the participants' socio-demographic and obstetric history and open-ended questions related to how participants experienced childbirth and perceptions of why they were treated that way while seeking care.

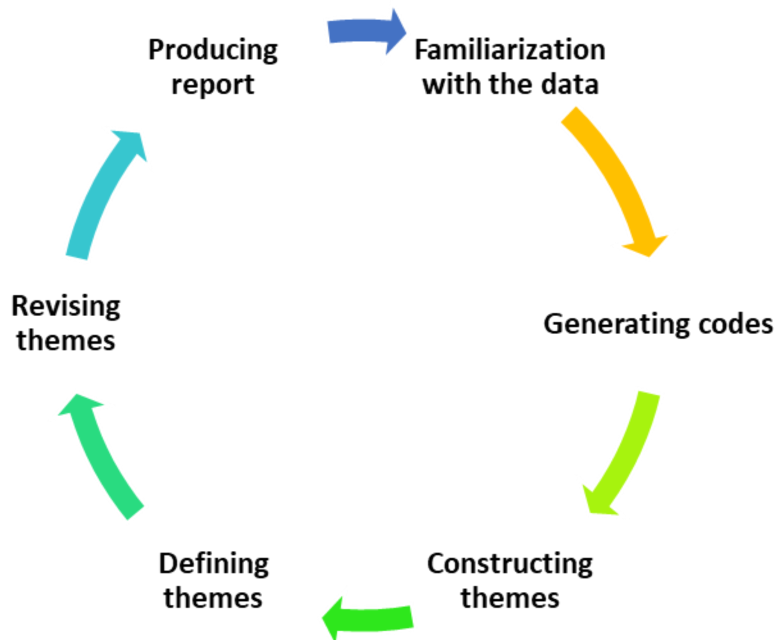
4.3.8 Data Management and Analysis

Audio-taped interviews were reviewed at the end of each IDI to ensure that the information captured was consistent with the study objectives. Audio recorded IDI were transcribed *verbatim* in Lango language and

translated to English. Fifty percent of the English transcripts were back-translated to the *Lango* language by a different translator to ensure correctness during translation. The translations were found to be accurate and stable thus it was not warranted to back translate the balance of the interviews. The transcripts were imported into a qualitative data management software, Atlas Ti version 7.5 for analysis (Friese, 2019).

Data were analysed following the reflexive thematic analysis (reflexive TA) technique described by Braun and Clarke (Braun & Clarke, 2006). Reflexive TA involves six phases as shown in Figure 4.3 below:

Figure 4.3: Six Phases of Reflexive Thematic Analysis



Note. Adapted from Using Thematic Analysis in Psychology by (Braun & Clarke, 2006)

An inductive approach was taken for the analysis, working with the data from the bottom-up exploring the participants' perspectives, whilst also examining the contexts from which the data were produced. The steps undertaken for the analysis are expounded below:

4.3.8.1 Data Familiarisation

I immersed myself in the data right from the start by overseeing every step of the data collection process. This included designing the interview questions and conducting the interviews. Specifically, during the interviews, I had the opportunity to connect with participants, establish rapport, delve into their narratives, and carefully review each interview before handing them over to an expert for transcription and translation. I read the transcripts several times and compared them against the audio recordings to get a deeper

perspective of the transcripts. As a result, I developed a strong familiarity with the interview data before embarking on the coding phase.

4.3.8.2 Generating Codes

Data coding involved a meticulous examination of each transcript, involving a systematic review of each line and applying codes to any identified meaningful elements. Primarily, the coding process adhered closely to the inductive semantic aspects, aligning with the participants' interpretation of their experiences. However, as the process evolved and transcripts were revisited, inductive latent coding was introduced, delving deeper into the underlying meaning beneath participants' statements. The coding focused on salience rather than frequency. Throughout this coding journey, I maintained a reflective journal to document my insights and any potential biases stemming from my own experiences, offering a space for contemplation on my data-related inclinations. This was shared with my supervisor, and we discussed the evolving data and analysis. Subsequently, the codes were consolidated into a separate Word document, a crucial step to ensure that the codes captured meaning independently. This allowed for further refinement of certain code wordings during this phase.

4.3.8.3 Constructing Themes

The process of deriving themes from the data commenced with the compilation and organisation of codes extracted from the interviews, aiming to represent the common threads in participants' expressions. By thoroughly examining the codes, revisiting the data, and drawing insights from my reflective journal's notes and diagrams, I began to discern emerging patterns within the data. I aggregated related codes, gradually shaping them into prospective themes and subthemes. Thematic maps proved invaluable in guiding my evolving comprehension of the data, leading to iterative adjustments as my understanding deepened.

4.3.8.4 Defining Themes

The development of themes involved an iterative approach, which entailed a back-and-forth exploration between the codes and the identification of emerging patterns. Multiple thematic maps were generated to visually represent how participants constructed meaning from their experiences within the entire dataset, shedding light on areas of inconsistency and convergence. Thematic maps served as a valuable visual aid, illustrating the interconnections and relationships among various ideas and patterns.

4.3.8.5 Revising and Naming Themes

Through the process of developing thematic maps, areas of overlap became evident, which led to further refinement of ideas. The generated themes on adolescents’ experiences of childbirth were compared to the

experience of care dimensions of the WHO quality of care framework for maternal and newborn health in health facilities (World Health Organization, 2016a) to guide their naming. Defining and articulating ideas to colleagues and supervisors brought helpful clarity about what could be defined as a theme, where related ideas fitted together into sub-themes, and also where separation of ideas was necessary. The theme names were chosen once there were clear differentiation between ideas.

4.3.8.6 Producing Report

The process of crafting each thematic report demanded a deeper level of clarity as I strived to articulate concepts and support them with a variety of participant quotes. The act of composing a thematic report extended beyond a mere concluding step; it involved a continued refinement process. This necessitated revisiting earlier stages iteratively to ensure that the ideas being conveyed faithfully reflected the data while aligning with the research objectives. Additionally, during this phase, connections were established with existing literature to enrich the understanding of the patterns identified within the data.

4.3.9 Scientific Rigour and Trustworthiness

Rigour refers to the steps to ensure trustworthiness in a naturalistic inquiry such as DQR (Denzin & Lincoln, 2018). The steps undertaken to ensure the trustworthiness of this study include credibility, transferability, dependability and confirmability, and are described below, in sections 4.3.9.1 to 4.3.9.4.

4.3.9.1 Credibility

Credibility is the degree to which a naturalistic study finding can be regarded as true for a given subject of inquiry and the context in which (Denzin, 2012; Denzin & Lincoln, 2018)the inquiry was conducted (Denzin, 2012; Denzin & Lincoln, 2018). Credibility was ensured through theoretical & methodological triangulation, member checking, and keeping an audit trail of data collection (Denzin, 2012; Denzin & Lincoln, 2018). Theoretical triangulation was applied by using the WHO Framework for Quality of Maternal And Newborn Care in Health Facilities, the Cultural Health Capital theory, and the Person-centred Care Framework for Reproductive Health Equity to give multiple, rather than single perspectives to examine the topic (Denzin, 2012; Denzin & Lincoln, 2018). Methodological triangulation was applied by using explanatory sequential MMR where data in Phase II was built on the data collected in Phase I (Denzin, 2012; Denzin & Lincoln, 2018). Member checking was done by restating and summarising information during the IDI and collecting referential adequacy materials (audio recordings and transcripts) against which findings and interpretations could be tested (Denzin, 2012; Denzin & Lincoln, 2018).

4.3.9.2 Transferability

Transferability is the degree to which the results of a study may be applicable in other contexts or with other respondents (Denzin & Lincoln, 2018).Transferability was ensured by doing MVS of the study participants who could fully express themselves to maximise the range of information uncovered (Denzin & Lincoln, 2018). In addition, a thick description of the study setting, context, study population, and research methods was provided throughout this research report (Denzin & Lincoln, 2018).

4.3.9.3 Dependability

Dependability is related to consistency in naturalistic inquiry and it is the ability of the findings to be replicated given the same population and context (Denzin & Lincoln, 2018). Dependability was ensured by establishing audit trail instruments such as audio recordings and transcripts against which verification could be done (Denzin & Lincoln, 2018). The researcher's supervisor also acted as an auditor and continuously examined and commented on the degree to which the study procedures/processes met acceptable standards for conducting qualitative research (Denzin & Lincoln, 2018).

4.3.9.4 Confirmability

Confirmability, also referred to as neutrality relates to how a researcher remains objective during the study process so that the results obtained are a sole function of the subject and context of inquiry and not of the researcher's biases, motivations, interests, and presuppositions (Denzin & Lincoln, 2018). Confirmability was ensured by practicing reflexivity, debriefing with participants through summarising the main points, and keeping audit trails (Denzin & Lincoln, 2018). The researcher clearly stated his philosophical positions and continuously kept a reflective journal throughout data collection and analysis. Debriefing meetings were organised with the supervisor to identify any tendency of interference with data collection based on the researcher's positionality. Data audit trails were kept through the Atlas Ti software from where the researchers could confirm whether the descriptions accurately reflected the participants' views.

4.3.9.5 Reflexivity

Reflexivity is a researcher's conscious and deliberate effort to be attuned to one's reactions to respondents and how the research account is constructed to identify and explicate the potential or actual effect of personal, contextual, and circumstantial aspects on the process and findings of the study and maintain their awareness of themselves as part of the world they study (Berger, 2015; Dodgson, 2019). Reflexivity was ensured through critical appraisal & self-reflection (Berger, 2015; Dodgson, 2019). The researcher re-

listened to the audio recordings multiple times to self-judge the content of the interview while keeping his positionality in check by keeping a journal during data collection and analysis.

4.4 Integration

Data integration is the combination of quantitative and qualitative findings to enable an in-depth understanding of a phenomenon in a manner that strengthens the value of mixed-methods research and reduces the single approach weaknesses (Fetters et al., 2013). Integration in MMR can occur at three levels, namely (i) design, (ii) methods, and (iii) interpretation and reporting (Fetters et al., 2013). In this study, integration occurred at all the three levels. Integration at the design level occurred through the selection of the explanatory sequential MMR design, a choice which was underpinned by the study research questions. At the methods level, integration occurred by connecting the quantitative data with qualitative data through sampling (Fetters et al., 2013). In other words, participants who participated in the survey in Phase I were selected to participate in the in-depth interview in Phase II. Finally, integration at the interpretation and reporting level occurred through the narrative approach, specifically the contiguous approach (Fetters et al., 2013). This approach involves the presentation of study results within a single report, but the qualitative and quantitative findings were reported in different chapters (Chapter five and six respectively).

4.5 Mixed-Methods Legitimation

Legitimation in MMR is the continuous iterative, interactive, and dynamic process to ensure the validity of MMR findings (Onwuegbuzie & Johnson, 2006). Onwuegbuzie and Johnson (2006) identified nine typologies of legitimation in MMR. These legitimation types include (a) inside-outside, (b) sample integration, (c) weakness minimisation, (d) sequential, (e) conversion, (f) paradigmatic mixing, (h) commensurability, (i) multiple validities, and (j) political legitimation. This study considered six of these typologies of legitimation as relevant to this study.

4.5.1 Sample Integration Legitimation

Sample integration is the extent to which the relationship between the quantitative and qualitative sampling designs yields a quality overall conclusion, explanation, or understanding of the research question(s) (Onwuegbuzie & Johnson, 2006). Onwuegbuzie and Johnson (2006) noted that when different samples are used for the quantitative and qualitative arm of a mixed-methods study, meta-inference, when data is collated, becomes problematic. In this study, sample integration legitimation was ensured by having the same participants from the quantitative phase participate in the and qualitative phase of the study and also having the same eligibility criteria for both arms of the study.

4.5.2 Inside-Outside Legitimation

Inside-outside legitimation is the degree to which the researcher accurately and appropriately utilises the *etic* (outsider) and *emic* (insider) perspectives during the description and explanation of study findings (Onwuegbuzie & Johnson, 2006). Although the emic/etic concept is more pronounced in qualitative research, mixed-method research is now a recognised research paradigm that represents both emic and etic viewpoints (Creswell & Clark, 2017; Onwuegbuzie & Johnson, 2006). The balance between the inside and outside viewpoints of the researcher in an MMR study is guided by the emphasis the researcher places on the quantitative and qualitative approaches (Onwuegbuzie & Johnson, 2006). This study was quantitative dominant although the qualitative arm was equally valued. Therefore, this study gave due diligence to both the quantitative and qualitative phases of the research in the same report giving a more balanced and useful viewpoint. Additionally, the continuous reviews by the research supervisor ensured that both the quantitative and qualitative phases of the study were rigorously described in the report.

4.5.3 Paradigmatic Mixing Legitimation

This refers to the extent to which the researcher's epistemological, ontological, and methodological beliefs that underlie the quantitative and qualitative approaches are successfully integrated into a usable package *(Onwuegbuzie & Johnson, 2006, p. 1256)*. According to Creswell and Clark (2017), MMR can take any of the three forms namely, quantitative dominant, qualitative dominant, or pure mixed research. This study adopted quantitative dominant type because of the choice of the MMR design, (explanatory sequential) while remaining true to the pure philosophical underpinnings for each phasic paradigm.

4.5.4 Weakness Minimisation

Weakness minimisation relates to how the weaknesses of one research approach are compensated by the strengths of another approach (Onwuegbuzie & Johnson, 2006). In this study, adolescents' experiences of care during childbirth in public health facilities which could not be examined by the quantitative approach were explored by the qualitative phase of the study.

4.5.5 Sequential Legitimation

Sequential legitimation relates to how the ordering of phases in a sequential mixed-method design may have potential effects on the meta-inferences drawn from the study findings (Onwuegbuzie & Johnson, 2006). This study did not reverse the ordering of the quantitative and qualitative phase of the explanatory sequential MMR design and so there was no risk of erroneous meta-inferences drawn from this study.

4.5.6 Multiple Validities

Multiple validities refers to the extent to which validity issues in an MMR are adequately and appropriately addressed to yield strong meta-inferences (Onwuegbuzie & Johnson, 2006). This was addressed by giving an in-depth description of how validity and rigour were ensured in both the quantitative and qualitative phases of the study.

4.6 Ethical Considerations

The World Medical Association Declaration of Helsinki requires that all research involving human research subjects should have a statement of the ethical considerations which indicates whether there is compliance with the principles enunciated in the Declaration (World Medical Association, 2013). The principles applicable to this study are discussed below in the sub-sections 4.6.1 to 4.6.10.

4.6.1 Scientific Soundness of Study

This research protocol was reviewed at different academic levels to establish the scientific merit of the study. The research addresses the call by the World Health Organization (World Health Organization, 2016a) for improved quality of maternal and newborn care within healthcare facilities with a clear study justification and significance. Additionally, the MMR design used was appropriate for answering the research question of the study (Creswell & Clark, 2017).

4.6.2 Ethical Approval

This study received two ethical approvals from the Human Research and Ethics Committee (HREC REF: 310/2022) based at the University of Cape Town (Appendix 4.1) and the Gulu University Research and Ethics Committee (GUREC-2022-480) based in Uganda (Appendix 4.2). The title of the protocol was amended in Uganda (Appendix 4.3) and South Africa (Appendix 4.4) and the protocol was also renewed annually in Uganda (Appendix 4.5) and South Africa (Appendix 4.6).

4.6.3 Permission to Conduct Study in Uganda

The permission to conduct this study in Uganda was obtained from offices of the Resident District Commissioner and the District Health Officer, Lira District (Appendix 4.7) and Uganda National Council of Science and Technology (HS2727ES) (Appendix 4.8). Study setting administrative clearance was also obtained from the administrators of the selected health facilities.

4.6.4 Researcher Competence

The Principal Investigator had the necessary research knowledge, skills, and experience to supervise this study while the researcher also had the prerequisite competency to pursue this study. The researcher also

received a training on responsible conduct of research and the protection of human research participants and was awarded a certificate (Appendix 4.17). Research assistants experienced in quantitative data collection were hired and further trained on the usage of data collection tools and responsible conduct of research.

4.6.5 Autonomy and Informed Consent

Written informed consent was obtained from adolescents aged 18 to 19 years (Appendix 4.11a&b). Parental/legal guardian consent was obtained with permission from adolescents aged 14 to 17 years (Appendix 4.12a&b). Thereafter, assent was sought from adolescents aged 14 to 17 years (Appendix 4.13a&b). Adolescents aged 14 to 17 years who wished to participate in the study without parental/legal guardian consent were treated as emancipated minors capable of self-determination (Appendix 4.14a&b) as supported by Ugandan's guideline for the conduct of scientific research in the country (Uganda National Council for Science and Technology [UNCST], 2014).

4.6.6 Privacy and Confidentiality

Privacy and confidentiality were maintained by using codes and pseudonyms instead of participants' names. Privacy was further enhanced by conducting the interviews within the participants' homes where they felt more comfortable. Computer-based data were password protected while permission to audio-record IDI was obtained from the participants, and the audio records were password protected. However, reported cases of abuse or neglect of a child (14 to 17 years), including, but not limited to, physical, sexual, and financial abuse or neglect were reported to the Child Protection and Family Unit of the Uganda Police Force (Appendix 4.18) (Justice Centre Uganda, 2021; Uganda National Council for Science and Technology [UNCST], 2014). This information was disclosed during the information-giving session and before consent was obtained from each participant. A total of five cases of neglect were reported to the research assistants.

4.6.7 Justice

Justice relates to treatment of study participants with fairness and impartiality during all stages of the research (World Medical Association, 2014). Justice was ensured by treating all participants with respect and dignity. The selection of participants was based on their meeting the inclusion criteria. A probability sampling technique was used in the quantitative component of the study to ensure equal chance of participating in the study.

4.6.8 Beneficence and Non-Maleficence

The principle of beneficence requires that the researcher act for the benefit of the human research participants and uphold the moral principle to protect and defend the right of others, prevent harm, remove conditions that cause harm, and protect vulnerable persons (World Medical Association, 2014). The principle of non-maleficence is an obligation not to harm the human research participants (World Medical Association, 2014). Beneficence and non-maleficence were ensured by performing a risk-benefit analysis. A brief risk-benefit analysis of this study is presented in sub-sections 4.6.8.1 to 4.6.8.3.

4.6.8.1 Benefit Analysis

Results of this study could be used by health service managers, policymakers, future pregnant adolescent girls, health facilities offering maternity care, and researchers in their quest to prevent and eliminate the mistreatment of adolescents during childbirth and improve the quality of maternal and newborn care during childbirth in health facilities. The research participants benefited by giving them a platform to express their experiences.

4.6.8.2 Risk Analysis

The study exposed participants to memories of discomforts, stigma, and distress because of sharing their childbirth experiences. This was addressed by pausing the interviews where necessary, comforting, and reassuring the participants. Additionally, a full-time qualified counsellor not affiliated with any health facility was available during all the interviews to provide counselling where needed and debriefing when needed. No participant requested the intervention of a counsellor during the interviews, suggesting that other strategies to calm their emotions worked well. Instances of mistreatment at the facility reported during the interview were reported to the facility administration while instances of other childhood-related abuse or neglect including, but not limited to, physical, sexual, emotional, and financial abuse or neglect were also reported to the Child Protection and Family Unit of the Uganda Police Force. Meanwhile, prospective study participants with postnatal depression detected during the screening before the survey were excluded from the study and referred to a nearby health facility for further investigations and clinical management. A total of eight participants were referred from this intervention.

4.5.8.3 Risk-Benefit Analysis Conclusion

The overall risk-benefit analysis demonstrated that the benefits of this study outweighed the potential risks.

4.6.9 Reimbursement

There was no direct monetary compensation for participating in this study. However, participants received compensation for their time worth Uganda shillings (UGX.) 5,000 (ZAR 21) for the survey (Phase I) and UGX. 20,000 (ZAR 85) for the in-depth interview (Phase II) as guided by the local research committee in Uganda. Participants who participated in both phases of the study were reimbursed for participating in each of the phases of the study.

4.6.10 Research and Covid-19

The field work for this study was conducted between March and October 2023 when Uganda had not yet been declared free of the Coronavirus Disease 2019 (Covid-19) by the Ministry of Health and so a clear risk management plan (Appendix 4.19) was developed and followed to mitigate the spread of the virus.

4.6.11 Dissemination of Results

A copy of this research dissertation will be available electronically in the University of Cape Town library for future reference. The results of the study will also be presented in both national & international conferences and published in peer-reviewed journals. Key findings and recommendations will be shared with the management and other key stakeholders of the health facilities that participated in the study.

4.7 Conclusion

This study used an explanatory sequential MMR design with two phases. The researcher discussed each phase separately to convey the methods followed in each step. Phase I focused on the quantitative component of the study that used a cross-sectional design and Phase II focused on the qualitative component of the study that used a QDR design. The chapter ended by stating how integration, mixed-methods legitimation, and observance of the Helsinki Declaration were done throughout the study. The next two chapters focus on the study findings of each of the study phases.

CHAPTER FIVE: QUANTITATIVE RESULTS

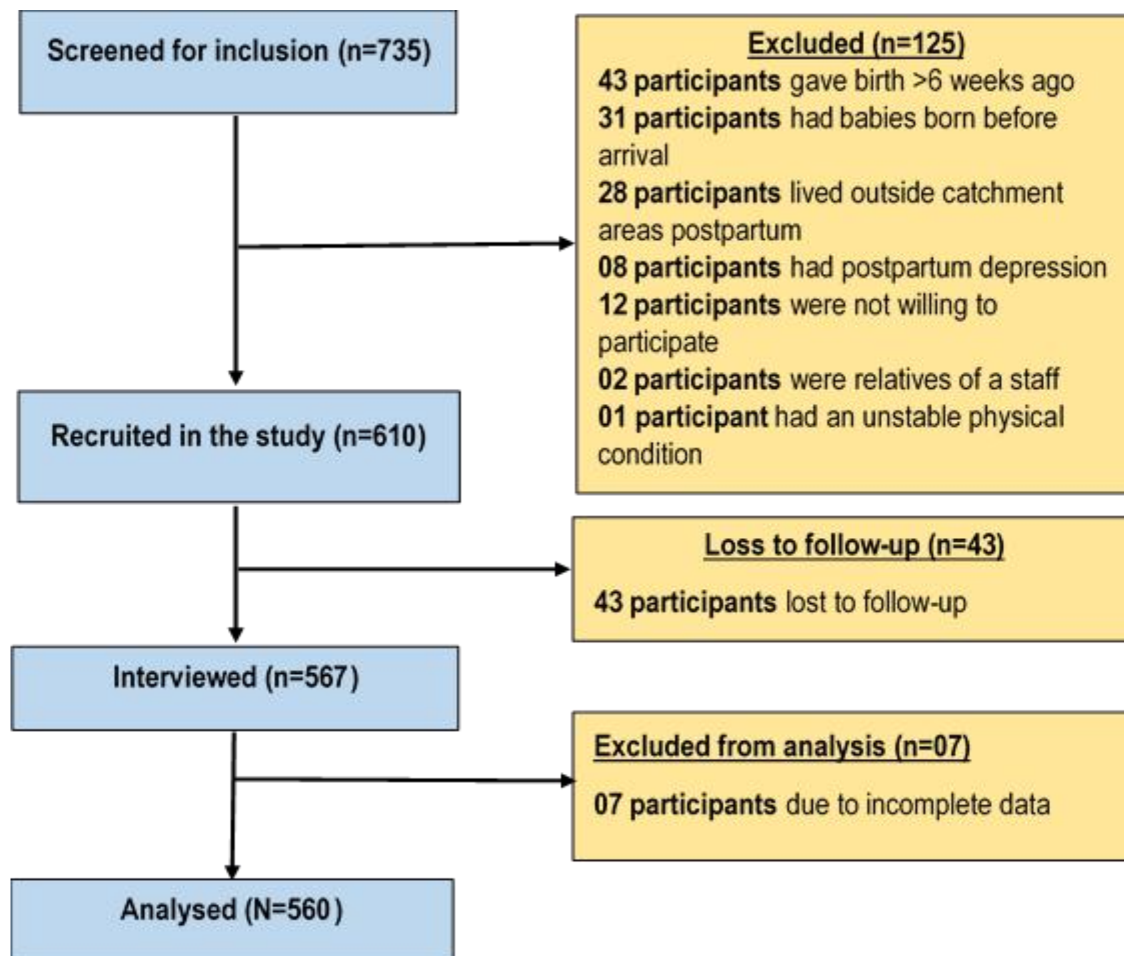
5. Introduction

This chapter presents the quantitative findings of this study following the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines for reporting observational studies (Von Elm et al., 2007) (Appendix 5.1). The chapter presents various aspects of the study including the characteristics of study participants (section 5.2), PCMC (section 5.3), satisfaction with care (section 5.4), future childbearing intentions (section 5.5), and concludes with a summary (section 5.6).

5.1 Study Participants

Out of 735 participants screened for eligibility to participate in the study between March and October 2023, 610 were eligible for the study. A total of 567 questionnaires were administered from the 610 calculated sample size giving a response rate of 92.95% (56/610) (Figure 5.1).

Figure 5.1: Flowchart for Recruitment of Study Participants



5.2 Characteristics of Study Participants

5.2.1 Sociodemographic Characteristics of Study Participants

Most of the participants (83.6%) were aged 18-19 years, and the median age was 18 years with an interquartile range of 18 to 19 years. Most of the participants had some level of education (97.7%), although were no longer in school (96.4%). Most of the participants were engaged in agricultural labour as a source of income (76.8%), married (85.0%), and were of the middle wealth quantile (61.3%) as shown in Table 5.1.

Table 5.1: Sociodemographic Characteristics of Study Participants (N=560)

Characteristics	Frequency (n=560)	Percent (%)
Age		
14-17	92	16.4
18-19	468	83.6
School Attendance		
No	540	96.4
Yes	20	3.6
Level of Education		
No formal education	13	2.3
Primary education	509	90.9
Secondary education	38	6.8
Occupation		
Agricultural labour	430	76.8
Casual labour	59	10.5
Self-employed	37	6.6
Unemployed/homemaker	34	6.1
Marital Status		
Single	24	4.3
Married	476	85.0
Cohabiting	48	8.6
Divorced/separated	12	2.1
Wealth Quantile[6]		
Lowest quantile	163	29.1
Middle quantile	343	61.3
Highest quantile	54	9.6

[6] Principal Components Analysis on ownership of durable assets (radio, television, car, motorcycle, bicycle, and telephone), source of drinking water (piped water, open well, borehole, and rivers/swamps), and type of house floor material (sand/cow dung, cement, tiles, and terrazzo) was used to assess wealth quantile Vyas, S., & Kumaranayake, L. (2006). Constructing socio-economic status indices: how to use principal components analysis. *Health Policy Plan*, *21*(6), 459-468. The wealth quantile was classified into three categories (lowest [25th)] middle [50th] and highest [75th]).

5.2.2 Obstetric Characteristics of Study Participants

More than three-quarters of the study participants had completed their first pregnancy (85.0%). Most of the participants had a spontaneous vaginal childbirth (95.9%), no maternal complications (62%), and no neonatal complications (96.3%). Meanwhile, more than two-thirds of the study participants gave birth in level III health facility (68.6%) and had birth companions (68.2%) (Table 5.2).

Table 5.2: Obstetric Characteristics of Study Participants (N=560)

Characteristics	Frequency (n=560)	Percent (%)
Gravidity		
1	476	85.0
>1	84	15.0
Parity		
1	501	89.5
>1	59	10.5
Number of Antenatal Visits		
≤4	195	34.8
5-7	312	55.7
≥8	53	9.5
Level of Health Facility		
Level IV health centre	176	31.4
Level III health centre	384	68.6
Mode of Childbirth		
Spontaneous vaginal birth	537	95.9
Cesarean section	23	4.1
Episiotomy (n=537)		
No	446	83.0
Yes	91	17.0
Time of Childbirth		
Day	148	26.4
Evening	182	32.5
Night	230	41.1
Birth Companion		
No	178	31.8
Yes	382	68.2
Maternal Complications		
No	350	62.5
Yes	210	37.5
Sex of Baby		
Male	268	47.9
Female	292	52.1
Newborn Complications		
No	539	96.3
Yes	21	3.7
Status of Newborn		
Dead	13	2.3
Alive	547	97.7

5.3 Person-Centred Maternity Care During Childbirth

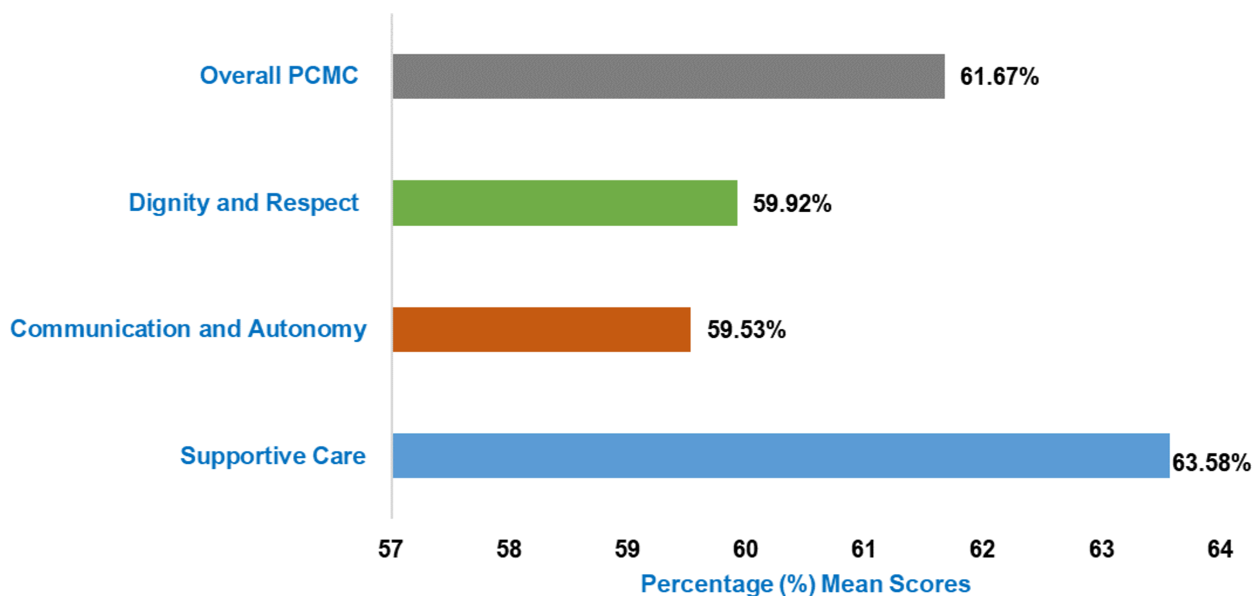
The PCMC mean score was 55.50 (SD±9.11) out of a maximum score of 90 whereas, the mean scores for the sub-scales were 10.78 (SD±2.17) out of 18 for dignity and respect, 16.07 (SD±4.62) out of 27 for communication and autonomy, and 28.61 (SD±4.62) out of 45 for supportive care (Table 5.3).

Table 5.3: Person-Centred Maternal Care and Sub-Scale Scores During Childbirth (N=560)

PCMC domain	Lowest Score	Highest Score	Mean	SD	Percentile		
					25th	50th	75th
PCMC	30	73	55.50	±9.11	49	57	63
Dignity and Respect	3	17	10.78	±2.17	10	11	12
Communication and Autonomy	4	25	16.07	±4.62	12	17	20
Supportive Care	13	38	28.61	±4.62	26	29	32

Upon standardisation of the mean scores (by dividing the summative score for sample by the potential maximum score multiplied by 100), the overall PCMC percentage mean score was 61.67% (SD±10.12) and the percentage mean scores for the sub-scales were 59.92% (SD±12.05) for dignity and respect, 59.53% (SD± 17.12) for communication and autonomy, and 63.58% (SD±9.92) for supportive care (See Figure 5.2 below).

Figure 5.2: Percentage Mean Scores of Person-Centred Maternity Care and Sub-Scale During Childbirth (N=560)



The distribution of the PCMC scores and its sub-scale scores during childbirth among study participants (Table 5.4) based on 25th (low), 50th (moderate), and 75th (high) percentile show that overall, more than three-quarters of participants (77.74%) had perceptions of moderate level of PCMC during childbirth. Similarly, most participants had perceptions of moderate level of dignity and respect (75.09%), communication and autonomy (45.89%), and supportive care (78%) during childbirth.

Table 5.4: Distribution of Adolescents' Perceptions of Person-Centred Maternity Care and Sub-Scales Scores (N=560)

Outcome Variable	Frequency (n=560)	Percent (%)
Overall PCMC		
Low	88	15.80
Moderate	433	77.74
High	36	6.46
Dignity and Respect		
Low	80	14.34
Moderate	419	75.09
High	59	10.57
Communication and Autonomy		
Low	187	33.39
Moderate	257	45.89
High	116	20.71
Supportive Care		
Low	61	10.91
Moderate	436	78.00
High	62	11.09

5.3.1 Factors Associated with Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth

Bivariate and multivariate analyses were performed to determine the factors associated with adolescents' perceptions of PCMC during childbirth in rural northern Uganda.

5.3.1.1 Sociodemographic Factors Associated with Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth (N=560)

In a bivariate analysis using a chi-square test, occupation (p=0.006) was the only sociodemographic factor that was statistically associated with adolescents' perceptions of PCMC during childbirth at p<0.05. Variables such as age, school attendance, level of education, marital status, and wealth quantile were not statistically associated with perceived PCMC during childbirth (Table 5.5).

Table 5.5: Association Between Sociodemographic Factors and Adolescents' Perception of Person-Centred Maternity Care During Childbirth (N=560)

Characteristics	Level of PCMC			χ^2	*p*-value
	Low (n=88) n (%)	Moderate (n=433) n (%)	High (n=36) n (%)		
Age					
14-17	20 (21.74)	68 (73.9)	4 (4.35)	3.43	0.180
18-19	68 (14.62)	365 (78.49)	32 (6.88)		
School Attendance					
No	86 (16.01)	418 (77.84)	33 (6.15)	2.80	0.247
Yes	2 (10.00)	15 (75.00)	3 (15.00)		
Level of Education					
No formal education	4 (30.77)	8 (61.54)	1 (7.69)		
Primary education	77 (15.22)	396 (78.26)	33 (6.52)	2.70	0.609
Secondary education	7 (18.42)	29 (76.32)	2 (5.26)		
Occupation					
Agricultural labour	65 (15.22)	334 (78.22)	28 (6.56)		
Casual labour	4 (6.78)	47 (79.66)	8 (13.56)	17.95	**0.006***
Self-employed	10 (27.03)	27 (72.97)	0 (0.00)		
Unemployed/homemaker	9 (26.47)	25 (73.53)	0 (0.00)		
Marital Status					
Single	7 (29.17)	17 (70.83)	0 (0.00)		
Married	66 (13.89)	374 (78.74)	35 (7.37)	12.19	0.058
Cohabiting	12 (25.53)	34 (72.34)	1 (2.13)		
Divorced/separated	3 (27.27)	8 (72.73)	0 (0.00)		
Wealth Quantile					
Lowest quantile	29 (17.79)	123 (75.46)	11 (6.75)		
Middle quantile	53 (15.50)	269 (78.65)	20 (5.85)	2.20	0.699
Highest quantile	6 (11.54)	41 (78.85)	5 (9.62)		

Note. *Significant Variable at p<0.05. χ^2, Chi-Square Value.

5.3.1.2 Obstetric Factors Associated with Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth (N=560)

Obstetric factors that were statistically associated with adolescents' perceptions of PCMC during childbirth at $p<0.05$ were gravidity ($p=0.027$), level of health facility ($p<0.001$), birth companionship ($p<0.001$), maternal complications ($p=0.004$), and newborn complications ($p=0.002$). The other variables (parity, number of antenatal care visits, mode of childbirth, episiotomy, time of childbirth, sex of baby, and status of newborn)

were not statistically associated with adolescents' perceptions of PCMC during childbirth among study participants (Table 5.6).

Table 5.6: Association Between Obstetric Factors and Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth (N=560)

Characteristics	Adolescents' Perceptions of PCMC				
	Low (n=88) n (%)	Moderate (n=433) n (%)	High (n=36) n (%)	χ^2	*p*-value
Gravidity					
1	69 (14.59)	377 (79.70)	27 (5.71)	7.24	**0.027***
>1	19 (22.62)	56 (66.67)	9 (10.71)		
Parity					
1	77 (15.46)	392 (78.71)	29 (5.82)	3.89	0.143
>1	11 (18.64)	41 (69.49)	7 (11.86)		
Number of Antenatal Visits					
≤4	25 (12.82)	153 (78.46)	17 (8.72)	8.32	0.081
5-7	54 (17.36)	244 (78.46)	13 (4.18)		
≥8	9 (17.65)	36 (70.59)	6 (6.46)		
Level of Health Facility					
Level IV health centre	44 (25.00)	128 (72.73)	4 (2.27)	21.61	**<0.001****
Level III health centre	44 (11.55)	305 (80.05)	32 (8.40)		
Mode of Childbirth					
Spontaneous vaginal birth	85 (15.92)	414 (77.53)	35 (6.55)	0.35	0.838
Caesarean section	3 (13.04)	19 (82.61)	1 (4.35)		
Episiotomy [n=537]					
No	76 (17.16)	342 (77.20)	25 (5.64)	5.83	0.054
Yes	9 (9.89)	72 (79.12)	10 (10.99)		
Time of Childbirth					
Day	29 (19.59)	112 (75.68)	7 (4.73)	7.88	0.096
Evening	23 (12.71)	150 (82.87)	8 (4.42)		
Night	36 (15.79)	171 (75.00)	21 (9.21)		
Birth Companion					
No	6 (3.43)	149 (85.14)	20 (11.43)	36.25	**<0.001****
Yes	82 (21.47)	284 (74.35)	16 (4.19)		
Maternal Complications					
No	67 (19.25)	264 (75.86)	17 (4.89)	11.00	**0.004***
Yes	21 (10.05)	169 (80.86)	19 (9.09)		
Sex of Baby					
Male	52 (19.40)	197 (73.51)	19 (7.09)	5.75	0.056
Female	36 (12.46)	236 (81.66)	17 (5.88)		
Newborn Complications					
No	79 (14.74)	421 (78.54)	36 (6.72)	12.71	**0.002***
Yes	9 (42.86)	12 (57.14)	0 (0.00)		
Status of Newborn					
Alive	86 (15.81)	422 (77.57)	36 (6.62)	0.94	0.624
Dead	2 (15.38)	11 (84.62)	0 (0.00)		

Note. *Significant Variable at p<0.05. **Significant Variable at p<0.001. χ^2, Chi-Square Value.

5.3.1.3 Multivariate Analysis Examining Factors Associated with Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth (N=560)

Factors independently associated with adolescents' perceptions of moderate/high PCMC during childbirth is presented in Table 5.7 and the table described thereafter.

Table 5.7: Factors Associated with Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth (N=560)

Characteristics	Level of PCMC	
	Moderate/High PCMC AOR [95% CI]	*p*-value
Marital status		
Single	Ref.	
Married	2.61 [1.01, 6.76]	**0.047***
Cohabiting	1.41 [0.45, 4.42]	0.552
Divorced/separated	1.13 [0.22, 5.91]	0.887
Occupation		
Agricultural labour	Ref.	
Casual labour	3.18 [1.52, 6.68]	**0.002***
Self-employed	0.67 [0.29, 1.53]	0.346
Unemployed/homemaker	0.62 [0.27, 1.42]	0.258
Number of Antenatal Visits		
≤4	Ref.	
5-7	0.52 [0.33, 0.83]	**0.007***
≥8	0.89 [0.40, 2.00]	0.786
Level of Health Facility		
Level IV health centre	Ref.	
Level III health centre	1.48 [0.89, 2.46]	0.134
Episiotomy [n=537]		
No	Ref.	
Yes	1.88 [1.05, 3.36]	**0.033***
Birth Companion		
No	Ref.	
Yes	0.34 [0.19, 0.60]	**<0.001****
Newborn Complications		
No	Ref.	
Yes	0.25 [0.09, 0.68]	**0.006***

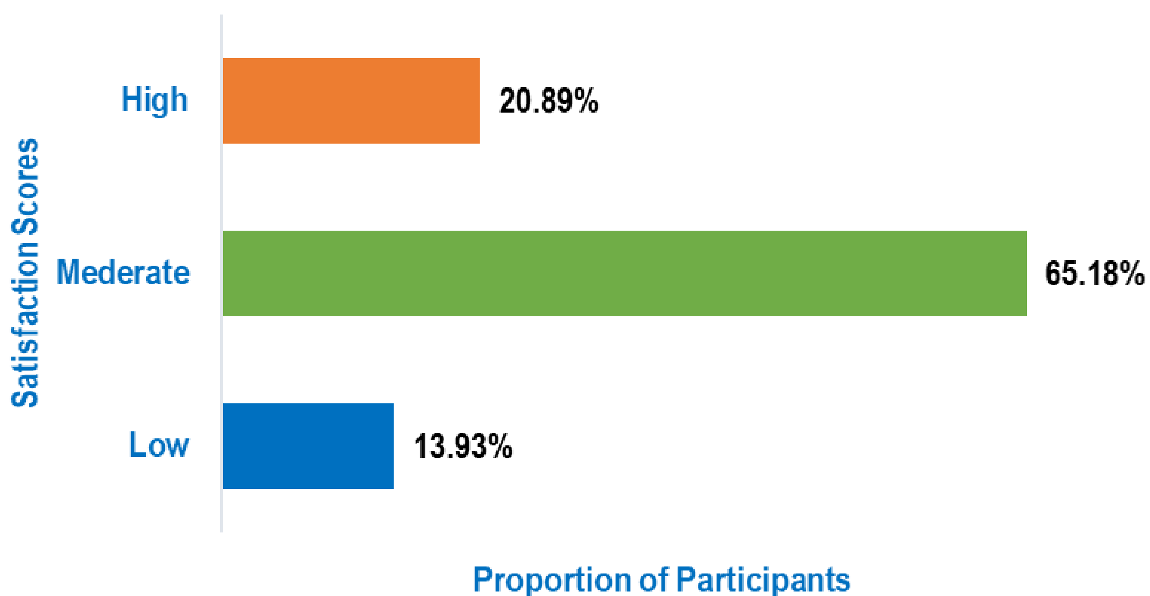
Note. *Significant Variable at $p<0.05$. **Significant Variable at $p<0.001$. Ref, Reference Category.

Married adolescents were 2.61 times more likely to have perceptions of moderate/high levels of PCMC during childbirth compared to single adolescents (AOR= 2.61, 95% CI: [1.01, 6.76]). Adolescents engaged in casual labour were 3.18 times more likely to have perceptions of moderate/high levels of PCMC during childbirth compared to their counterparts engaged in agricultural labour (AOR= 3.18, 95% CI: [1.52, 6.68]). Participants who had episiotomy were 1.88 times more likely to have perceptions of moderate/high levels of PCMC during childbirth compared to those who did not (AOR= 1.88, 95% CI: [1.05, 3.36]). However, participants who had five to seven antenatal visits were 48% less likely to have perceptions of moderate/high levels of PCMC during childbirth compared to those who had fewer visits (AOR= 0.52, 95% CI: [0.33, 0.83]). Participants who had birth companions were 66% less likely to have perceptions of moderate/high levels of PCMC during childbirth compared to those without birth companions (AOR= 0.34, 95% CI: [0.19, 0.60]). Those whose newborns had complications were 75% less likely to have perceptions of moderate/high levels of PCMC during childbirth (AOR= 0.25, 95% CI: [0.09, 0.68]).

5.4 Satisfaction with Care During Childbirth

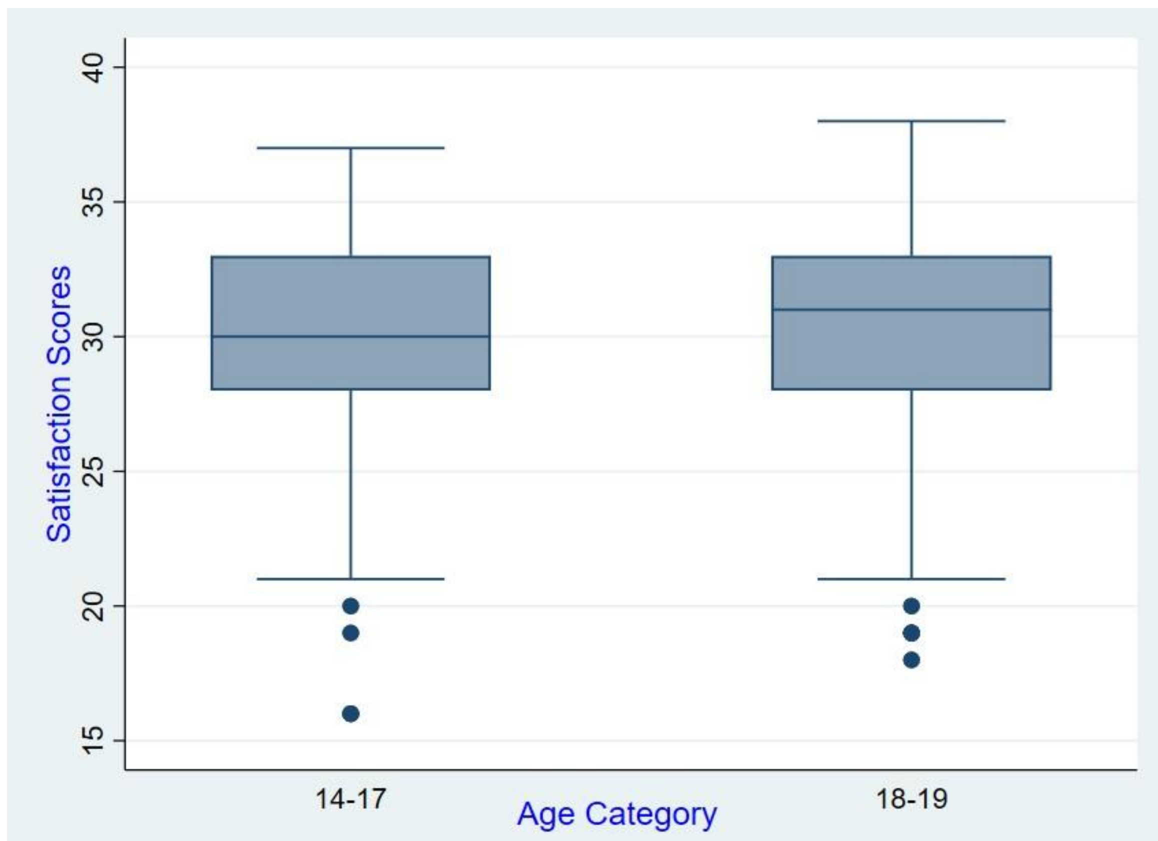
The overall satisfaction with care mean score was 30.12 (SD±4.10) out of the maximum score of 42 with the lowest score of 16 and highest score of 38. The distribution of the satisfaction scores based on percentiles showed that 117 respondents (20.89%) had high scores (>33 score), 365 respondents (65.18%) had moderate scores (28-33 score), and 78 respondents (13.93%) had low scores (<28 score), as presented in Figure 5. 3 below.

Figure 5.3: Bar Graph of Distribution of Satisfaction Scores Among Study Participants (N=560)



The distribution of the overall satisfaction with care score across the age categories indicates that the older adolescents (18-19 years) were more satisfied with care compared to the younger adolescents (14-17 years) (Figure 5.4).

Figure 5.4: Box Plot of Satisfaction Mean Scores by Age Categories Among Participants (N=560)



5.4.1 Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Satisfaction with Care

Bivariate and multivariate analyses were performed to examine the association between adolescents' perceptions of PCMC during childbirth and satisfaction with care. The multivariate analysis was performed while controlling for the influence of sociodemographic and obstetric factors.

5.4.1.1 Bivariate Analysis Examining the Association Between Adolescents' Perceptions of Person-Centred Maternity Care and Satisfaction with Care During Childbirth (N=560)

For both PCMC and the three sub-scales, adolescent participant who perceived low levels of PCMC during childbirth had statistically significantly lower satisfaction with care scores compared to those who perceived moderate or high levels (Table 5.8).

Table 5.8: Association between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Satisfaction with Care (N=560)

Outcome Variable	n (%)	Satisfaction Mean (±SD)	F-value	*p*-value
PCMC				
Low	88 (15.80)	26.44 (±3.75)		
Moderate	433 (77.74)	30.77 (±0.63)	51.40	**<0.001****
High	36 (6.46)	31.64 (±3.55)		
Dignity and Respect				
Low	80 (14.34)	28.84 (±5.35)		
Moderate	419 (75.09)	30.32 (±3.86)	4.80	**0.009***
High	59 (10.57)	30.54 (±3.47)		
Communication and Autonomy				
Low	187 (33.39)	27.87 (±3.72)		
Moderate	257 (45.89)	30.45 (±3.74)	74.00	**<0.001****
High	116 (20.71)	33.05 (±3.35)		
Supportive Care				
Low	61 (10.91)	26.66 (±3.85)		
Moderate	436 (78.00)	30.39 (±3.98)	31.04	**<0.001****
High	62 (11.09)	31.81 (±3.26)		

Note. *Significant Variable at p<0.05. **Significant Variable at p<0.001. SD, Standard Deviation.

5.4.1.2 Bivariate Analysis Examining the Association Between Sociodemographic Factors and Satisfaction with Care During Childbirth Among Study Participants (N=560)

In the bivariate analysis, the sociodemographic factors that were significantly associated with satisfaction with care during childbirth at $p<0.05$ were level of education ($p=0.034$) and occupation ($p<0.001$). There was no evidence of a statistical association between age, school attendance, marital status, and wealth quantile, and satisfaction with care during childbirth among adolescents (Table 5.9).

Table 5.9: Association between Sociodemographic Factors and Satisfaction with Care During Childbirth Among Adolescents (N=560)

Characteristics	n (f)	Satisfaction Mean (±SD)	t/F-value	*p*-value
Age				
14-17	92 (16.4)	29.82 (±4.39)	-0.80	0.426
18-19	468 (83.6)	30.19 (±4.05)		
School attendance				
No	540 (96.4)	30.14 (±4.12)	0.47	0.636
Yes	20 (3.6)	29.70(±4.01)		
Level of education				
No formal education	13 (2.3)	29.15 (±3.31)	3.40	**0.034***
Primary education	509 (90.9)	30.27 (±4.13)		
Secondary education	38 (6.8)	28.58 (±3.70)		
Occupation				
Agricultural labour	430 (76.8)	29.97 (±4.08)	14.82	**<0.001****
Casual labour	59 (10.5)	33.07 (±3.06)		
Self-employed	37 (6.6)	29.05 (±3.37)		
Unemployed/homemaker	34 (6.1)	28.15 (±4.31)		
Marital status				
Single	24 (4.3)	29.63 (±2.90)	1.47	0.221
Married	476 (85.0)	30.27 (±4.08)		
Cohabiting	48 (8.6)	29.27 (±4.46)		
Divorced/separated	12 (2.1)	28.75 (±5.08)		
Wealth quantile				
Lowest quantile	163 (29.1)	30.16 (±4.38)	1.61	0.201
Middle quantile	343 (61.3)	30.26 (±4.05)		
Highest quantile	54 (9.6)	29.19 (±3.43)		

Note. *Significant Variable at p<0.05. **Significant Variable at p<0.001. SD, Standard Deviation.

5.4.1.3 Bivariate Analysis Examining the Association Between Obstetric Factors and Satisfaction with Care During Childbirth Among Study Participants (N=560)

Obstetric factors that were significantly associated with satisfaction with care during childbirth were the level of health facility (*p*=0.006), birth companionship (*p*=0.037), and sex of baby (*p*=0.020) (Table 5.10).

Table 5.10: Association Between Obstetric Factors and Satisfaction with Care During Childbirth Among Study Participants (N=560)

Characteristics	n (f)	Satisfaction Mean (±SD)	t/F-value	*p*-value
Gravidity				
1	476 (85.0)	30.09 (±4.07)	-0.50	0.617
>1	84 (15.0)	30.33 (4.28)		
Parity				
1	501 (89.5)	30.04 (±4.06)	-1.43	0.154
>1	59 (10.5)	30.85 (±4.42)		
Number of Antenatal Visits				
≤4	195 (34.8)	29.86 (±4.23)		
5-7	312 (55.7)	30.16 (±3.89)	1.42	0.243
≥8	53 (9.5)	30.92 (±4.77)		
Level of Health Facility				
Level IV health centre	176 (31.4)	29.43 (±3.60)	-2.75	**0.006***
Level III health centre	384 (68.6)	30.45 (±4.28)		
Mode of Childbirth				
Spontaneous vaginal birth	537 (95.9)	30.11 (±4.13)	-0.37	0.714
Caesarean section	23 (4.1)	30.43 (±3.49)		
Episiotomy [n=537]				
No	446 (83.0)	30.18 (±4.14)	0.79	0.430
Yes	91 (17.0)	29.80 (±4.11)		
Time of Childbirth				
Day	148 (26.4)	29.95 (±3.96)		
Evening	182 (32.5)	30.21 (±4.20)	0.20	0.819
Night	230 (41.1)	30.17 (±4.13)		
Birth Companion				
No	178 (31.8)	30.66 (±3.90)	2.09	**0.037***
Yes	382 (68.2)	29.88 (±4.17)		
Maternal Complications				
No	350 (62.5)	30.24 (±4.49)	0.82	0.412
Yes	210 (37.5)	29.94 (±3.77)		
Sex of Baby				
Male	268 (47.9)	29.71 (±3.99)	-2.34	**0.020***
Female	292 (52.1)	30.51 (±4.18)		
Newborn Complications				
No	539 (96.3)	30.18 (±4.07)	1.67	0.097
Yes	21 (3.7)	28.67 (±4.81)		
Status of Newborn				
Dead	13 (2.3)	28.54 (±5.04)	-1.41	0.158
Alive	547 (97.7)	30.16 (±4.08)		

Note. *Significant Variable at $p<0.05$. SD, Standard Deviation.

5.4.1.4 Multivariate Analysis Examining the Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Satisfaction with Care (N=560)

The multivariate analysis in model 1 [with the PCMC as the main independent variable] is described below and presented in Table 5.11.

Participants who perceived moderate and high levels of PCMC during childbirth had statistically significantly higher satisfaction with care scores (β=4.01, 95% CI [3.14, 4.88], $p < 0.001$ and β=4.38, 95% CI [2.91, 5.86], $p < 0.001$ respectively) compared to those who perceived low levels. Also, participants who engaged in casual labour had a statistically significantly higher satisfaction with care scores (β=3.09, 95% CI [2.05, 4.13], $p < 0.001$) compared to those engaged in agricultural labour (Table 5.11).

Table 5.11: Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Satisfaction with Care (N=560)

Variables	β [95% CI]	*p*-value
PCMC		
Low	Ref.	
Moderate	4.01 [3.14, 4.88]	**<0.001****
High	4.38 [2.91, 5.86]	**<0.001****
Level of education		
No formal education	Ref.	
Primary education	1.82 [-0.24, 3.89]	0.084
Secondary education	0.37 [-1.97, 2.71]	0.756
Occupation		
Agricultural labour	Ref.	
Casual labour	3.09 [2.05, 4.13]	**<0.001****
Self-employed	-1.32 [-1.58, 0.93]	0.610
Unemployed/homemaker	-1.23 [-2.53, 0.07]	0.063
Parity		
1	Ref.	
>1	0.80 [-0.19, 1.80]	0.114
Level of Health Facility		
Level IV health centre	Ref.	
Level III health centre	0.02 [-0.71, 0.75]	0.962
Birth Companion		
No	Ref.	
Yes	0.06 [-0.68, 0.81]	0.865
Newborn Complications		
No	Ref.	
Yes	0.86 [-0.83, 2.56]	0.317

Note. *Significant Variable at $p<0.05$. **Significant Variable at $p<0.001$. Ref, Reference Category. CI, Confidence Interval.

The multivariate analysis in model 2 [with PCMC sub-scales as the main independent variables] is described below and presented in Table 5.12.

Adolescent participants who perceived moderate and high levels of communication and autonomy during childbirth had statistically significantly higher satisfaction with care scores (β=2.32, 95% CI [1.54, 3.10], $p<$ 0.001 and β=4.49, 95% CI [3.49, 5.49], $p<$ 0.001 respectively) compared to those who perceived low levels.

Participants who perceived moderate and high levels of supportive care during childbirth had statistically significantly higher satisfaction with care scores (β=2.30, 95% CI [1.29, 3.31], $p<$ 0.001 and (β=2.60, 95% CI [1.23, 3.96], $p<$ 0.001 respectively) compared to those who perceived low levels.

There was no evidence of an association between the perceived level of dignity and respect and satisfaction with care during childbirth (Table 5.12).

Table 5.12: Association Between Adolescents' Perceptions of Person-Centred Maternity Care Sub-Scales During Childbirth and Satisfaction with Care (N=560)

PCMC Sub-Scale[a]	β [95% CI]	*p*-value
Dignity and Respect		
Low	Ref.	
Moderate	0.85 [-0.02, 1.72]	0.055
High	0.19 [-1.07, 1.46]	0.765
Communication and Autonomy		
Low	Ref.	
Moderate	2.32 [1.54, 3.10]	**<0.001****
High	4.49 [3.49, 5.49]	**<0.001****
Supportive Care		
Low	Ref.	
Moderate	2.30 [1.29, 3.31]	**<0.001****
High	2.60 [1.23, 3.96]	**<0.001****

Note. **Significant Variable at p<0.001. Ref, Reference Category. CI, Confidence Interval.

[a]The model controlled for level of education, occupation, parity, place of childbirth, birth companionship, sex of baby, newborn complication, and status of baby.

5.5 Future Childbearing Intentions

Regarding adolescents' future childbearing intentions, more than three-quarters of the participants would like to have another child in the future (82.14%), would return to the same health facility for the next childbirth (82.68%), and agree that they would recommend where they gave birth to a sister or a friend (84.65%) (Table 5.13).

Table 5.13: Future Childbearing Intentions of Study Participants (N=560)

Adolescents' Future Childbearing Intentions	Frequency (n=x)	Percent (%)
Would like to have another child		
No	14	2.50
Yes	460	82.14
Don't Know	86	15.36
Choice for next childbirth		
Same health facility	463	82.68
Different health facility	20	3.57
At home	00	00.00
Don't know	77	13.75
I would recommend the same facility to a sister or friend		
Strongly agree	107	19.11
Agree	367	65.54
Neutral	75	13.39
Disagree	8	1.43
Strongly disagree	3	0.54

5.5.1 Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Future Childbearing Intentions

Bivariate and multivariate analyses were performed to examine the association between adolescents' perceptions of PCMC during childbirth and future childbearing intentions. The analyses were performed for each of the three indicators of adolescents' future childbearing intentions (intentions to give birth in the future, intentions to give birth in the same facility in the future, and intentions to recommend the same facility to a sister or a friend). The multivariate analyses were performed while controlling for the influence of sociodemographic and obstetric factors.

5.5.1.1 Bivariate Analysis Examining the Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth *and Future Childbearing Intentions (N=560)*

The association between adolescents' perceptions of PCMC during childbirth and future childbearing intentions (intentions to give birth in the future, intentions to give birth in the same facility in the future, and intentions to recommend the same facility to a sister or a friend) is presented in Table 5.14 and described in sub-sections 5.5.1.1.1-5.5.1.1.3:

Table 5.14: Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Future Childbearing Intentions (N=560)

Characteristics	Adolescents' Future Childbearing Intentions		
	Would like to have another child (n=463) COR [95% CI]	Same facility next childbirth (n=460) COR [95% CI]	Would recommend the facility to sister or friends (n=474) COR [95% CI]
PCMC			
Low	Ref.	Ref.	Ref.
Moderate	0.82 [0.44, 1.53]	**3.36 [2.02, 5.59]****	**5.69 [3.39, 9.54]****
High	1.17 [0.39, 3.54]	**9.71 [2.19, 43.14]***	-
Dignity and Respect			
Low	Ref.	Ref.	Ref.
Moderate	0.67 [0.33, 1.35]	0.99 [0.54, 1.83]	**1.85 [1.04, 3.28]***
High	**0.38 [0.16,0.92]***	**4.31 [1.19, 15.65]***	**9.50 [2.12, 42.49]***
Communication and Autonomy			
Low	Ref.	Ref.	Ref.
Moderate	0.74 [0.45, 1.22]	**5.05 [2.98, 8.53]****	**3.97 [2.36, 6.66]****
High	0.88 [0.47, 1.64]	**4.30 [2.20, 8.41]****	**9.49 [3.67, 24.51]****
Supportive Care			
Low	Ref.	Ref.	Ref.
Moderate	0.43 [0.18, 1.02]	**2.39 [1.32, 4.31]***	**5.64 [3.17, 10.03]****
High	1.24 [0.36, 4.31]	**9.59 [2.67, 34.41]***	-

Note. *Significant Variable at $p<0.05$. **Significant Variable at $p<0.001$. Ref, Reference Category. COR, Crude Odds Ratio. CI, Confidence Interval.

5.5.1.1.1 Intentions to Have Another Child in the Future

Perceived high level of dignity and respect was significantly associated with *a*dolescents' intentions to have another child in the future [column 2] (COR=0.38, 95% CI [0.16,0.92]). Meanwhile, there was no evidence of a statistical association between the perceptions of PCMC and sub-scales of communications and autonomy, and supportive care and adolescents' intentions to have another child in the future.

5.5.1.1.2 Intentions to Give Birth in the Same Facility in the Future

Perceived moderate and high levels of PCMC were statistically significantly associated with adolescents' intention to give birth in the same facility in the future [column 3] (COR=3.36, 95% CI [2.02, 5.59] and COR=9.71, 95% CI [2.19, 43.14] respectively).

Perceived high level of dignity and respect was statistically significantly associated with adolescents' intentions to give birth in the same facility in the future (COR=4.31, 95% CI [1.19, 15.65]).

Perceived moderate and high levels of communication and autonomy among participants were statistically significantly associated with adolescents' intentions to give birth in the same facility in the future (COR=5.05, 95% CI [2.98, 8.53] and COR=4.30, 95% CI [2.20, 8.41] respectively).

Perceived moderate and high levels of supportive care were statistically significantly associated with adolescents' intentions to give birth in the same facility in the future (COR=2.39, 95% CI [1.32, 4.31] and COR=9.59, 95% CI [2.67, 34.41] respectively).

5.5.1.1.3 Intentions to Recommend the Same Facility to a Sister or a Friend

Perceived moderate level of PCMC during childbirth was statistically significantly associated with adolescents' intentions to recommend the same facility to a sister or a friend [column 5] (COR=5.69, 95% CI [3.39, 9.54]).

Perceived moderate and high levels of dignity and respect during childbirth were statistically significantly associated with participants' intentions to give birth in the same facility in the future (COR=1.85, 95% CI [1.04, 3.28] and COR=9.50, 95% CI [2.12, 42.49] respectively).

Perceived moderate and high levels of communication and autonomy during childbirth were also statistically significantly associated with participants' intentions to give birth in the same facility in the future (COR=3.97, 95% CI [2.36, 6.66] and COR=9.49, 95% CI [3.67, 24.51] respectively).

Finally, perceived moderate level of supportive care during childbirth was also statistically significantly associated with adolescents' intentions to recommend the same facility to a sister or a friend (COR=5.64, 95% CI [3.17, 10.03]) (Table 5.14).

5.5.1.2 Bivariate Analysis Examining the Association between Sociodemographic Factors and Future Childbearing Intentions Among Study Participants (N=560)

The association between sociodemographic factors and future childbearing intentions among adolescents (intentions to give birth in the future, intentions to give birth in the same facility in the future, and intentions to recommend the same facility to a sister or a friend) is presented in Table 5.15 and the description follows:

Table 5.15: Association between Sociodemographic Factors and Future Childbearing Intentions Among Study Participants (N=560)

Characteristics	Adolescents' Future Childbearing Intentions		
	Would like to have another child (n=463) COR [95% CI]	Same facility next childbirth (n=460) COR [95% CI]	Would recommend the facility to sister or friends (n=474) COR [95% CI]
Age			
14-17	Ref.	Ref.	Ref.
18-19	**1.96 [1.16, 3.29]***	1.20 [0.68, 2.12]	1.69 [0.97, 2.96]
School attendance			
No	Ref.	Ref.	Ref.
Yes	1.24 [0.36, 4.32]	-	3.55 [0.57, 26.87]
Level of education			
No formal education	Ref.	Ref.	Ref.
Primary education	1.32 [0.36, 4.91]	1.50 [0.40, 5.55]	1.61 [0.43, 5.97]
Secondary education	3.5 [0.61, 20.10]	0.79 [0.22, 4.30]	3.50 [0.61, 20.10]
Occupation			
Agricultural labour	Ref.	Ref.	Ref.
Casual labour	0.72 [0.37, 1.41]	0.88 [0.41, 1.89]	1.28 [0.55, 2.93]
Self-employed	0.74 [0.33, 1.69]	**0.21 [0.10, 0.42]****	0.53 [0.24, 1.19]
Unemployed/homemaker	0.95 [0.38, 2.39]	**0.26 [0.12, 0.54]****	0.66 [0.28, 1.59]
Marital status			
Single	Ref.	Ref.	Ref.
Married	**3.11 [1.31, 7.36]***	**3.26 [1.37, 7.72]***	**2.65 [1.06, 6.64]***
Cohabiting	2.60 [0.87, 7.80]	2.02 [0.70, 5.86]	1.11 [0.37, 3.29]
Divorced/separated	0.84 [0.20, 3.46]	1.80 [0.38, 8.45]	2.06 [0.36, 11.91]
Wealth quantile			
Lowest quantile	Ref.	Ref.	Ref.
Middle quantile	1.11 [0.69, 1.79]	1.27 [0.79, 2.05]	**1.66 [1.02, 2.70]***
Highest quantile	1.17 [0.52, 2.65]	1.70 [0.71, 4.11]	2.56 [0.96, 6.98]

Note. *Significant Variable at p<0.05. **Significant Variable at p<0.001. Ref, Reference Category. COR, Crude Odds Ratio. CI, Confidence Interval

Participants' intentions to have another child in the future [column 2] were statistically significantly associated with being older (18-19 years) (COR=1.96, 95% CI [1.16, 3.29]) and being married (COR=3.11, 95% CI [1.31, 7.36]).

Adolescents' intentions to give birth in the same facility in the future [column 3] were statistically significantly associated with being self-employed (COR=0.21, 95% CI [0.10, 0.42]), being unemployed (COR=0.26, 95% CI [0.12, 0.54]), and being married (COR=3.26, 95% CI [1.37, 7.72]).

Participants' intentions to recommend the same facility to a sister or a friend [column 4] were statistically significantly associated with being married (COR=2.65, 95% CI [1.06, 6.64]) and belonging to the middle wealth quantile (COR=1.66,95% CI [1.02, 2.70]). The other sociodemographic variables were not statistically associated with adolescents' future childbearing intentions.

5.5.1.3 Bivariate Analysis to Examine Association Between Obstetric Factors and Future Childbearing Intentions Among Study Participants (N=560)

The association between obstetric factors and future childbearing intentions among adolescents is described below and presented in Table 5.16 thereafter:

Study participants' intentions to give birth to another child in the future [column 2] were negatively statistically associated with receiving episiotomy (COR=0.25, 95% CI [0.15, 0.41]) and maternal complications during childbirth (COR=0.34, 95% CI [0.22, 0.53]), but positively associated birth companionship (COR=2.23, 95% CI [1.43, 3.46])

Participants' intentions to give birth in the same facility in the future [column 3] were positively statistically significantly associated with giving birth in a level III health centre (COR=2.08, 95% CI [1.33, 3.26]) and giving birth in the evening (COR=3.04, 95% CI [1.65, 5.60]), but negatively associated and birth companionship (COR=0.34, 95% CI [0.19, 0.60]).

Finally, adolescent participants' intention to recommend the same facility to a sister or a friend [column 4] was positively statistically significantly associated with giving birth in a level III health centre (COR=3.04, 95% CI [1.90, 4.87]), and giving birth in the evening or night (COR=32.46, 95% [1.33, 4.54] or COR=1.65,95% CI [0.97, 2.81]), but negatively associated birth companionship (COR=0.21, 95% CI [0.10, 0.43]).

Table 5.16: Association Between Obstetric Factors and Future Childbearing Intentions Among Study Participants (N=560)

Characteristics	Adolescents' Future Childbearing Intentions		
	Would like to have another child (n=463) COR [95% CI]	Same facility next childbirth (n=460) COR [95% CI]	Would recommend facility to sister or friends (n=474) COR [95% CI]
Gravidity			
1	Ref.	Ref.	Ref.
>1	1.22 [0.65, 2.31]	1.66 [0.82, 3.33]	0.89 [0.48, 1.67]
Parity			
1	Ref.	Ref.	Ref.
>1	1.07 [0.52, 2.20]	1.63 [0.72, 3.70]	0.77 [0.38, 1.55]
Number of Antenatal Visits			
≤4	Ref.	Ref.	Ref.
5-7	0.82 [0.52, 1.31]	0.76 [0.47, 1.23]	0.90 [0.54, 1.49]
≥8	1.96 [0.72, 5.29]	1.19 [0.49, 2.90]	0.82 [0.36, 1.86]
Level of Health Facility			
Level IV health centre	Ref.	Ref.	Ref.
Level III health centre	0.87 [0.54, 1.40]	**2.08 [1.33, 3.26]***	**3.04 [1.90, 4.87]****
Mode of Childbirth			
Spontaneous birth	Ref.	Ref.	Ref.
Cesarean section	2.34 [0.54, 10.16]	0.46 [0.18, 1.15]	0.86 [0.28, 2.58]
Episiotomy [n=537]			
No	Ref.	Ref.	Ref.
Yes	**0.25 [0.15, 0.41]****	0.72 [0.41, 1.26]	0.99 [0.53, 1.85]
Time of Childbirth			
Day	Ref.	Ref.	Ref.
Evening	1.11 [0.61, 2.02]	**3.04 [1.65, 5.60]****	**2.46 [1.33, 4.54]***
Night	0.71 [0.42, 1.23]	1.50 [0.90, 2.46]	**1.65 [0.97, 2.81]***
Birth Companion			
No	Ref.	Ref.	Ref.
Yes	**2.23 [1.43, 3.46]****	**0.34 [0.19, 0.60]****	**0.21 [0.10, 0.43]****
Maternal Complications			
No	Ref.	Ref.	Ref.
Yes	**0.34 [0.22, 0.53]****	0.92 [0.59, 1.44]	1.14 [0.71, 1.84]
Sex of Baby			
Male	Ref.	Ref.	Ref.
Female	0.83 [1.54, 1.28]	1.26 [0.81, 1.95]	1.38 [0.87, 2.19]
Newborn Complications			
No	Ref.	Ref.	Ref.
Yes	0.92 [0.30, 2.80]	0.89 [0.29, 2.69]	0.76 [0.25, 2.32]
Status of Newborn			
Dead	Ref.	Ref.	Ref.
Alive	0.83 [0.18, 3.82]	2.17 [0.65, 7.19]	1.68 [0.45, 6.22]

Note. *Significant Variable at $p<0.05$. **Significant Variable at $p<0.001$. Ref, Reference Category. COR, Crude Odds Ratio. CI, Confidence Interval.

5.5.1.4 Multivariate Analysis Examining the Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Future Childbearing Intentions (N=560)

The multivariate logistic regression in model 1 [with the PCMC as the main independent variable while controlling for other socio-demographic and obstetric variables] examining the association between PCMC and future childbearing intentions of participants is described below and presented in Table 5.17. (See Table 5.17 on the next page).

There was no evidence of an association between perceived moderate and high levels of PCMC during childbirth and adolescents' intention to have another child in the future (AOR=0.90, 95% CI [0.42, 1.94] and AOR=1.59, 95% CI [0.47, 5.37] respectively). Other variables independently associated with intentions to have another child in the future were being married (AOR=4.49, 95% CI [1.53, 13.22]), 5-7 antenatal visits (AOR=0.56, 95% CI [0.32, 0.98]), episiotomy (AOR=0.34, 95% CI [0.19, 0.59]), and maternal complication (AOR=0.44 [0.24, 0.79]).

Participants who had perceptions of moderate and high levels of PCMC during childbirth had 2.84 and 5.60 higher odds respectively of choosing the same facility for the next childbirth compared to those who had perceptions of low PCMC levels (AOR=2.84, 95% CI [1.61, 5.00] and AOR=5.60, 95% CI [1.19, 26.43] respectively). Other variables independently associated with intentions to choose the same facility for the next childbirth were being self-employed (AOR=0.26 [0.11, 0.59]) or unemployed/homemaker (AOR=0.37 [0.15, 0.91]) and giving birth in the evening hours (AOR=2.53 [1.34, 4.76]).

Participants who had perceptions of moderate levels of PCMC during childbirth had 4.31 higher odds of recommending the same facility to a sister or a friend compared to those who had perceptions of low levels (AOR=4.31, 95% CI [2.46, 7.54]). The only other variable that was independently associated with intentions to recommend the same facility to a sister or a friend was giving birth in the evening hours (AOR=2.01 [1.03, 3.92]).

Table 5.17: Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Future Childbearing Intentions (N=560)

Characteristics	Adolescents' Future Childbearing Intentions		
	Would like to have another child (n=463) AOR [95% CI]	Same facility next childbirth (n=460) AOR [95% CI]	Would recommend facility to sister or friends (n=474) AOR [95% CI]
PCMC			
Low	Ref.	Ref.	Ref.
Moderate	0.90 [0.42, 1.94]	**2.84 [1.61, 5.00]****	**4.31 [2.46, 7.54]****
High	1.59 [0.47, 5.37]	**5.60 [1.19, 26.43]***	-
Age		NA	
14-17	Ref.		Ref.
18-19	**1.99 [1.12, 3.56]***		1.21 [0.60, 2.44]
Level of education		NA	
No formal education	Ref.		Ref.
Primary education	1.13 [0.24, 5.29]		1.02 [0.20, 5.33]
Secondary education	4.40 [0.54, 36.03]		3.03 [0.38, 24.42]
Occupation	NA		
Agricultural labour		Ref.	Ref.
Casual labour		0.85 [0.35, 2.07]	0.93 [0.34, 2.57]
Self-employed		**0.26 [0.11, 0.59]***	0.67 [0.25,1.80]
Unemployed/homemaker		**0.37 [0.15, 0.91]***	1.04 [0.34, 3.18]
Marital status			
Single	Ref.	Ref.	Ref.
Married	**4.49 [1.53, 13.22]***	1.90 [0.66, 5.36]	1.17 [0.35, 3.94]
Cohabiting	3.47 [0.91,13.28]	1.70 [0.50, 5.73]	0.93 [0.26, 3.39]
Divorced/separated	0.62 [0.11, 3.58]	1.41 [0.26, 7.61]	1.60 [0.25, 10.06]
Wealth quantile	NA	NA	
Lowest quantile			Ref.
Middle quantile			1.53 [0.89, 2.64]
Highest quantile			2.14 [0.64, 7.13]
Number of Antenatal Visits		NA	NA
≤4	Ref.		
5-7	**0.56 [0.32, 0.98]***		
≥8	1.03 [0.34, 3.10]		
Health Facility Level	NA		
Level IV health centre		Ref.	Ref.
Level II Health centre		1.20 [0.68, 2.12]	1.78 [0.97, 3.27]
Episiotomy [n=537]		NA	
No	Ref.		Ref.
Yes	**0.34 [0.19, 0.59]****		
Time of Childbirth	NA		
Day		Ref.	Ref.
Evening		**2.53 [1.34, 4.76]***	**2.01 [1.03, 3.92]***
Night		1.20 [0.68, 2.11]	1.32 [0.71, 2.44]
Birth Companion			
No	Ref.	Ref.	Ref.
Yes	1.76 [0.98, 3.16]	0.66 [0.34, 1.31]	0.47 [0.20, 1.11]
Maternal Complications		NA	NA
No	Ref.		
Yes	**0.44 [0.24, 0.79]***		

Note. *Significant Variable at $p<0.05$. **Significant Variable at $p<0.001$. Ref, Reference category. NA, Not Applicable. AOR, Adjusted Odds Ratio. CI, Confidence Interval. (-), Missing or Outrageous Values

The multivariate logistic regression in model 2 [with PCMC sub-scales as the main independent variables while controlling for other socio-demographic and obstetric variables] examining the association between PCMC and future childbearing intentions of participants is presented in Table 5.18 and described below:

Table 5.18: Association Between Adolescents' Perceptions of Person-Centred Maternity Care Sub-Scales During Childbirth and Future Childbearing Intentions (N=560)

PCMC Sub-scale [a]	Adolescents' Future Childbearing Intentions		
	Would like to have another child (n=463) AOR [95% CI]	Same facility next childbirth (n=460) AOR [95% CI]	Would recommend facility to sister or friends (n=474) AOR [95% CI]
Dignity and Respect			
Low	Ref.	Ref.	Ref.
Moderate	0.86 [0.38, 1.93]	0.69 [0.35, 1.38]	1.11 [0.57, 2.13]
High	0.53 [0.18, 1.53]	1.26 [0.34,4.70]	2.16 [0.42, 11.15]
Communication and Autonomy			
Low	Ref.	Ref.	Ref.
Moderate	1.10 [0.53,2.12]	**1.75 [0.86, 3.53]****	1.67 [0.90, 3.09]
High	1.03 [0.45, 2.36]	2.24 [0.97, 5.18]	**3.42 [1.14, 10.24]***
Supportive Care			
Low	Ref.	Ref.	Ref.
Moderate	0.52 [0.17,1.63]	1.75 [0.86, 3.53]	**4.52 [2.36, 8.66]****
High	1.31 [0.30,5.69]	**5.10 [1.20, 21.59]***	-

Note. *Significant variable at p<0.05. **Significant variable at p<0.001. Ref, Reference category. (-), Missing or Outrageous Values

[a]The model controlled for age, school attendance, level of education occupation, occupation, marital status, wealth quantile, parity, gravidity, place of childbirth, birth companionship, sex of baby, newborn complication, the status of the baby, number of antenatal care visit, mode of childbirth, episiotomy, time of childbirth, and maternal complications.

There was no evidence of an association between perceived moderate and high levels of dignity and respect during childbirth and adolescents' intentions to give birth in the future (AOR=0.86, 95% CI [0.38, 1.93] and AOR=0.53, 95% CI [0.18, 1.53] respectively), for choosing to give birth in the same facility in the future (AOR=0.69, 95% CI [0.35, 1.38] and AOR=1.26, 95% CI [0.34,4.70] respectively), or to recommend the same facility to a sister or a friend (AOR=1.11, 95% CI [0.57, 2.13] and AOR=2.16, 95% CI [0.42,11.15] respectively).

Participants who had perceptions of moderate levels of communication and autonomy during childbirth had 1.75 higher odds of choosing the same facility for the next childbirth compared to those who had low scores (AOR=1.75, 95% CI [0.86, 3.53]). Similarly, adolescents who had perceptions of high levels of communication and autonomy during childbirth had 3.42 higher odds of recommending the same facility to a sister or a friend compared to those who had perceptions of low levels (AOR=3.42 [1.14, 10.24]).

Adolescents who perceived high levels of supportive care during childbirth had 5.10 higher odds of choosing the same facility in the future compared to those who had low levels (AOR=5.10, 95% CI [1.20, 21.59]).

Those who had perceptions of moderate levels of supportive care had 4.52 higher odds of recommending the same facility to a sister or a friend compared to those who had low levels (AOR=4.52 [2.36, 8.66]).

5.6 Conclusion

The overall perceived level of PCMC during childbirth among adolescents in rural northern Uganda was moderate. The factors positively associated with adolescents' perceptions of PCMC during childbirth included being married and engaging in casual labour while those negatively associated with it included attending five to seven antenatal visits, receiving episiotomy, having a birth companion, and having a newborn with complications. Most participants expressed moderate to high levels of satisfaction with care during childbirth. There was a statistically significant association between moderate to high level of PCMC during childbirth and satisfaction with care. Most adolescents expressed a desire to have another child in the future, give birth in the same facility, and recommend it to others. Moderate to high levels of PCMC were associated with adolescents' future childbearing intentions, although the significance varied. The subsequent chapter delves into the qualitative findings of this study.

CHAPTER SIX: QUALITATIVE RESULTS

6. Introduction

This chapter presents the qualitative findings of this study in line with the COnsolidated criteria for REporting Qualitative research (COREQ) (Tong et al., 2007) (Appendix 6.1). The chapter presents the characteristics of the study participants (section 6.1), their experiences of care during facility-based childbirth (section 6.2), and drivers of experiences of care (section 6.3), and concludes with a summary of the chapter (section 6.4).

6.1 Characteristics of Study Participants

In total 14 in-depth interviews were conducted. Participants' ages ranged from 15 to 19 years, the majority (92.86%) attained primary education, 21.43% were formally married. More than three-quarters of the participants (78.57%) had given birth once, half (50%) gave birth in a level III health centre (H/C III), and all participants had spontaneous vaginal birth (SVB) (Table 6.1). A short description of each participant, portraying characteristics and contexts that were observed during the interviews is provided in Appendix 6.2.

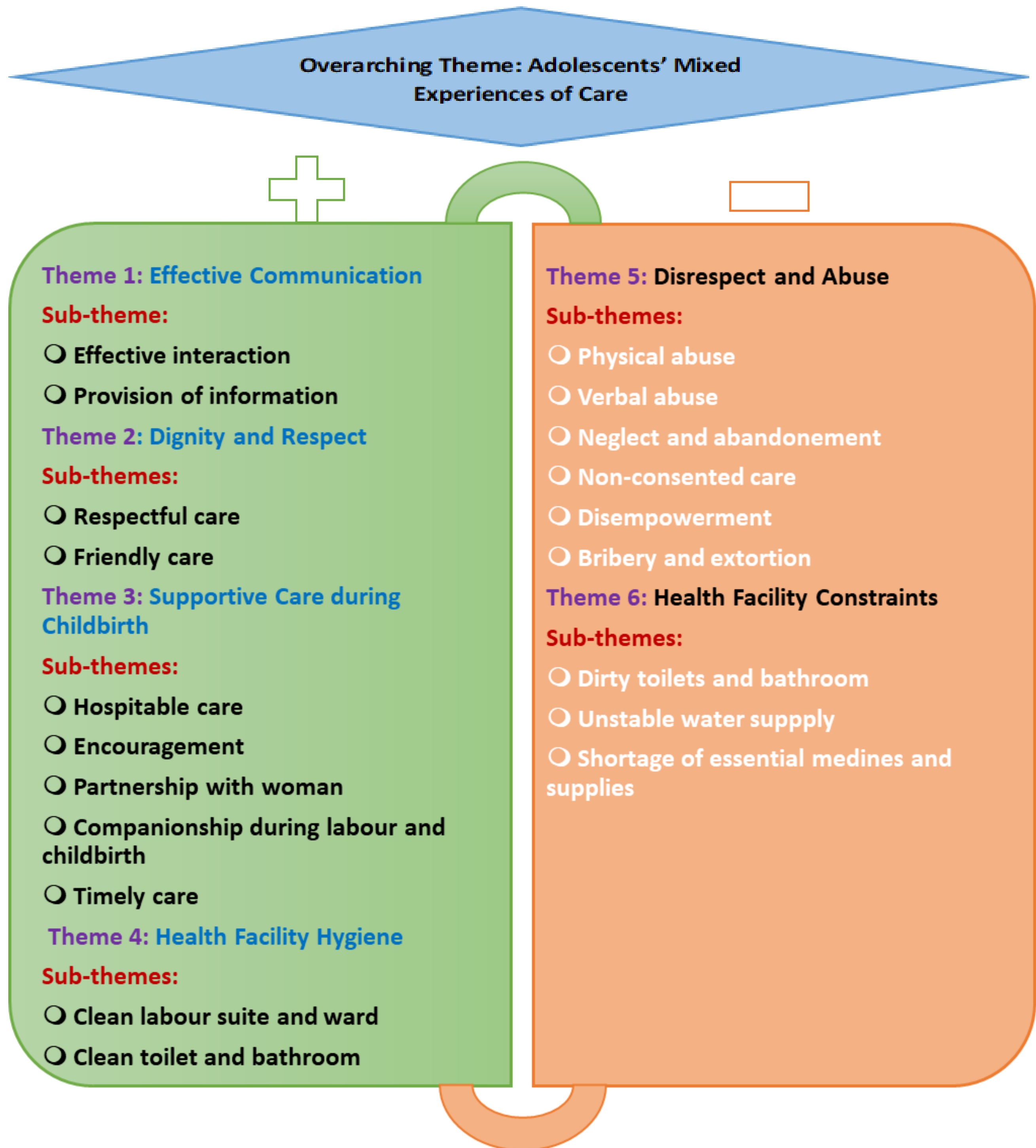
Table 6.1: Characteristics of Study Participants (N=14)

Pseudonyms	Age	Level of Education	Marital Status	Occupation	Parity	Facility Level	Mode of Birth
Emily	17	Primary	Cohabiting	Farmer	02	H/C III	SVB
Chloe	19	Primary	Married	Farmer	01	H/C III	SVB
Grace	18	Primary	Cohabiting	Farmer	01	H/C III	SVB
Lily	17	Primary	Cohabiting	Housewife	01	H/C III	SVB
Sophia	17	Primary	Married	Farmer	01	H/C III	SVB
Harper	19	Primary	Cohabiting	Housewife	01	H/C IV	SVB
Mia	18	Primary	Married	Housewife	01	H/C IV	SVB
Isabella	15	Primary	Cohabiting	Housewife	01	H/C IV	SVB
Taylor	17	Primary	Cohabiting	Tailor	01	H/C IV	SVB
Campbell	19	Primary	Cohabiting	Farmer	02	H/C III	SVB
Amelia	18	No education	Separated	Farmer	02	H/C IV	SVB
Ella	16	Primary	Cohabiting	Farmer	01	H/C III	SVB
Scarlett	18	Primary	Cohabiting	Farmer	01	H/C IV	SVB
Susan	18	Primary	Cohabiting	Farmer	01	H/C IV	SVB

6.2 Adolescents' Experiences of Care During Childbirth

Mixed experiences of care were identified as the overarching theme. This comprised four positive themes and two negative themes as summarised in Appendix 6.3 (Thematic map) and Figure 6.1.

Figure 6.1: Thematic Map of Experiences of Care During Childbirth Among Study Participants



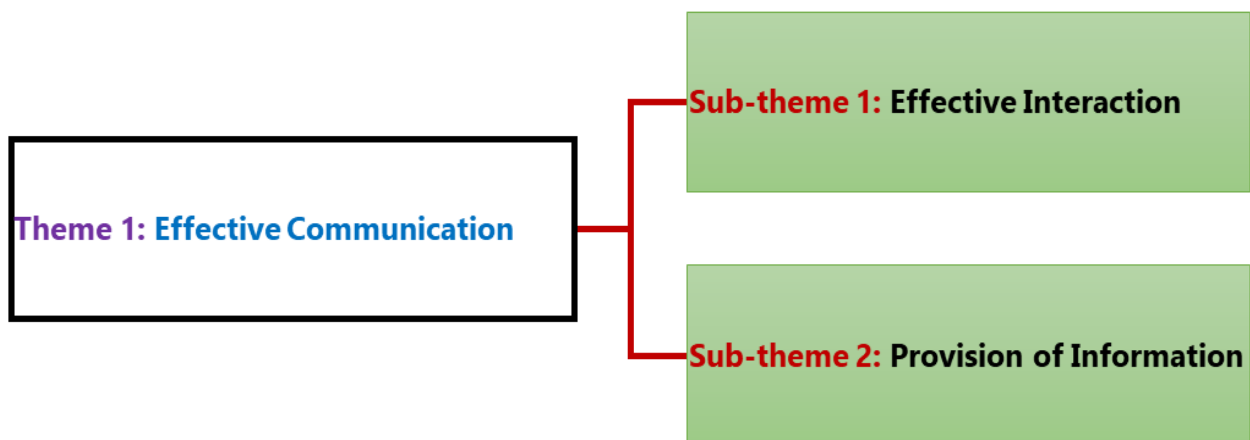
Overall, there were mixed experiences during childbirth. The themes relating to the positive experiences are presented below followed by the themes relating to the negative experiences.

6.2.1 Positive Experiences of Care During Childbirth

6.2.1.1 Theme 1: Effective Communication

Effective communication during childbirth plays a crucial role in shaping the overall birthing experience for adolescents. In this study, adolescents expressed that the effective communication they had with the care providers and the information that they provided during labour and childbirth assisted them to enjoy their birthing experience (Figure 6.2).

Figure 6.2: Theme 1-Effective Communication



6.2.1.1.1 Sub-Theme 1: Effective Interaction

Most of the participants interviewed expressed positive experiences of care related to cordial interactions with healthcare providers during their childbirth journey. They highlighted that the midwives talked to them in a friendly manner and communicated respectfully as typified by responses from these participants:

> *"She was humble while talking to me and was not rude. They were talking calmly to me."* **(Scarlett, 18-year-old, Para 1)**

> *"We were even interacting well with joy and I would see and tell those people were liking me because our conversation was going on well."* **(Ella, 16-year-old, Para 1)**

The positive interactions with adolescents resulted in words of encouragement as in the case of a teenager giving birth for the second time:

"She was interacting well with me and she said I should persevere and I will give birth well." **(Amelia, 18-year-old, Para 2)**

How the healthcare provider interacted with the adolescents determined whether they would be positively treated by the healthcare providers during the process of labour and childbirth. Most of the adolescents did not have any problem with how the midwives communicated with them as noted below:

"She told me nothing that would make me have problems with her." **(Chloe, 19-year-old, Para 1)**

6.2.1.1.2 Sub-Theme 2: Provision of Information

The responsibility of answering questions and addressing concerns usually falls on the skilled health personnel who look after the labouring woman. Midwives are suited for this role since they, of all the health professionals, spend the most time with women in labour. Providing health information is critical in creating a positive birth experience, especially for adolescents who might be giving birth for the first time.

"They kept telling me even the time I was giving birth they told me that I should push the baby [when I feel the contraction is strong]." **(Amelia, 18-year-old, Para 2)**

The recurring use of the phrase "they kept telling me" underscores a continuous and supportive communication flow. For some adolescents, telling them when they would give birth and the progress of labour greatly improved their experiences of childbirth:

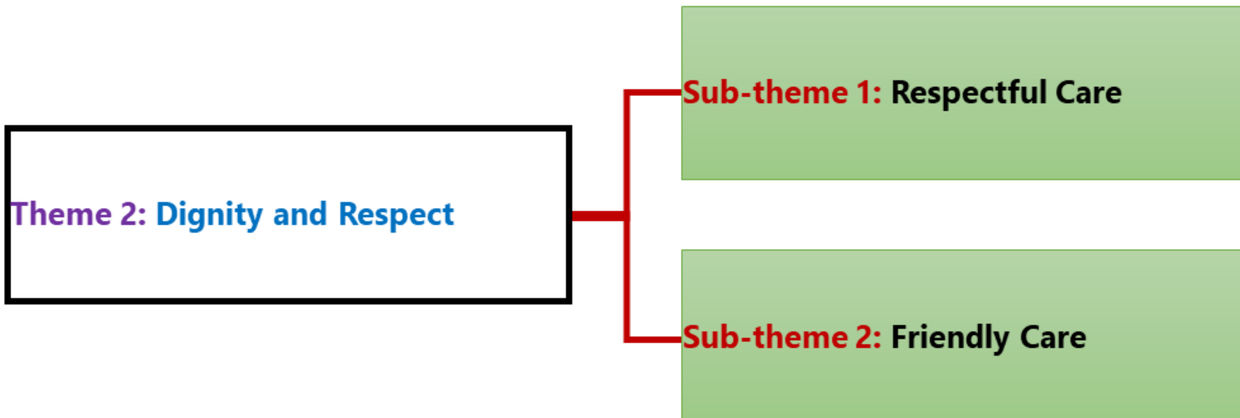
"I was told there was progress [participant smiled] and I was asked to be walking around. I then walked around but reaching around 7:00 pm, things became hot and I gave birth at 9:00 pm." **(Grace, 18-year-old, Para 1)**

"I was told there is some progress in the labour process and then the baby started pushing out and I continued to also push but I was told my pelvis is narrow [and she was given an episiotomy]." **(Isabella, 15-year-old, Para 1)**

6.2.1.2: Theme 2: Dignity and Respect

The theme of dignity and respect had two distinct yet interwoven sub-themes of respectful care and friendly care (Figure 6.3).

Figure 6.3: Theme 2-Dignity and Respect



6.2.1.2.1 Sub-Theme: Respectful Care

Participants emphasised the nuanced ways in which respect was demonstrated, highlighting a holistic approach to care that extended beyond verbal communication. This was embodied by a quote from one of the participants who was an orphan and came to give birth in the hospital alone:

> *"When I reached, the midwife gave me the bed where I was admitted. She* [midwife] *then asked me to pick the urine mat* [mackintosh] *and go with it to labour suite and she examined me very well. She* [midwife] *was humble while talking to me"* **(Scarlett, 18-year-old, Para 1)**

Even to one of the youngest participants, Ella who was only 16 years of age, she perceived and reported respect while receiving care as noted below:

> *"…there was maximum respect"* **(Ella, 16-year-old, Para 1)**

Even though participants were not sure how they would be treated during childbirth, they reported a lack of mistreatment which amounted to respectful care as embodied by quotes from some of these participants:

> *"I was not slapped at all. There was no issue and the nurse was the one who helped me to push the baby without any problem, they didn't quarrel with me, and I wasn't told anything. I gave birth smoothly because I didn't go through hardship it was just okay".* **(Sophia, 17-year-old, Para 1)**

> *"When I was in bed they never shouted at me, if the baby tries to come out and again goes back, they never slapped me."* **(Scarlett, 18-year-old, Para 1)**

“They didn’t shout at or do something bad [she looked timid throughout the interview].” **(Isabella, 15-year-old, Para 1)**

6.2.1.2.2 Sub-Theme 2: Friendly Care

Many participants indicated a positive shift in the caregiver's approach, signalling a transition from professional care to a more personal, friendly connection. The adolescents experienced friendly care which was perceived in the form of general love and liking for them during care. This suggested a nurturing environment, where emotional well-being was recognised as integral to overall health as reported by some of these participants:

“She started being friendly to me during my pregnancy…. Ever since I started my antenatal visit, she showed me love.” **(Chloe, 19-year-old, Para 1)**

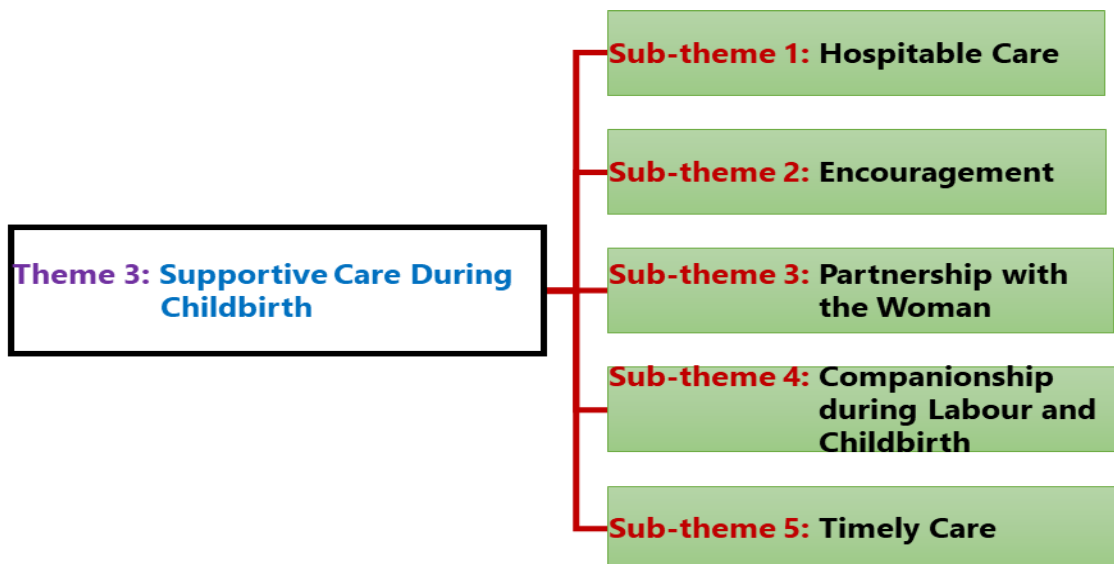
“She loved me at a higher level and then told me to deliver well and then I delivered well without complications.” **(Sophia, 17-year-old, Para 1)**

“I would see and tell those people were liking me. They showed me love.” **(Ella, 16-year-old, Para 1)**

6.2.1.3 Theme 3: Supportive Care During Childbirth

Adolescent mothers received appropriate support during childbirth which was in the form of hospitable care, encouragement, partnership, companionship, and timely care (Figure 6.4 below).

Figure 6.4: Theme 3-Supportive Care During Childbirth



6.2.1.3.1 Sub-Theme 1: Hospitable Care

Most of the participants expressed positive experiences related to the hospitality they received during childbirth. The hospitable care was seen by adolescents as a warm welcome and respectful reception upon arrival at the health facility:

> *"Labour pain started on Monday night and then I went to the hospital on Tuesday around 4:30 pm, we were well received, and I was given necessary services and I never got any problem."* **(Susan, 18-year-old, Para 1)**

> *"When I reached the nurse welcomed me and treated me very well up to the time that I gave birth."* **(Chloe, 19-year-old, Para 1)**

> *"I reached the hospital and the nurse [midwife] who received me was in the rank of a sister [senior midwife]. She received me so well"* **(Sophia, 17-year-old, Para 1)**

6.2.1.3.2 Sub-Theme 2: Encouragement

The healthcare providers encouraged and reassured the adolescents during labour which fostered a positive experience during childbirth. Some participants were reassured about the outcome of pregnancy. This encouraged them to go through the experience of childbirth as teenage mothers as cited by these participants:

> *"She said I should persevere [the labour pain] and that I will give birth well [implying there will be no complication]."* **(Amelia, 18-year-old, Para 2)**

> *"If the baby pushed, she would say, you persevere".* **(Grace, 18-year-old, Para 1)**

For some adolescents, the absence of complications during labour was used by skilled health personnel to motivate them. Some healthcare providers used the fact that in recent times, adolescents were having normal spontaneous vaginal birth even more than older women to inspire adolescents in labour.

> *"The nurse told me that my childbirth would be okay without any complication and also said that young girls are giving birth without complications compared to old women"* **(Sophia, 17-year-old, Para 1)**

Some participants expressed gratitude to the skilled health personnel for encouraging them to ambulate throughout labour which resulted in a positive birth experience:

“She also encouraged me to exercise by helping me to walk around while talking to me happily.” **(Chloe, 19-years-old, Para 1)**

6.2.1.3.3 Sub-Theme 3: Partnership with the Adolescents

Participants emphasised the importance of skilled health personnel forming a partnership with them during the childbirth process. This collaboration in the form of physical presence and quality of care, contributed to a sense of trust and support as typified by feedback from some of the participants:

“One important thing that I know is the nurse [midwife] *was on my side. She gave me hope and confidence to give birth without any problem."* **(Sophia, 17-year-old, Para 1)**

“When I entered the labour suite, I immediately climbed onto the bed where both midwives were waiting for me. And then, without any delay, I gave birth” **(Harper,19-year-old, Para 1)**

"The nurse was there [during labour and childbirth] *and she waited to receive the baby."* **(Ella, 16-year-old, Para 1)**

Some of the midwives cleaned up the mothers and supported them so that they did not fall off the bed while wrestling with labour pain on the delivery bed:

“The midwife was with me up to the time I gave birth. She even cleaned me up.” **(Scarlett, 18-year-old, Para 1)**

“At some point when I would feel like falling down the nurse would support me.” **(Chloe, 19-year-old, Para 1)**

6.2.1.3.4 Sub-Theme 4: Companionship During Labour and Childbirth

Besides the partnership the adolescents had with the midwives during childbirth, most of the participants highlighted the presence and support of birth companions of their choice during labour and childbirth. The presence of supportive companions, such as family members and traditional birth attendants, played a key role in shaping the labour and childbirth experiences of adolescents through the provision of emotional and practical support:

"My neighbour who is a traditional birth attendant went with me and was present in the labour suite during childbirth." **(Susan, 18-year-old, Para 1)**

"*They were helping me [mother-in-law and neighbour] to wash clothes, cook, boil tea and drinking water."* **(Emily, 17-year-old, Para 2)**

"My mother-in-law and even Olwede [pseudonym for the husband] went along with us [transported her to the hospital]. She was allowed [inside the labour suite]. It was Olwede [pseudonym for the husband] that was not in [the labour suite] because he seemed to be having some fear." **(Sophia, 17-year-old, Para 1)**

6.2.1.3.5 Sub-Theme 5: Timely Care

Participants noted that they received timely care during their childbirth experiences.

"Immediately I reached, they took me to the examination room, I was examined and told I was about to give birth." **(Susan, 18-year-old, Para 1)**

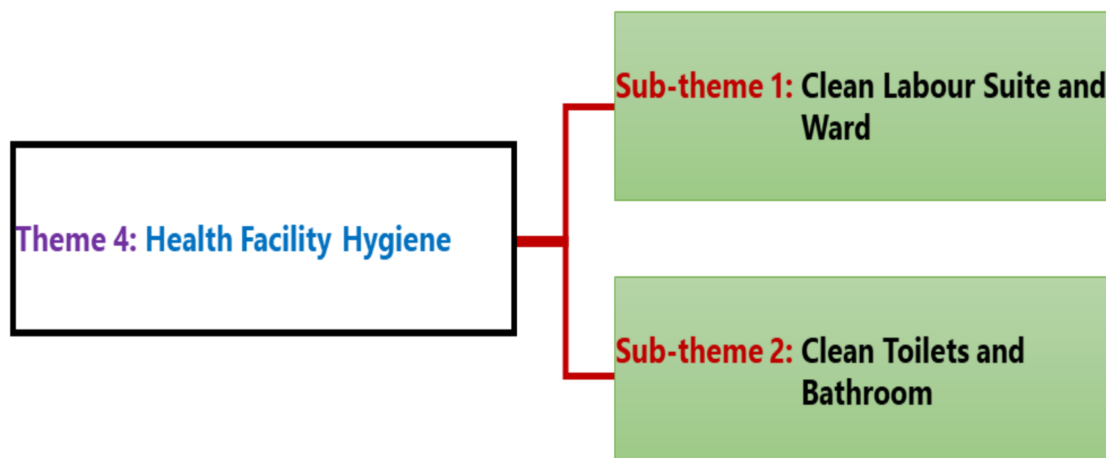
"She examined me immediately without wasting time." **(Sophia, 17-year-old, Para 1)**

"I went straight to the nurse and examined me and said the baby was on its way." **(Harper,19-year-old, Para 1)**

6.2.1.4 Theme 4: Health Facility Hygiene

A pervasive theme was identified concerning the pivotal role of hygiene in shaping adolescents' experiences during childbirth. The nuances of health facility hygiene unfolded through two interconnected dimensions of clean labour suite/ward and clean washrooms (toilets and bathrooms) as summarised in Figure 6.5.

Figure 6.5: Theme 4-Health Facility Hygiene



6.2.1.4.1 Sub-Theme 1: Clean Labour Suite and Ward

Within the health facility, participants consistently appraised the cleanliness of the labour suite and general ward as integral components of their overall experience. Their sentiments, encapsulated in the following excerpts, underscore the significance attributed to the hygiene of these critical spaces:

> *"The place was generally clean like the labour suite, the floor was clean because immediately someone delivers the place would be cleaned up and even the toilets."* **(Ella, 16-year-old, Para 1)**

> *"The hospital* [the general ward] *was clean and even the labour suite was clean."* **(Grace, 18-year-old, Para 1)**

> *"Like on the day, I went there were people that had given birth and their attendants had cleaned the labour suite and the general ward even the compound was looking clean."* **(Chloe, 19-year-old, Para 1)**

In other cases, the adolescents accepted to clean the delivery bed and the labour suite floor themselves to enlist favourable treatment from the healthcare providers as was the case for Chloe:

> *"As a person who has just given birth you need to clean the labour bed and floor which I didn't get any problem with it and that made them* [midwives] *to like me."* **(Chloe, 19-years-old, Para 1)**

6.2.1.4.2 Sub-Theme 2: Clean Toilet and Bathroom

Complementary to the appraisal of the labour suite and ward as clean, participants articulated their satisfaction with the cleanliness of toilet and bathroom facilities within the health facility. This sub-theme underscores adolescents' discernment of sanitation beyond the immediate context of childbirth, extending to the ancillary areas crucial for their overall well-being. Although it was not very clean, the participants felt that the hygiene of the toilets and the bathrooms was good as cited by some of these participants:

> *"The washrooms were generally clean like the bathroom and toilet I had to clean after I had used."* **(Emily, 17-year-old, Para 2)**

> *"The place was generally clean […] even the toilets, bathrooms."* **(Ella, 16-year-old, Para 1)**

> *"The bathrooms and toilets were being used well and were clean."* **(Grace, 18-year-old, Para 1)**

In other health facilities, either the toilet or bathroom was not clean at any given point in time as noted by some of these participants:

> *"The place where I got services from was clean, the toilet was good, it was the bathroom that was not clean and was unbearable."* **(Susan, 18-year-old, Para 1)**

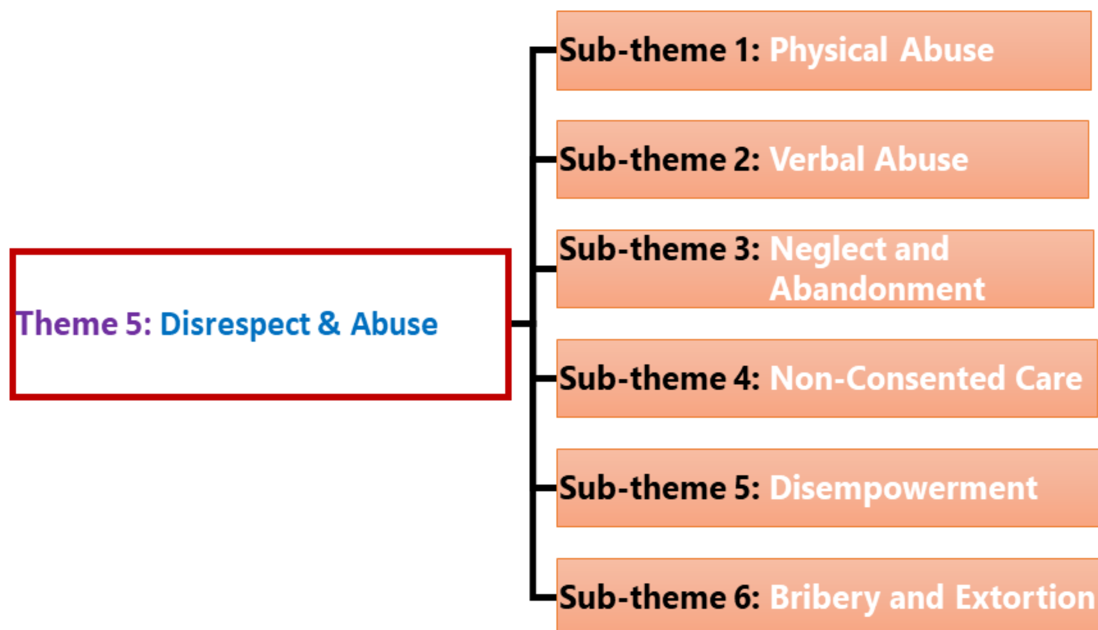
6.2.2 Negative Experiences of Care During Childbirth

Although most adolescents experienced positive birth experiences, some of them experienced negative experiences during their care. The negative experiences were in the form of disrespect and abuse and poor amenities and services.

6.2.2.1 Theme 5: Disrespect and Abuse (D&A)

Some participants experienced disrespect and abuse. The disrespect and abuse of adolescents during childbirth manifested in six multifaceted dimensions (a) physical abuse, (b) verbal abuse, (c) neglect and abandonment, (d) non-consented care, (e) disempowerment, and (f) bribery and extortion (Figure 6.6 below).

Figure 6.6:Theme 5-Disrespect and Abuse



6.2.2.1.1 Sub-Theme 1: Physical Abuse

Physical abuse was one form of D&A experienced by adolescent mothers during childbirth. Some adolescents recounted incidents of physical abuse which included slapping, inappropriate examination, and repair of the episiotomy without anesthesia as noted below:

"I was stitched [after episiotomy] but it was very painful, I was stitched without put on anesthesia". **(Lily, 17-year-old Para 1)**

One participant described a midwife's act that resulted in immediate physical harm:

"Hmm, she [the midwife] gave me a very terrible slap on my thigh, and my thigh got paralysed instantly." **(Mia, 18-year-old, Para 1)**

The presence of relatives of the adolescents did not stop the midwife from physically assaulting the labouring adolescent as noted by one of the participants:

"I was slapped like twice even and my stepmother was just there looking. [Besides], she was touching [palpating] me in a painful way." **(Lily, 17-year-old Para 1)**

6.2.2.1.2 Sub-Theme 2: Verbal Abuse

Verbal abuse by midwives was a common form of D & A experienced by these participants during childbirth. They reported that midwives used harsh language and demeaning comments on them, while others were judgmental and critical of them. Verbal abuse also manifested in the form of threatening adolescents regarding the likely adverse birth outcomes associated with adolescent pregnancies which created a sense of fear among adolescents.

"They said that I should open up my vagina well because they are not the ones who inserted my husband's penis into my vagina." **(Mia, 18-year-old, Para 1)**

"Aaaa, she wasn't treating me well because the abusive languages she was using were heavy [participant felt shy to verbalise the vulgar words used towards her]." **(Campbell, 19-year-old, Para 2)**

"They then told me that if I push so hard and my uterus gets torn it would be my own problem." **(Mia, 18-year-old, Para 1)**

Some of the adolescents were scolded for being out of school and getting pregnant at a tender age, something they resented and made them feel unwelcome at the health facility.

"Mm, I was also told I should go back to school that I am still young to be in marriage [started to look away in anger]." **(Emily, 17-year-old, Para 2)**

"I am not the one who told you to get pregnant while you are still young [facial grimace instantly appeared as she recounted her experience]." **(Harper,19-year-old, Para 1)**

6.2.2.1.3 Sub-Theme 3: Neglect and Abandonment

Participants shared distressing accounts of being left alone during labour, such as one of the participants who delivered without assistance. This neglect and abandonment during childbirth exposed adolescents to heightened vulnerability.

"I delivered alone and the nurse [midwife] only received the baby." **(Emily, 17-year-old, Para 2)**

"The nurse came when the baby's head was already out then she came and cut the cord and took the baby on the weigh scale and she moved out because there was no cloth, and my stepmother removed her skirt to cover the baby." **(Lily, 17-year-old Para 1)**

In some instances, the healthcare providers were not present in the hospital and the relatives had to call the healthcare providers from the staff quarters to attend to the adolescent mothers or assist the adolescent mother to give birth without the help of a midwife.

"By the time I was in labour pain, it was so serious and they went to call the midwife and when she arrived, I had already given birth because my husband didn't know where the staff room was so he kept knocking one door after the other". **(Campbell, 19-year-old, Para 2)**

"I started pushing the baby behind the house and I called my mother-in-law and she found me already pushing then she asked me to go inside to bed. When we reached the bed the nurse wasn't around and yet I had the labour urge to push". **(Mia, 18-year-old, Para 1)**

6.2.2.1.4 Sub-Theme 4: Non-Consented Care

Despite positive initial interactions, some of the participants reported that they were not allowed to exercise their rights for self-determination during childbirth which may have violated their rights. Some were denied the opportunity to choose their preferred birthing position while others were examined without seeking their consent.

"She instructed me to lay and lift my legs which I did but at one point I pushed and then my energy got depleted but she kept on shouting at me that I should hurry up pushing the baby." **(Grace, 18-year-old, Para 1)**

“They just started the procedure. The Nurse came and inserted her hands in my vagina [without seeking my consent]” **(Sophia, 17-year-old, Para 1)**

6.2.2.1.5 Sub-Theme 5: Disempowerment

Participants shared experiences of feeling disempowered during healthcare encounters. Disempowerment was perceived by the adolescents as limited opportunities to ask questions regarding their labour process, hospital dynamics, and/ or their well-being and that of their babies:

“I wasn’t given any opportunity to ask even a single question and the way I was treated I could hardly ask any question.” **(Mia, 18-year-old, Para 1)**

“Hmm, I did not ask for any question even I didn’t respond to her [when she was asked].” **(Grace, 18-year-old, Para 1)**

In some cases, the midwives covertly placed adolescents under duress to name their babies after them as narrated in the excerpts below:

“He told me I should name my child after him. I did not tell him [I didn’t want to name my child after him]. I was fearing he would shout at me.” **(Amelia, 18-year-old, Para 2)**

6.2.2.1.6 Sub-Theme 6: Bribery and Extortion

Many of the participants expressed instances of financial exploitation which reflected a system where unofficial payments were often required for various aspects of care. Adolescent mothers felt coerced to comply because of the fear of the likely neglect and abandonment that could result from failure to pay the bribe/extortion fees. In public health facilities in Uganda, mothers are not required to buy any medicine or supplies while receiving care, but this was not the case with the care of some of the adolescents. Some of these unofficial payments were disguised as the mother’s contribution towards buying cleaning agents, gloves, and toilet paper as noted below:

“She was asking for detergent, washing soap, and then my mother-in-law bought and I said since she has helped me so much, I will get something and visit her at her home.” **(Chloe, 19-year-old, Para 1)**

"In that first examination that she did, there was only one pair of gloves that she used, so when she came back for the second examination there were no gloves in the maama kit[7] *that we had and she asked us to pay a sum of Ugx. 2,500* [USD 0.7] *for the gloves, we told her that we had no money."* **(Mia, 18-year-old, Para 1)**

In some instances, the bribery and extortion were concealed as payments for birth registration, and birth registration cards were retained until adolescents paid for the card as remarked by some of these participants:

"We had carried Ugx. 25,000 (USD 7) of which my husband had just borrowed. Everyone was paying for the card and if you have not paid you would not be given the card. Both young and old women were paying the same amount before getting the card." **(Ella, 16-year-old, Para 1)**

"[…] they again asked for Ugx. 3,000 (USD 0.8) [for the birth registration card] *and they said if that money is not there then we would not be discharged when we gave that Ugx. 3,000 (USD 0.8), we were discharged."* **(Campbell, 19-year-old, Para 2)**

Meanwhile, in other cases, the healthcare providers bluntly asked the mothers to give them money as a token of appreciation, a form of corruption as noted below:

"[...] They asked for some money and I think they were given Ugx. 15.000 (USD 4.2) because I didn't pay much attention to that since my mother-in-law was there to handle." **(Ella, 16-year-old, Para 1)**

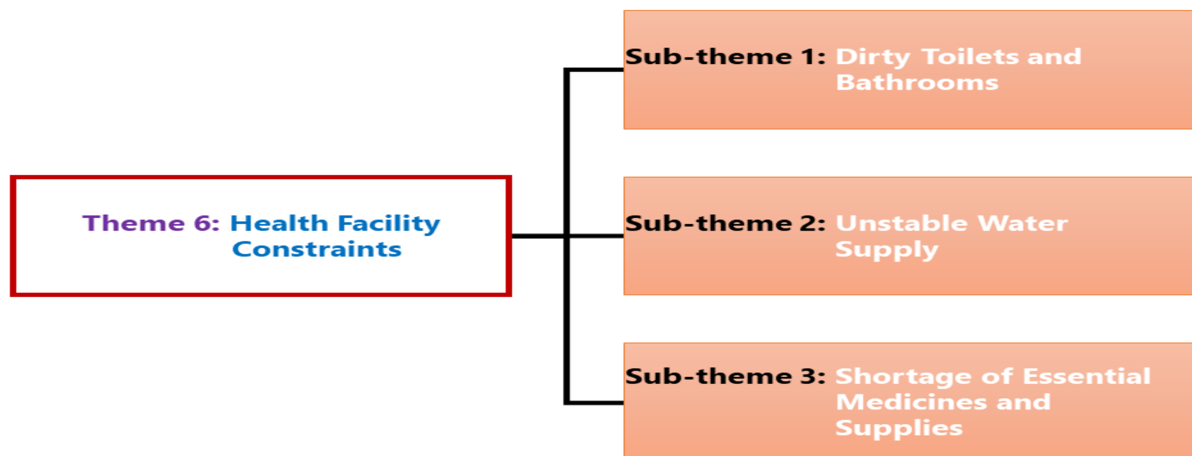
"We pleaded saying there is no money [but the midwife insisted on the money] *and we gave Ugx. 10,000 (USD 2.8)."* **(Mia, 18-year-old, Para 1)**

6.2.2.2 Theme 6: Health Facility Constraints

The health facility constraints were critical aspects that shaped the overall experience of adolescents during childbirth. This theme comprises of sub-themes that highlight the state of toilets and bathrooms, as well as the stability of the water supply (Figure 6.7 below).

[7] Maama kit is a free pack given to women seeking maternity care in government health facilities to ensure that child birth is conducted in a clean environment. The pack consists of basic supplies that are required at child birth such as sterile gloves, plastic sheets, cord ligature, razor blades, tetracycline, cotton, bathing soap and sanitary pads. In 2016, the Maama kit was expanded to include chlorhexidine for umbilical cord care following approval of use by Uganda's Ministry of Health (Appendix 6.4).

Figure 6.7:Theme 6-Health Facility Constraints



6.2.2.2.1 Sub-Theme 1: Dirty Toilets and Bathrooms

Some participants provided varied perspectives on the cleanliness of the facility, specifically highlighting concerns about the state of toilets and bathrooms:

> *"It is the toilets that sometimes could be dirty in that you find faeces and urine on the floor and no one bothers to clean it, and the bathrooms sometimes were very dirty. You could find that those women who have just delivered have bathed and their blood flooded on the floor."* **(Chloe, 19-year-old, Para 1)**

> *"There was so much dirtiness sometimes if you go to bath you find blood on the floor they have not cleaned and then the toilets you find cotton dumped and other dirty things of which if you walk in barefooted you can contract incurable diseases."* **(Lily, 17-year-old Para 1)**

Participants expressed that while the hygiene in the labour suite was maintained in some cases, the hygiene in the toilets and bathrooms was poor. This compelled some of them to clean the bathrooms and toilets themselves before use or to simply use the facilities the way they were:

> *"The toilets and bathrooms were not clean at all, I had no choice but to* [clean it myself] *and bath in it like that."* **(Campbell, 19-year-old, Para 2)**

> *"Where I delivered from was clean* […]*. You know once there are many people they keep the place dirty, a person urinates or defecates anyhow* [….]*."* **(Grace, 18-year-old, Para 1)**

"The hospital was clean [ward and labour suite] but the toilet was not okay. Inside was very dirty with very bad smell, the floor had a lot of very dirty stuff, and the bathroom had visible human faeces making it very difficult for women like us who had just given birth to bathe from inside." **(Mia, 18-year-old, Para 1)**

6.2.2.2.2 Sub-Theme 2: Unstable Water Supply

Concerns were raised regarding the stability of water supply as a basic amenity required for the maintenance of facility hygiene as well hygiene of clients. Unstable water supply was cited as the main cause of the dirty bathrooms and toilets. These concerns are personified in quotes from some of these adolescents:

"Sometimes there would be no water most especially if the borehole breaks down and at times when there is water you find that attendants are not willing to do the cleaning." **(Chloe, 19-years-old, Para 1)**

Sometimes the participants were forced to fetch water from outside the hospital premises:

"There is water, tap water but there was a time when it was off the entire night but then it got back the following morning. Water was being collected from [a secondary school located about 2 km from the health facility] and was far." **(Susan, 18-year-old, Para 1)**

"There is water, we would collect water from the other side of the hospital [outside the hospital]." **(Mia, 18-year-old, Para 1)**

6.2.2.2.3 Sub-Theme 3: Shortage of Essential Medicines and Supplies

Some participants shared experiences where there were no essential medicines for managing common complications during pregnancy and childbirth. One of the interviewees never received any treatment during labour because of a lack of medicines although the doctor had told her that she needed medications.

"I was not injected till I returned home. I was not given any kind of medication and they told me that if I were to be treated then I needed to buy medication which I didn't have money." **(Chloe, 19-year-old, Para 1)**

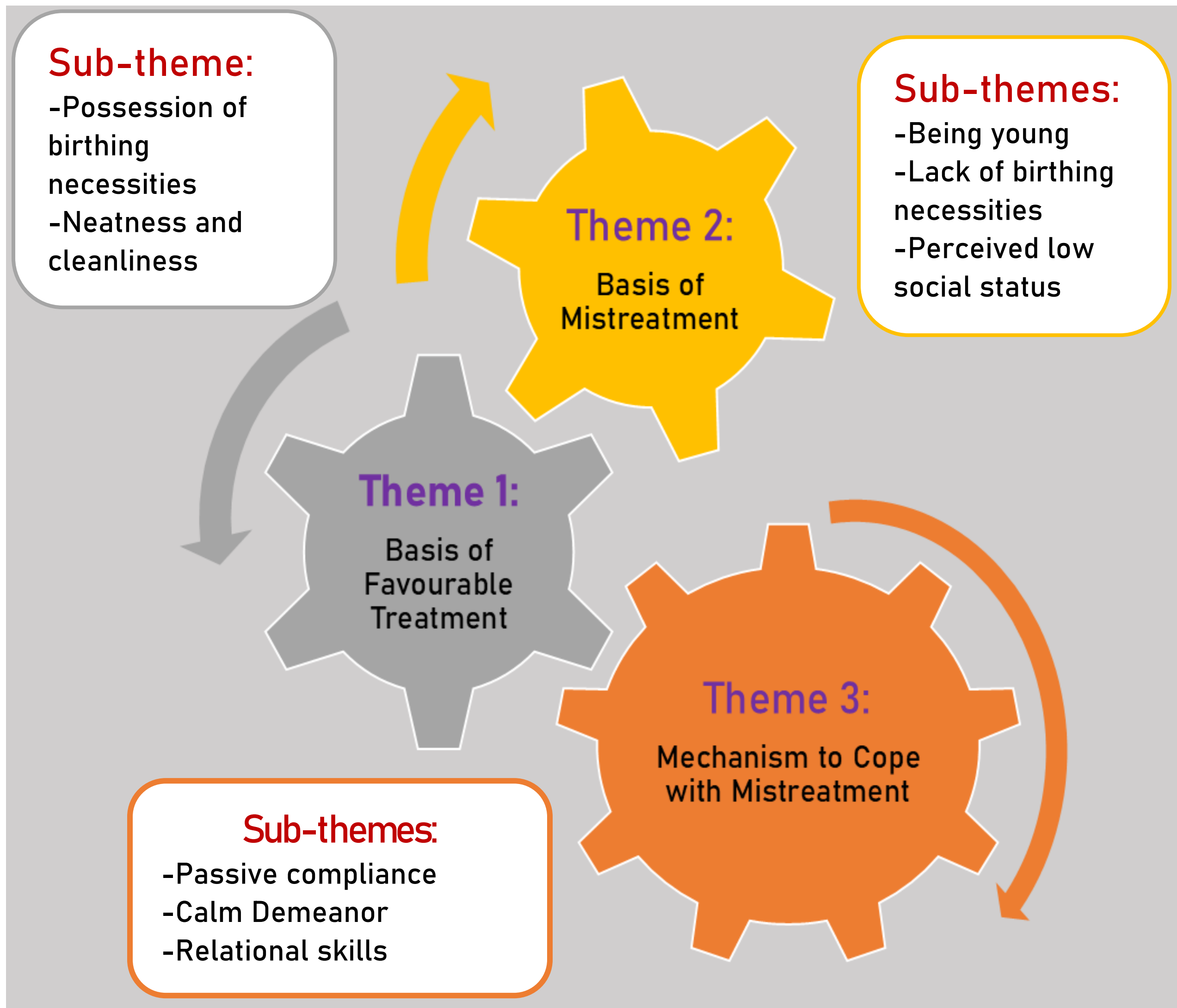
For some participants, they had to buy all the gloves that were used for their care upon being told that there was nothing available in stock for use.

"All the gloves that were used are the ones we bought, we bought four pairs". **(Mia, 18-year-old, Para 1)**

6.3 Drivers of Adolescents' Experiences of Care During Childbirth

This section presents the drivers of adolescents' mixed experiences of care during childbirth as summarised in Appendix 6.5. The drivers of mixed experiences have been categorised into three themes: (i) basis for favourable treatment, (ii) basis for mistreatment, and (iii) mechanisms to cope with mistreatment as summarised in Figure 6.8 below.

Figure 6.8: Thematic Map of Drivers of Experiences of Care During Childbirth Among Participants



The themes of drivers of adolescents' mixed experiences revolve around the concept of individuals actively exerting control, making choices, and taking actions to ensure their survival and well-being during the critical and vulnerable period of childbirth. The drivers of adolescent experiences emphasise the significance of grooming, personal hygiene, possession of birthing necessities, young age, social status, compliance with instructions, personal demeanours, and relational skills in navigating the maternity unit. These themes

suggest that individuals can influence and shape their birthing experiences through the aforementioned means and also highlight the empowerment of individuals to influence how they are treated during childbirth.

6.3.1 Theme 1: Basis for Favourable Treatment

Many adolescent mothers highlighted that they received positive or favourable treatment during childbirth. Participants consistently highlighted that possessing birthing necessities and maintaining cleanliness and neatness were key factors leading to favourable treatment as expounded below:

6.3.1.1 Sub-Theme 1: Possession of Birthing Necessities

In public health facilities in Uganda, women who come for childbirth are expected to have essential items such as the maama kit (see appendix 6.4) and supplies to be used during delivery because of limited supplies in the healthcare facilities, although these are public health facilities where services are expected to be totally free of charge. Participants thought that possessing these essential birth requirements was a catalyst for positive attention from healthcare providers. For instance, one participant said:

> *"What made my life easy there [referring to hospital] was because I had all the birthing necessities like maama kit, the scan result, basin, and baby's clothes. When the midwife saw those items, she was very happy with me."* **(Scarlett, 18-year-old, Para 1)**

Other participants suggested that the number of pieces of baby clothes that they had besides other birthing necessities played a key role in their favourable treatment as cited by these participants:

> *"I had bought enough clothes for the baby and the things I had were enough. I had a new petticoat, knickers and I had them all in addition to a thermos flask among others."* **(Campbell, 19-year-old, Para 2)**

> *"I had prepared for my childbirth very well. I had nine pieces of baby's sheets [small and large] plus the maama kit. When I pushed the baby, everyone wanted to carry my baby."* **(Susan, 18-year-old, Para 1)**

6.3.1.2 Sub-Theme 2: Neatness and Cleanliness

Adolescent participants perceive a good outlook, grooming, personal hygiene, and presenting themselves cleanly and smartly as a powerful influencing factor in garnering favourable treatment from healthcare providers. Participants emphasised the role of cleanliness in shaping healthcare providers' perceptions, as illustrated by these quotes:

"She liked me because she said that if a woman is going to deliver you have to be clean. I had bathed, and my clothes were clean." **(Sophia, 17-year-old, Para 1)**

"All you need is to go when you are smart when you have washed your clothes." **(Susan, 18-year-old, Para 1)**

"A friend of mine from [a sub-county] *came when she had not bathed and the nurse quarrelled at her but for me, I had gone when I had bathed and my clothes were clean."* **(Scarlett, 18-year-old, Para 1)**

Because of the value attached to personal grooming, adolescents and their caregivers made it a point to always bath and wash their clothes from time to time as noted by this participant:

"I was also clean because I would go and bath and my clothes were being washed all the time." **(Ella, 16-years-old, Para 1)**

6.3.2 Theme 2: Basis for Mistreatment

Although the participants reported positive treatment, there were instances of negative treatment. Adolescents identified several factors contributing to mistreatment during childbirth. The sub-themes within this category provide a nuanced understanding of the complex dynamics influencing mistreatment.

6.3.2.1 Sub-Theme 1: Being Young

Participants frequently highlighted age as a driver of mistreatment, with healthcare providers assuming that younger individuals were incapable of handling childbirth as seen in the excerpts below:

"It is because when you are still young, they assume you are unable to give birth." **(Lily, 17-year-old Para 1)**

"Maybe they also looked at me as being too young to be a mother. That could be why they mistreated me while other women were being taken care of nicely." **(Campbell, 19-year-old, Para 2)**

"Being young seemed to make me invisible in the labor room; they treated me like I didn't know anything, like my pain didn't matter." **(Mia, 18-year-old, Para 1)**

These quotes accentuate the prevalent stereotypes associated with being young leading to mistreatment by skilled health personnel.

6.3.2.2 Sub-Theme 2: Lack of Birthing Necessities

The absence of essential items, such as baby's sheets and scan results, contributed to negative treatment. Although the birthing necessities were not made known explicitly to adolescents, and some of the requirements were not critically needed, participants reported being mistreated when they lacked these items.

> *"Some people go when they have enough things but for me I went with nothing even without baby's sheets and that angered the nurse [midwife]."* **(Amelia, 18-year-old, Para 2)**

> *"They judge and treat you according to the items you have carried along to the hospital. You might have gone with only two small baby clothes and yet they need a minimum of five heavy, good clothes. As for me I didn't have all the items they wanted. Maybe that is why I was mistreated"* **(Mia, 18-year-old, Para 1)**

The absence of essential items like gloves and obstetric scan results prompted the healthcare providers to neglect and abandon some participants as cited below:

> *"We didn't have any luggage, nothing to use to examine me and the nurse said I can decide to leave you and then she walked away."* **(Lily, 17-year-old Para 1)**

6.3.2.3 Sub-Theme 3: Perceived Low Social Status

Besides the mistreatment of adolescents based on material possessions, social status emerged as one of the key factors influencing the experiences of adolescents with care in public health facilities. Adolescents reported harsh treatment when perceived as being of low social status and attributed mistreatment during childbirth to their socio-economic status.

> *"They treat people according to how you are, if they see you are of some [high] class then they fairly treat you but if they see you are of low class they treat you harshly."* **(Mia, 18-year-old, Para 1)**

When I asked the participants why they were mistreated, some had these to say:

> *"I even don't know, sometimes they could have seen how I am that's why they treated me like that."* **(Amelia, 18-year-old, Para 2)**

> *"Maybe she saw the way I was, maybe I looked different from others that go to her [referring to the midwife]. Maybe she saw me [referring to her appearance and grooming] and undermined me [looked down on me]."* **(Harper,19-year-old, Para 1)**

6.3.3 Theme 3: Mechanisms to Cope with Mistreatment

Participants employed adaptive strategies to navigate mistreatment during childbirth, revealing a complex interplay of passive compliance, calm demeanour, and soft interpersonal skills.

6.3.3.1 Sub-Theme 1: Passive Compliance

Participants shared instances where compliance with instructions, even in the face of mistreatment and contrary to their preferences, was deemed necessary to avert further mistreatment. This passive approach served as a coping mechanism, ensuring that they adhered to healthcare providers' directives to mitigate further challenges. These passive compliances are noted in the responses of some of the participants:

> *"Whatever I was told to do, I did. Even the way they instructed me to push the baby I followed. I was also told to walk around … which I followed."* **(Amelia, 18-year-old, Para 2)**

> *"If you are given instructions you need to follow, and sometimes if you are called maybe to check on your weight on a scale or that you are going to be examined then you need to hurry because if you delay, they get angry."* **(Susan, 18-year-old, Para 1)**

> *"I was following the instructions being given, if the nurse says don't bend, I would not bend, if she tells me to walk, I would as well walk."* **(Scarlett, 18-year-old, Para 1)**

Participants knew that they needed to follow the instructions to avoid angering the healthcare personnel.

> "It is only that when you are told to do something and then you need to follow into details." **(Amelia, 18-year-old, Para 2)**

> *"What you are told to do, do it, if you are given what to eat, eat it. If they are taking good care of you, giving you water to bath and you are bathing there is no problem."* **(Ella, 16-year-old, Para 1)**

6.3.3.2 Sub-Theme 2: Calm Demeanour

Maintaining composure and avoiding disruptive behaviour were highlighted as ways to cope with mistreatment. Participants shared how they withheld their tears, suppressed their emotions, and continued to ambulate in the face of labour pain to avoid being mistreated by healthcare personnel evidenced by quotes herein:

> *"I was so calm without any issues [not disturbing the midwife]. That how they want you to behave, or else you are slapped, abused, of shamed"* **(Sophia, 17-year-old, Para 1)**

"I was not disturbing them or even misbehaving I was just walking around and not crying. I was just being myself, trying to cope with the situation the best way I knew how." **(Emily, 17-year-old, Para 2)**

"I did not tell her I was fearing as she would have shouted at me." **(Grace, 18-year-old, Para 1)**

6.3.3.3 Sub-Theme 3: Relational Skills

Demonstrating respect and positive social skills were reported as effective in receiving better care. Participants acknowledged the impact of interpersonal dynamics such as being friendly and respectful towards the care providers was the key to coping with mistreatment.

"If you go to the hospital, you should know how to relate with the health workers. It's not always easy, especially when you're feeling unwell, but being able to communicate openly and respectfully can lead to better treatment during childbirth." **(Ella, 16-years-old, Para 1)**

"My character and lifestyle make people admire me [started to smile] in terms of socialising because I am very easy to talk to and I also like to start conversations with people." **(Chloe, 19-years-old, Para 1)**

"All you need is to be respectful in the way you talk to these people [referring to midwives]. I saw how my friend was slapped when she raised her voice at the nurse [midwife] and from that time, I learned to be respectful while talking to the nurse [midwife]" **(Susan, 18-year-old, Para 1)**

6.4 Conclusion

Adolescent participants had mixed encounters with care reflecting both positive and negative experiences of care albeit the positive experiences somewhat outweighed the negative experiences. The key drivers to their experiences were possession or lack of birthing necessities, grooming, young age, perceived low social status, passive compliance, calm demeanour, and relational skills.

CHAPTER SEVEN: DISCUSSION

7. Introduction

The study examined PCMC during childbirth in health facilities among adolescents in rural northern Uganda, its influence on satisfaction with care and future childbearing intentions and explored the drivers of adolescents' experiences of care during childbirth. The study was underpinned by three theories, namely, the WHO Framework for Quality of Maternal and Newborn Care, the Person-Centred Care for Reproductive Health Equity Framework, and the Cultural Health Capital Theory.

The overall level of PCMC during childbirth among adolescents in rural northern Uganda was moderate. The factors positively associated with PCMC included being married and engaging in casual labour while those negatively associated included attending five to seven antenatal visits, receiving episiotomy, having a birth companion, and having a newborn with complications. Most participants expressed moderate to high satisfaction with care. Moderate and high PCMC scores were positively associated with satisfaction with care during childbirth. Most adolescents expressed intentions to have another child, return to the same facility for future childbirth, and recommend the same facility to a sister or friend. Moderate and high PCMC scores were positively associated with intentions to choose the same facility for the next childbirth and recommend facility to a sister or friend.

Adolescents had mixed experiences during childbirth, ranging from positive experiences of effective communication, dignity and respect, supportive care, and health facility hygiene to negative experiences of disrespect and abuse, and health facility constraints. Negative experiences were driven by lack of birthing necessities, younger age, and perceived low social status while positive experiences were driven by passive compliance, calm demeanor, soft interpersonal skills, possession of birthing necessities, cleanliness, and smartness.

This chapter discusses the key findings related to the study objectives which were to (i) assess the level of Person-Centred Maternity Care (PCMC) during childbirth and associated factors, (ii) examine the association between PCMC and satisfaction with care, (iii) examine the association between PCMC and future childbearing intentions, (iv) explore adolescents' experiences of childbirth, and (v) identify the drivers of adolescents' experiences of care during childbirth. The chapter also integrates the quantitative and qualitative findings by way of explanation and comparing areas of agreement and disagreement. The chapter ends by presenting the study strengths, limitations, and contribution of the study.

7.1 Person-Centred Maternity Care During Childbirth

The overall PCMC and its sub-domains of dignity and respect, communication and autonomy, and supportive care during childbirth was measured using the PCMC tool. The overall PCMC and sub-scale scores were categorised into low, moderate, and high. Low was defined as scores in the lower 25th percentile, moderate as scores between the 50th and 75th percentile and scores in the top 75th percentile were defined as high (Afulani, Diamond-Smith, et al., 2017).

7.1.1 Person-Centred Maternity Care

The overall PCMC percentage mean score was 62% which indicates that participants had a perceptions of moderate PCMC during childbirth. This results aligns with the results of studies conducted in Ethiopia, Kenya, India, Pakistan, and Nepal, which found moderate levels of PCMC among women who gave birth in public health facilities (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Hameed et al., 2023b; Kiti et al., 2022; Montagu et al., 2020; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Sudhinaraset et al., 2019; Tarekegne et al., 2022; Tomita et al., 2023). The qualitative interviews highlighted resource constraints, a culture of disrespect and abuse, negative attitudes and behaviours of healthcare providers towards adolescents as some of the factors that could have contributed to the moderate scores rating of PCMC. These results highlight the importance of training skilled healthcare personnel in PCMC approaches and strengthening the demand for person-centred care, regardless of the demographic characteristics of women.

7.1.2 Dignity and Respect

Participants perceived a moderate level of dignity and respect (60%). This was consistent with the theme of dignity and respect in the qualitative interviews embodied by respectful and friendly care. This finding aligns with a study conducted among women of reproductive age in Pakistan, which also reported a moderate level of dignity and respect at 55% (Hameed et al., 2023b). However, the findings of this study differ from the much higher levels of 81-87% in Ethiopia, 74-82% in Kenya, and 78% in India (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Kiti et al., 2022; Montagu et al., 2020; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Sudhinaraset et al., 2019; Tarekegne et al., 2022; Tomita et al., 2023). The perceptions of moderate dignity and respect among adolescents, in contrast to the generally higher scores among older women, highlight the vulnerability of adolescent mothers to being mistreated during childbirth (Bohren et al., 2019; Irinyenikan et al., 2022; Lusambili et al., 2020; Maya et al., 2018). This emphasises the need for targeted adolescent friendly maternity care.

7.1.3 Communication and Autonomy

Previous studies have underscored a high violation of the autonomy of women in areas of communication, decision-making, involvement in their care, and consenting processes (Bohren et al., 2019; Füzy et al., 2020; Irinyenikan et al., 2022; Lusambili et al., 2020). The high disregard for their autonomy may be attributed to lack of empowerment. The lack of empowerment of women may manifest as lack of birthing necessities, perceived low social status, and passive compliance to instructions as highlighted in the qualitative arm of this study. Contrary to previous studies, our study notes that adolescents received at least a moderate level of communication and autonomy during childbirth (60%). The disparity in findings could be attributed to the differences in the study setting. This study was conducted among adolescents who gave birth in primary health facilities where the healthcare providers tend to have close connections with the clients since they are usually part of that closed community. The generally low patient load in primary health facilities also fosters effective communication between clients and providers, and the promotion of clients' autonomy during care (Kim & White, 2018).

7.1.4 Supportive Care

Adolescent mothers should be provided with supportive care during childbirth that is sensitive to their needs and strengthens their capability for a positive childbirth experience (World Health Organization, 2016b). Previous studies reported moderate levels of support during childbirth (Dagnaw et al., 2022; Dagnaw et al., 2020; Getahun et al., 2022; Hameed et al., 2023b; Montagu et al., 2020; Odiase et al., 2021; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Tarekegne et al., 2022). Types of support include hospitable care, encouragement, partnership, companionship, and timely care as highlighted in the qualitative arm of this study. These findings are consistent with the results of this study where participants also reported moderate levels of support during childbirth (64%). These findings suggest that there is room for improvement when it comes to support rendered to women during childbirth.

7.1.5 Factors Associated with Adolescents' Perceptions Person-Centred Maternity Care During Childbirth

The factors positively associated with adolescents' perceptions of moderate/high PCMC during childbirth were being married (AOR= 2.61, 95% CI: [1.01, 6.76]), engagement in casual labour (AOR= 3.18, 95% CI: [1.52, 6.68]), and having an episiotomy (AOR= 1.88, 95% CI: [1.05, 3.36]). The factors negatively associated with adolescents' perceptions of PCMC during childbirth were attending five to seven antenatal visits (AOR= 0.52, 95% CI: [0.33, 0.83]), having birth companions (AOR= 0.34, 95% CI: [0.19, 0.60]), and having a newborn who had complications (AOR= 0.25, 95% CI: [0.09, 0.68]). These findings indicate that myriad

factors influence adolescents' perceptions of PCMC during childbirth in public health facilities in rural northern Uganda.

In this study, participants who were married were significantly more likely to report higher PCMC scores compared to those who were single. This was consistent with studies conducted in Kenya, where being married was significantly associated with higher PCMC scores (Afulani, Sayi, et al., 2018; Kiti et al., 2022). These findings are plausible because culturally, childbirth within marriage confers respect on the mother from healthcare providers as opposed to pregnancy outside marriage (Baba et al., 2020). Marriage might also provide a better support system during labour and childbirth, which could explain the perceptions of higher PCMC during childbirth among the married adolescents participants (Kashaija et al., 2020). These findings highlight the potential positive impact of marriage as a support system for adolescents during childbirth.

A multi-country study conducted in Ghana, Guinea, and Nigeria found the presence of labour and birth companions to reduce the risk of mistreatment and abuse of women by healthcare providers (Balde et al., 2022). Similarly, studies conducted in Sri Lanka and Kenya have found a positive association between birth companionship and higher PCMC (Kiti et al., 2022; Rishard et al., 2021). However, this study found a reduced likelihood of experiencing higher PCMC among participants who had birth companions compared to those who had no birth companions. This could be explained by the difference in the type of birth companion in this study. Adolescents were often brought to the health facility by their mother-in-law, who may not be the best birth companion due to the new relationship and the possibility of being an unwanted daughter-in-law. In low-middle-income countries, older women hold positions of authority regarding maternal and child health and serve as caregivers, decision-makers, and provide practical support for the younger women (Aubel, 2021). This may sometimes translate to poor supportive care as recounted by some of the participants during the qualitative interviews. These findings highlight the need to evaluate the effect of the type of birth companions on PCMC among adolescents during childbirth.

Participants who were engaged in casual labour such digging for daily income reported significantly higher PCMC scores compared to their counterparts engaged in agricultural labour. This could be attributed to the fact that casual labour gives these adolescents daily income as opposed to agricultural labour which is seasonal. This enables adolescents engaged in casual labour to have disposal income to purchase the necessary birthing necessities and dress well thus attracting favourable treatment as noted in the qualitative arm of the study. This result is consistent with the results of studies conducted in Kenya which revealed that economically empowered women had higher PCMC scores (Afulani, Sayi, et al., 2018; Kiti et al., 2022;

Odiase et al., 2021). These findings highlight the potential connection between economic empowerment and PCMC. Casual labour not only be associated with women's economic empowerment but also serves as a proxy for other forms of empowerment, including psychosocial empowerment (Afulani, Sayi, et al., 2018; Biswas & Banu, 2023; Senapati & Ojha, 2019; Wekwete, 2014). These findings suggest that enabling women to engage in income-generating activities can potentially improve their birthing experiences including perceptions of PCMC during childbirth.

The WHO recommendations on intrapartum care for a positive childbirth experience recommends an episiotomy in case of tight perineum and the episiotomy should be provided after providing effective local anaesthesia and obtaining informed consent (World Health Organization, 2018). This study found that participants who had episiotomy were 1.88 times more likely to report moderate to high levels of PCMC during childbirth compared to those who did not. The higher PCMC scores among participants who received an episiotomy may relate to how the episiotomy was done especially the provision of information, consenting process, and provision of adequate analgesia. This finding contradicts the results of previous studies that did not find any connection between episiotomy and PCMC during childbirth (Dagnaw et al., 2020; Getahun et al., 2022; Oluoch-Aridi, Afulani, Makanga, et al., 2021; Rishard et al., 2021; Tarekegne et al., 2022). These results suggest that when an episiotomy is performed according to the new WHO recommendation, it may improve women's perceptions of PCMC and enhance the overall experience of care during labour.

Unlike previous studies which found a positive association between the number of antenatal care visits and PCMC during childbirth (Getahun et al., 2022; Tarekegne et al., 2022), this study revealed that participants who had five to seven antenatal visits were 48% less likely to report moderate or high levels of PCMC during childbirth compared to those who had fewer visits. This may be explained by the influence of repeated antenatal care visits which may have contributed to disruption of economic activity and loss of income (Banke-Thomas et al., 2021). Repeated exposure to the antenatal clinic may also contributed to elevated cultural health capital, heightened expectations of care, increased exposure to mistreatment, and consequently a perception of lower PCMC during childbirth (Dubbin et al., 2013; Shim, 2010). These inconsistencies in findings call for further research to examine the association between antenatal care visits and PCMC among adolescents in different settings.

Adolescent participants whose newborns experienced complications were 75% more likely to report lower levels of PCMC compared to those whose newborns had no complications. This finding is understandable because adverse perinatal outcomes are known to have a negative influence on women's utilisation and

perceptions of the care (Dowse et al., 2020; Heslehurst et al., 2018; Muwema et al., 2024; Shiferaw et al., 2021). This result is similar to the results of a study conducted in Kenya among 531 women, which found that women with high PCMC scores were significantly less likely to have experienced newborn complications such as birth asphyxia, hypothermia, low birth weight compared to those with low PCMC scores (Sudhinaraset et al., 2020). These findings highlight the impact of adverse perinatal outcomes on women's perceptions of care and emphasise the importance of addressing and preventing perinatal complications to enhance the overall care experience for mothers.

7.2 Satisfaction with Care During Childbirth

Satisfaction with care provides another dimension to evaluate the quality of care. This study examined the level of satisfaction among adolescents regarding care during childbirth in public health facilities in rural northern Uganda. The overall mean satisfaction score was found to be 30.12 (SD ± 4.10) out of a maximum score of 42. Most respondents (65.18%) reported moderate satisfaction scores (28-33). The moderate satisfaction with care could be attributed to the adolescents' mixed experiences during childbirth, ranging from positive experiences of effective communication, dignity and respect, supportive care, and health facility hygiene to negative experiences of disrespect and abuse, and health facility constraints.

The moderate satisfaction with care differs from that of a multi-country study conducted in Ghana, Guinea, Myanmar, and Nigeria, which reported high levels of satisfaction with childbirth care among women of reproductive age (Maung et al., 2022). The results of this study are also inconsistent with the findings of studies conducted in high-income countries such as Italy, Norway, Slovakia, and Brazil, where high levels of satisfaction with labour and childbirth care were reported, with satisfaction rates exceeding 80% (Bains et al., 2021; Lazzerini et al., 2020; Mazúchová et al., 2020; Passarelli et al., 2019).

The significant difference in findings between this study and the previous ones could be attributed to various factors, such as differences in the study population, data collection methods, and healthcare systems. This study specifically focused on adolescents, a group known to be particularly susceptible to mistreatment during childbirth compared to older women, while the previous studies examined the general population in higher income countries (Bohren et al., 2019; Irinyenikan et al., 2022). Data collection methods varied, the current study used the Six Simple Questions tool which is brief and easy to administer to assess satisfaction with care, whereas the multi-country study employed one question on the Community Survey Tool, and the Italian study relied on a single question rated on a 10-point Likert scale (Lazzerini et al., 2020; Maung et al., 2022). Meanwhile, the Brazilian study utilised the North Bristol Modified Mackey Childbirth Satisfaction Rating

Scale questionnaire (Passarelli et al., 2019). Moreover, it's worth noting that the healthcare system in Uganda is generally weaker in comparison to middle and high-income countries (Marchildon et al., 2021).

7.2.1 Association Between Adolescents' Perceptions of Person-Centred Maternity Care During Childbirth and Satisfaction with Care

This study examined the association between the PCMC and the sub-scale items with satisfaction with care during childbirth. PCMC had a statistically significant association with satisfaction with care as did the PCMC sub-scales of communication and autonomy and supportive care. These findings show that PCMC particularly aspects of supportive care, and communication and autonomy, are associated with adolescents' satisfaction with care during childbirth.

7.2.1.1 PCMC and Satisfaction with Care

Participants who had perceptions of moderate and high levels of PCMC during childbirth had statistically significantly higher satisfaction scores compared to those who had perceptions of low levels. This finding suggests a strong positive association between higher levels of PCMC and satisfaction with care during childbirth. This result aligns with a study conducted in Sri Lanka, which included 400 women, and found a positive correlation between PCMC and satisfaction with care during childbirth (Rishard et al., 2021). Unlike the Sri Lanka study, this research also sheds light on the extent to which low, moderate and high levels of PCMC influence women's report of satisfaction with care during childbirth by performing a multiple linear regression analysis. The results of these studies support the World Health Organization (2016a) call for the implementation of quality care for maternal and newborn care in health facilities to achieve a positive intrapartum outcome.

7.2.1.2 Dignity and Respect, and Satisfaction with Care

This study found no evidence of association between dignity and respect, and satisfaction with care during childbirth. This result contradicts previous studies conducted in Italy, the Netherlands, and the USA, which found that women who were treated with dignity and respect were more likely to report being satisfied with the care they received during childbirth (Gregory et al., 2019; Lazzerini et al., 2020; Peters et al., 2019). A multi-country study conducted in Ghana, Guinea, Myanmar and Nigeria also found that women who experienced mistreatment during childbirth were more likely to report lower satisfaction with care (Maung et al., 2022). The inconsistency in findings provides an opportunity to explore the role of respect and dignity on adolescent's perceptions of PCMC during facility-based childbirth in different settings.

7.2.1.3 Communication and Autonomy and Satisfaction with Care

Study participants who had perceptions of moderate and high levels of communication and autonomy during childbirth reported significantly higher satisfaction with care scores. This finding indicates that adolescent participants with perceptions of moderate and high levels of PCMC had a higher likelihood of being satisfied with care during childbirth compared to those with low scores. The communication between clients and providers, as well as promoting clients' autonomy during birth, are the foundation for providing care that is respectful, responsive, and based on the preferences and values of the clients (Afulani et al., 2020; Sudhinaraset et al., 2017; Van der Pijl et al., 2021). The results of this study are similar to findings from studies conducted in Italy, Iran, the Netherlands, and the USA, which demonstrated that effective communication between facility staff and women during childbirth was positively associated with women's satisfaction with care (Gregory et al., 2019; Lazzerini et al., 2020; Peters et al., 2019; Shamoradifar et al., 2022). These results demonstrate that enhancing communication and autonomy in childbirth care is positively associated with satisfaction with care.

7.1.2.3 Supportive Care and Satisfaction with Care

Support during childbirth and the physical facility environment are crucial aspects of support for women during childbirth which understandably enhance their satisfaction with care (World Health Organization, 2016a). In this study, participants who had perceptions of moderate and high levels of supportive care during childbirth reported significantly higher satisfaction with care scores compared to those with low levels. This result aligns with findings from previous studies conducted in Sri Lanka, China, Slovakia, Mozambique, Turkey, and Brazil (Demirel et al., 2022; Liu et al., 2021; Lopes et al., 2021; Mazúchová et al., 2020; Mocumbi et al., 2019; Rishard et al., 2021). These results are supported by the qualitative finding of this study which found that supportive care during childbirth manifested as hospitable care, encouragement, partnership with the women, and companionship during labour and childbirth was associated with a positive childbirth experience. Supportive care may also be contributed by the condition of the health facility such as hygiene of the bathroom, toilets and labour suites. These findings highlight the importance of promoting companionship during childbirth and improving the physical facilities of healthcare facilities to enhance the quality of maternal and newborn care.

7.3. Future Childbearing Intentions

Future childbearing intentions of adolescents following their childbirth was also assessed. The childbearing intentions included intentions to have children in the future, give birth at the same facility, and recommend the facility to a sister or friend. Despite moderate levels of PCMC during childbirth, adolescents' future childbearing intentions were high, demonstrating resilience, confidence in healthcare services, and a positive perception within their community.

7.3.1 Intentions to Have Another Child in the Future

This study found that 82% of the participants expressed a desire to have another child in the future, accounting for more than three-quarters of the participants. This result is consistent with similar studies conducted in China and Israel among women of reproductive age, which also reported high rates of fertility intentions after facility-based childbirth (Preis et al., 2020; Zeng et al., 2023). The intention to have another child is plausible considering the young age range of the study participants (14 to 19 years) and because most of them had only given birth once (89.5%). These results challenge the prevailing argument that adolescent childbirth experiences are largely negative and may be damaging to their future fertility intentions (Füzy et al., 2020; Lusambili et al., 2020; Preis et al., 2020). These findings suggest that women including adolescents may have preconceived fertility goals they would like to achieve regardless of their age and birth experiences.

7.3.2 Intentions to Give Birth in the Same Facility in the Future

Similarly, the study found that over three-quarters of participants (82.68%) would choose the same health facility for their next childbirth, regardless of their previous childbirth experience. The intention to give birth in the same facility underscores the reported moderate to high level of satisfaction with care among adolescents. The choice to return to the same facility could have been influenced by limited options for free government health facilities in the geographic area, long distance to the next facility, and inability to afford care in private health facilities due to their income levels or it may be low expectations for the quality of care in public health facilities. Preference to give birth in the same facility is consistent with a study in Kenya, which reported that 85% of the women would choose the same provider/facility for their next childbirth (Sudhinaraset et al., 2020). The strong preference of adolescents to choose the same health facility for future childbirths, despite different childbirth experiences, highlights the significant role of accessibility and financial constraints in influencing healthcare decisions (Bowser & Hill, 2010). It also highlights that perhaps their childbirth experiences were not so negative as to warrant finding somewhere else.

7.3.3 Intentions to Recommend the Same Facility to a Sister or a Friend

Recommending a relative to access healthcare in the same facilities underscores the perception of quality of care. Like the preference to give birth in the same facility, a significant majority of participants (84.6%) agreed that they would recommend their birthplace to a sister or friend. This is likely because these participants had largely positive childbirth experiences, as unpacked in the qualitative findings. These results align with a multi-country study conducted in Ghana, Guinea, Myanmar, and Nigeria, among 2672 women which revealed that 90% of these women would recommend their birthplace to others, such as friends or family (Maung et al., 2022). Similar findings were also reported in studies conducted in Italy (79.3%), Mozambique (94.2%), and Guatemala (85%) (Lazzerini et al., 2020; Mocumbi et al., 2019; Peca & Sandberg, 2018). The high level of agreement among women including adolescents in recommending their birthplace to others may reflect the degree to which care was perceived and their families' preferences, needs, and values during pregnancy and childbirth. These findings underscore the importance of positive childbirth experiences in shaping individuals' perceptions of care and health-seeking patterns.

7.3.4 Association Between Person-Centred Maternity Care and Future Childbearing Intentions

The relationship between PCMC and its sub-scales and adolescents' future childbearing intentions was examined statistically. Although there was no evidence of association between the overall PCMC or its sub-scales with intentions to have another child in the future, there was evidence of association between PCMC and intentions to give birth in the same facility in the future or recommend it to others. Notably, intentions to give birth in the same facility or recommend it to others in the future were significantly associated with supportive care, communication, and autonomy sub-scales. These findings indicate that improving PCMC, particularly aspects of communication, autonomy, and supportive care may positively influence adolescents' intentions to use the same facility for future births or recommend it to others.

7.3.4.1 PCMC and Intentions to Have Another Child in the Future

One of the interesting findings of this study was that the overall PCMC or sub-domains were not associated with adolescents' fertility intentions. This finding is consistent with a study conducted in Kenya which found no evidence of an association between PCMC scores and women's fertility intentions (Sudhinaraset et al., 2020). However, this finding contradicts previous studies that found evidence of association between domains of PCMC such as supportive care, dignity, and respect and intentions to give birth in the future (Lazzerini et al., 2020; Maung et al., 2022; Peca & Sandberg, 2018; Preis et al., 2020; Zeng et al., 2023). The differences in findings could be due to variations in study power and participant characteristics. For example, the study conducted by Preis et al. (2020) among Israel's women found that most of the participants

(88%) had decided prenatally on their desired number of children which speaks to a clear fertility plan among those in that context.

It is also worth noting that adolescents are more likely to experience mistreatment during childbirth than older women (Bohren et al., 2019; Kruk et al., 2014; Lusambili et al., 2020; Oosthuizen et al., 2017), and this increases their chances of normalising disrespect and abuse during childbirth. This could potentially minimise the influence of disrespect and abuse on their decision-making regarding future childbearing. The discrepancies between the findings of this study and previous studies call for further research on the association between PCMC and women's future childbearing intentions.

7.3.4.2 PCMC and Intentions to Give Birth in the Same Facility in the Future

PCMC fosters an environment that promotes trust, satisfaction, and positive relationships between women and healthcare providers (Sudhinaraset et al., 2017). This study found that participants who had perceptions of moderate and high levels of PCMC during childbirth said that they would return to the same health facility for subsequent childbirth compared to those with low levels. This was particularly evident in adolescent participants who received appropriate supportive care, communication, and autonomy during childbirth. This finding aligns with the results of a study conducted in Kenya, Guatemala, and Italy which revealed that women with higher PCMC scores had significantly higher odds of expressing a willingness to return to the same facility for future childbirth compared to those with low PCMC scores (Lazzerini et al., 2020; Peca & Sandberg, 2018; Sudhinaraset et al., 2020). Therefore, future interventions aimed at improving adolescents' utilisation of maternal and newborn care services should prioritise strengthening the implementation of PCMC, particularly in terms of supportive care, communication between clients and providers, and promoting clients' autonomy during care.

7.3.4.3 PCMC and Intentions to Recommend the Same Facility to a Sister or a Friend

Participants who had perceptions of moderate and high levels of PCMC during childbirth said that they would recommend the facility to a sister or friend compared to those who had perceptions of low levels with PCMC sub-domains of supportive care, communication, and autonomy playing key roles in the observed association. This finding is plausible because implementing PCMC creates an environment where adolescents feel confident and connected to the facility, making them comfortable recommending it to others (Sudhinaraset et al., 2017). This result is consistent with results of studies conducted in Kenya, Guatemala, Ghana, Guinea, Myanmar, and Nigeria, which also found that implementing PCMC is associated with women's likelihood of recommending the facility (Maung et al., 2022; Peca & Sandberg, 2018; Sudhinaraset

et al., 2020). These results underscore the importance of implementing PCMC especially the aspects of dignity and respect, communication between clients and providers, and the promotion of clients' autonomy in fostering confidence and connection to the facility.

7.4 Adolescents' Experiences of Care During Childbirth

This study explored adolescents' experiences during childbirth and found mixed experiences of care. The themes related to positive childbirth experiences included effective communication, dignity and respect, supportive care during childbirth, and health facility hygiene. Conversely, disrespectful and abusive behaviour and constraints within health facilities were identified as contributing to negative childbirth experiences. The themes identified in this study align with the experience dimensions of quality of maternal and neonatal care outlined in the WHO Framework for Quality of Maternal and Newborn Care (World Health Organization, 2016a, 2019a).

Previous studies have mostly highlighted the negative experiences of mistreatment of women during childbirth (Bohren et al., 2019; Bowser & Hill, 2010; Füzy et al., 2020; Irinyenikan et al., 2022). Contrary to previous studies, our study noted that adolescents generally reported positive experiences during childbirth ranging from effective communication, dignity and respect, supportive care, and hygienic health facilities. The overwhelmingly positive childbirth experiences reported by adolescents may be influenced by their past social interactions and lower expectations of healthcare due to their disadvantaged societal position, which aligns with Bourdieu's concept of 'habitus' (Bourdieu, 2018; Shim, 2010). Additionally, the positive childbirth experiences could be because they gave birth in lower-level health facilities (H/C III and H/C IV) with less workload compared to higher-level health facilities, which facilitates individualised care (Asamani et al., 2015; Ogu et al., 2017). These findings highlight the importance for healthcare providers to recognise the diverse experiences and expectations of different demographic groups, such as adolescents, during childbirth, and to tailor their care accordingly to promote positive outcomes and satisfaction with care.

Despite more evidence of positive experiences, the negative experiences are quite serious, and one could argue that they tip the balance of experiences of these adolescent participants. The forms of mistreatment reported by the study participants included physical and verbal abuse, neglect and abandonment, non-consented care, disempowerment, bribery, and extortion. Participants also reported negative experiences related to dirty toilets and bathrooms, an unstable water supply, and a shortage of essential medicines and supplies. Adolescent participants attributed these negative experiences to lack of birthing necessities, younger age, and perceived low social status by skilled care providers. The poor amenities and provision of

services could also be attributed poor infrastructure maintenance and inefficient supply chain management, all of which lead to substandard conditions (Asim et al., 2023; Buback et al., 2022; Okedo-Alex et al., 2020; Warren et al., 2017). These abuses are a violation of human rights, of professional practice and exploitation of people at a point of great vulnerability and they contravene multiple international human rights frameworks, including the Respectful Maternity Care Charter, Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, which guarantee the right to health, informed consent, and freedom from torture and degrading treatment (Alfredsson & Eide, 2023; Alston, 2020; White Ribbon Alliance, 2011).

These findings align with the results of previous studies conducted in South Africa, Ghana, Guinea, Myanmar, and Nigeria among adolescents, which reported similar accounts of mistreatment during childbirth among adolescents (Bohren et al., 2019; Füzy et al., 2020; Irinyenikan et al., 2022). They are also consistent with results of studies conducted in other low-middle-income countries, where poor health facility environment was identified as one of the factors contributing to negative birth experiences (Afulani, Kirumbi, et al., 2017; Ahmed et al., 2023; Oluoch-Aridi, Afulani, Guzman, et al., 2021). These findings call for strengthening the demand for respectful and dignified care during childbirth to ensure a positive childbirth experience.

7.5 Drivers of Adolescents' Mixed Experiences of Care During Childbirth

The study examined the factors influencing adolescents' childbirth experiences and three main themes were identified namely, the reasons for receiving favourable treatment, the reasons for mistreatment, and mechanisms for coping with mistreatment. These findings demonstrate how adolescents actively assert control, make decisions, and take steps to safeguard their survival and well-being during the crucial and vulnerable period of childbirth. The results also shed light on the reasons why some adolescents are treated positively while others face negative treatment during facility-based childbirth.

Participants identified several factors contributing to mistreatment during childbirth, such as being young, lack of birthing necessities (basin, surgical gloves, obstetric scan results, mackintosh), and perceived low social status. Being young may result in inexperience in navigating the maternity setting and a lack of social support networks, which is necessary to protect against mistreatment while seeking care (Dubbin et al., 2013; Shim, 2010; Zamani et al., 2019). The absence of birthing requirements and low socioeconomic status may lead to a lack of resources and personal agency in accessing healthcare, thus resulting in mistreatment (Dubbin et al., 2013; Shim, 2010). These results are consistent with previous studies, which have reported young age, low socioeconomic status, and lack of social support as factors contributing to the mistreatment

of adolescents during childbirth (Adler et al., 2020; Chabbert et al., 2021; Fenaroli et al., 2019; Hosseini Tabaghdehi, Kolahdozan, et al., 2020; Vedam et al., 2019). These findings help to explain and understand the social production of mistreatment during childbirth among vulnerable groups and may be useful in designing targeted interventions to prevent mistreatment in this group.

According to the Cultural Health Capital Theory (Shim, 2010), material possessions and one's looks represent objectivised capital, which serves as indicators of favourable social and economic status and empowerment (Dubbin et al., 2013; Shim, 2010). They may also serve as a proxy for other forms of empowerment, including sociocultural, cognitive, and psychosocial empowerment, ultimately resulting in favourable treatment (Shim, 2010). Participants reported that having the necessary birthing requirements and maintaining cleanliness and a neat appearance were key factors leading to their favourable treatment. This finding aligns with previous studies which found that empowered women from higher socioeconomic backgrounds were more likely to receive favourable care during childbirth (Afulani, Sayi, et al., 2018; Chabbert et al., 2021).

7.6 Reflection on Positionality

It is important to reflect on how my positionality especially during Phase II of the study evolved as I come to the end of my research project. Again, positionality refers to the researcher’s worldview and the positions that s/he adopts while carrying out research and how that position influences the conduct of research (Holmes, 2020). My positionality was in my ontological, epistemological, and methodological positions about the study subject matter, research participants, and the study context.

Ontologically, in Phase II of the study, I embraced the position of social constructivism. Social constructivism assumes that reality is shaped through social interactions, in which individuals collectively create shared meanings and realities (Saunders et al., 2009). As both a nurse-midwife and a researcher, I initially held the belief that adolescents' experiences during childbirth were predominantly negative, and I was eager to explore this further during my in-depth interviews. However, I discovered that many of the adolescents actually had positive childbirth experiences, albeit with some negative aspects.

As a midwife educator, I have heard various accounts of poor experiences of care during childbirth from my students. I thought I would be somewhat desensitised to listening to explicit accounts of mistreatment of adolescents during childbirth. However, I still found myself curious about these negative experiences and probed further. This could be because there weren't as many overt forms of abuse as I had anticipated, and it was my first time conducting in-depth interviews on this topic. Additionally, my decision to take an emic position during the interviews allowed the adolescent participants to express their experiences of care during

childbirth using socially and culturally specific terminologies or references that are meaningful to them and that enriched the study.

Epistemologically, I took a subjective stance when examining adolescents' experiences of care during childbirth and the factors that influence these experiences. This approach allowed me to delve into the various ways in which adolescents perceive and are impacted by care, something that would not have been feasible otherwise. Drawing on my prior knowledge of PCMC, I was also able to closely observe any emerging forms of PCMC during the interviews. However, the themes that unravelled regarding the drivers of adolescents' experiences of care during childbirth will significantly broaden the existing literature on this topic.

Methodologically, I used an inductive approach for data analysis and later compared the themes with the frameworks used in the study. This turned out to be a wise decision as it allowed the themes to naturally emerge. By later juxtaposing the themes with the frameworks, it gave the study structure and facilitated the presentation and discussion of the research results.

7.7 Study Strengths and Limitations

7.7.1 Study Strengths

One of the major strengths of this study lies in its utilisation of a mixed-methods research design, which conferred numerous advantages. The incorporation of a mixed-methods research design fostered a unified comprehension of the research phenomenon which would otherwise be limited using a single methodological approach.

Secondly, the use of established frameworks in Phase I (WHO Framework for the Quality of Maternal and Newborn Health Care and Person-centred Care Framework for Reproductive Health Equity (Sudhinaraset et al., 2017; World Health Organization, 2016a)) of the study ensured a rigorous conceptualisation of the study and a systematic assessment of the outcome variables. Furthermore, the use of the Cultural Health Capital Theory (Shim, 2010) offered a concise approach to explaining some of the drivers of care during childbirth among adolescents.

Thirdly, this study focused on a unique population (adolescents) in the context of public primary health facilities in rural northern Uganda whose experiences during childbirth had been under-studied. The results of this study provided valuable insights into the quality of maternal and newborn care services in the study setting, especially on aspects of PCMC during childbirth and how it influences experience of care, satisfaction with care, and future childbearing intentions among adolescents. The use of the local dialect during the

interviews also allowed the participants to express their feelings and emotions in a manner that enriched the understanding of adolescents' experiences of care during childbirth and their drivers.

Finally, the tools used for the measurement of PCMC during childbirth (PCMC scale), satisfaction with care (Six Simple Questions), and future childbearing intentions (Community Survey Tool) were all valid based on their Cronbach Alpha values. This increased the confidence in the study findings in a manner that promote the utilisation of the study findings in practice, research, and policy formulation.

7.7.2 Study Limitations

7.7.2.1 Generalisability

The survey results of this study may not apply to adolescents who give birth in private health facilities and urban settings since this study was conducted specifically among adolescents who gave birth in public health facilities located in rural areas of northern Uganda. However, the results of this study may prompt future research among adolescents giving birth in private and urban settings in northern Uganda or other regions to corroborate or challenge these finding.

7.7.2.2 Cross-Sectional Nature of the Survey

The cross-sectional nature of the survey limited our ability to establish causal relationships between the outcome variables (PCMC, satisfaction with care, and future childbearing intentions) and independent variables. This limitation prevented exploration of temporal dynamics and determining the directionality of relationships among variables. Therefore, the findings should be interpreted cautiously, considering the inherent constraints of the study design in inferring causality. Future research that utilises longitudinal or experimental designs would be valuable in gaining a better understanding of the causal pathways underlying the associations between the outcome and independent variables.

7.7.2.3 Recall Bias

The measurement of PCMC, satisfaction with care, future childbearing intentions, and experiences of care relied on self-reporting, which could have introduced recall bias. However, this was minimised by conducting the survey and the in-depth interviews between two and six weeks after childbirth when participants' memories of the experience were still vivid.

7.7.2.4 Social Desirability Bias

Participants may have been hesitant to fully disclose their negative childbirth experiences out of fear of mistreatment and the denial of services during subsequent facility visits. To address this, interviews were

conducted within the community in a private and friendly environment to ensure that conversations could not be overheard. Participants were also reassured that their confidentiality would be maintained throughout the study. Furthermore, the potential influence of social desirability bias was minimised by utilising trained research assistants who were skilled in communicating with adolescents and who were not healthcare providers.

7.7.2.5 Short Follow-Up Time

The relatively short four-week follow-up time frame disqualified some adolescents from participating in the study, potentially affecting the diversity of the study participants. However, the survey used a cluster sampling technique to recruit as many eligible participants as possible, which could have mitigated this limitation. Also, the maximum variation sampling applied in the qualitative arm of the study improved the inclusivity of the study.

7.7.2.6 Outsider/Etic Perspective

The researcher's familiarity with issues surrounding maternity care, as a nurse-midwife, could have provided external perspectives on adolescents' childbirth experiences. However, this also poses a risk of incomplete understanding or misinterpretation of the observed phenomenon. Nonetheless, the researcher was reflexive and maintained awareness of his positionality by keeping a journal during data collection and analysis. This practice facilitated critical appraisal and self-reflection throughout the data collection process.

7.7.2.7 Confirmation Bias

The researcher could have produced interpretations that were aligned with preconceived ideas or the study framework during the thematic analysis. This was minimised by utilising the inductive thematic analysis technique and maintaining a balance between the study framework and the perspectives of the participants by demonstrating the connection between the framework, the literature, and the narratives of the participants. The coding of some of the transcripts by the researcher’s supervisor also minimised this bias.

7.7.2.8 Response Bias

The application of nested sampling by selecting of participants who participated in Phase I of the study to participate in Phase II of the study could have biased the responses of participants since some of the questions asked during the survey were similar to questions asked during the in-depth interview. However, the risk of response bias was minimised by allowing at least one month to elapse between the survey and the in-depth interview.

7.8 Contribution of the Study to Gaps in the Literature

This study extended the boundary of literature on adolescents' perceptions of PCMC during childbirth. Firstly, by conducting the study in Uganda, a country where literature on PCMC during childbirth is limited. Secondly, since the focus of this study was on adolescent, it added literature on adolescents' perceptions of PCMC during childbirth in a unique population. It further examined whether there is variation in PCMC among early (14-15 years), middle (16-17 years), and older (18-19 years) adolescents.

This is one of the few studies that used Principal Component Analysis (PCA) to estimate the wealth of adolescents postnatally. PCA is a valuable statistical tool for estimating the wealth of a population, particularly in resource-constrained settings by capturing the multi-faceted nature of wealth through composite indices. This method enabled the researcher to overcome the challenges of direct income measurement, which can be unreliable or unavailable, and provided a robust, data-driven proxy for socio-economic status of adolescents who gave birth in public health facilities in rural northern Uganda. Employing PCA facilitated a more nuanced understanding of the socio-economic determinants of adolescent childbirth experience.

This study enhanced understanding of the relationship between adolescents' perceptions of PCMC and important outcomes, such as satisfaction with care and intentions for future childbearing. By providing empirical evidence on how PCMC, including its sub-domains of dignity and respect, communication and autonomy, and supportive care, influences adolescents' perceptions of care, this study emphasised the critical importance of PCMC in improving maternity experiences. Additionally, the study revealed how positive care experiences during childbirth can lead to greater satisfaction and more positive attitudes towards future childbearing. These connections underscore the need for healthcare systems to prioritise PCMC to enhance maternal health outcomes and address the unique needs of adolescent mothers. Therefore, the findings of this study contribute to the broader discussion on maternal health by advocating for policy changes and training programs that focus on providing compassionate, respectful, and individualised care.

This study expands the scope of literature beyond adolescents' experiences to systematically investigate the drivers of their experiences during healthcare interactions. By examining these factors from the perspective of adolescents, we asked them to explain why they received positive or negative treatment during childbirth. This approach provided new insights, moving beyond the rhetoric surrounding the determinants of mistreatment of older women during childbirth, to offer a more comprehensive understanding of adolescents' perspectives of why they received positive or negative treatment.

This study also expanded the existing literature on how adolescent empowerment can significantly impact healthcare interactions. By exploring the role of empowerment in shaping adolescents' experiences and outcomes during facility-based childbirth, this research provided valuable insights into how empowered adolescents navigate and influence their healthcare environments. Specifically, the study delved into the concept of cultural health capital during childbirth, identifying key elements such as objectivized capital that contribute to favourable treatment by healthcare providers. This understanding is crucial for ensuring equitable care, as it highlights how cultural health capital can mitigate the effects of socioeconomic disparities and enhance the quality of care received.

Finally, this study is arguably one of the first studies to explore how adolescent women cope with mistreatment during facility-based childbirth. Some of the adolescents developed adaptive strategies to handle mistreatment during childbirth, demonstrating a complex interplay of compliant behaviour, a calm demeanour, and effective interpersonal skills. These findings support Shim's theoretical assertion that individuals can modify their styles of interaction to circumvent mistreatment during childbirth.

7.9 Conclusion

This study examined the positive experiences of adolescent mothers during childbirth, as well as the difficulties they face and how they navigate those challenges. The findings highlight the importance of individual-centred maternal care, overall satisfaction with care, and future pregnancy plans. The study underscores the need for targeted interventions to enhance the quality of maternal healthcare services and promote positive outcomes for adolescents and their infants.

CHAPTER EIGHT: CONCLUSION AND RECOMMENDATIONS

8. Introduction

The concluding chapter summarises the study's research questions, draws conclusions based on the key findings, and makes recommendations for midwifery education, health service management, future research, and policy.

8.1 Conclusion

The study examined adolescents' perceptions of PCMC during facility-based childbirth in rural northern Uganda and how their perceptions influence their satisfaction with care and future childbearing intentions (intentions to give birth, give birth in the same facility, and recommend the same facility to a sister or friend), and explored the drivers of adolescents' experiences of care during childbirth.

Adolescents' perceptions of PCMC during childbirth was assessed using the PCMC scale and data analysis consisted of descriptive statistics, a Chi-square test of association, and multivariate ordinal Logistic regression. Adolescents' perceptions of PCMC during childbirth was generally moderate. Participants who were married, engaged in casual labour, and had an episiotomy were more likely to report moderate to high levels of PCMC during childbirth while those who had five to seven antenatal visits, birth companions, and newborn complications were less likely to report moderate or high levels of PCMC during childbirth. These results show that there are gaps in the implementation of PCMC during childbirth reported by adolescents in primary health facilities in rural northern Uganda. The results of this study can be used to inform the design of interventions to strengthen the implementation of PCMC in primary health facilities in northern Uganda. The results also merit further investigations into how and why birth companionship and more antenatal care visits were negatively associated with PCMC during childbirth among adolescents.

Adolescents' satisfaction with care during childbirth was assessed using the Six Simple Questions (SSQ) tool. A multiple linear regression was run to examine the association between adolescents' perceptions of PCMC during childbirth and satisfaction with care while controlling for the influence of socio-demographic and obstetric characteristics. Most of the participants were generally satisfied with care during childbirth. There was evidence of association between adolescents' perceptions of PCMC and sub-scales of communication, autonomy, and supportive care during childbirth and satisfaction with care. Meanwhile, there was no evidence of the association between the dignity and respect sub-scale and satisfaction with care. These findings may be useful in advancing a conceptual model of Person-Centred Care for Reproductive

Health Equity (PCCRHE) Framework. More research is needed to corroborate the relationship between dignity, respect, and satisfaction with care among adolescents.

Adolescents' future childbearing intentions were assessed using questions on the Community Survey Tool (CST). A multivariate logistic regression was performed to test the association between the PCMC and adolescents' future childbearing intentions while controlling for the influence of socio-demographic and obstetric characteristics. More than three-thirds of adolescents expressed positive intentions toward future childbirth and demonstrated a strong likelihood of returning to and recommending the same health facility. This study helped to expand the WHO Framework for Maternal and Newborn Care in Health Facilities by underscoring the influence of PCMC on women's experience of care and future childbearing intentions. The study findings can be used to strengthen the demand for quality maternal and newborn care to improve women's utilisation of maternal and newborn care services.

Qualitative descriptive research (QDR) design was used to explore adolescents' experiences of care during childbirth and the drivers of how they are treated during childbirth. Individual in-depth interviews were conducted among 14 purposively sampled adolescents who participated in phase I of the study. Inductive thematic data analysis was conducted to identify, analyse, and report patterns within data. Participants' experiences of care during childbirth were multifaceted, encompassing a continuum of positive and negative dimensions. The positive experiences highlighted effective communication, dignity and respect, supportive care, and health facility hygiene, while negative experiences centred around disrespect and abuse, as well as health facility constraints. The drivers of positive experiences of care were possessing birth necessities, smartness, passive compliance to instructions, calm demeanour, and possession of soft interpersonal skills during labour and childbirth while the drivers of negative experiences of care were being young, lack of birthing necessities, and perceived low social status. These findings point to the vulnerability of adolescents during childbirth and the need to be responsive to needs during maternity care to mitigate their vulnerabilities and associated negative outcomes.

8.2 Recommendations

After carefully considering the study findings, the following recommendations are made for midwifery education, practice, future research, and policy.

8.2.1 Midwifery Education

- Midwifery educators should design and incorporate PCMC throughout their midwifery programmes that emphasise the importance of providing care that is person-centred during maternity care.

- Midwifery educators should emphasise adolescent-friendly pregnancy and childbirth care during pre- and in-service trainings.
- Training institutions should train pre-service midwives on implementing PCMC during childbirth and identifying the factors that influence women's perceptions of PCMC during maternity care.

8.2.2 Health Service Management

- The Ministry of Health should train in-service midwives on implementing PCMC during childbirth and identify the factors that influence women's perceptions of PCMC during maternity care.
- The Ministry of Health should offer in-service training for midwives on the developmental tasks of adolescents and their social dependence which are different from adult women.
- District and hospital managers should develop and implement community-based interventions to raise awareness about the importance of PCMC and empower adolescent mothers to advocate for adolescent-friendly services.
- Skilled healthcare providers with healthcare management should provide supportive care during childbirth, maintain effective communication with clients, and promote client autonomy to encourage them to give birth in the same facility or recommend it to others in the future.

8.2.3 Future Research

- Qualitative research is needed to explore the reasons behind the moderate level of PCMC and satisfaction with care among adolescents. Also, the barriers to the provision and uptake of high-quality care to adolescent mothers in this group should be identified.
- Since this study used a cross-sectional design to examine the relationship between adolescents' perceptions of PCMC during childbirth and satisfaction with care and future childbearing intentions, longitudinal studies are needed to examine the impact of PCMC on these outcomes.
- Research should also focus on understanding the role of dignity and respect in adolescents' satisfaction with care and future childbearing intentions despite not finding a significant relationship with satisfaction with care and future childbearing intentions in this study.
- This study showed that adolescents who had birth companions were less likely to receive moderate or high PCMC during childbirth, contrasting with the findings of many similar studies. Future cross-sectional studies should examine this association and assess the types of birth companions that adolescent mothers typically have.
- This study also found that more antenatal care visits was negatively associated with adolescents' perceptions of PCMC during childbirth. Further cross-sectional studies are needed to further examine

the association between antenatal care visits and PCMC among adolescents in different contexts to corroborate or challenge this study findings.

- Future qualitative studies should further investigate the specific strategies that adolescents employ to navigate mistreatment during childbirth, as well as how these strategies may differ across various cultural and socioeconomic contexts. The long-term effects of these adaptive strategies on both maternal and neonatal outcomes should also be examined using longitudinal study designs.

8.2.4 Policy

- The Ministry of Health should prioritise the integration of person-centred approaches into maternal care guidelines and protocols, ensuring that they are adolescent-friendly and promote respectful maternity care.
- Policymakers should address the drivers of negative childbirth experiences among adolescents, such as the lack of birthing necessities and perceived low social status, through policy interventions aimed at improving access to essential resources and promoting equity in healthcare.
- Through the Ministry of Gender, Labour, and Social Development, the Government of Uganda should allocate a budget specifically aimed at economically empowering adolescent women and mothers to improve their social status and end poverty in all its forms among this vulnerable group.

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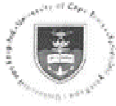
APPENDICES

Appendix 4.1: Ethical Approval from South Africa[8]



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

E52 – Room 46, Old Main Building
Groote Schuur Hospital
Observatory 7925
Email: hrec-enquiries@uct.ac.za
Website: https://health.uct.ac.za/home/human-research-ethics

9th December 2022

HREC REF: 310/2022

A/Prof S Clow
Health & Rehabilitation Sciences
Nursing & Midwifery
Email: Sheila.clow@uct.ac.za
Student Email: (Mr Samson Udho) udhsam001@myuct.ac.za

Dear A/Prof Clow

PROJECT TITLE: DISRESPECT AND ABUSE OF ADOLESCENTS, AGED 10-19 YEARS DURING FACILITY-BASED CHILDBIRTH IN UGANDA: A MIXED-METHODS STUDY-PHD CANDIDATE-MR SAMSON UDHO

Thank you for submitting your response to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

The following documents are noted and approved for the above study:

- New protocol application (FHS013) (version 16 February 2022)
- Synopsis
- Research Protocol including
  - Poster for the invitation of study participants (Appendix II)
  - Participants' screening tool (Appendix III)
  - Questionnaire (Appendix IV)
  - In-depth interview guide (Appendix V)
  - Information sheet and consent form for adolescents, aged 18 to 19 years (Appendix VI)
  - Information sheet and consent form for parent/legal guardian of adolescents, aged 14 to 17 years (Appendix VII)
  - Information sheet and assent form for adolescents, aged 14 to 17 years (Appendix VIII)
  - Information sheet and consent form for emancipated adolescents, aged 14 to 17 years (Appendix IX)
  - A protocol for handling suspected child abuse or neglect during the conduct of research (Appendix X)
  - Covid-19 risk management plan (Appendix XI)
  - Study timeline (Appendix XII)
  - Budget (Appendix XIII)

HREC REF 310/2022

Approval is granted for one year until the 9th December 2023

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: https://health.uct.ac.za/home/human-research-ethics)

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Please also note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF number 310/2022 in all your correspondence.

Yours sincerely

PROFESSOR MARC BLOCKMAN
CHAIRPERSON, FACULTY OF HEALTH SCIENCE HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
NHREC-registration number: REC-210208-007

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2020), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

HREC REF 310/2022

[8] Study title was amended to, "Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study"

Appendix 4.2: Ethical Approval from Uganda[9]

21/02/2023

To: Samson Udho

Lira University
+256785588257

Type: Initial Review

Re: GUREC-2022-480: Respectful maternity care in childbirth among adolescents aged 14 to 19 years in rural northern Uganda: a mixed-method study, 2.0, 2023-02-10

I am pleased to inform you that the Gulu University REC, through expedited review held on **19/01/2023** approved the above referenced study.
Approval of the research is for the period of **21/02/2023** to **21/02/2024.**

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 addenda 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.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **21/02/2024** 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.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by Gulu University REC:

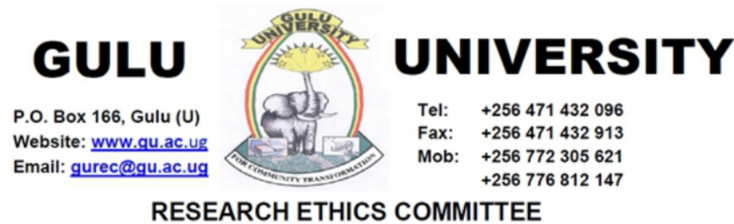
[9] Study title was amended to, "Facility-Based Childbirth in Rural Northern Uganda: Adolescents' Experiences and Perceived Perceptions of Person-Centered Care"

No.	Document Title	Language	Version Number	Version Date
1	Informed consent form for emancipated adolescents, aged 14 to 17 years phase II	Lango	2.0	2023-02-10
2	Informed consent form for emancipated adolescents, aged 14 to 17 years phase II	English	2.0	2023-02-10
3	Informed consent form for emancipated adolescents, aged 14 to 17 years phase I	Lango	2.0	2023-02-10
4	Informed consent form for emancipated adolescents, aged 14 to 17 years phase I	English	2.0	2023-02-10
5	Informed assent form for adolescents, aged 14 to 17 years phase II	Lango	2.0	2023-02-10
6	Informed assent form for adolescents, aged 14 to 17 years phase II	English	2.0	2023-02-10
7	Informed assent form for adolescents, aged 14 to 17 years phase I	Lango	2.0	2023-02-10
8	Informed assent form for adolescents, aged 14 to 17 years phase I	English	2.0	2023-02-10
9	Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years phase II	Lango	2.0	2023-02-10
10	Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years phase II	English	2.0	2023-02-10
11	Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years phase I	Lango	2.0	2023-02-10
12	Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years phase I	English	2.0	2023-02-10
13	Informed consent form for adolescents, aged 18 to 19 year for phase II	Lango	2.0	2023-02-10
14	Informed consent form for adolescents, aged 18 to 19 year for phase II	English	2.0	2023-02-10
15	Informed consent form for adolescents, aged 18 to 19 year for phase I	Lango	2.0	2023-02-10
16	Informed consent form for adolescents, aged 18 to 19 year for phase I	English	2.0	2023-02-10
17	Participants' screening tool	Lango	2.0	2023-02-10
18	Participants' screening tool	English	2.0	2023-02-10
19	Covid-19 Risk Management Plan	English	2.0	2023-02-10
20	Data collection tools	Lango	2.0	2023-02-10
21	Data collection tools	English	2.0	2023-02-10
22	Data collection tools	Lango	2.0	2023-02-10
23	Data collection tools	English	2.0	2023-02-10
24	Protocol	English	2.0	2023-02-10

Yours Sincerely

Dr. Gerald OBAI
For: Gulu University REC

Appendix 4.3: Amendment of Protocol from Uganda



21/02/2024

To: Samson Udho

Lira University
+256785588257
Type: Protocol Amendment

Re: Respectful maternity care in childbirth among adolescents aged 14 to 19 years in rural northern Uganda: a mixed-method study

I am pleased to inform you that at the convened meeting on **08/02/2024**, the **Gulu University REC** voted to approve the changes to the study titled **Respectful maternity care in childbirth among adolescents aged 14 to 19 years in rural northern Uganda: a mixed-method study** reference Number **GUREC-2022-480**.

Please note that the approval of the research is valid until **21/02/2025**. The approved changes to the study include;

1

As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

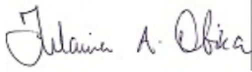
1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC eight weeks prior to the expiration date of **21/02/2025** 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.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to notify the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents reviewed in this application by **Gulu University REC**:

No.	Document Title	Language	Version Number	Version Date
1	Appendix XV. Covid-19 risk management plan_English_Version 3.0	English	3.0	2024-02-21
2	Appendix XIV. A protocol for handling suspected child abuse or neglect during the conduct of research_English_Version 3.0	English	3.0	2024-02-21
3	Appendix XIIIb. Information sheet and consent form for emancipated adolescents aged 14-19for phase II_Lango_Version 3.0	Lango	3.0	2024-02-21
4	Appendix XIIIa. Informed consent form for emancipated adolescents, aged 14 to 17 years for phase II_English_Version 3.0	English	3.0	2024-02-21
5	Appendix XIIb. Information sheet and consent form for emancipated adolescents aged 18-19 years for phase I_Lango_Version 3.0	Lango	3.0	2024-02-21
6	Appendix XIIa. Informed consent form for emancipated adolescents, aged 14 to 17 years for phase I_English_Version 3.0	English	3.0	2024-02-21
7	Appendix XIb. Information sheet and assent form for adolescents, aged 14 to 17 years for phase II_Lango_Version 3.0	Lango	3.0	2024-02-21
8	Appendix XIa. Information sheet and assent form for adolescents, aged 14 to 17 years phase II_English_Version 3.0	English	3.0	2024-02-21
9	Appendix Xb. Information sheet and assent form for adolescents, aged 14 to 17 years for phase I_Lango_Version 3.0	Lango	3.0	2024-02-21
10	Appendix Xa. Information sheeet and assent form for adolescents, aged 14 to 17 years phase I_English_Version 3.0	English	3.0	2024-02-21
11	Appendix IXb. Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years for phase II_Lango_Version 3.0	Lango	3.0	2024-02-21
12	Appendix IXa. Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years for phase I_English_Version 3.0	English	3.0	2024-02-21
13	Appendix VIIIb. Information sheet and consent form for parents or legal guardians of adolescents, aged 14 to 17 years for phase I_Lango_Version 3.0	Lango	3.0	2024-02-21
14	Appendix VIIIa. Information sheet and	English	3.0	2024-02-21

	consent form for parents or guardians of adolescents, aged 14 to 17 years for phase I_English_Version 3.0			
15	Appendix VIIb. Information sheet and consent form for adolescents, aged 18 to 19 years for phase II_Lango_Version 3.0	Lango	3.0	2024-02-21
16	Appendix VIIa. Information sheet and consent form for adolescents, aged 18 to 19 years for phase II_English_Version 3.0	English	3.0	2024-02-21
17	Appendix VIb. Information sheet and consent form for adolescents, aged 18 to 19 years for phase I_Lango_Version 3.0	Lango	3.0	2024-02-21
18	Appendix VIa. Information sheet and consent form for adolescents, aged 18 to 19 years for phase I_English_Version 3.0	English	3.0	2024-02-21
19	Appendix Vb. In-depth interview (IDI) guide_Lango_Version 3.0	Lango	3.0	2024-02-21
20	Appendix Va. In-depth interview (IDI) guide_English_Version 3.0	English	3.0	2024-02-21
21	Appendix IVb. Questionnaire_Lango_Version 3.0	Lango	3.0	2024-02-21
22	Appendix IVa. Questionnaire_English_Version 3.0	English	3.0	2024-02-21
23	Appendix IIIb. Participants' screening tool_Lango_Version 3.0	Lango	3.0	2024-02-21
24	Appendix IIIa. Participants' screening tool_English_Version 3.0	English	3.0	2024-02-21
25	Appendix IIb. Poster of invitation of study participants_Lango_Version 3.0	Lango	3.0	2024-02-21
26	Appendix IIa: Poster of invitation of study participants-English_Language (Version 3.0)	English	3.0	2024-02-21
27	Proposal_Clean Copy	English	3.0	2024-02-21

Yours Sincerely



Julaina A. Obika (PhD)
For: Gulu University REC

Appendix 4.4: Amendment of Protocol from South Africa

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

Form FHS006: Protocol Amendment

HREC office use only (FWA00001637; IRB00001938)		
☑ Approved	☑ Type of review: Expedited	☐ Full committee
This serves as notification that all changes and documentation described below are approved.		
Signature HREC Chairperson / Designee	[signature]	Date 2/7/2024

Note: All **Major** amendments must include a **Cover Letter** and a local **PI Synopsis** justifying the changes for the amendment. Please note that incomplete amendment submissions will not be reviewed.

Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za with subject line: FHS006 + (HREC Reference number).

HUMAN RESEARCH
ETHICS COMMITTEE
- 5 JUL 2024
HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

The latest forms are found on our website.

http://www.health.uct.ac.za/fhs/research/humanethics/forms

Please also clarify your plan for research-related activities during COVID-19 lockdown.

Comments from the HREC to the Principal Investigator:
Note: The approval of this protocol amendment does not grant annual approval. Please complete the FHS016 / FHS017 form for annual approval at least one month before study expiration.

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	27.06.2024	
HREC REF Number	310/2022	
Protocol Title	Disrespect and abuse of adolescents, aged 10-19 years during facility-based childbirth in Uganda: a mixed-methods study	
Protocol Number (if applicable)	310/2022	
Principal Investigator	Assoc. Prof. Sheila E. Clow	
Department / Office Internal Mail Address	F45 Room 49, Groote Schuur Hospital Old Main Building	
1.1 Is this a major or a minor amendment? (see FHS006hlp) Major (tick box) Minor (tick box)	☐ Major	☑ Minor
1.2 Does this protocol receive US Federal funding?	☐ Yes	☑ No

1.3 If the amendment is a major amendment <u>and</u> receives US Federal Funding, does the amendment require full committee approval? **Note:** Any protocol amendments for **Full Committee Review** MUST be submitted on the monthly HREC submission dates. (Please email an electronic copy to hrec-enquiries@uct.ac.za)	☐ Yes	☑ No
1.4 Did the initial study require UCT No-Fault Insurance	☐ Yes	☑ No

2. List of Proposed Amendments with Revised Version Numbers and Dates

Please itemise on the page below, all amendments with revised version numbers and dates, which need approval.
This page will be detached, signed and returned to the PI as notification of approval. Please add extra pages if necessary.

01. Study title

CHANGED FROM:
~~Disrespect and abuse of adolescents, aged 10-19 years during facility-based childbirth in Uganda: a mixed-methods study~~
CHANGED TO:
Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

3. Protocol status (tick ✓)

☐	Open to enrolment
☐	No participants have been enrolled
✓	Closed to enrolment (tick ✓)
☑	Research-related activities are ongoing
☐	Research-related activities are complete, long-term follow-up only
☐	Research-related activities are complete, data analysis only

4. Proposed changes will affect: (tick ✓ all the categories that apply)

Protocol	
☐	Study objectives, design (including investigator's brochure, clinical activities, study length)
☐	Study instruments, questionnaires, interview schedules
☐	Sample size
☐	Recruitment methods
☐	Eligibility criteria (inclusion and exclusion criteria)

☐	Drug/device (composition, amount, schedule, route of administration, combination with other drugs/devices, safety information)
☐	Data collection/ analysis
☐	Principal Investigator. (Please attach revised conflict of interest and PI declaration statements. Refer: sections 7 and 8.4 in the New Protocol Application Form FHS013)
☐	Consent form and information sheet
☐	Recruitment materials (e.g. advertisements)
☐	Administrative (e.g. change in sponsor's name, change in contact information)
☑	Other. Please specify: The amendment will not affect the parameters/sections of the study above.

**Note: Amendment changes involving study length, sample size, additional sites and eligibility criteria (i.e. inclusion of minors and /or pregnant woman) need to be declared to the Insurance office. Please liaise via fhs.sponsorship@uct.ac.za regarding the required documentation and information to be submitted to obtain an updated UCT No-fault Insurance Certificate- it should be included herewith*

4.1 In your opinion, will there be any **increase** in risk, discomfort or inconvenience to participants?	☐ Yes	☑ No
If yes, please provide a detailed justification/explanation:		

4.2 What follow-up action do you propose for participants who are already enrolled in the study?	
☐	Inform current participants as soon as possible
☐	Re-consent current participants with revised consent/assent forms (append)
☑	No action required
☐	Other. Please describe:

5. Detailed description of the change(s)

Please attach, for each amendment, a summary of all changes which clearly indicates:

i. Old wording (e.g. ~~strikethrough~~ text, CHANGED FROM and CHANGED TO)
ii. New wording (e.g. *italicized*, **bold**, tracked)
iii. Detailed rationale/ justification/ explanation for each change

6. Ethics Review for Amendment Levy – cost including vat

Amendment Review Costs including VAT

Please tick amount to be billed:

Submission Type	Description	New fee (Vat Incl.)	tick ✓
Research funded solely from UCT departmental/ divisional/group budget	Major/ Minor Amendments	R0,00	☐
Non-sponsored student research for degree purposes at UCT/Other Universities & Colleges	Major/ Minor Amendments	R0,00	☑
Protocol amendment - Major (FHS006 Form)	Clinical Trial & International Grant Funded Research - Any changes to the protocol that requires Full Committee review	R8 000.00	☐
Protocol amendment - Major (FHS006 Form)	Clinical Trial & International Grant Funded Research - Any change to the protocol that requires Expedited review that does not require Full Committee Review	R5 000,00	☐
Protocol amendment - Minor (FHS006 Form)	Clinical Trial & International Grant Funded Research - Minor amendments, administrative changes that do not affect study design e.g. changes to informed consent form, changes in study staff, etc.	R2 250,00	☐
Protocol amendment - Major (FHS006 Form)	National grant funded research - Any change to the protocol that requires Full Committee review	R7 000,00	☐
Protocol amendment - Major (FHS006 Form)	National grant funded research - Any change to the protocol that requires Expedited review that does not require Full Committee review	R2 500,00	☐
Protocol amendment - Minor (FHS006 Form)	National grant funded research - Minor amendments, administrative changes that do not affect study design e.g. changes to informed consent form, changes in study staff, etc.	R1 000,00	☐

NB: Protocols funded by UCT (e.g. departmental funding / student research) and by certain grant funding organizations (e.g. MRC, NRF, CANSA,) are exempt from these charges.

Please provide details for Invoicing, either complete section 1 or 2 :

1. Invoice billing – Directly to Sponsor

Sponsor's name	
Billing Address of Sponsor:	
Vat Number:	
Contact person:	
Telephone number:	
Email Address:	

2. Internal Journal Billing:

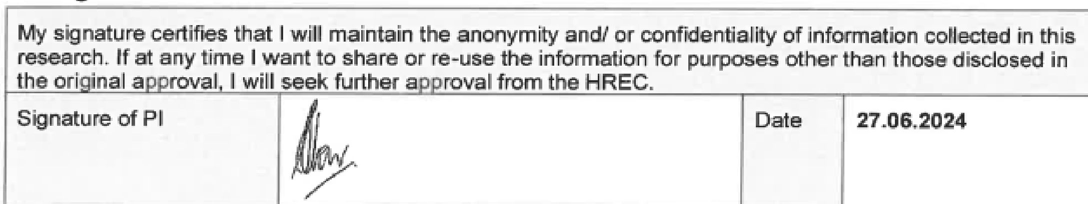
Fund Number:	
Cost Centre Number:	
Account Holder Name:	
Division of Account Holder:	

7. Amendment Submission checklist (tick ✓)

7.1 Please tick that all the documents are attached before submitting to the HREC. NB: Incomplete submissions will not be processed	
☑	Latest FHS006 form completed with all sections completed as per our website
☑	Cover Letter
☑	PI Justification/ Summary for the reasons for the amendment
☑	Protocol - Track changes & Clean Copy (where necessary)
☐	Informed Consent Forms (ICF), if applicable (Any changes made to ICF tracked & clean copy)
☐	Any other additional documentation in support of amendment
☐	Updated no fault insurance certificate (if applicable)

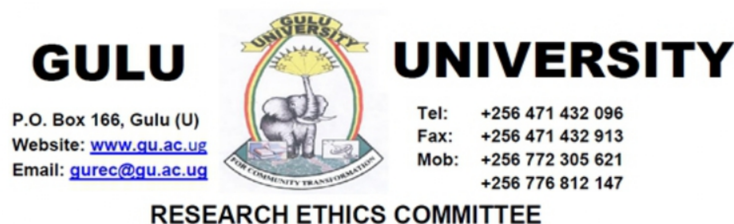
Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za with subject line: FHS006 + (HREC Reference number). The latest forms are found on our website.

8. Signature



My signature certifies that I will maintain the anonymity and/ or confidentiality of information collected in this research. If at any time I want to share or re-use the information for purposes other than those disclosed in the original approval, I will seek further approval from the HREC.			
Signature of PI		Date	**27.06.2024**

Appendix 4.5: Renewal of Ethical Approval from Uganda



21/02/2024

To: Samson Udho

Lira University
+256785588257

Type: Annual Renewal

Re: Facility-Based Childbirth in Rural Northern Uganda: Adolescents' Experiences and Perceived Perceptions of Person-Centered Care

I am pleased to inform you that at the **110th** convened meeting on **08/02/2024**, the **Gulu University REC** reviewed the progress report to the above study reference number **GUREC-2022-480** and found it satisfactory. In this respect, annual renewal of the study is granted. The study was initially approved on **21/02/2023** and expired on **21/02/2024**.

The Approval of the research is for the period of **21/02/2024** to **21/02/2025.**

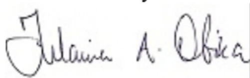
As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda 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.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC eight weeks prior to the expiration date of **21/02/2025** 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.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to notify the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.
8. **All approved study documents should be stamped by the REC before commencement of data collection.**

The following is the list of all documents reviewed in this application by **Gulu University REC**:

No.	Document Title	Version	Date
1	In-depth interview (IDI) guide_Lango_Version 2.0		2024-02-05
2	In-depth interview (IDI) guide_English_Version 2.0		2024-02-05
3	Protocol_English_Version 2.0		2024-02-05
4	Appendix XV. Covid-19 risk management plan_English_Version 2.0		2024-02-05
5	Appendix XIIIb. Information sheet and consent form for emancipated adolescents aged 14-19 for phase II_Lango_Version		2024-02-05
6	Appendix XIIIa. Informed consent form for emancipated adolescents, aged 14 to 17 years for phase II-English_Version 2.0		2024-02-05
7	Appendix XIIb. Information sheet and consent form for emancipated adolescents aged 18-19 years for phase I_Lango_Version 2.0		2024-02-05
8	Appendix XIIa. Informed consent form for emancipated adolescents, aged 14 to 17 years for phase I-English_Version 2.0		2024-02-05
9	Appendix XIb. Information sheet and assent form for adolescents, aged 14 to 17 years for phase II_Lango_Version 2.0		2023-02-05
10	Appendix XIa. Information sheet and assent form for adolescents, aged 14 to 17 years phase II-English_Version 2.0		2024-02-05
11	Appendix Xb. Information sheet and assentform for adolescents, aged 14 to 17 years for phase I_Lango_Version 2.0		2024-02-05
12	Appendix Xa. Information sheeet and assent form for adolescents, aged 14 to 17 years phase I-English_Version 2.0		2024-02-05
13	Appendix IXb. Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years for phase II_Lango_Version 2.0		2024-02-05
14	Appendix IXa. Informed consent form for parents or legal guardians of adolescents, aged 14 to 17 years for phase II-English_Version 2.0		2024-02-05
15	Appendix VIIIb. Information sheet and consent form for parentslegal guardians of adolescents, aged 14 to 17 years for phase I_Lango_Version 2.0		2024-02-05
16	Informed consent form for adolescents, aged 18 to 19 year for phase II_Lango_Version 2.0		2024-02-05
17	Informed consent form for adolescents, aged 18 to 19 year for phase II_English_Version 2.0		2024-02-05
18	Informed consent form for adolescents, aged 18 to 19 year for phase I_Lango_Version 2.0		2024-02-05
19	Informed consent form for adolescents, aged 18 to 19 year for phase I_English_Version 2.0		2024-02-05
20	Questionnaire_Lango_Version 2.0		2024-02-05
21	Questionnaire_English_Version 2.0		2024-02-05
22	Participants' screening tool_Lango_Version 2.0		2024-02-05
23	Participants' screening tool_English_Version 2.0		2024-02-05

Yours Sincerely



Julaina A. Obika (PhD)

Appendix 4.6: Renewal of Ethical Approval from South Africa

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938) **This serves as notification of annual approval, including any documentation described below.**					
☐ Approved	Annual progress report		Approved until/next renewal date		30.7.2025
☐ Not approved	See attached comments				
Signature Chairperson of the HREC/ Designee		[signature]	Date Signed		7/7/2024

Note: Please email this form and supporting documents (if applicable) in a combined pdf-file to hrec-enquiries@uct.ac.za.
Please clarify your plan for research-related activities during COVID-19 lockdown.
Please use the latest form found on our website:
http://www.health.uct.ac.za/fhs/research/humanethics/forms

Comments to PI from the HREC
Thank you for your Study Deviation 310/2022

HREC Chair Signature [signature]
Date: 7/7/2024

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	27.05.2024		
HREC REF Number	310/2022	Current Ethics Approval was granted until	9th December 2023
Protocol title	Disrespect and abuse of adolescents, aged 10-19 years during facility-based childbirth in Uganda: a mixed-methods study		
Protocol number (if applicable)	HREC REF 310/2022		
Are there any sub-studies linked to this study?	☐ Yes	☑ No	
If yes, could you please provide the HREC Reference number for all sub-studies? **Note:** A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	Assoc. Prof. Sheila E. Clow		

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Department / Office Internal Mail Address	F45 Room 49, Groote Schuur Hospital Old Main Building

1.1 Does this protocol receive US Federal funding?	☐ Yes	☑ No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval? **Note:** Any annual approvals for **Full Committee** review MUST be submitted on the monthly HREC submission dates. (Please send electronic copy for full committee review to hrec-submission@uct.ac.za)	☐ Yes	☑ No

If yes in 1.2 please complete section 1.3 below for invoicing purposes

1.3 Ethics Renewal Fee

Please **(tick ✓)**appropriate box for billing purposes:

Submission Type	***Description***	***New fee (Vat Incl.)***	***tick ✓***
Research funded solely from UCT departmental/ divisional/group budget	Annual evaluation of research progress report for re-certification	**R0,00**	☐
Non-sponsored student research for degree purposes at UCT/Other Universities & Colleges	Annual evaluation of research progress report for re-certification	**R0,00**	☑
Annual re-certification / Progress report (FHS016 Form)	Clinical Trial & International Grant Funded Research - Annual evaluation of research progress report for re-certification for Full Committee Approval	**R7000,00**	☐
Annual re-certification / Progress report (FHS016 Form)	Clinical Trial & International Grant Funded Research - Annual evaluation of research progress report for re-certification for Expedited review	**R3 710.00**	☐
Annual re-certification / Progress report (FHS016 Form)	National grant funded research - Annual evaluation of research progress report for re-certification for Full Committee Approval	**R6000.00**	☐
Annual re-certification / Progress report (FHS016 Form)	National Grant funded research for Annual evaluation of research progress report for re-certification for Expedited review	**R1 500,00**	☐

NB: Protocols funded by UCT (e.g. departmental funding / student research) and by certain grant funding organizations (e.g. MRC, NRF, CANSA,) are exempt from these charges.

Please provide details for Invoicing, either complete section 1 or 2 :

1. Invoice billing – Directly to Sponsor

Sponsor's name	
Billing Address of Sponsor:	
Vat Number:	

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Contact person	
Telephone number	
Email Address	
2. **Internal Journal Billing:**	
Fund Number:	
Cost Centre Number:	
Account Holder Name:	
Division of Account Holder:	

2. List of documentation for approval

Not applicable

3. Protocol status (tick ✓)

☐	Open Enrolment
☑	Closed to enrolment (tick ✓)
☑	Research-related activities are ongoing
☐	Research-related activities are complete, long-term follow-up only
☐	Research-related activities are complete, data analysis only
☐	Main study is complete but sub-study research-related activities are ongoing
☐	Study is closed → Please submit a Study Closure Form (FHS010)

4. Enrolment

Number of participants enrolled to date	574
Number of participants enrolled, since last HREC Progress report (continuing review)	574
Additional number of participants still required	N/A

5. Refusals

Total number of refusals (participants invited to join the study, but refused to take part)	09

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

6. Cumulative summary of participants

Total number of participants who provided consent	**574**
Number of participants determined to be ineligible (i.e. after screening)	125
Number of participants currently active on the study	00
Number of participants completed study (without events leading to withdrawal)	574
Number of participants withdrawn at participants' request (i.e. changed their mind)	00
Number of participants withdrawn by PI due to toxicity or adverse events	00
Number of participants withdrawn by PI for other reasons (e.g. pregnancy, poor compliance)	00
Number of participants lost to follow-up. Please comment below on reasons for loss of follow-up.	43
The interviews were being conducted in the communities so some of the participants could not be traced because of change of address and unavailable phone contacts	
Number of participants no longer taking part for reasons not listed above. Please provide reasons below:	00

7. Progress of study

Please provide a brief summary of the research to date including the overall progress and the progress since the last annual report as well as any relevant comments/issues you would like to report to the HREC:
Since we obtained ethics approval from HREC on 9 December 2022, we further sought ethics approval from Uganda from Gulu University Research and Ethics Committee (GUREC-2022-480) on 21 February 2023 and Uganda National Council for Science and Technology (HS2727ES) on 02 March 2023. Data collection commenced on 15 March 2023. We completed collection of quantitative data on 15 October 2023 and subsequently completed qualitative data analysis on 31 October 2023 and completed data analysis in March 2024. The writing of the thesis is almost complete. We have no substantial ethical or scientific issues accruing from field data collection to report to HREC. However, we need to amend the research title to give a proper reflection of the study findings (*See Form FHS006*). Also, we request for an extension of the HREC approval for a further 12 months to allow time to complete the study.

8. Protocol violations and exceptions (tick ✓ all that apply)

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

☑	No prior violations or exceptions have occurred since the original approval
☐	Prior violations or exceptions have been reported since the last review and have already been acknowledged or approved
☐	Unreported minor violations that have occurred since the last review, as well as significant deviations not yet reported, are attached for review

9. Amendments (tick ✓ all that apply)

☑	No Prior amendments have been made since the original approval
☐	Prior amendments have been reported since the last review and have already been approved
☑	New protocol changes/ amendments are requested as part of this continuing review (See note below)

Note: If new protocol changes are being requested in this review, please complete an amendment form (FHS006).
Specific changes in the amended protocol and consent/assent forms must be **bolded**, *italicised* or tracked and all changes must include a rationale.

10. Adverse events

10.1 Please provide below or attach a narrative summary of serious adverse events and/ or unanticipated problems since the last progress report. Please indicate changes made to the protocol and informed consent document(s) as a result (if not already reported to the HREC). Please comment on whether causality to any study procedure or intervention could be established.
During data collection, we encountered 05 adolescent participants who had given birth and had been neglected by the man/boy. We asked the participants to formally report this case and we took the initiative to report the matter to Police as suspected cases of child abuse or neglect as guided by our Protocol for Handling Suspected Child Abuse or Neglect During Conduct of Research.

10.2 Have participants received appropriate treatment/ follow-up/ referral when indicated (e.g. in the case of abnormal or incidental clinical findings, distress or anxiety)?		
☐ Yes	☐ No	☑ Not applicable
If yes, please describe:		

11. Summary of Monitoring and Audit Activities (tick ✓)

11.1 Was this study monitored or audited by an external agency (e.g. SAHPRA, FDA)?		
☐ Yes	☐ No	☑ Not applicable

11.2 Did a Data and Safety Monitoring Board publish a report?		
☐ Yes	☐ No	☑ Not applicable

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

11.3 If yes, please identify the agency and attach a summary of the findings.					
Agency Name		Report attached	☐ Yes	☐ No	☐ Not applicable
		DSMB report attached	☐ Yes	☐ No	☐ Not applicable

11.4 Has there been any agency, institutional or other inquiry into non-compliance in this study, or any finding of non-compliance concerning a member of the research team?	
☐ Yes	☑ No
If yes, please explain:	

12. Level of risk (tick ✓)

12.1 In light of your experience of this research, please indicate whether the level of risk to participants has:	
☐	Increased
☐	Decreased
☑	Shown no change
If there has been a change, please explain:	

12.2 Please provide a narrative summary of recent relevant literature that may have a bearing on the level of risk.
Not Applicable

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

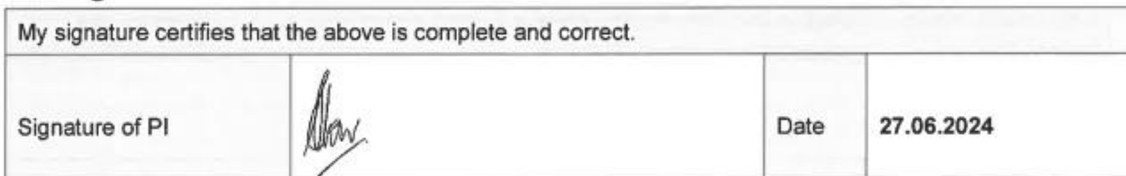
13. Insurance

Please confirm that valid no fault insurance is still in place? **(tick ✓)**			
☐ Yes	☐ No		☑ Not Applicable – N/A
If yes, please complete the following:			
Insurer's name:			
Policy no.		*Coverage Period:	
For UCT sponsored studies please liaise the Insurance office via fhs.sponsorship@uct.ac.za regarding the required documentation and information required obtain a renewed UCT No-fault Insurance Certificate.			

14. Statement of conflict of interest

Has there been any change in the conflict of interest status of this protocol since the original approval? (tick ✓)	
☐ Yes	☑ No
If yes, please explain and if necessary, attach a revised conflict of interest statement (Section #7 in the New Protocol Application Form FHS013):	

15. Signature

My signature certifies that the above is complete and correct.			
Signature of PI		Date	**27.06.2024**

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Appendix 4.7: Administrative Clearance from Lira District

LIRA UNIVERSITY

P.O. Box 1035
Lira, Uganda
Tel: +256-41469471
Web: www.lirauni.ac.ug
Email: health.faculty@lirauni.ac.ug

FACULTY OF NURSING AND MIDWIFERY
DEPARTMENT OF MIDWIFERY

22nd February 2023

The Executive Secretary,
UNCST.

Thru: The Resident District Commissioner,
Lira District.

Thru: The District Health Officer,
Lira District.

Dear Sir/Madam,

Administrative clearance to conduct academic research in Lira District, northern Uganda

This letter serves to request your office to grant me permission to conduct my doctoral research among adolescents (14 to 19 years) in Lira District, northern Uganda.

I am a certified nurse-midwife by profession from Uganda. I work as a Lecturer at Lira University in the Faculty of Nursing and Midwifery. I hold a Bachelor of Nursing and Master of Nursing (Midwifery & Women's Health) Degree from Makerere University, Uganda. I am currently pursuing a Doctor of Philosophy (PhD) in Nursing at the University of Cape Town, South Africa under the supervision of Associate Professor Sheila E. Clow.

My research project is entitled, ***"Respectful maternity care in childbirth among adolescents aged 14 to 19 years in rural northern Uganda: a mixed-method study"***. The study protocol has been approved by the University of Cape Town Human Research and Ethics Committee (**HREC REF: 310/2022**) and Gulu University Research and Ethics Committee (**GUREC-2022-480**).

I will be grateful for your kind consideration.

Yours faithfully

Mr. Samson Udho
LECTURER / PhD STUDENT

Appendix 4.8: Clearance from Uganda National Council of Science and Technology (UNCST)

Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Our Ref: HS2727ES **2 March 2023**

Samson Udho
Lira University
Lira

Re: Research Approval: **Respectful maternity care in childbirth among adolescents aged 14 to 19 years in rural northern Uganda: a mixed-method study**

I am pleased to inform you that on **02/03/2023**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of **02/03/2023** to **02/03/2024**.

Your research registration number with the UNCST is **HS2727ES**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project. As the Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. Keeping all co-investigators informed of the status of the research.
2. Submitting all changes, amendments, and addenda to the research protocol or the consent form (where applicable) to the designated Research Ethics Committee (REC) or Lead Agency for re-review and approval **prior** to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local REC for review with copies to the National Drug Authority and a notification to the UNCST.
4. Unanticipated problems involving risks to research participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST notification after review by the REC.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. An annual progress report and approval letter of continuation from the REC must be submitted electronically to UNCST. Failure to do so may result in termination of the research project.

Please note that this approval includes all study related tools submitted as part of the application as shown below:

No.	Document Title	Language	Version Number	Version Date
1	Study Tools	English	2.0	20 February 2023
2	Covid-19 risk management plan	English	2.0	24 February 2023
3	Study Tools	Lango	2.0	10 February 2023
4	Study timelines	English	2.0	24 February 2023
5	Informed consent/assent forms	English	2.0	24 February 2023
6	Informed consent/assent forms	Lango	2.0	24 February 2023
7	Questionnaire	English	2.0	24 February 2023
8	Questionnaire	Lango	2.0	24 February 2023
9	In-depth interview guide	English	2.0	24 February 2023
10	In-depth interview guide	Lango	2.0	24 February 2023
11	Project Proposal	English	2.0	
12	Approval Letter	English		
13	Administrative Clearance	English		

Yours sincerely,

Hellen Opolot
For: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

LOCATION/CORRESPONDENCE

Plot 6 Kimera Road, Ntinda
P.O. Box 6884
KAMPALA, UGANDA

COMMUNICATION

TEL: (256) 414 705500
FAX: (256) 414-234579
EMAIL: info@uncst.go.ug
WEBSITE: http://www.uncst.go.ug

Appendix 4.9a: Poster for Invitation of Study Participants (English Version)

Your childbirth experiences are important and worth being shared!

ATTENTION!!

1) Are you an adolescent girl, aged 14 to 19 years?
2) Have you given birth to a baby in a public maternity facility in Lira District?
3) Would you like an opportunity to share your childbirth experiences?

Participate in our study as we examine and explore what young women, aged 14 to 19 years, experience while giving birth in public maternity facilities in northern Uganda.
This study is being done through the University of Cape Town, South Africa, and has been approved by Human Research and Ethics Committees in South Africa and Uganda and cleared by the Uganda National Council of Science and Technology

THANK YOU

CONTACT DETAILS

Samson Udho

0785 588 257

0785 588 257

udhson10@gmail.com

OR

udhsam001@myuct.ac.za

Appendix 4.9b: Poster for Invitation of Study Participants (Lango Version)

Lok amako nyodo ni pire tek dang mwero ile kede lwak

Lok tami kan!!

1) Ibedo nyako me mwaka 14 tuno kede iyi 19?
2) Anaka inywal iot yat agamente ame tye iyi Lira District?
3) Imito nwogo gum me leyo kit ame nywalo atini obedo kede?

Dony iyi ikweda wa ka olwodo kit ame otero kede mon me mwaka 14 tuno kede iyi 19 ka otye anyal iot yat agamentee ame tye iyi Lira District, itung malo me Uganda.
Ikweda man jo ame tye adoro obe ka kwan amalo me Cape Town, ame tye ilobe me South Africa. Kwan man obin ocwako nibeo ibot oloc apirgitek me lobo South Africa kede lobo Uganda. Gamente me Uganda dang omio twero me timo kwan man iyi Uganda.

APWOYO

Yore me kubere

Samson Udho

0785 588 257

0785 588 257

udhson10@gmail.com

OR

udhsam001@myuct.ac.za

Appendix 4.10a: Participants' Screening Tool (English Version)

Study title

Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

Introduction

I am Samson Udho, a nurse/midwife and currently a student at the University of Cape Town, South Africa where I'm doing research to get a Doctoral Degree. My study is being supervised by Professor Sheila E. Clow who works at the same University. We would like to find out what teenage mothers go through while giving birth in government health facilities. The information you will share may help us to understand what young women in your age group go through while giving birth in government maternity facilities so that we find ways to promote respectful maternity care for teenagers.

I will ask you six questions to check whether you are eligible to participate in the study. I will read the questions to you and you will respond to the questions with either a "no" or "yes" answer.

Screening questions:

1. Were you admitted to this health facility for childbirth?
   0. No
   1. Yes
2. Are you 14-19 years of age?
   0. No
   1. Yes
3. Are you a staff member of this health facility?
   0. No
   1. Yes
4. Do you have a first-degree relative (parent, guardian, brother, sister) in this health facility?
   0. No
   1. Yes
5. Will you live within Amach, Ogur, Barr, Barr, Agweng, and Aromo sub-county (Appendix I) at two to six weeks after childbirth?
   0. No
   1. Yes
6. Are you willing to participate in this study two to six weeks after childbirth?
   0. No
   1. Yes
7. Do you feel you are now in a stable health condition?
   0. No
   1. Yes

8. I have blamed myself unnecessarily when things went wrong.

0. No
1. Yes

9. I have felt scared or panicky for no very good reason.
   0. No
   1. Yes
10. I have been anxious or worried for no good reason.
    0. No
    1. Yes

Note: The woman is eligible to participate in the study if responses to question 1, 2, 5, & 6= ''Yes'' and question 3, 4, 7, 8, 9, and 10= ''No''

Is the woman eligible?

0. Not eligible
1. Eligible

If the woman is "Not eligible", sign, date, and do not recruit the woman into the study.
Sign: …………………………………………….. Date: ………………………………………………

If the woman is "Eligible", sign, date, and recruit the woman into the study
Sign: …………………………………………………….. Date: ………………………………………..

Recruitment number: ……………….Telephone: …………… Address: ……………………………

Appendix 4.10b: Participants' Screening Tool (Lango Version)

Wi kop me kwan:

Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal.

Nyutu wi kop:

An abedo Samson Udho, abedo naci/wonacola ame ikom kare ni abedo atin kwan ii University me Cape Town, South Africa kan ame atye atimo ikweda me nwongo rwom me bedo kede digrii. Ngat ame tye aloyo wia ikwan man obedo Professor Sheila E. Clow ame dang tio ii University acel ame atye akawan iye ni. Wan otye omito nyango kit ame otero kede mon atino ka tye anywal gini idakatale me ot nywal ame obedo mega gamente. Ngec ame yin ibino miyo wa twero bedo me konyo me miyo wa nyang kit ame otero kede mon atino amwaka gi pe bor kede megi ka otye onywal gini idakatale me ot nywal ame obedo mega gamente me wek onen yore ango ame oromo tingo malo rwom me woro ame onyuto ka otye amiyo kony ame omio bot mon atino ikare me nywal.

Abino penyi apeny abicel me nyango ka itwero bedo iyi kwan man. Abino kwano apenye magi boti eka ite gamo ni pe onyo ee.

Apeny me yeko jo:

1. Onwongo jo ogami itana iyi dakatali me nywal?
   0. Pe
   1. Ee
2. Itye ikin mwaka 14 tuno naka 19?
   0. Pe
   1. Ee
3. Ibedo atic iyi dakatal kan?
   0. Pe
   1. Ee
4. Nyo Itye kede wati moro idakatal kan (twero bedo anywali, ngat agwoki, omini, amini) ame okwano tuno naka irwom me digwiri?
   0. Pe
   1. Ee
5. Pwod nyo imede kede bedo igomala Amach, Ogur, Barr, Agweng nyo Aromo kan pi kare moro aromo cabit aryo tuno naka iyi abicel iyonge nywal?
   0. Pe
   1. Ee
6. Iromo ye jale me bedo ikwan man pi kare aromo cabit aryo tuno naka cabit abicel iyonge nywal?
   0. Pe
   1. Ee
7. Inwongo ni yot komi dong tye odwogo aber?
   0. Pe
   1. Ee

8. Angolo kop ikoma kenekene iyore ame pe pore ikare ame jami pe woto aber
    0. Pe
    1. Ee
9. Abedo kede lworo nyo myel kom abongo tyen koporo keken.
    0. Pe
    1. Ee
10. Abedo kede myel cuny onyo para abongo tyen koporo keken
    0. Pe
    1. Ee

Nen aber: Dako no romo bedo ikwan man ka agam pi apeny namba 1,2,5, & 6 = "Ee" kede ka apeny pi namba 3,4.7,8, 9 & 10 =" Pe"

Dako no romo bedo ikwan?

0. Pe romo
1. Romo

Ka dako no "Pe romo", mi ket cinge, nino dwe eka pe ite coyo dako no ikwan.
Ket cinge: ……………………………………………... Nino dwe: ………………………………………………

Ka dako no "Romo", mi ket cinge, nino dwe eka ite coyo dako no ikwan.
Keto cing: ……………………………………………... Nino dwe: ………………………………………………
Namba me coye:……………….Namba Cim: …………………..… Kabedo: ………………………………..

Appendix 4.11a: Information Sheet and Consent Form for Adolescents, Aged 18 to 19 Years (English Version)

Study title:
Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

Investigator:
Samson Udho

Principal Investigator:
Sheila E. Clow

Institution:
University of Cape Town, South Africa

Study sponsor:
This research is self-sponsored.

Greeting and Introduction:
I am Samson Udho, a student at the University of Cape Town, South Africa. I am doing research to get a Doctoral Degree and my supervisor is Professor Sheila E. Clow.

Study Purpose:
We want to do research on teenage mothers to find out their birth experiences as teenagers giving birth in government health facilities so that we find ways to improve maternity care given to teenagers.

Study Procedures:
You will be asked some questions for about an hour about how your past childbirth went. This interview will not be recorded. You may be selected to participate in a follow-up interview that will last for no more than one hour to share your experiences while giving birth in detail. This time the interview will be audio-recorded. In case you participate in the second interview, a counsellor will talk to you after our interview to make sure that you are okay.

Who will participate in the study and where is the study going to be conducted?
You have been chosen to participate in this study because you are a teenage mother who gave birth in one of the selected government hospitals for this research. The interview(s) will be conducted at your home in a place of your convenience.

Risks/Discomforts:
Nothing harmful will happen to you while participating in this study. If any of the questions make you feel sad and you want to stop or have a break that will be fine. I will make sure that there is a trained counsellor who can listen to you and speak with you if you would like that. If we discover that you have postnatal

depression during the screening process, you will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.

Benefits of the research study:
Participating in this study may make you feel better about your past experience while giving birth. Again, what you tell us may help us to come up with better ways to support other teenage mothers while giving birth.

Study Costs:
There will be no additional costs incurred as a result of participating in this study.

Compensation for participation in the study:
You will be given UGX. 5,000 (ZAR 21) in-kind items for the first part of the interview. If you are selected to participate in the second part of the interview, you will again be given items worth UGX. 20,000 (ZAR 85).

Questions about the study:
In case you have any questions about this study, you can contact Samson Udho by telephone number: 0785 588 257. You may also contact his research Supervisor, Professor Sheila Clow by telephone number: +27 83 659 5266.

Questions about participants' rights:
In case you have any questions about your welfare and rights in this study, you can contact Professor Marc Blockman, Chair of the Faculty of Health Sciences Human Research Ethics Committee by email: marc.blockman@uct.ac.za , or by telephone number: +27 21 650 1236. You can also contact the Chairperson, Gulu University Research and Ethics Committee, Dr. Gerald Obai on telephone number 0772 305 621, or the Uganda National Council for Science and Technology on telephone number 0414 705 500.

Dissemination of study feedback or study findings:
A copy of this research report will be kept by the University of Cape Town for future use by other researchers. The results of the study will also be printed and shared in meetings with other researchers. Important findings will also be shared with the government hospitals.

Statement of voluntariness:
You are free to accept or refuse to participate in this study. You also have a right to stop participating in the study at any time without penalty.

Approval of the research study:
This study has been approved by the relevant authorities in South Africa and Uganda. The Government of Uganda has also given permission to conduct this study in Uganda.

Confidentiality:
Your name and other identifying personal details are not required. The information that I share will only be accessed by the researchers. However, the researcher is required to report information about any child abuse or neglect to the police and the health facility administration.

Statement of consent from adolescents, aged 18 to 19 years:

.... has explained the study to me. I understand what is expected from me. I have had an opportunity to ask questions about the study and have been answered in the best way for me to understand. If there are any other questions that I have to ask later, I will freely approach the study representatives whose contact I have been given. I understand that my participation is voluntary and my consent can be withdrawn any time I wish to do so, without any penalty or loss of benefits entitled to. A copy of this form will be provided to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

No ☐ **Yes** ☐

I agree to be approached to participate in part II of the study:

No ☐ **Yes** ☐

I agree to the audio recording of the interview in part II of the study:

No ☐ **Yes** ☐

Name: …………………….…Signature/thumbprint of participant: ……………………..Date: ………………

Name: …………………………..…Signature of witness: ……………………..Date: ……………………

Name:. ……………………………Signature of interviewer: ……………………..Date: ……………………..

Summary of the information sheet for adolescents, aged 18 to 19 years

- I am Samson Udho, and I study at the University of Cape Town, South Africa. My research supervisor is Professor Sheila Clow.
- We are doing research that might help your hospital do more to help young women receive better maternity care.
- In our research, we will talk to many young women who gave birth in hospitals and ask them a number of questions including how they were treated during their most recent childbirth.
- We will have a conversation that will last for about one hour. No medical tests will be done on you and nothing will be done that will make you feel unsafe.
- If any of the questions make you feel sad and you want to stop or have a break that will be fine.
- I will make sure that there is a trained counsellor who can listen and speak with you if you like that.
- There will be no immediate and direct benefit to you, but your participation is likely to help us find out more about how young women want to be treated during childbirth.
- You will be given Ugx. 5000 for the first part of the study and another Ugx 20,000 if you are selected to participate in the second part of the study.
- We will not be sharing information about you outside of the research team. The information that we collect will be kept confidential but the researchers will be able to see it.
- If any incidence of child abuse or neglect is reported during our conversation, we will be required to report the matter to the relevant authorities for further inquiry.
- If we discover that you have postnatal depression, you will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.
- At the end of the study, we will be sharing what we have learned from the participants.
- You may choose not to participate in this study and you do not have to take part in this research if you do not wish to do so.
- If you have any questions you may ask them now or later, even after the study has started.
- If you wish to ask questions later, you may contact Samson Udho by telephone number: 0785 588 257 or Professor Sheila Clow by telephone number: +27 83 659 5266.
- This proposal has been reviewed and approved by the relevant committees in South Africa and Uganda whose task is to make sure that research participants are protected from harm.
- If you wish to find out more about these committees contact Professor Marc Blockman (South Africa) by telephone no:+27 21 650 1236 or Dr. Gerald Obai (Uganda) on telephone no: 0772 305 621.

Appendix 4.11b: Information Sheet and Consent Form for Adolescents, Aged 18 to 19 Years (Lango Version)

Wi kop me kwan:

Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal.

Ngata atye atimo ikweda:

Samson Udho

Ngata atye aloyo ikweda:

Sheila E. Clow

Ka kwan:

University me Cape Town, South Africa

Ngata aculo pi kwan man:

Dan atye atimo ikweda man en aye aculu.

Amot kede Nyutu wi kop:

An abedo Samson Udho, atin kwan iyi University me Cape Town ame tye ilobo south Africa. An atye atimo ikweda man me nwongo Ph.D, dano ame tye aloyo wia iyi ikweda man obedo Profesa Sheila E. Clow.

Tyen kop me kwan:

Wan otye omito timo ikweda ikom toto atino me nyango ngo ame gin oboe iye ikare me nywal acalo jo atino ame onywal idakatale agamente me miyo wa nwongo yo me yubu kony me nywal ame omio bot toto atino.

Yore me kwan:

Jo bino penyi kede apenyogo pi cawa aromo acel akwako kite ame nywalo atini ame pwod obedo me agiki ni owoto kede. Mako dwon pe bino bedo iyi kwan man. Onyo dok otwero yeri me bedo iyi kwan okene ame alubu yor man ame dang pe bino kato cawa aromo acel me wek inywak atutut ngo ame yin ibeo iye ikare ame onwongo itye inywal. Iyi kwan me aryo en aye mako dwon bino bedo iye. Ka ame onwongo itye ikwan me aryo no, dano ame opwonyere itic me mado cuny jo bino lok kedi iyunge kwan me neno ni yin itye ame iwinyo aber.

Nga ame abedo iyi kwan man kede kwene ame kwan man bino bedo iye?

Yin obin oyeri me bedo ikwan man pien yin ibedo toto atidi ame obin onywal idakatal agamete acel ame obin oyero pi timo ikweda man. Kwan man obino timo pacu kan ame yin inwongo ni itye agonya.

Gin akelo peko/ Amio kwo bedo atek:

Pe tye ginoro ame akelo awano ikom bedo ni ikwan man. Ka onyo apenyoro kiken iyi akina apenye omio yii owang ame imito kong gik onyo weo nwongo dang pe rac. Abino neno ni dano ame opwonyere ilok akwako kweyo cuny jo obedo atye me winyo iboti kede dang lok kede ka ame imito.

Ka obino nwongo ni itye kede two para atut onyo wang yic ame obin iyunge yin nywal, wan obino kwanyi oko iyi kwan man eka ote cwali idakatal acok kedi me wek onen peko no kede miyo kony ame mite

Adwongi aber aya ikwan:

Bedo ni ikwan man twero miyi winyo aber akwako ngo ame ibeo iye ikara okato ame onwongo itye inywal. Kede dang ngo ayin ikobiwa twero konyo wa me donyo kede yore abeco amyero kony kede toto atino ikare me nywal.

Cul pi kwan:

Pe tye kit culoro okene ame yin ibino donyo iye acalo adwogi me bedo ikwan man.

Pwoc pi bedo iyi kwan:

Jo bino miyi ciling 5,000 (ZAR 21) kun nwongo abeo iyi jami ame amiyi pi bedo ni iyi kwan me acel. Ka ame dok ote oyeri me bedo ikwan me aryo, nwongo dok obino miyi jami awelere tuno ciling. 20,000 (ZAR 85).

Apeny akwako kwan:

Ka ame nyo itye kede apenyoro akwako kwan man, iromo goyo cim bot Samson Udho kun ibeo iyi namba cim 0785 588 257. Itwero dang tuno bot ngat atye aloye ikwan man, Professor Sheila Clow kun ibeo iyi namba cim: +27 83 659 5266.

Apeny akwako twero adano ame abedo iyi kwan:

Ka ame nyo itye kede apeny akwako ber bedo kede twero ni iyi kwan man, itwero kubere kede Professor Marc Blockman, Wankom, Faculty of Health Sciences Human Research Ethics Committee Kun ibeo iyi email: marc.blockman@uct.ac.za , onyo namba cim: +27 21 650 1236. Itwero dang kubere kede wankom, Gulu University Research and Ethics Committee, Dr. Gerald Obai iyi namba cim 0772 305 621, onyo Uganda National Council for Science and Technology iyi namba cim 0414 705 500.

Kit ame obino pok adwogi oya ikwan man onyo ngec ame onwgere:

Kopi me ripot me kwan man obino gwoko iyi University me Cape Town pi jo okene ame abino timo ikweda iyi anyim. Ngo ame bino nwongere ikom kwan man obino coyo ipupara eka ote nywako iyi cokere kede jo oken ame dang timo ikweda. Ngo ame onwongere apiretek obino nywako kede dakatale agamente.

Lok amako jale me bedo iyi kwan:

Itye agonya me ye nyo kwero me bedo iyi kwan man. Itye dang kede twero me weka bedo ikwan man icawa moro keken abongo itango.

Cwaka pi kwan:

Kwan man obin ocwako nibeo ibot oloc apirgitek me lobo South Africa kede lobo Uganda. Gamente me Uganda dang omio twero me timo kwan man ii Uganda.

Imung akwako kwan:

Nyingi kede jami anyutu nga ame yin ibedo pe amite. Ngec ame an anywako abedo ka ame angeye bot jo ame timo ikweda. Kadi bed amano, ngat ame tye atimo ikweda man bino miyo ngec akwako nywaro otino nyo weko otino abongo gwok bot polici karecel kede bot otela me dakatal.

Lok ame moko ye ame oya ibot jo atino atye ikin mwaka 18 tuno 19

.......………………………………………………………. otita lok ikom kwan man. Anyang dang ngo ame otye amito ibota. Abedo dang kede kare me penyo apeny akwako kwan man kede dang omia agam iyore aber te miya nyang. Ka tye kit apenyore ame myero pwod apeny iyonge, abino bedo agonya ate penyo jo ame tye atelo wi kwan man ame dang omia namba cim gi ni. Anyang ni bedo na ikwan man obedo me jale ame dang otwero kwanyo ye na me bedo ikwan man icawa moro kiken ame cunya owinyo abongo itango onyo rwenyo kit ginoro kiken ame amyero anwong iyi bedo ikwan man. Kopi me pupara ni dang jo bino miya.

Aye me bedo ikwan man kun lubere kede ngec ame ocoye iyi pupara ni.

Pe ☐ **Ee** ☐

Aye ni otwero lwonga me bedo ikwani pi dul me aryo:

Pe ☐ **Ee** ☐

Aye ni myero mak dwona iyi kwan me dul me aryoo

Pe ☐ **Ee** ☐

Nying: ……………………………..…Alama cing ngat atye ikwan: ………………Nino dwe: …………………

Nying: ………………………………....Alama cing acaden: ………………….Nino dwe: ……………………

Nying: ……………………………Alama cing ngat amiyo apeny: ……………..Nino dwe: ………………..

Ngec ame oyungu acek pi jo atino amwaka gi tye 18 tuno 19

- An abedo Samson Udho, ame akwano ii University me Cpe Town, South Africa. Atel wia ikwan me ikweda ni obedo Professor Sheila Clow.
- Wan otye otim ikweda ame twero konyo dakatal ame yin iwoto iye me neno ni otio atek me kony mon atino me nwongo kony aber me nywal.
- Iyi ikweda ni, wan olok kede mon atino apol ame nwongo onywal idakatale kun openyo gi apeny apol ame kwako kit ame obin otero gi kede ikare me nywal gi ame obedo acegi ni.
- Wan obino bedo kede leyo lok pi cawa aromo acel. Pe tye apima moro me dakatal ame obino timo ikomi kede pe tye ginoro ame obino timo ame amiyo kwo ni abedo atek.
- Ka tye apenyoro ame mio yii wang, eka ite tamo ni myero igik oko, onyo tamo ni kong iwe nwongo dang pe rac.
- Abino neno ni dano ame opwonyere ilok me kweyo cuny jo obedo atye me winyo kede dang lok kedi ka ame imito.
- Pe tye ginoro ame anwongere oyototot me konyi ento bedo ni ikwan twero konyo wa me nyango atut kite ango ame mon atino mito ni myero ter gi kede ikare me nywal.
- Jo bino miyi cilling 5,000 pi dul ikweda me aceli, eka ciling 20,000 okene dok obino medi ka ce oyeri dok me bedo iyi dul kwan me aryo.
- Wan pe obino miyo ngecoro kiken akwako komi bot jo okene ame pe tye iyi akina jo ame tye atimo ikweda man. Ngec ame wan orao obino gwoko me imung nikwanyo ka jo ame tye atimo ikweda man en aye bino bedo kede kare me neno.
- Ka koporo kiken ame kwako nywaro onyo kwero gwoko atin bino kato icawa me leyo lok, wan otye kede twero me cwalo kopere oko bot dul ame loo kodi kopo me wek gi okwed yore atutut.
- Ka obino nwongo ni itye kede two para atut onyo wang yic ame obin iyunge yin nywal, wan obino kwanyi oko iyi kwan man eka ote cwali idakatal acok kedi me wek onen peko no kede miyo kony ame mite.
- Iyi agiki me kwan man, wan obino nywako jami ame wan onwongo ibot jo ame obedo iyi kwan.
- Yin iromo yero pe me bedo ikwan man kede pe myero idony ikwan ka ame pe itye imito.
- Ka itye kede apenyoro iromo penyo icawani onyo icen, akadi dang iyonge ame kwan ocakere oko.
- Ka nyo cunyi owinyo me penyo apenyoro iyonge acen, iromo lok kede Samson Udho iyi namba cim 0785 588 257, onyo professor Sheila Clow iyi amba cim +27 83 659 5266.

- Tam/plan me tic ame oco ping kani obin ongio dok ote moko aber nibeo iyi dul komiti ame tye ilobo South Africa kede Uganda ame ticgi tye me neno ni ginoro arac pe otimere ikom jo ame abedo ikwan.
- Ka nyo imito ngeyo jami mogo okene akwako dul komiti man itwero goyo cim bot Profesa Marc Blockman (me lobo South Africa) namba cim +27 21 650 1236 onyo Dr. Gerald Obai (me lobo Uganda) namba cim 0772 305 621.

Appendix 4.12a: Information Sheet and Consent Form for Parents/Legal Guardians of Adolescents, Aged 14 to 17 Years (English Version)

Study title:
Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

Investigator:
Samson Udho

Principal Investigator:
Sheila E. Clow

Institution:
University of Cape Town, South Africa

Study sponsor:
This research is self-sponsored.

Greeting and Introduction:
I am Samson Udho, a student at the University of Cape Town, South Africa. I am doing research to get a Doctoral Degree and my supervisor is Professor Sheila E. Clow.

Study Purpose:
We want to do research on teenage mothers to find out their birth experiences as teenagers giving birth in government health facilities so that we find ways to improve maternity care given to teenagers.

Study Procedures:
If you give consent for us to speak to your child, your child will then be asked to assent to participate in the study. If she assents, your child will be asked some questions for about an hour about how her past childbirth went. This interview will not be recorded. She may be selected to participate in a follow-up interview that will last for no more than one hour to share her experiences while giving birth in detail. This time the interview will be audio-recorded. In case she participates in the second interview, a counsellor will talk to her after our interview to make sure that she is okay.

Who will participate in the study and where is the study going to be conducted?
Your child has been chosen to participate in this study because she is a teenage mother who gave birth in one of the selected government hospitals for this research. The interview(s) will be conducted at home in a place of your child's convenience.

Risks/Discomforts:
Nothing harmful will happen to your child while participating in this study. If any of the questions make your child feel sad and she wants to stop or have a break that will be fine. I will make sure that there is a trained counsellor who can listen to her and speak with her if you would like that. If we discover that your child has

postnatal depression, she will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.

Benefits of the research study:

Participating in this study may make your child feel better about her past experience while giving birth. What she tells us may help us to come up with better ways to support other teenage mothers while giving birth.

Study Costs:

Your child will not incur any additional costs as a result of participating in this study.

Compensation for participation in the study:

Your child will be given UGX. 5,000 (ZAR 21) in-kind items for the first part of the interview. If you are selected to participate in the second part of the interview, you will again be given items worth UGX. 20,000 (ZAR 85).

Questions about the study:

In case you have any questions about this study, you can contact Samson Udho on telephone number: 0785 588 257. You may also contact his research Supervisor, Professor Sheila Clow on telephone number: +27 83 659 5266.

Questions about participants' rights:

In case you have any questions about your child's welfare and rights in this study, you can contact Professor Marc Blockman, Chair of the Faculty of Health Sciences Human Research Ethics Committee by email: marc.blockman@uct.ac.za , or by telephone number: +27 21 650 1236. You can also contact the Chairperson, Gulu University Research and Ethics Committee, Dr. Gerald Obai on telephone number 0772 305 621, or the Uganda National Council for Science and Technology on telephone number 0414 705 500.

Dissemination of study feedback or study findings:

A copy of this research report will be kept by the University of Cape Town for future use by other researchers. The results of the study will also be printed and shared in meetings with other researchers. Important findings will also be shared with the government hospitals.

Statement of voluntariness:

Your child is free to accept or refuse to participate in this study. Your child also has a right to stop participating in the study at any time without penalty.

Approval of the research study:

This study has been approved by the relevant authorities in South Africa and Uganda. The Government of Uganda has also given permission to conduct this study in Uganda.

Confidentiality:

Your child's name and other identifying personal details are not required. The information that she will share will only be accessed by the researchers. However, the researcher is required to report information about any child abuse or neglect to the police and the health facility administration.

Statement of consent from parent/legal guardian of adolescents, aged 14 to 17 years:

.... has explained the study to me. I understand what is expected from my child. I have had an opportunity to ask questions about the study and have been answered in the best way for me to understand. If there are any other questions that I have to ask later, I will freely approach the study representatives whose contact I have been given. I understand that the participation of my child is voluntary and her consent can be withdrawn any time she wishes to do so, without any penalty or loss of benefits entitled to her. A copy of this form will be provided to me.

I agree to my child to participate in part I of the study.

No ☐ **Yes** ☐

I agree to my child being approached to participate in part II of the study.

No ☐ **Yes** ☐

I agree to the audio recording of the interview with my child in part II of the study.

No ☐ **Yes** ☐

Name of the child: ……………………………………………….

Name: ………………..…Signature/thumbprint of parent/guardian: ……………………..Date: ……………

Name: ………………………………..…Signature of witness: ……………………..Date: ……………………

Name:. ……………………………Signature of interviewer: ……………………..Date: ……………………..

Summary of the information sheet for parent/legal guardian of adolescents, aged 14 to 17 years

- I am Samson Udho, and I study at the University of Cape Town, South Africa. My research supervisor is Professor Sheila Clow.
- We are doing research that might help the hospital where your child gave birth do more to help young women receive better maternity care.
- In our research, we will talk to many young women who gave birth in hospitals and ask them a number of questions including how they were treated during their most recent childbirth.
- If you give us permission to speak to your child, we will have a conversations that will last for about one hour. No medical tests will be done or anything that will make your child feel unsafe.
- If any of the questions make your child feel sad and she may stop or have a break.
- We will make sure that there is a trained counsellor to listen and speak to your child if she would like.
- There will be no immediate and direct benefit to your child, but her participation is likely to help us find out more about how young women want to be treated during childbirth.
- Your child will be given Ugx. 5000 for the first part of the study and another Ugx 20,000 if she is selected to participate in the second part of the study.
- We will not be sharing information about your child outside of the research team. The information that we collect will be kept confidential but the researchers will be able to see it.
- If any incidence of child abuse or neglect is reported during our conversation with your child, we will be required to report the matter to the relevant authorities for further inquiry.
- If we discover that your child has postnatal depression, she will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.
- At the end of the study, we will be sharing what we have learned from the participants.
- Your child may choose not to participate in this study and she does not have to take part in this research if she does not wish to do so.
- If you have any questions you may ask them now or later, even after the study has started.
- If you wish to ask questions later, you may contact Samson Udho by telephone number: 0785 588 257 or Professor Sheila Clow by telephone number: +27 83 659 5266.
- This proposal has been reviewed and approved by the relevant committees in South Africa and Uganda whose task is to make sure that research participants are protected from harm.
- If you wish to find out more about these committees contact Professor Marc Blockman (South Africa) by telephone no: +27 21 650 1236 or Dr. Gerald Obai (Uganda) on telephone no: 0772 305 621.

Appendix 4.12b: Information Sheet and Consent Form for Parents/Legal Guardians of Adolescents, Aged 14 to 17 Years (Lango Version)

Wi kop me kwan:

Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal

Ngata atye atimo ikweda

Samson Udho

Ngata atye aloyo ikweda:

Sheila E. Clow

Ka kwan:

University me Cape Town, South Africa

Ngata aculo pi kwan:

Dan atye atimo ikweda man en aye aculu.

Amot kede Nyutu wi kop:

An abedo Samson Udho, atin kwan iyi University me Cape Town ame tye ilobo south Africa. An atye atimo ikweda man me nwongo Ph.D, dano ame tye loyo wia iyi ikweda man obedo Profesa Sheila E. Clow.

Tyen kop me kwan:

Wan otye omito timo ikweda ikom toto atino me nyango ngo ame gin oboe iye ikare me nywal acalo jo atino ame onywal idakatale agamente me miyo wa nwogo yo me yubu kony me nywal ame omio bot jo atino.

Yore me kwan:

Ka imio wa twero me lok kede atini, obino penyo twero atini me ye bedo ikwan. Ka ame oye, jo bino penye kede apenyogo pi cawa aromo acel akwako kite ame nywalo atin ame en onywalo acegi ni obedo kede. Mako dwon pe bino bedo iyi kwan man. Onyo dok ka oyere me bedo iyi kwan okene ame alubu yor man ame dang pe bino kato cawa aromo acel me wek en nywak atutut ngo ame en obeo iye ikare onwongo tye anywal. Iyi kwan me aryo ni en aye mako dwon bino bedo iye. Ka ame en obedo ikwan me aryo no, dano ame opwonyere itic me mado cuny jo bino lok kede iyunge kwan me neno ni en tye aber.

Nga ame abedo iyi kwan man kede kwene ame kwan man bino bedo iye?

Atini jo oyer me bedo ikwan man pien obedo toto atidi ame obin onywal idakatal agamete acel ame obin oyero pi timo ikweda man. Kwan man obino timo pacu kana ame atini nwongo ni etye agonya.

Gin akelo peko/ Amio kwo bedo atek:

Pe tye ginoro ame bino kelo awano ikom atini iyi bedo mere ikwan man. Ka onyo apenyoro owang yia ame te miye tamo ni kong egik onyo ewe nwongo dang pe rac. Abino neno ni dano ame opwonyere ilok akwako kweyo cuny jo obedo atye me winyo ibote kede dang lok kede ka ame en amito.

Ka obino nwongo ni atini tye kede two para atut onyo wang yic ame obin iyunge en inywal, wan obino kwanye oko iyi kwan man eka ote cwale idakatal acok kede me wek onen peko no kede miyo kony ame mite.

Adwongi aber aya ikwan:

Bedo atini ikwan ni twero miyo atini winyo aber akwako ngo ame en beo iye ikara okato ame onwongo en tye anywal. Kede dang ngo ame en akobiwa twero konyo wa me donyo kede yore abeco amyero kony kede toto atino ikare me nywal.

Cul pi kwan:

Pe tye kit culoro okene ame atini bino donyo iye acalo adwogi me bedo ikwan man.

Pwoc pi bedo iyi kwan:

Jo bino miyo atini ciling 5,000 (ZAR 21) kun nwongo abeo iyi jami ame amiye pi bedo mere iyi kwan me acel. Ka ame dok ote oyere me bedo ikwan me aryo, nwongo dok obino miye jami awelere tuno ciling. 20,000 (ZAR 85).

Apeny akwako kwan:

Ka ame nyo itye kede apenyoro akwako kwan man, iromo goyo cim bot Samson Udho kun ibeo iyi namba cim 0785 588 257. Itwero dang tuno bot ngat atye aloye ikwan man, Professor Sheila Clow kun ibeo iyi namba cim: +27 83 659 5266.

Apeny akwako twero adano ame abedo iyi kwan:

Ka ame nyo itye kede apeny akwako ber bedo kede twero atini iyi kwan man, itwero kubere kede Professor Marc Blockman, Wankom, Faculty me Health Sciences Human Research Ethics Committee Kun ibeo iyi email: marc.blockman@uct.ac.za , onyo namba cim: +27 21 650 1236. Itwero dang kubere kede wankom, Gulu University Research and Ethics Committee, Dr. Gerald Obai iyi namba cim 0772 305 621, onyo Uganda National Council for Science and Technology iyi namba cim 0414 705 500.

Kit ame obino pok adwogi oya ikwan man onyo ngec ame onwgere:

Kopi ripot me kwan man obino gwoko iyi University me Cape Town pi jo okene ame bino timo ikweda iyi anyim. Ngo ame bino nwongere ikom kwan man obino coyo ipupara eka ote nywako iyi cokere kede jo oken ame dang timo ikweda. Ngo ame onwongere apiretek obino nywako kede dakatale agamente.

Lok amako jale me bedo iyi kwan:

Atini tye agonya me ye nyo kwero bedo iyi kwan man. Tye dang kede twero me weka bedo ikwan man icawa moro keken abongo itango.

Cwaka pi kwan:

Kwan man obin ocwako nibeo ibot oloc apirgitek me lobo South Africa kede lobo Uganda. Gamente me Uganda dang omio twero me timo kwan man ii Uganda.

Imung akwako kwan:

Nying atini kede jami anyutu nga ame en bedo pe amite. Ngec ame an anywako abedo ka ame angeye bot jo ame timo ikweda. Akadi bed amano, ngat ame tye atimo ikweda man bino miyo ngec akwako nywaro otino nyo weko otino abongo gwok bot polici karecel kede bot otela me dakatal.

Lok me moko ye ame oya ibot anywal/dano acik oyeye me gwoko atin me mwaka 14 tuno 17

.......…………………………………………………… otita lok ikom kwan man. Anyang dang ngo ame otye amito ibot atina. Abedo dang kede kare me penyo apeny akwako kwan man kede dang omia agam iyore aber te miya nyang. Ka tye kit apenyore ame myero pwod apeny iyonge, abino bedo agonya ate penyo jo ame tye atelo wi kwan man ame dang omia namba cim gi ni. Anyang ni bedo atina ikwan man obedo me jale ame dang otwero kwanyo ye mere me bedo ikwan man icawa moro kiken ame cunye owinyo abongo itango onyo rwenyo kit ginoro kiken ame amyero en nwong iyi bedo ikwan man. kopi me pupara ni dang jo bino miya.

Aye me atina ibedo iyi dul kwan me acel

Pe ☐ **Ee** ☐

Aye ni jo romo lwongo atina pi bedo iyi dul kwan me aryo

Pe ☐ **Ee** ☐

Aye ni myero mak dwon atina iyi dul kwan me aryo

Pe ☐ **Ee** ☐

Nying atin: ……………………………………………….

Nying: ……………….……………Alama cing anywal/dano agwoko atin: ……………..Nino dwe: …………

Nying: ……………………………..…Alama cing acaden: …………………..Nino dwe: …...………………

Nying:. …………………………………..Alam cing ngat amiyo apeny: ……….…..Nino dwe:……………..

Ngec ame oyungu acek pi anywal/dano acik oyeye me gwoko atin me mwaka 14 tuno naka 17

- An abedo Samson Udho, ame akwano ii University me Cpe Town, South Africa. Atel wia ikwan me ikweda ni obedo Professor Sheila Clow.
- Wan otye otim ikweda ame twero konyo dakatal ame atini onywal iye me neno ni otio atek me kony mon atino me nwongo kony aber me nywal.
- Iyi ikweda wa ni, wan olok kede mon atino apol ame nwongo onywal idakatale kun openyo gi apeny apol ame kwako kit ame obin otero gi kede ikare me nywal gi ame obedo acegi ni.
- Ka ame imio wa twero me lok kede atini, obino obedo kede leyo lok pi cawa aromo acel. Pe tye apima moro me dakatal ame obino timo ikome kede pe tye ginoro ame obino timo ame amiyo kwo mere abedo atek.
- Ka tye apenyoro ame mio yi atini wang, en twero kong gik oko onyo nwongo weo moro.
- Wan obino neno ni dano ame opwonyere ikom lok me kweyo cuny jo obedo atye me winyo kede lok atini ka ame en amito.
- Pe tye ginoro ame anwongere oyototot me konyo atini ento bedo mere ikwani twero konyo wa me nyango atut kite ango ame mon atino mito ni myero ter gi kede ikare me nywal.
- Jo bino miyo atini cilling 5,000 pi dul ikweda me acel, eka ciling 20,000 okene ka dok oyere me bedo iyi dul kwan me aryo.
- Wan pe obino miyo ngecoro kiken akwako komi bot jo okene ame pe tye iyi akina jo ame tye atimo ikweda man. Ngec ame wan orao obino gwoko me imung nikwanyo ka jo ame tye atimo ikweda man en aye bino bedo kede kare me neno.
- Ka koporo kiken ame kwako nywaro onyo kwero gwoko atin bino kato icawa me leyo lok kede atini, wan otye kede twero me cwalo kopere oko bot dul ame loo kodi kopo me wek gi okwed yore atutut.
- Ka obino nwongo ni atini kede two para atut onyo wang yic ame obin iyunge en nywal, wan obino kwanye oko iyi kwan man eka ote cwale idakatal acokcok me wek onen peko no kede miyo kony ame mite.
- Iyi agiki me kwan man, wan obino nywako jami ame wan onwongo ibot jo ame obedo iyi kwan.
- Atini romo yero pe me bedo ikwan man kede pe myero dony ikwan ka ame pe tye amito.
- Ka itye kede apenyoro iromo penyo icawani onyo icen, akadi dang iyonge ame kwan ocakere oko.
- Ka nyo cunyi owinyo me penyo apenyoro iyonge acen, iromo lok kede Samson Udho iyi namba cim 0785 588 257, onyo professor Sheila Clow iyi amba cim +27 83 659 5266.

- Tam/plan me tic ame oco ping kani obin ongio dok ote moko aber nibeo iyi dul komiti ame tye ilobo South Africa kede Uganda ame ticgi tye me neno ni ginoro arac pe otimere ikom jo ame abedo ikwan.
- Ka nyo imito ngeyo jami mogo okene akwako dul komiti man itwero goyo cim bot Profesa Marc Blockman (me lobo South Africa) namba cim +27 21 650 1236 onyo Dr. Gerald Obai (me lobo Uganda) namba cim 0772 305 621.

Appendix 4.13a: Information Sheet and Assent Form for Adolescents, Aged 14 to 17 Years (English Version)

Study title:
Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

Investigator:
Samson Udho

Principal Investigator:
Sheila E. Clow

Institution:
University of Cape Town, South Africa

Study sponsor:
This research is self-sponsored.

Greeting and Introduction:
I am Samson Udho, a student at the University of Cape Town, South Africa. I am doing research to get a Doctoral Degree and my supervisor is Professor Sheila E. Clow.

Study Purpose:
We want to do research on teenage mothers to find out their birth experiences as teenagers giving birth in government health facilities so that we find ways to improve maternity care given to teenagers.

Study Procedures:
Your parent/legal guardian has given us permission to speak to you but you are required to assent or refuse to participate in the study. You will be asked some questions for about an hour about how your past childbirth went. This interview will not be recorded. You may be selected to participate in a follow-up interview that will last for no more than one hour to share your experiences while giving birth in detail. This time the interview will be audio-recorded. In case you participate in the second interview, a counsellor will talk to you after our interview to make sure that you are okay.

Who will participate in the study and where is the study going to be conducted?
You have been chosen to participate in this study because you are a teenage mother who gave birth in one of the selected government hospitals for this research. The interview(s) will be conducted at your home in a place of your convenience.

Risks/Discomforts:
Nothing harmful will happen to you while participating in this study. If any of the questions make you feel sad and you want to stop or have a break that will be fine. I will make sure that there is a trained counsellor who can listen to you and speak with you if you would like that. If we discover that you have postnatal

depression, you will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.

Benefits of the research study:
Participating in this study may make you feel better about your past experience while giving birth. Again, what you tell us may help us to come up with better ways to support other teenage mothers while giving birth.

Study Costs:
There will be no additional costs incurred as a result of participating in this study.

Compensation for participation in the study:
You will be given UGX. 5,000 (ZAR 21) in-kind items for the first part of the interview. If you are selected to participate in the second part of the interview, you will again be given items worth UGX. 20,000 (ZAR 85).

Questions about the study:
In case you have any questions about this study, you can contact Samson Udho by telephone number: 0785 588 257. You may also contact his research Supervisor, Professor Sheila Clow by telephone number: +27 83 659 5266.

Questions about participants' rights:
In case you have any questions about your welfare and rights in this study, you can contact Professor Marc Blockman, Chair of the Faculty of Health Sciences Human Research Ethics Committee by email: marc.blockman@uct.ac.za , or by telephone number: +27 21 650 1236. You can also contact the Chairperson, Gulu University Research and Ethics Committee, Dr. Gerald Obai on telephone number 0772 305 621, or the Uganda National Council for Science and Technology on telephone number 0414 705 500.

Dissemination of study feedback or study findings:
A copy of this research report will be kept by the University of Cape Town for future use by other researchers. The results of the study will also be printed and shared in meetings with other researchers. Important findings will also be shared with the government hospitals.

Statement of voluntariness:
You are free to accept or refuse to participate in this study. You also have a right to stop participating in the study at any time without penalty.

Approval of the research study:
This study has been approved by the relevant authorities in South Africa and Uganda. The Government of Uganda has also given permission to conduct this study in Uganda.

Confidentiality:
Your name and other identifying personal details are not required. The information that I share will only be accessed by the researchers. However, the researcher is required to report information about any child abuse or neglect to the police and the health facility administration.

Statement of assent from adolescents, aged 14 to 17 years:

.... has explained the study to me. I understand what is expected from me. I have had an opportunity to ask questions about the study and have been answered in the best way for me to understand. If there are any other questions that I have to ask later, I will freely approach the study representatives whose contact I have been given. I understand that my participation is voluntary and my consent can be withdrawn any time I wish to do so, without any penalty or loss of benefits entitled to. A copy of this form will be provided to me.

I agree to participate in part I of the study.

No ☐ **Yes** ☐

I agree to be approached to participate in part II of the study.

No ☐ **Yes** ☐

I agree to the audio recording of the interview in part II of the study.

No ☐ **Yes** ☐

Name: ……………………..…Signature/thumbprint of participant: ……………………..Date: ………………

Name: ………………………………..…Signature of witness: ……………………..Date: ……………………

Name:. ……………………………Signature of interviewer: ……………………..Date: ……………………..

Summary of the information sheet for adolescents, aged 14 to 17 years

- I am Samson Udho, and I study at the University of Cape Town, South Africa. My research supervisor is Professor Sheila Clow.
- We are doing research that might help your hospital do more to help young women receive better maternity care.
- In our research, we will talk to many young women who gave birth in hospitals and ask them a number of questions including how they were treated during their most recent childbirth.
- Your parent/legal guardian has given us permission to speak to you but you are required to assent or refuse to participate in the study. We will have a conversation that will last for about one hour. No medical tests will be done or anything that will make you feel unsafe.
- If any of the questions make you feel sad and you want to stop or have a break that will be fine.
- I will make sure that there is a trained counsellor to listen and speak with you if you would like that.
- If we discover that you have postnatal depression, you will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.
- There will be no immediate and direct benefit to you, but your participation is likely to help us find out more about how young women want to be treated during childbirth.
- You will be given Ugx. 5000 for the first part of the study and another Ugx 20,000 if you are selected to participate in the second part of the study.
- We will not be sharing information about you outside of the research team. The information that we collect will be kept confidential but the researchers will be able to see it.
- If any incidence of child abuse or neglect is reported during our conversation, we will be required to report the matter to the relevant authorities for further inquiry.
- At the end of the study, we will be sharing what we have learned from the participants.
- You may choose not to participate in this study if you wish to do so and nothing will happen to you.
- If you have any questions you may ask them now or later, even after the study has started.
- If you wish to ask questions later, you may contact Samson Udho by telephone number: 0785 588 257 or Professor Sheila Clow by telephone number: +27 83 659 5266.
- This proposal has been reviewed and approved by the relevant committees in South Africa and Uganda whose task is to make sure that research participants are protected from harm.
- If you wish to find out more about these committees contact Professor Marc Blockman (South Africa) by telephone no: +27 21 650 1236 or Dr. Gerald Obai (Uganda) on telephone no: 0772 305 621.

Appendix 4.13b: Information Sheet and Assent Form for Adolescents, Aged 14 to 17 Years (Lango Version)

Wi kop me kwan:

Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal.

Ngata atye atimo ikweda:

Samson Udho

Ngata atye aloyo ikweda:

Sheila E. Clow

Ka kwan:

University me Cape Town, South Africa

Ngata aculo pi kwan:

Dan atye atimo ikweda man en aye aculu.

Amot kede Nyutu wi kop:

An abedo Samson Udho, atin kwan iyi University me Cape Town ame tye ilobo south Africa. An atye atimo ikweda man me nwongo Ph.D, dano ame tye loyo wia iyi ikweda man obedo Profesa Sheila E. Clow.

Tyen kop me kwan:

Wan otye omito timo ikweda ikom toto atino me nyango ngo ame gin oboe iye ikare me nywal acalo jo atino ame onywal idakatale agamente me miyo wa nwogo yo me yubu kony me nywal ame omio bot jo atino.

Yore me kwan:

Anywali/dano ame gwoki omio wa twero me lok kedi ento pwod tye boti me ye nyo kwero bedo ikwan man. Jo bino penyi kede apenyogo pi cawa aromo acel akwako kite ame nywalo atini ame pwod obedo me agiki ni owoto kede. Mako dwon pe bino bedo iyi kwan man. Onyo dok jo twero yeri me bedo iyi kwan okene ame alubu yor man ame dang pe bino kato cawa aromo acel me wek inywak atutut ngo ame yin ibeo iye ikare onwongo itye inywal. Iyi kwan me aryo en aye mako dwon bino bedo iye. Ka ame onwongo itye ikwan me aryo no, dano ame opwonyere iyi tic me mado cuny jo bino lok kedi iyunge kwan me neno ni yin itye ame iwinyo aber.

Nga ame abedo iyi kwan man kede kwene ame kwan man bino bedo iye?

Yin oyeri me bedo ikwan man pien yin ibedo toto atidi ame obin onywal idakatal agamete acel ame obin oyero pi timo ikweda man. Kwan man obino timo pacu kana ame yin inwongo ni itye agonya

Gin akelo peko/ Amio kwo bedo atek:

Pe tye ginoro ame akelo awano ikom iyi bedo ni ikwan man. Ka onyo apenyoro kiken iyi akina apenye omio yii owang ame imito kong gik onyo weo nwongo dang pe rac. Abino neno ni dano ame opwonyere ilok akwako kweyo cuny jo obedo atye me winyo iboti kede dang lok kede ka ame imito.

Ka obino nwongo ni itye kede two para atut onyo wang yic ame obino iyunge yin nywal, wan obino kwanyi oko iyi kwan man eka ote cwali idakatal acok kedi me wek onen peko no kede miyo kony ame mite

Adwongi aber aya ikwan:

Bedo ni ikwan man twero miyi winyo aber akwako ngo ame ibeo iye ikara okato ame onwongo itye inywal. Kede dang ngo ayin ikobiwa twero konyo wa me donyo kede yore abeco amyero kony kede toto atino ikare me nywal.

Cul pi kwan:

Pe tye kit culoro okene ame yin ibino donyo iye acalo adwogi me bedo ikwan man.

Pwoc pi bedo iyi kwan:

Jo bino miyi ciling 5,000 (ZAR 21) kun nwongo abeo iyi jami ame amiyi pi bedo ni iyi kwan me acel. Ka ame dok ote oyeri me bedo ikwan me aryo, nwongo dok obino miyi jami awelere tuno ciling. 20,000 (ZAR 85).

Apeny akwako kwan:

Ka ame nyo itye kede apenyoro akwako kwan man, iromo goyo cim bot Samson Udho kun ibeo iyi namba cim 0785 588 257. Itwero dang tuno bot ngat atye aloye ikwan man, Professor Sheila Clow kun ibeo iyi namba cim: +27 83 659 5266.

Apeny akwako twero adano ame abedo iyi kwan:

Ka ame nyo itye kede apeny akwako ber bedo kede twero ni iyi kwan man, itwero kubere kede Professor Marc Blockman, Wankom, Faculty of Health Sciences Human Research Ethics Committee Kun ibeo iyi email: marc.blockman@uct.ac.za , onyo namba cim: +27 21 650 1236. Itwero dang kubere kede wankom, Gulu University Research and Ethics Committee, Dr. Gerald Obai iyi namba cim 0772 305 621, onyo Uganda National Council for Science and Technology iyi namba cim 0414 705 500.

Kit ame obino pok adwogi oya ikwan man onyo ngec ame onwgere:

Kopi me ripot me kwan man obino gwoko iyi University me Cape Town pi jo okene ame bino timo ikweda iyi anyim. Ngo ame bino nwongere ikom kwan man obino coyo ipupara eka ote nywako iyi cokere kede jo oken ame dang timo ikweda. Ngo ame onwongere apiretek obino nywako kede dakatale agamente.

Lok amako jale me bedo iyi kwan:

Itye agonya me ye nyo kwero me bedo iyi kwan man. Itye dang kede twero me weko bedo ikwan man icawa moro keken abongo itango.

Cwaka pi kwan:

Kwan man obin ocwako nibeo ibot oloc apirgitek me Iobo South Africa kede Iobo Uganda. Gamente me Uganda dang omio twero me timo kwan man iyi Uganda.

Imung akwako kwan:

Nyingi kede jami anyutu nga ame yin ibedo pe amite. Ngec ame an anywako abedo ka ame angeye bot jo ame timo ikweda. Akadi bed amano, ngat ame tye atimo ikweda man bino miyo ngec akwako nywaro otino nyo weko otino abongo gwok bot polici karecel kede bot otela me dakatal.

Lok ame moko ye ame oya ibot jo atino ame tye iyi akin mwaka 14 tuno 17

.......………………………………………………………. otita lok ikom kwan man. Anyang dang ngo ame otye amito ibota. Abedo dang kede kare me penyo apeny akwako kwan man kede dang omia agam iyore aber te miya nyang. Ka tye kit apenyore ame myero pwod apeny iyonge, abino bedo agonya ate penyo jo ame tye atelo wi kwan man ame dang omia namba cim gi ni. Anyang ni bedo na ikwan man obedo me jale ame dang otwero kwanyo ye na me bedo ikwan man icawa moro kiken ame cunya owinyo abongo itango onyo rwenyo kit ginoro kiken ame amyero anwong iyi bedo ikwan man. Kopi me pupara ni dang jo obino miya.

Aye me bedo ikwan man kun lubere kede ingec ame ocoye ipupara ni.

Pe ☐ **Ee** ☐

Aye ni otwero lwonga me bedo ikwani pi dul me aryo:

Pe ☐ **Ee** ☐

Aye me mako dwona pi apeny ame abedo idul me aryo me kwan man

Pe ☐ **Ee** ☐

Nying: ……………………………..….Alama cing ngat atye ikwan: ………………Nino dwe: …………………

Nying: ……………………………….....Alama cing acaden: ………………….Nino dwe: ……………………

Nying: ……………………………Alama cing ngat amiyo apeny: ………………Nino dwe: ………………..

Ngec ame oyungu acek pi jo atino amwaka gi tye 14 tuno 17

- An abedo Samson Udho, ame akwano ii University me Cpe Town, South Africa. Atel wia ikwan me ikweda ni obedo Professor Sheila Clow.
- Wan otye otim ikweda ame twero konyo dakatal ame yin iwoto iye me neno ni otio atek me kony mon atino me nwongo kony aber me nywal.
- Iyi ikweda ni, wan olok kede mon atino apol ame nwongo onywal idakatale kun openyo gi apeny apol ame kwako kit ame obin otero gi kede ikare me nywal gi ame obedo acegi ni.
- Anywali/dano ame gwoki omio wa twero me lok kedi ento nwongo tye boti me ye nyo kwero bedo ikwan man. Pe tye apima moro me dakatal ame obino timo ikomi kede pe tye ginoro ame obino timo ame amiyo kwo ni abedo atek.
- Ka tye apenyoro ame mio yii wang, eka ite tamo ni myero igik oko, onyo tamo ni kong iwe nwongo dang pe rac.
- Abino neno ni dano ame opwonyere ilok me kweyo cuny jo obedo atye me winyo kede dang lok kedi ka ame imito
- Ka obino nwongo ni itye kede two para atut onyo wang yic ame obin iyunge ame yin inywal, wan obino kwanyi oko iyi kwan man eka ote cwali idakatal acok kedi me wek onen peko no kede miyo kony ame mite.
- Pe tye ginoro ame anwongere oyototot me konyi ento bedo ni ikwan twero konyo wa me nyango atut kite ango ame mon atino mito ni myero ter gi kede ikare me nywal.
- Jo bino miyi cilling 5,000 pi dul ikweda me aceli, eka ciling 20,000 okene dok obino medi ka ce oyeri dok me bedo iyi dul kwan me aryo.
- Wan pe obino miyo ngecoro kiken akwako komi bot jo okene ame pe tye iyi akina jo ame tye atimo ikweda man. Ngec ame wan orao obino gwoko me imung nikwanyo ka jo ame tye atimo ikweda man en aye bino bedo kede kare me neno.
- Ka koporo kiken ame kwako nywaro onyo kwero gwoko atin bino kato icawa me leyo lok, wan otye kede twero me cwalo kopere oko bot dul ame loo kodi kopo me wek gi okwed yore atutut.
- Iyi agiki me kwan man, wan obino nywako jami ame wan onwongo ibot jo ame obedo iyi kwan.
- Yin iromo yero pe me bedo ikwan man kede pe myero idony ikwan ka ame pe itye imito.
- Ka itye kede apenyoro iromo penyo icawani onyo icen, akadi dang iyonge ame kwan ocakere oko.
- Ka nyo cunyi owinyo me penyo apenyoro iyonge acen, iromo lok kede Samson Udho iyi namba cim 0785 588 257, onyo professor Sheila Clow iyi amba cim +27 83 659 5266.

- Tam/plan me tic ame oco ping kani obin ongio dok ote moko aber nibeo iyi dul komiti ame tye ilobo South Africa kede Uganda ame ticgi tye me neno ni ginoro arac pe otimere ikom jo ame abedo ikwan.
- Ka nyo imito ngeyo jami mogo okene akwako dul komiti man itwero goyo cim bot Profesa Marc Blockman (me lobo South Africa) namba cim +27 21 650 1236 onyo Dr. Gerald Obai (me lobo Uganda) namba cim 0772 305 621.

Appendix 4.14a: Information Sheet and Consent Form for Emancipated Adolescents, Aged 14 to 17 Years (English Version)

Study title:
Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

Investigator:
Samson Udho

Principal Investigator:
Sheila E. Clow

Institution:
University of Cape Town, South Africa.

Study sponsor:
This research is self-sponsored.

Greeting and Introduction:
I am Samson Udho, a student at the University of Cape Town, South Africa. I am doing research to get a Doctoral Degree and my supervisor is Professor Sheila E. Clow.

Study Purpose:
We want to do research on teenage mothers to find out their birth experiences as teenagers giving birth in government health facilities so that we find ways to improve maternity care given to teenagers.

Study Procedures:
You will be asked some questions for about an hour about how your past childbirth went. This interview will not be recorded. You may be selected to participate in a follow-up interview that will last for no more than one hour to share your experiences while giving birth in detail. This time the interview will be audio-recorded. In case you participate in the second interview, a counsellor will talk to you after our interview to make sure that you are okay.

Who will participate in the study and where is the study going to be conducted?
You have been chosen to participate in this study because you are a teenage mother who gave birth in one of the selected government hospitals for this research. The interview(s) will be conducted at your home in a place of your convenience.

Risks/Discomforts:
Nothing harmful will happen to you while participating in this study. If any of the questions make you feel sad and you want to stop or have a break that will be fine. I will make sure that there is a trained counsellor who can listen to you and speak with you if you would like that. If we discover that you have postnatal

depression, you will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.

Benefits of the research study:

Participating in this study may make you feel better about your past experience while giving birth. Again, what you tell us may help us to come up with better ways to support other teenage mothers while giving birth.

Study Costs:

There will be no additional costs incurred as a result of participating in this study.

Compensation for participation in the study:

You will be given UGX. 5,000 (ZAR 21) in-kind items for the first part of the interview. If you are selected to participate in the second part of the interview, you will again be given items worth UGX. 20,000 (ZAR 85).

Questions about the study:

In case you have any questions about this study, you can contact Samson Udho by telephone number: 0785 588 257. You may also contact his research Supervisor, Professor Sheila Clow by telephone number: +27 83 659 5266.

Questions about participants' rights:

In case you have any questions about your welfare and rights in this study, you can contact Professor Marc Blockman, Chair of the Faculty of Health Sciences Human Research Ethics Committee by email: marc.blockman@uct.ac.za , or by telephone number: +27 21 650 1236. You can also contact the Chairperson, Gulu University Research and Ethics Committee, Dr. Gerald Obai on telephone number 0772 305 621, or the Uganda National Council for Science and Technology on telephone number 0414 705 500.

Dissemination of study feedback or study findings:

A copy of this research report will be kept by the University of Cape Town for future use by other researchers. The results of the study will also be printed and shared in meetings with other researchers. Important findings will also be shared with the government hospitals.

Statement of voluntariness:

You are free to accept or refuse to participate in this study. You also have a right to stop participating in the study at any time without penalty.

Approval of the research study:

This study has been approved by the relevant authorities in South Africa and Uganda. The Government of Uganda has also given permission to conduct this study in Uganda.

Confidentiality:

Your name and other identifying personal details are not required. The information that I share will only be accessed by the researchers. However, the researcher is required to report information about any child abuse or neglect to the police and the health facility administration.

Statement of consent from adolescents, aged 14 to 17 years:

.... has explained the study to me. I understand what is expected from me. I have had an opportunity to ask questions about the study and have been answered in the best way for me to understand. If there are any other questions that I have to ask later, I will freely approach the study representatives whose contact I have been given. I understand that my participation is voluntary and my consent can be withdrawn any time I wish to do so, without any penalty or loss of benefits entitled to. A copy of this form will be provided to me.

I agree to participate in part I of the study.

No ☐ **Yes** ☐

I agree to be approached to participate in part II of the study.

No ☐ **Yes** ☐

I agree to the audio recording of the interview in part II of the study.

No ☐ **Yes** ☐

Name: ……………………..…Signature/thumbprint of participant: ……………………..Date: …………………

Name: ………………………………..…Signature of witness: ……………………..Date: ……………………

Name:. ……………………………Signature of interviewer: ……………………..Date: ……………………..

Summary of the information sheet for emancipated adolescents, aged 14 to 17 years

- I am Samson Udho, and I study at the University of Cape Town, South Africa. My research supervisor is Professor Sheila Clow.
- We are doing research that might help your hospital do more to help young women receive better maternity care.
- In our research, we will talk to many young women who gave birth in hospitals and ask them a number of questions including how they were treated during their most recent childbirth.
- We will have a conversation that will last for about one hour. No medical tests will be done on you and nothing will be done that will make you feel unsafe.
- If any of the questions make you feel sad and you want to stop or have a break that will be fine.
- I will make sure that there is a trained counsellor who can listen to you and speak with you if you would like that.
- There will be no immediate and direct benefit to you, but your participation is likely to help us find out more about how young women want to be treated during childbirth.
- You will be given Ugx. 5000 for the first part of the study and another Ugx 20,000 if you are selected to participate in the second part of the study.
- We will not be sharing information about you outside of the research team. The information that we collect will be kept confidential but the researchers will be able to see it.
- If any incidence of child abuse or neglect is reported during our conversation, we will be required to report the matter to the relevant authorities for further inquiry.
- If we discover that you have postnatal depression, you will be excluded from the study and referred to a nearby health facility for further investigations and clinical management.
- At the end of the study, we will be sharing what we have learned from the participants.
- You may choose not to participate in this study if you wish to do so and nothing will happen to you.
- If you have any questions you may ask them now or later, even after the study has started.
- If you wish to ask questions later, you may contact Samson Udho by telephone number: 0785 588 257 or Professor Sheila Clow by telephone number: +27 83 659 5266.
- This proposal has been reviewed and approved by the relevant committees in South Africa and Uganda whose task is to make sure that research participants are protected from harm.
- If you wish to find out more about these committees contact Professor Marc Blockman (South Africa) by telephone no: +27 21 650 1236 or Dr. Gerald Obai (Uganda) on telephone no: 0772 305 621.

Appendix 4.14b: Information Sheet and Consent Form for Emancipated Adolescents, Aged 14 To 17 Years (Lango Version)

Wi kop me kwan:

Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal.

Ngata atye atimo ikweda:

Samson Udho

Ngata atye aloyo ikweda:

Sheila E. Clow

Ka kwan:

University me Cape Town, South Africa

Ngata aculo pi kwan:

Dano ame tye atimo ikweda man en aye aculu.

Amot kede Nyutu wi kop:

An abedo Samson Udho, atin kwan iyi University me Cape Town ame tye ilobo south Africa. An atye atimo ikweda man me nwongo Ph.D, dano ame tye aloyo wia iyi ikweda man obedo Profesa Sheila E. Clow.

Tyen kop me kwan:

Wan otye omito timo ikweda ikom toto atino me nyango ngo ame gin oboe iye ikare me nywal acalo jo atino ame onywal idakatale agamente me miyo wa nwongo yo me yubu kony me nywal ame omio bot mon atino.

Yore me kwan:

Jo bino penyi kede apenyogo pi cawa aromo acel akwako kite ame nywalo atini ame pwod obedo me agiki ni owoto kede. Mako dwon pe bino bedo iyi kwan man. Onyo dok otwero yeri me bedo iyi kwan okene ame alubu yor man ame dang pe bino kato cawa aromo acel me wek inywak atutut ngo ame yin ibeo iye ikare onwongo itye inywal. Iyi kwan me aryo en aye mako dwon bino bedo iye. Ka ame onwongo itye ikwan me aryo no, dano ame opwonyere itic me kweyo cuny jo bino lok kedi iyunge kwan me neno ni yin itye ame iwinyo aber.

Nga ame abedo iyi kwan man kede kwene ame kwan man bino bedo iye?

Yin obin oyeri me bedo ikwan man pien yin ibedo toto atidi ame obin onywal idakatal agamete acel ame obin oyero pi timo ikweda man. Kwan man obino timo pacu kan ame yin inwongo ni itye agonya.

Gin akelo peko/ Amio kwo bedo atek:

Pe tye ginoro ame akelo awano ikomi iyi bedo ni ikwan man. Ka onyo apenyoro kiken iyi akina apenye omio yii owang ame imito kong gik onyo weo nwongo dang pe rac. Abino neno ni dano ame opwonyere ilok akwako kweyo cuny jo obedo atye me winyo kede dang lok kedi ka ame imito.

Ka obino nwongo ni itye kede two para atut onyo wang yic ame obino iyunge yin inywal, wan obino kwanyi oko iyi kwan man eka ote cwali idakatal acok kedi me wek onen peko no kede miyo kony ame mite.

Adwongi aber aya ikwan:

Bedo ni ikwan man twero miyi winyo aber akwako ngo ame ibeo iye ikara okato ame onwongo itye inywal. Kede dang ngo ayin ikobiwa twero konyo wa me donyo kede yore abeco amyero kony kede toto atino ikare me nywal.

Cul pi kwan:

Pe tye kit culoro okene ame yin ibino donyo iye acalo adwogi me bedo ikwan man.

Pwoc pi bedo iyi kwan:

Jo bino miyi ciling 5,000 (ZAR 21) kun nwongo abeo iyi jami ame amiyi pi bedo ni iyi kwan me acel. Ka ame dok ote oyeri me bedo ikwan me aryo, nwongo dok obino miyi jami awelere tuno ciling. 20,000 (ZAR 85).

Apeny akwako kwan:

Ka ame nyo itye kede apenyoro akwako kwan man, iromo goyo cim bot Samson Udho kun ibeo iyi namba cim 0785 588 257. Itwero dang tuno bot ngat atye aloye ikwan man, Professor Sheila Clow kun ibeo iyi namba cim: +27 83 659 5266.

Apeny akwako twero adano ame abedo iyi kwan:

Ka ame nyo itye kede apeny akwako ber bedo kede twero ni iyi kwan man, itwero kubere kede Professor Marc Blockman, Wankom, Faculty of Health Sciences Human Research Ethics Committee Kun ibeo iyi email: marc.blockman@uct.ac.za , onyo namba cim: +27 21 650 1236. Itwero dang kubere kede wankom, Gulu University Research and Ethics Committee, Dr. Gerald Obai iyi namba cim 0772 305 621, onyo Uganda National Council for Science and Technology iyi namba cim 0414 705 500.

Kit ame obino poko kede adwogi oya ikwan man onyo ngec ame onwgere:

Kopi me ripot me kwan man obino gwoko iyi University me Cape Town pi jo okene ame abino timo ikweda iyi anyim. Ngo ame bino nwongere ikom kwan man obino coyo ipupara eka ote nywako iyi cokere kede jo oken ame dang timo ikweda. Ngo ame onwongere apiretek obino nywako kede dakatale agamente.

Lok amako jale me bedo iyi kwan:

Itye agonya me ye nyo kwero me bedo iyi kwan man. Itye dang kede twero me weka bedo ikwan man icawa moro keken abongo itango.

Cwaka pi kwan:

Kwan man obin onwongo cwak nibeo ibot oloc apirgitek me lobo South Africa kede lobo Uganda. Gamente me Uganda dang omio twero me timo kwan man iyi Uganda.

Imung akwako kwan:

Nyingi kede jami anyutu nga ame yin ibedo pe amite. Ngec ame an anywako abedo ka ame angeye bot jo ame timo ikweda. Kadi bed amano, ngat ame tye atimo ikweda man bino miyo ngec akwako nywaro otino nyo weko otino abongo gwok bot polici karecel kede bot otela me dakatal.

Lok me miyo twero ame ya ibot jo atino atye ikin mwaka 14 tuno 17

.... otita lok ikom kwan man. Anyang dang ngo ame otye amito ibota. Abedo dang kede kare me penyo apeny akwako kwan man kede dang omia agam iyore aber te miya nyang. Ka tye kit apenyore ame myero pwod apeny iyonge, abino bedo agonya ate penyo jo ame tye atelo wi kwan man ame dang omia namba cim gi ni. Anyang ni bedo na ikwan man obedo me jale ame dang otwero kwanyo ye na me bedo ikwan man icawa moro kiken ame cunya owinyo abongo itango onyo rwenyo kit ginoro kiken ame amyero anwong iyi bedo ikwan man. Kopi me pupara ni dang jo bino miya. Aye me bedo ikwan man kun lubere kede ngec ame ocoye ipupara ni.

Pe ☐ **Ee** ☐

Aye ni otwero lwonga me bedo ikwani pi dul me aryo:

Pe ☐ **Ee** ☐

Aye me mako dwona pi apeny ame abedo idul me aryo me kwan man

Pe ☐ **Ee** ☐

Nying: ....Alama cing ngat atye ikwan: ....Nino dwe: ....

Nying: ....Alama cing acaden: ....Nino dwe: ....

Nying: ....Alama cing ngat amiyo apeny: ....Nino dwe: ....

Ngec ame oyungu acek pi jo atino ame loye iwigi kengi kun tye ikin mwaka 14 tuno naka 17

- An abedo Samson Udho, ame akwano ii University me Cpe Town, South Africa. Atel wia ikwan me ikweda ni obedo Professor Sheila Clow.
- Wan otye otim ikweda ame twero konyo dakatal ame yin iwoto iye me neno ni otio atek me kony mon atino me nwongo kony me nywal aber.
- Iyi ikweda ni, wan olok kede mon atino apol ame nwongo onywal idakatale kun openyo gi apeny apol ame kwako kit ame obin otero gi kede ikare me nywal gi ame obedo acegi ni.
- Wan obino bedo kede leyo lok pi cawa aromo acel. Pe tye apima moro me dakatal ame obino timo ikomi kede pe tye ginoro ame obino timo ame amiyo kwo ni abedo atek.
- Ka tye apenyoro ame mio yii wang, eka ite tamo ni myero igik oko, onyo tamo ni kong iwe nwongo dang pe rac.
- Abino neno ni dano ame opwonyere ilok me kweyo cuny jo obedo atye me winyo kede dang lok kedi ka ame imito
- Pe tye ginoro ame anwongere oyototot me konyi ento bedo ni ikwan twero konyo wa me nyango atut kite ango ame mon atino mito ni myero ter gi kede ikare me nywal.
- Jo bino miyi cilling 5,000 pi dul ikweda me aceli, eka ciling 20,000 okene dok obino medi ka ce oyeri dok me bedo iyi dul kwan me aryo.
- Wan pe obino miyo ngecoro kiken akwako komi bot jo okene ame pe tye iyi akina jo ame tye atimo ikweda man. Ngec ame wan orao obino gwoko me imung nikwanyo ka jo ame tye atimo ikweda man en aye bino bedo kede kare me neno.
- Ka koporo kiken ame kwako nywaro onyo kwero gwoko atin bino kato icawa me leyo lok, wan otye kede twero me cwalo kopere oko bot dul ame loo kodi kopo me wek gi okwed yore atutut.
- Ka obino nwongo ni itye kede two para atut onyo wang yic ame obin iyunge yin inywal, wan obino kwanyi oko iyi kwan man eka ote cwali idakatal acok kedi me wek onen peko no kede miyo kony ame mite.
- Iyi agiki me kwan man, wan obino nywako jami ame wan onwongo ibot jo ame obedo iyi kwan.
- Yin iromo yero pe me bedo ikwan man kede pe myero idony ikwan ka ame pe itye imito.
- Ka itye kede apenyoro iromo penyo icawani onyo icen, akadi dang iyonge ame kwan ocakere oko.
- Ka nyo cunyi owinyo me penyo apenyoro iyonge cen, iromo lok kede Samson Udho iyi namba cim 0785 588 257, onyo professor Sheila Clow iyi amba cim +27 83 659 5266.

- Tam/plan me tic ame oco ping kani obin ongio dok ote moko aber nibeo iyi dul komiti ame tye ilobo South Africa kede Uganda ame ticgi tye me neno ni ginoro arac pe otimere ikom jo ame abedo ikwan.
- Ka nyo imito ngeyo jami mogo okene akwako dul komiti man itwero goyo cim bot Profesa Marc Blockman (me lobo South Africa) namba cim +27 21 650 1236 onyo Dr. Gerald Obai (me lobo Uganda) namba cim 0772 305 621.

Appendix 4.15a: Questionnaire (English Version)

Study title

Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study

Introduction

I am Samson Udho, a nurse/midwife and currently a student at the University of Cape Town, South Africa where I'm doing research to get a Doctoral Degree. My study is being supervised by Professor Sheila E. Clow who works at the same University. We would like to find out what teenage mothers go through while giving birth in government health facilities. The information you will share may help us to understand what young women in your age group go through while giving birth in government maternity facilities so that we find ways to improve maternity care given to teenagers.

I will read the survey questions to you and give you instructions on how to respond to the questions. Feel free to seek clarification in case you have not heard or understood any of the questions. All your responses will be anonymous & confidential. Also, know that I am not a healthcare worker or a staff in any healthcare facility.

General information

a) Has the woman provided written consent to participate in the study?
   0. No (*Stop the interview and record as nonresponse*)
   1. Yes (*Proceed with the interview*)

b) Questionnaire number (Same as recruitment number): …………………............

c) Date of childbirth: ………………………………………………………………

d) Date of interview: ………………………………………………………………

e) Interviewer's name: …………………………………………………………..

SECTION I: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Now I am going to ask you some questions about your socioeconomic status and well-being.

1. How old are you in complete years? …………………………..

2. a) Are you currently attending school?
   0. No
   1. Yes

   b) If no, do you plan to return to school following your childbirth?
   0. No
   1. Yes

3. What is your highest level of education so far?[10]
   0. No formal education
   1. Primary education

[10] Adapted from Uganda Bureau of Statistics (UBOS) and ICF. (2016). *Uganda Demographic and Health Survey 2016: Key Indicators Report*. https://www.health.go.ug/sites/default/files/Demographic%20and%20Health%20Survey.pdf. Note: Education categories refer to the highest level of education attended, whether or not that level was completed (primary education= grade 1 - 7; secondary education = grade 8 - 13).

    2. Secondary education
    3. More than secondary education
4. What is your current occupation?[11]
    0. Agricultural labor
    1. Casual labor
    2. Salaried worker
    3. Self-employed in petty trade
    4. Self-employed small-scale industry
    5. Unemployed/homemaker
    6. Others
5. What is your marital status?
    0. Single
    1. Married
    2. Cohabiting
    3. Divorced/separated
    4. Widowed
6. What are your estimated household resources (socio-economic index)?

S/N	Item	No=0	Yes=1
Durable asset ownership (Tick all that applies)			
1.	Radio		
2.	Television set		
3.	Motor cycle		
4.	Car		
5.	Bicycle		
6.	Telephone		
7.	Fridge		
Source of drinking water supply (Tick one that applies)			
8.	Piped water		
9.	Open well/spring		
10.	Borehole		
11.	River/swamp		
Type of floor material (Tick one that applies)			
12.	Sand/cow dung		
13.	Cement		
14.	Tiles		
15.	Terrazzo		
16.	Others		

[11] Adopted from Afulani, P. A., Sayi, T. S., & Montagu, D. (2018). Predictors of person-centered maternity care: the role of socioeconomic status, empowerment, and facility type. *BMC health services research*, *18*(1), 1-16.

Section II: Obstetric history

Now I am going to ask you about your past pregnancy and childbirth.

1. How many times have you been pregnant? ………………………….
2. How many times have you given birth to a baby (that lived or died) that you carried for at least seven months? ………………………………………….
3. How many antenatal clinic visits did you attend during your last pregnancy? ……………………………
4. In which health facility did you give birth?
   0. Amach HC IV
   1. Ogur HC IV
   2. Barr HC III
   3. Aromo HC III
   4. Agweng HC III
   5. Abala HC III
   6. Alik HC III
5. a) What was your mode of childbirth for your most recent childbirth?
   0. Spontaneous vaginal childbirth
   1. Cesarean section
   2. Instrumental
   3. Don't know

   b) If you had spontaneous vaginal childbirth, did you receive an episiotomy?
   0. No
   1. Yes
6. What time did you give birth?
   0. Day (6:00 am to 2:59 pm)
   1. Evening (3:00 pm to 6:59 pm)
   2. Night (7:00 pm to 5:59 am)
7. Did you have a birth companion of your choice during your childbirth?
   0. No
   1. Yes
8. a) Did you have any complications during your childbirth?
   0. No
   1. Yes

   a) If yes, please specify …………………………………………………..
9. At your most recent childbirth, how many babies did you give birth to?
   0. One baby
   1. Two babies
   2. More than two babies

10. What is (was) the sex of your baby (babies)?
    0. Male
    1. Female
11. a) Did your baby (babies) have any complications after childbirth?
    0. No
    1. Yes

    b) If yes, please specify …………………………………………………..

    c) Is this baby (babies) still alive?
    0. No
    1. Yes

Section III: Person-Centered Maternity Care:

<table>
<tr><td colspan="6">"Now I am going to ask you some questions about your experiences in the health facility during your childbirth.
Remember that all the questions in this section refer specifically to the time you were in the health facility for this last childbirth. Also, know that everything you tell me is confidential and will not be shared with the health facility."</td></tr>
<tr><td>QUESTION</td><td colspan="5">RESPONSE OPTIONS</td></tr>
<tr><td rowspan="2">1. What do you think about the amount of time you waited to be attended to by the doctors, nurses, or other health care providers? Would you say it was very short, somewhat short, somewhat long, or very long?</td><td>Very short</td><td>Somewhat short</td><td>Somewhat long</td><td colspan="2">Very long</td></tr>
<tr><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td rowspan="2">2. During your time in the health facility did the doctors, nurses, or other health care providers introduce themselves to you when they first came to see you? If yes: Was it a few of them, most of them, or all of them?</td><td>No, none of them</td><td>Yes, a few of them</td><td>Yes, most of them</td><td colspan="2">Yes, all of them</td></tr>
<tr><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td colspan="6">"Now I will ask you some questions specifically about how you were treated at the health facility. Tell me if the following things happened all the time, most of the time, a few times, or it never happened. You can say a few times if it happened one or two times, and most of the time will be if it happened 3 or more times, but not always. For some questions, I will ask specifically if something occurred during labor, childbirth, or after childbirth. If I do not specify please answer based on your experiences during the entire time you were in the facility from labor till discharge."
Probe for all questions: If the woman just responds yes, ask them: "Did this occur a few times, most of the time, or all the time?"</td></tr>
<tr><td rowspan="2">3. Did the doctors, nurses, or other health care providers call you by your name?</td><td>No, never</td><td>Yes, a few times</td><td>Yes, most of the time</td><td colspan="2">Yes, all the time</td></tr>
<tr><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td>4. Did the doctors, nurses, or other staff at the facility treat you with respect?</td><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td>5. Did the doctors, nurses, and other staff at the facility treat you in a friendly manner?</td><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td>6. During examinations in the labor room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed?</td><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td>7. Do you think your health information was or will be kept confidential at this facility?</td><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td rowspan="2">8. Did you feel like the doctors, nurses or other staff at the facility involved you in decisions about your care?</td><td>No, never</td><td>Yes, a few times</td><td>Yes, most of the time</td><td>Yes, all the time</td><td>Did not have to make any decisions</td></tr>
<tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td rowspan="2">9. Did the doctors, nurses or other staff at the facility ask your permission/ consent before doing procedures on you?</td><td>No, never</td><td>Yes, a few times</td><td>Yes, most of the time</td><td colspan="2">Yes, all the time</td></tr>
<tr><td>0</td><td>1</td><td>2</td><td colspan="2">3</td></tr>
<tr><td>10. During childbirth, were you able to be in the position of your choice?</td><td>No, never</td><td>Yes, a short time</td><td>Yes, most of the time</td><td colspan="2">Yes, all the time</td></tr>
</table>

	0	1	2	3	
11. Did the doctors, nurses or other staff at the facility speak to you in a language you could understand?	*No, never*	*Yes, a few times*	*Yes, most of the time*	*Yes, all the time*	
	0	1	2	3	
12. Did the doctors and nurses explain to you why they were doing examinations or procedures on you?	0	1	2	3	
13. Did the doctors and nurses explain to you why they were giving you any medicine?	*No, never*	*Yes, a few times*	*Yes, most of the time*	*Yes, all the time*	*Did not get any medicine*
	0	1	2	3	4
14. Did the doctors and nurses at the facility talk to you about how you were feeling?	No, never	Yes, a few times	Yes, most of the time	Yes, all the time	
	0	1	2	3	
15. Do you think that the doctors, nurses or other staff at the facility tried to understand your anxieties and fears?	*No, never*	*Yes, a few times*	*Yes, most of the time*	*Yes, all the time*	*Did not have any anxieties or fears*
	0	1	2	3	4
16. Did you feel you could ask the doctors, nurses or other staff at the facility any questions you had?	No, never	Yes, a few times	Yes, most of the time	Yes, all the time	
	0	1	2	3	
17. Were you allowed to have someone you wanted (from outside of staff at the facility, such as family or friends) to stay with you during labor?	No, never	Yes, a few times	Yes, most of the time	Yes, all the time	I did not want someone to stay with me
	0	1	2	3	4
18. Were you allowed to have someone you wanted to stay with you during childbirth?	0	1	2	3	4
19. When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention?	No, never	Yes, a few times	Yes, most of the time	Yes, all the time	
	0	1	2	3	
20. Do you feel the doctors or nurses did everything they could to help control your pain?	0	1	2	3	
21. Did the doctors, nurses, or other health providers shouted at you, scolded, insulted, threatened, or talked to you rudely? (If yes) will you say this happened once, a few times, or many times?	No, never	Yes, once	Yes, a few times	Yes, many times	
	0	1	2	3	
22. Were you treated roughly like pushed, beaten, slapped, pinched, physically restrained, or gagged? (If yes) will you say this happened once, a few times, or many times?	0	1	2	3	
23. Did the doctors, nurses, or other staff at the facility ask you or your family for money other than the official cost?	No, never	Yes, a few times	Yes, most of the time	Yes, all the time	
	0	1	2	3	
24. Do you think there was enough health staff in the facility to care for you?	0	1	2	3	
25. Did you feel the doctors, nurses, or other staff at the facility took the best care of you?	0	1	2	3	
26. Did you feel you could completely trust the doctors, nurses or other staff at the facility with regards to your care?	0	1	2	3	
"The next set of questions is about the health facility environment"					
27. Thinking about the labor and postnatal wards, did you feel the health facility was crowded?	No, never	Yes, once	Yes, a few times	Yes, many times	
	0	1	2	3	
28. Thinking about the wards, washrooms and the general environment of the health facility, will you say the facility was very clean, clean, dirty, or very dirty?	Very dirty	Dirty	Clean	Very clean	
	0	1	2	3	

29. Was there water in the facility?	No, never	Yes, a few times	Yes, most of the time	Yes, all the time
	0	1	2	3
30. Was there electricity in the facility?	0	1	2	3
31. In general, did you feel safe in the health facility?	0	1	2	3
PCMC total Score: 90 **Dignity and respect full score: 18** **Communication and autonomy: 27** **Supportive care: 45**				

Section IV: Satisfaction with Childbirth

Please think about the care you received during your last childbirth and choose the number which best indicates your agreement or disagreement with each of the following statements where 1= strongly disagree and 7= strongly agree

1) Experience has shown that I can have appropriate and adequate control over my care.

   Strongly disagree Strongly agree
   1 2 3 4 5 6 7

2) The person(s) responsible for my care are/were caring and compassionate.

   Strongly disagree Strongly agree
   1 2 3 4 5 6 7

3) Problems that have arisen up to now have not been dealt with effectively.

   Strongly disagree Strongly agree
   1 2 3 4 5 6 7

4) My needs have been addressed with appropriate consideration for my time.

   Strongly disagree Strongly agree
   1 2 3 4 5 6 7

5) The overall organisation of my care has not been appropriate.

   Strongly disagree Strongly agree
   1 2 3 4 5 6 7

6) I would choose the same type of care for my next pregnancy.
   Strongly disagree Strongly agree

   1 2 3 4 5 6 7

Section V: Future Childbearing Intentions

Based on your most recent childbirth experience, please choose the number which best indicates your future childbearing intentions.

1. In the future, I would like to have another child:

    0. No
    1. Yes
    2. Don't know

2. Based on your most recent childbirth experience, where would you choose for your next childbirth?

    0. Same health facility
    1. Different health facility
    2. At my home
    3. At somebody else's home
    4. Don't know

3. Do you agree or disagree with this statement: "I would recommend this health facility to a sister or friend"

    0. Strongly agree
    1. Agree
    2. Neutral
    3. Disagree
    4. Strongly disagree

Appendix 4.15b: Questionnaire (Lango Version)

Wi kop me kwan:

Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal.

Nyutu wi kop:

An abedo Samson Udho, ame obedo naci/wonacola ame ikom kare ni abedo atin kwan ii University me Cape Town, South Africa kan ame atye atimo ikweda me nwongo rwom me bedo kede digrii. Ngat ame tye aloyo wia ikwan man obedo Professor Sheila E. Clow ame dang tio ii University acel ame atye akawan iye ni. Wan otye omito nyango kit ame otero kede mon atino ka owoto gini me nywal idakatale ame obedo mega gamente. Ngec ame yin ibino miyo wa twero bedo me konyo me miyo wa nyang kit ame otero kede mon atino amwaka gi pe bor kede megi ka ame gin owoto gini me nwongo kony alubere kede nywal idakatale ame obedo mega gamente me wek wa onwong yoo me tingo malo rwom me gwok ame omio bot mon atino.

Abino kwani apeny pi kwan me ikweda man ate miyi ngeyo kit yore ango amyero igam apeny magi. Bed agonya me penyo pi nyango ka ame pe iwinyo apeny aber onyo ka pe inyang apenyoro no. Agam ducu ame yin ibino miyo abedo abong nyutu nga ayin ibedo kede dang dok abedo me imung. Kede dang, nge ni an pe abedo atic me yotkom kede dang pe abedo atic kanoro keken ame obedo ka tic me yotkom.

Ngec imalo malo

f) Dako no ocoo cinge ping me ye bedo ikwan?
   2. Pe (Gik apeny ite coyo ni agam ape)
   3. Ee (*Mede anyim kede apeny*)

g) Namba me apeny (rom kede namba me coye) ………………………………

h) Nino dwe ame onywalo atin iye: …………………………………………………………………

i) Nino dwe ame apeny obedo iye: …………………………………………………………………

j) Nying ngat atye amiyo apeny: …………………………………………………………………

Section I: Bedo karacel kede jo ame rwom gi papat

Aman awot penyi kede apeny ame kwako kite me bedo ni-tic ilim kede bedo aber.

7. Itye kede mwaka adi, /awene onywali awene? …………………………..

8. a) Onyo aman itye wot i school?
   2. Pe
   3. Ee

   c) Ka pe, nyo pwod itye kede plan me dok iyunge nywali ni?
   2. Pe
   3. Ee

9. Rwom mene me kwan adit adong igik iye?
   4. Pe okwano
   5. kwan me primary
   6. kwan me cinia
   7. Kwan ame okato cinia

10. Tic ango ame itye itiyo ikomkareni?
    7. Tic me poto
    8. Tic a pe okwano pire
    9. Tic me ocara
    10. Cato wil atitino
    11. Tic ken irwom anok
    12. Tic ape oculo/Tic paco
    13. Tic okene
11. Bedo ni akwako nyomere tye ningo?
    5. Pwod tye kene
    6. Onyomere
    7. Bedo kede icoo kun pe inyomere
    8. Nyom obale/Opokere
    9. Dako too
12. Kodi jami mene me yi ot ame igeco ni tye? (kit me kwo kede jam atye)?

S/N	Jami	Pe=0	Ee=1
Jami amaka ame rii (Gwet ducu en ame tye)			
17.	Radio		
18.	Television set		
19.	Opik		
20.	Otoka		
21.	Gali		
22.	Cim		
23.	Fridge		
Ka omo pii amata (Gwet men ame otio kede)			
24.	Paipo		
25.	Akong		
26.	Tangci		
27.	Pii nam		
Gin otio kede me puyo di ot			
28.	Kwoyo/ cet dyang		
29.	Cementi		
30.	Tiles		
31.	Terrazzo		
32.	Men oken		

Section II: Kop ame kwako yac kede nywal ame okato

Aman dong apenyi akwako yaci ame okato angec kede nywal

12. Iyac odoko tyen adii? ………………………….
13. Tyen adii ame yin inywal kede (twero bedo ni atin pwod tye kwo onyo kadi otoo oko) kun nwongo yaci no otuno aromo dwete abiro? ……………………………
14. Tyen adii ame iwoto iye iyi apima pi yaci me gikini? ……………………………
15. Dakatal mene ame inywal iye?
    7. Amach HC IV
    8. Ogur HC IV
    9. Barr HC III
    10. Aromo HC III
    11. Agweng HC III
    12. Aromo HC III
    13. Alik HC III
16. a) Kit yore ango ame inywal kede iyi nywal apwod bedo me agiki ni?
    4. Nywal me acola
    5. Nywal me ayanga
    6. Wayo atin kede nyonyo
    7. Pe ngeo

c) Ka inywal nibeo iyi acola, onyo jo ongedi?
    2. Pe
    3. Ee
17. Cawa mene ame inywal iye?
    3. Idiko (6:00 am to 2:59 pm)
    4. Idyeceng (3:00 pm to 6:59 pm)
    5. Idyewor (7:00 pm to 5:59 am)
18. Ibedo kede kare me wot kede dano ame nwongo cunyi opwo me en teri ikare ame iwot nywal?
    2. Pe
    3. Ee
19. a) Ibin inwongo peki moro ikare ame inywal?
    2. Pe
    3. Ee

    b) Ka ee, mia kong ange ………………………………………………………..
20. Iyi nywal ame apwod igiki kede ni, inywalo otino adii?
    3. Atin acel
    4. Otino aryo
    5. Otino akato aryo
21. Atin/otino ame inywalo no nwongo obedo tu-tungene?
    2. Awobi/Owobe
    3. Nyako/Onyira

22. a) Atin/otino ame inywalo no onyo obedo kede peki moro iyunge nywale gi?
    2. Pe
    3. Ee
  d) Ka ee, mia kong ange ………………………..……………………………..
  e) Atino/otino no pwod tye kwo? …………………………………………………..
    2. Pe
    3. Ee

Section III: Kony Me Nyodo Kun Opero Pi Ngat Acel-Acel:

"Aman dong awot peny apeny akwako bedo ni idakatal ikare ame nwongo itye inywal.
Poyo ni apeny ducu amako kakan atye ka pi kare ame onwongo iwoto idakatal pi nywal ame apwod igik kede ni.
Amito dang ni inge ni jami ducu ame itye ikoba ni bino bedo me imung dang pe obino miyo dakatal ngeyo.

APENY	**AGAM ME AYERA**				
32. Tam ango iromo miyo akwako cawa ame ibin ibedo kede pi kuru docta, naci, onyo otic okene me dakatal me miyi kony? Iromo kobo ni onwongo cek atek, cek idyere dyere, bor idyere dyere, bor atek?	*Cek atek*	*Cek idyere-dyere*	*Bor idyere-dyere*	*Bor atek*	
	0	1	2	3	
33. Ikare ame onwongo itye idakatal onyo dokta,naci,kede otic okene me dakatal obin onyute boti iyi acaki me bino gi?,ka ee:, obedo nok gi, pol gi onyo gin ducu?	*Pe, pe moro keken*	*Ee, nok gi*	*Ee, pol gi*	*Ee,gin ducu*	
	0	1	2	3	

"Aman dong apenyi kede apenyogo akwako kit ame oteri kede idakatal. Mia ange ka jami ame abino akobi ni obedo timere kara ducu, pol kare, kare anok onyo pe atwali. Itwero kobo ni kare anok ka otimere icel nyo tyen aryo, eka pol kare nwongo otimere tyen adek nyo akato oko ento pe kare ducu. Pi apeny okene, abino penyi atutut ka ginoro obin otimere ikare me onwongo itye irem, nywal, onyo iyonge nywalo atin. Ka ame pe apoki kin gi, tem iteki me miyo agam akwako ngo ame otimere pi kare ame onwongo itye idakatall cako ikare me rem tunu kede inino ame okwanyi kede"
Dony atutut iyi apeny ducu: Ka dako no okobo ka ni ee, peny dok: "Gin otimere kare anok, pol kare, onyo ikare ducu?"

34. Onyo dokta,naci, kadi otic okene me dakatal kong olwongi kede nyingi?	*Pe, atwali*	*Ee ,kare anok*	*Ee, pol kare*	*Ee , kare ducu*	
	0	1	2	3	
35. Onyo dokta ,naci kede otic okene me dakatal onyutu woro ikomi ikare ame otye atic ikomi?	0	1	2	3	
36. Onyo dokta, naci kede otic okene me dakatal oteri iyore ame otero kede owote?	0	1	2	3	
37. Ikare ame onwongo jo tye apimi iyi ot nywal, jo owumi kede cuka/alangit onyo keto katen me gengo jo okene pe neni?	0	1	2	3	
38. Itamo ni ngec akwako yota komi jo obin ogwoko onyo jo agwoko me mung iyi dakatali?	0	1	2	3	
39. Inwongo ni dokta,naci onyo otic okene me dakatal omii kare me moko tami pi kony amyero jo mii?	*Pe, atwali*	*Ee, kare anok*	*Ee, pol kare*	*Ee, kare ducu*	*Nwongo pe mite me an moko tamoro*
	0	1	2	3	4
40. Nyo dokta, naci kede otic okene me dakatal obin openyo twero nyo ye ni ame pwod pe ocaka tic ikomi?	*Pe, atwali*	*Ee, kare anok*	*Ee, kare apol*	*Ee, kare ducu*	
	0	1	2	3	
41. Ikare onwongo itye inywal nyo jo miyi ibutu kit ame onwongo cunyi owinyo kede?	*Pe, atwali*	*Ee, kare anok*	*Ee, pol kare*	*Ee, kare ducu*	
	0	1	2	3	

No.	Question					
42.	Onyo dokta, naci kede otic okene me dakatal obedo loko kedi ileb ame onwongo inyang?	*No, never Pe, atwali*	*Ee, kare anok*	*Ee. Pol kare*	*Ee, kare ducu*	
		0	1	2	3	
43.	Nyo dokta kede naci obin okobi ngo omio gi obedo pimi onyo tic ikomi?	0	1	2	3	
44.	Nyo dokta kede naci obedo kobi pi ngo onwongo otye amiyi gin kit yatoro kiken?	*Pe, atwali*	*Ee, kare anok*	*Ee, Pol kare*	*Ee, kare ducu*	*Pe ongwongo yatoro kiken*
		0	1	2	3	4
45.	Nyo dokta kede naci ame nwongo tye idakatal obedo lok kedi me nyango kit ame onwongo itye iwinyo kede?	No, never Pe, atwali	Ee, kare anok	Ee, pol kare	Ee, kare ducu	
		0	1	2	3	
46.	Itamo ni doktae,naci onyo otic okene me dakatal obin otemo niang ikom poto cuny onyo lworo ame onwongo itye kede?	*Pe, atwali*	*Ee, kare anok*	*Ee, kare apol*	*Ee, ikare ducu*	*Nwongo pe kede poto cuny nyo lworo*
		0	1	2	3	4
47.	I bedo winyo icunyi ni nwongo iromo penyo doktae,naci onyo otic okene me dakatal kede apenyogo ame onwongo itye kede?	Pe, atwali	Ee, kare anok	Ee, kare apol	Ee, kare ducu	
		0	1	2	3	
48.	Obin oyeyi ngatoro ame nwongo cunyi owinyo (apat kede dano me yi dakatal ento ngat ame oya ioko calo jo paco nyo owote) me bino bedo kedi ikare ame nwongo itye irem?	Pe, atwali	Ee, kare anok	Ee, kare apol	Ee, kare ducu	Nwongo pe atye amito ngatoro me bedo keda.
		0	1	2	3	4
49.	Obin oyeyi me bedo kede ngatoro ame cunyi nwongo owinyo ni ibed kedi ikare me nywal?	0	1	2	3	4
50.	Ikare ame nwongo itye imito akonya, inwongo ni doktae,naci onyo otic okene me dakatal omii kony ?	Pe, atwali	Ee, kare anok	Ee, tyen apol	Ee, kare ducu	
		0	1	2	3	
51.	Itamo ni doktae,onyo naci obin otemo itek gi me juko arem ame onwongo itye iye?	0	1	2	3	
52.	Onyo doktae, naci, kadi otic okene me dakatal oredo iwi, oyeti, oburi, nyo oloko kedi idwon amalu (ka ee) iromo kobo ni otimere icel, pi kare anok onyo tyen apol?	Pe, atwali	Ee, icel	Ee, kare anok	Ee, tyen apol	
		0	1	2	3	
53.	Onyo jo obin oteri arac calo pwodi, bapi, cori ngwenyi, gengi nyo guri kan ading? Ka agam tye ni ee, iromo kobo ka otimere icel, kare anok onyo tyen apol	0	1	2	3	
54.	Onyo dokta, naci kede otic okene me dakatal openyi onyo openyo jo ipaco kede cente moro apat kede en amyero nwongo icul?	Pe, atwali	Ee, kare anok	Ee, pol kare	Ee, kare ducu	
		0	1	2	3	
55.	Itamo ni otic me yotkom nwongo tye ame oromo idakatal me miyi kony?	0	1	2	3	
56.	Itamo ni docta, naci kede otic okene me dakatal ogwoki gini iyore aber?	0	1	2	3	
57.	Ibedo kede gen atut ikom dokta, naci kede otic okene me dakatal alubere kede kony ame gin obedo omiyi?	0	1	2	3	
” Apeny okene ni tye akwako kan ame orumu dakatal”						
58.	Ka ame itamo akwako ot acola kede ot ame oketo jo iye iyunge nywal, nwongo ineno bala dakatal opong?	Pe, atwali	Ee, icel	Ee, kare nok	Ee, tyen apol	
		0	1	2	3	
		Col atek	Col	Cil	Cila atek	

59. Ka ame itamo ikom wudi me buto, cangat/toilet kede dong kan oguro dakatal ducu, iromo kobo ni dakatal nwongo col atek, col, cil, onyo cil atek?	0	1	2	3
60. Pii onwongo ttye idakatal?	Pe, atwali	Ee, kare anok	Ee, pol kare	Ee, kare ducu
	0	1	2	3
61. Mac elengtwic onwongo tye idakatal?	0	1	2	3
62. Iyi neno ni alutu, onwongo itye agonya iyi dakatal?	0	1	2	3
PCMC total Score: 90 **Dignity and respect full score: 18** **Communication and autonomy: 27** **Supportive care: 45**				

Section IV: Yeng kede kit ame anywal owoto kede

Kong itam akwako kony ame inwongo ikare ame onwongo iwoto pi nywal ame pwod igik kede ni eka ite yero namba ame nyutu kit ame iyeng onyo pe iyeng kede kop ame ocoye ni. 1= pe ayeng kede atek 7= ayeng kede atek

7) Jami ame otimere angec nyutu ni atye kede yore opore dang oromo me bedo kede twero akwaka.
Pe yeng kede atek — Yeng kede atek
1 2 3 4 5 6 7

8) Dano/Jo ame myero mia kony tye/ nwongo tye amiyo iyore aber dang kede mara.
Pe yeng kede atek — Yeng kede atek
1 2 3 4 5 6 7

9) Peki ame nwongo onwongere pwod pe ocobo iyore ame opore tuno naka icawani
Pe yeng kede atek — Yeng kede atek
1 2 3 4 5 6 7

10) Mitte na ocobo kun lubere kede cawa opore ame onwongo atye amito
Pe yeng kede atek — Yeng kede atek
1 2 3 4 5 6 7

11) Yuba pi kit ame omia kede kony nwongo pe tye iyore ame opore
Pe yeng kede atek — Yeng kede atek
1 2 3 4 5 6 7

12) Nwongo pwod aromo yero kodi kony acelo pi yac okene ame abedo kede.
Pe yeng kede atek — Yeng kede atek
1 2 3 4 5 6 7

Section V: Nyutu mitte me nywal iyi anyim

Alubere kede ngo ame otimere ikare me nywal ame pwod otimere ikomi acegi ni, akwayi me yero agam ame nyutu mitte ni me nywal iyi anyim.

2. Iyi anyim, an pwod amito ni abed kede atin okene.

    3. Ee
    4. Pe
    5. Pe ngeo

4. Alubere kede ngo ame ibeo iye ikare ame inywalo atin ame pwod igik kede ni, kwene ame iromo yero pi nywalo atin okene?

    5. Dakatal acel ame kong abin anywal iye
    6. Dakatal okene
    7. Paco tura
    8. Paco adano okene
    9. Pe ngeo

5. Iye onyo pe iye kede kop man, "aromo kobo ber adakatal man bot amina onyo awota"

    5. Aye atek
    6. Aye
    7. Dyere-dyere
    8. Pe ayee
    9. Pe aye kom Atwal

Appendix 4.16a: In-Depth Interview Guide (English Version)

1.	Study title	Adolescents' Experiences of Care During Childbirth in Health Facilities in Rural Northern Uganda: A Mixed-Methods Study
2.	Introduction	My name is Samson Udho and I am a Doctoral (Ph.D.) student at the University of Cape Town (UCT), South Africa. As part of the fulfillment of my Degree, I am conducting research on what young women, aged 10 to 19 years go through while giving birth in public maternity facilities in Uganda. You were selected to participate in the second part of the study because of your unique experiences and ability to express yourself. During our conversation, I will ask you open questions and you'll narrate to me your answer. In case you want to stop talking during our conversation because you're upset and want to collect yourself before continuing, feel free to do so. All the information you share with me will be anonymous & confidential.
3.	Respondent ID	
4.	Date of the interview	
5.	Interview strategies	Repetition, summarising, uh huh, anything else, can you tell me more
6.	Socio-demographic characteristics	1) Could you please tell me more about yourself?
7.	Obstetric history	2) Could you please share with me your history of pregnancy and giving birth?
8.	Disrespect and abuse	3) When you gave birth to your last child, what was that experience like?
9.	Drivers of disrespect and abuse	4) Do you feel you were treated differently from other women who were also giving birth at the same health facility? 5) Could you please share with me why do you think you were treated differently?
10.	Closure	I think we are coming to the end of this conversation, is there anything more you would like to add? You shared A, B, and C regarding your experiences as an adolescent during childbirth and why you are treated differently. Is this a fair representation of what we talked about? Thank you for your time and participation.

Appendix 4.16b: In-Depth Interview Guide (Lango Version)

11.	Wi kop me kwan	Nyodo Iyi Dakatal Me Calo Me Tumalu Me Uganda: Kit Ame Otero Kede Mon Atino Kede Tam Gi Amako Kony Me Dakatal
12.	Nyutu wi kop	Nyinga obedo Samson Udho, abedo atin kwan ame tye akwan me nwongo Ph.D ii University me Cape Town (UCT) ame tye ilobo South Africa. Acalo yore acel me cobo kwana me nwongo digri man, atye atimo ikweda ikom ngo amon atino ame mwaka gi cakere iyi 10 tuno naka 19, beo iyi kun nwongo gi tye anywal idakatale me ot nywal obedo mega gamenta me Uganda. Yin obin oyeri me bedo ikwan me aryo ni pien jami ame yin ibeo iye inywal ame okato ca dok kite moro tye apapat kede dang pi kwiri ni me nyutu nga ame yin ibedo. Iyi lok wa ni, an abino penyi apeny ame mio yin kare me miya agami iyore atutut. Ka nyo imito ni igik lok oko idyere me lok wa ni onyo pien nwongo ginoro owango yii ame mio itamo ni kong ibed anok ame pwod pe imede anyim, bed agonya me timo kito. Ngec ducu ame yin ileo keda bino bedo ame mio yin pe ingeye kede dang abedo me imung.
13.	Namba adano ame tye ikwan	
14.	Nino dwe me kwan	
15.	Yore ame atic kede me apeny	Nwoyo, yungu, uh huh, ginoro okene, mede kede koba
16.	Bedo karacel kede jo ame rwom gi papat	6) Nyo iromo koba kong atutut akwako nga ayin ibedo?
17.	Kop ame kwako yac kede nywal ame okato	7) Onyo iromo leyo keda kit ame yaci kede nywal obedo kede?
18.	Woro ape kede nywaro twero	8) Ikare ame inywalo atini apwod igik kede ni, iromo koba kong kit ame obedo kede?
19.	Jami amio woro bedo ape kede nywaro twero	9) Onyo inwongo ni yin dok jo obin oteri ikit apat kede kite ame otero kede mon okene ame dang nwong tye anywal I dakatal acel no? 10) Onyo kong iromo leyo keda ngo ame otimere ame omio itamo ni yin dok oteri ikit apat?
20.	Giko apeny	Atamo ni otye dong otunu oko iyi agiki me leyo loki, onyo tye ginoro okene ame imito meddo? Yin inywako A, B kede C alubere kede jami ame ibeo iye acalo dano atidi ikare ame nwongo itye inywal kede dang ngo omio yin dok jo oteri iyore apat kede jo okene. Inwongo ni obedo anyut aber akwako ngo ame wan oloko? Apwoyo pi jalo cawani me bedo ikwan man.

Appendix 4.17: Certificate of Training-Responsible Conduct of Research and Protection of Human Research Participants

HEPI-TUITAH
GRANT No: R25TW011210
MGH 1811

Health Professionals Education Partnership Initiative-Transforming Ugandan Institutions Training Against HIV/AIDS (HEPI-TUITAH)

Certificate of Attendance

This certificate is awarded to

MR. SAMSON UDHO

For attending the Responsible Conduct of Research (RCR) training from 24th to 28th January 2022

Offered by

The HEPI-TUITAH Program

Funded by

The National Institutes of Health through Forgaty International Centre - USA under

Topics covered:

1. Introductions, Shared Values, Professional Codes & workshop objectives
2. Government regulation for research/institutional policies
3. Research misconduct: fabrication, falsification, plagiarism
4. Rights and welfare of human subjects and communities
5. Role of Research Ethics committees, Consent and assent in research.
6. Vulnerable groups
7. Conflict of interest
8. Data ownership, sharing and protection
9. Authorship and Publication practices
10. Collaboration in Research

Prof. Celestino Obua
PI HEPI-TUITAH Project

Dr. Odongo Pancras Odull
Lead Trainer

CIRHT
The Center for International Reproductive Health Training

GRANT NO: SUBK00016913

LIRA UNIVERSITY THE BEACON

SEXUAL AND REPRODUCTIVE HEALTH RESEARCH ENHANCEMENT PROJECT (SRH-REP) - LIRA UNIVERSITY

Certificate of Attendance

This certificate is awarded to

Mr. SAMSON UDHO

for attending the Human Subject Protection Course (HSP)
from 13th - 16th June 2022

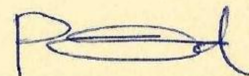
Offered by:
SRH - REP Project

Funded by:
Center for International Reproductive Health - The University of Michigan.

Topics Offered:

1. *Evolution of research ethics*
2. *Principles of research ethics*
3. *Regulatory system of research in Uganda*
4. *Informed consent process*
5. *Responsibilities of investigators*
6. *Conflict of interest in research*
7. *Care of participants in research*
8. *Review of research protocols*
9. *Data ownership, authorship, and publication practices*
10. *Collaboration in research*
11. *Vulnerable group*

Assoc. Prof. Okaka Opio Dokotum
The Deputy Vice-Chancellor Academics
Lira University



Dr. Pancras Odongo Odull
Lead Trainer

Appendix 4.18: A Protocol for Handling Suspected Child Abuse or Neglect During Conduct of Research

1. Introduction

Maltreatment is a serious medical and psychosocial problem that impacts millions of children each year (Wekerle et al., 2014). The most common forms of reported child maltreatment include neglect (75%), physical abuse (17%), and sexual abuse (8.3%) (Wekerle et al., 2014). In addition to producing acute pain and suffering, maltreatment can cause long-term psychological and physiological harm, including impaired brain development, learning, and cognition; anxiety, depression; borderline personality disorder; drug and alcohol abuse; chronic illnesses; and increased risks of juvenile delinquency and criminality (Lippard & Nemeroff, 2020; Strathearn et al., 2020).

Reporting suspected child maltreatment can pose ethical challenges for researchers because they may be uncertain whether abuse or neglect has occurred and are wary of making a false report, which could cause the family significant distress and damage their relationship with the investigators (Shanley et al., 2009). A key issue in deciding whether to make a report is whether they have sufficient evidence to justify making a report and researchers must rely on their judgment and experience when making this determination (Shanley et al., 2009).

When reporting is legally mandated, investigators must follow the law and report their suspicions to Child Protection and Family Unit (Resnik & Randall, 2018). When reporting is not legally mandated, investigators still have an ethical obligation to report to help prevent additional maltreatment and allow children to obtain access to services needed to recover from abuse or neglect (Resnik & Randall, 2018). The purpose of this protocol is to explicate how cases of child abuse will be handled and reported in this study. The protocol highlights the responsibilities of a researcher when faced with a suspected case of child abuse, potential signs of child abuse, how to respond to the signs of child abuse, where to report suspected cases of child abuse, and how to make a report for a suspected case of child abuse.

2. Responsibilities of the research investigators when faced with a suspected case of child abuse or neglect

Research investigators are legally and ethically obligated to:

- Notify the study participant that they are under obligation to report any case of child abuse or neglect during the information session to sign the assent form.
- Notify the parents of study participant that they are under obligation to report any case of child abuse or neglect during the information session to sign the parental consent form.
- Make a report to the Child Protection and Family Unit of the Uganda Police Force if you believe on reasonable grounds that a child is in need of protection from child abuse or neglect.
- Link the abused or neglected child to a qualified counsellor within the catchment area of Lira District (but not affiliated to where the study was conducted) to provide counseling and debriefing where needed.
- Make a report to the facility administration you believe on reasonable grounds that a child was mistreated during childbirth.
- Make the report as soon as practicable after forming your belief.

Note: As a research investigator, you don't have to prove that the abuse or neglect has occurred, you simply have to report the matter.

3. Potential signs of child abuse

During data collection, the researcher and the research assistants should pay attention to the following signs:

- Disclosure – if the child tells you they have been abused.
- Physical signs of abuse or neglect – these could include bruises, burns, fractures (broken bones), or poor hygiene.
- Behavioural signs of abuse or neglect – these could include showing little or no emotion when hurt, wariness of their parents (or others), signs of alcohol or drug misuse, report of age-inappropriate sexual behaviour, or wearing long sleeves and trousers in hot weather (to hide bruises).

4. How to respond to the signs of child abuse

The investigators should gather information and facts when faced with potential signs of child abuse or neglect. The investigators should consider the following approaches to gather information and facts about child abuse or neglect:

- Make notes – record what you observe.
- Consult colleagues – get support and advice from other research investigators.
- Talk to the child – do this with respect for the child's need for privacy and confidentiality.
- Talk to the parent or parents – only if you believe it will not jeopardise the safety of the child, or compromise a child protection or police investigation should this be required.

5. Where to report suspected cases of child abuse or neglect

In this study, cases of child abuse or neglect will be reported to the Child Protection and Family Unit, Lira Central Police Station of the Uganda Police Force by the researcher. Meanwhile, instances of mistreatment of children during childbirth at the facility will be compiled, analyzed and reported to the health facility administration in anonymised aggregate form.

6. How to make a report of suspected cases of child abuse

The researcher will make a written report about the suspected case child abuse or neglect. When reporting a suspected case of child abuse or neglect, the following details will be captured:

- The child's name, age, and address.
- The reason for believing that the injury or behaviour is the result of abuse or neglect.
- Assessment report of the immediate danger to the child or children.
- Description of the injury or behaviour observed.
- The current whereabouts of the child.
- Any other information about the family.
- Any specific cultural or other details that will help to care for the child, for example, cultural origins, interpreter or disability needs

Appendix 4.19: Covid-19 Risk Management Plan

1. Introduction

Uganda reported her first case of Covid-19 on 21st March 2020 (Ministry of Health, 2022). Since then, as of 12th February 2022, there have been 162,443 confirmed cases, 99,487 cumulative recoveries, 3,565 deaths, 2,389,360 tests conducted, and 14,973,293 total doses of Covid-19 vaccines administered (Ministry of Health, 2022). The government responded by putting in place a series of Covid-19 mitigation measures such as the closure of borders both through land and air, closure of institutions including schools, a ban on both public and private transport, ban on mass gatherings to promote social distancing, lockdowns, dawn to dusk curfews, hand washing, and wearing of face masks among other mitigation measures (Ministry of Health, 2020b).

After nearly two years of lockdown, on the 31st of December 2021, the government of Uganda moved to lift all Covid-19-related restrictions by the end of January 2022 in a phased manner. However, the observance of standard operating procedures for Covid-19 particularly hand washing and wearing of face masks were upheld. This document gives justification for the conduct of this study during the Covid-19 pandemic and guidelines to minimise the risk of Covid-19 infection during data collection between March and October 2023.

2. Conduct of study during Covid-19 pandemic

The Covid-19 pandemic has led to system-wide disruption of maternity care in a manner that makes the pandemic a risk factor for disrespect and abuse (D&A) during childbirth (Ashish et al., 2021; Rocca-Ihenacho & Alonso, 2020; Sadler et al., 2020). This is partly because of the restructuring in regards to infrastructure, human resources, and clinical practice guidelines within the healthcare sector to accommodate the new burden of Covid-19 (Ashish et al., 2021; Rocca-Ihenacho & Alonso, 2020; Sadler et al., 2020). Infrastructure-wise, some maternity units had to close down to free up space for Covid-19 triage, quarantine, and treatment of positive cases (Ashish et al., 2021; Rocca-Ihenacho & Alonso, 2020). In terms of human resources, some staff has been forced to take up roles in the Covid-19 task force at facility and district levels as a way of task-shifting creating critical shortages in maternity units (Ashish et al., 2021). Meanwhile, prohibition of companionship during labour, immediate separation and isolation from the newborn, and the prevention of breastfeeding have been some of the changes in clinical guidelines (Sadler et al., 2020).

The World Health Organization (WHO) guidelines for COVID-19 clinical management recognise these dangers and clearly state that all pregnant women, including those with confirmed or suspected COVID-19 infection (and taking into account the severity of the maternal condition), should have access to woman-centered, respectful, skilled care (World Health Organization, 2020a). Therefore, undertaking this study during this pandemic highlighted some of these mistreatments in childbirth under the pretext of Covid-19 adjustments in the healthcare system. It also informed a "building-back-better" approach in the post-pandemic period.

3. Protection and safety of the research team during data collection

3.1 Data collection team. The data collection team will consist of the researcher and four research assistants during phase I and two research assistants during phase II.

3.2 Applying standard precautions against Covid-19. The researcher budgeted for face masks and hand sanitisers. The research assistants will be sensitised to maintain a social distance of one metre from others, cover their mouth and nose with a tissue when coughing or sneezing & dispose of the used tissues in the nearest waste bin, and offer a face mask to participants before data collection.

3.3 Maintaining team communication remotely. The researcher will create a WhatsApp group that will include all the research assistants. This platform will be used to share ideas and address issues arising during data collection. We will have weekly group meetings between the research assistants and the primary investigator and/ or co-investigator.

3.4 Community entry. The principal researcher will draft an introduction letter supported by the ethical and administrative clearances and give it to research assistants to present to the Local Council (LC) leadership indicating the places/facilities they will be going to for data collection for easy contact tracing in case the need arises.

3.5 In case of illness during data collection: The researcher will give explicit instructions to the research assistants during their orientation. They will be instructed not to go for data collection if they develop or suspect to have developed any signs and symptoms consistent with those of Covid-19 and to get in touch with the regional Covid-19 response team for immediate attention. The researcher will avail the research assistants with the contact details of the regional Covid-19 response team.

4. Protection and safety of the participants

4.1 Participant enrollment. Participants who are exhibiting symptoms consistent with Covid-19 (coughing and sneezing) will not be recruited into the studies at the time of recruitment.

4.2 Informed consent processes. The research assistants will carry out in-person enrolment and consenting of study participants. All research assistants and study participants will use face masks during the consenting process and remain 1.5 meters apart.

4.3 Data collection process. This will involve a face-to-face survey in phase I and in-depth interviews in phase II. The researcher has budgeted face masks for research assistants and study participants as a safety measure (Appendix XI). Additionally, the research assistants will have hand sanitisers which they will use from time to time. All interviews will be conducted with researchers and participants one meter apart.

4.4 Participant compensation/refreshments. To limit Covid-19 transmission accruing from handling of in-kind tokens of appreciation and compensation for the time given to the study participants will be disinfected with a sanitiser by the research assistants before handing them over to the participants. Hand washing and/ or sanitising will be encouraged after handing over the items to the study participant.

Appendix 5.1: Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Guidelines for Reporting Observational Studies

	Item No	Recommendation	Page No
Title and abstract			
	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	Cover Page viii-xi
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	viii-xi
		Introduction	
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	1-3; 19-20
Objectives	3	State specific objectives, including any pre-specified hypotheses	41
		Methods	
Study design	4	Present key elements of study design early in the paper	52
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	6-17
Participants	6	Give the eligibility criteria, and the sources and methods of selection of participants	53-54
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	55
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	55-57
Bias	9	Describe any efforts to address potential sources of bias	57-58
Study size	10	Explain how the study size was arrived at	54
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	58-59
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	58-59
		(*b*) Describe any methods used to examine subgroups and interactions	58-59
		(*c*) Explain how missing data were addressed	58-59
		(*d*) If applicable, describe analytical methods taking account of sampling strategy	58-59
		(*e*) Describe any sensitivity analyses	58-59
		Results	
Participants	13*	(a) Report numbers of individuals at each stage of study—e.g. numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	73
		(b) Give reasons for non-participation at each stage	73

		(c) Consider use of a flow diagram	73
Descriptive data	14*	(a) Give characteristics of study participants (e.g. demographic, clinical, social) and information on exposures and potential confounders	73-74
		(b) Indicate number of participants with missing data for each variable of interest	N/A
Outcome data	15*	Report numbers of outcome events or summary measures	76-77
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (e.g., 95% confidence interval). Make clear which confounders were adjusted for and why they were included	76-97
		(*b*) Report category boundaries when continuous variables were categorised	76-97
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	N/A
Other analyses	17	Report other analyses done—e.g. analyses of subgroups and interactions, and sensitivity analyses	76-94
Discussion			
Key results	18	Summarise key results with reference to study objectives	121
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	135-137
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	121-138
Generalisability	21	Discuss the generalisability (external validity) of the study results	121-138
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	N/A

Appendix 6.1: Consolidated Criteria for Reporting Qualitative Research (COREQ)

No. Item	Guide Questions/Description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	62
2. Credentials	What were the researcher's credentials? e.g. PhD, MD	62
3. Occupation	What was their occupation at the time of the study?	62
4. Gender	Was the researcher male or female?	62
5. Experience and training	What experience or training did the researcher have?	62
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	62
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	62
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	62
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	59-60
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	59-61
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	61
12. Sample size	How many participants were in the study?	61
13. Non-participation	How many people refused to participate or dropped out? Reasons?	61
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	61-62
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	62
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	98
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	62
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the researcher use audio or visual recording to collect the data?	62
20. Field notes	Were field notes made during and/or after the interview or focus group?	62
21. Duration	What was the duration of the interviews or focus group?	62
22. Data saturation	Was data saturation discussed?	61
23. Transcripts returned	Were transcripts returned to participants for comment and/or	62

	correction?	
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	62-63
25. Description of the coding tree	Did authors provide a description of the coding tree?	62-63
26. Derivation of themes	Were themes identified in advance or derived from the data?	62-63
27. Software	What software, if applicable, was used to manage the data?	62-63
28. Participant checking	Did participants provide feedback on the findings?	N/A
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	98-120
30. Data and findings consistent	Was there consistency between the data presented and the findings?	98-120
31. Clarity of major themes	Were major themes clearly presented in the findings?	98-120
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	98-120

Appendix 6.2: Description of Study Participants[12]

Emily, a 17-year-old girl who had given birth twice, had completed primary-level six education. She was cohabiting with her boyfriend, who had not yet fulfilled the dowry requirement per Lango tradition. Her labour began at home, and she was accompanied to the hospital by her mother-in-law and a neighbour. Emily had a spontaneous vaginal delivery at a level III health centre during her most recent childbirth. Although she experienced tears during birth, they were not severe, and she mentioned that her healing process was slow. While the interview with Emily initially proceeded smoothly, I sensed some reservation in some of her responses. Nevertheless, Emily overall reported positive birth experiences.

Chloe, a 19-year-old adolescent who completed primary education up to the sixth level, was officially married and her recent childbirth was the second one. She gave birth to a healthy baby boy weighing 2.5 kilograms through a spontaneous vaginal childbirth at a level III health centre. She expressed contentment working as a peasant farmer alongside her husband. The interview with Chloe began slowly but gained momentum as we progressed. She mentioned giving birth alone and experiencing delays in receiving care at the health facility, although there were no reports of abuse. Chloe also acknowledged instances of bribery at the facility. She admitted to not expecting much support from the hospital as she hadn't been accompanied by her mother-in-law. Overall, she expressed mixed feelings about her care experience.

Grace was 18 years when she gave birth to a baby girl by spontaneous vaginal delivery. She had completed primary school at the time of our interview and she was cohabiting with her spouse. Her childbirth happened in a nearby level III health centre. During the interview, Grace was calm and she fervently shared her experiences of childbirth. She also highlighted some of the challenges she was having after childbirth in her romantic relationship. We felt that the interviewee gave us quality time and responded well to all the interview questions.

Lily was a 17-year-old housewife who had completed her primary level of education. She gave birth in a nearby health center level III to a healthy baby girl weighing 2.6 kilograms. She was accompanied to the hospital by her husband who is a peasant farmer. Her labour began when she had gone to the sugarcane plantation at around 7:00 hours and that is when her membranes ruptured but she didn't realise it was labour pain. Her experience of care was a classic case of mistreatment during facility-based childbirth. She was targeted as soon as she arrived at the facility. Her looks and grooming didn't help her cause given the fact that her labour pain started when she was working in the garden. The healthcare providers had no sympathy for her. Lily faced the wrath of her decision to become pregnant while young. Even after failing to care for Lily properly, the healthcare providers still asked for a token of appreciation from the mother.

The subsequent interview was with **Sophia**, a 17-year-old mother who gave birth in a level III health centre. Sophia is married and earned her livelihood through farming. She was accompanied by her mother-in-law to the hospital during labour. Throughout the interview, Sophia exhibited a friendly demeanor, frequently smiling and demonstrating excellent communication skills. She reported a positive experience at the health facility,

[12] The names of participants used are pseudonyms

stating that she did not encounter mistreatment and received support during the birthing process without any complications.

The sixth interview was conducted with **Harper**, a 19-year-old mother who had completed primary-level education and was cohabiting with her spouse. Harper was a housewife who depended on her spouse for daily living. She attended four antenatal visits and gave birth just before the fifth visit. She gave birth through spontaneous vaginal birth to a healthy baby girl. This was her first childbirth and she gave birth in a level IV health centre. During the interview, she didn't seem troubled about her experiences of childbirth. She seemed to have tolerated many things although couldn't verbalise everything. Although it was apparent that she witnessed and experienced some level of mistreatment during childbirth, she was overall content with how she was treated. I felt Harper could have shared more, although she was somewhat shy and didn't speak as much as I wished on the day of the interview.

The seventh interview was with **Mia**, an 18-year-old mother who had completed primary level six before marriage. She arrived at the maternity unit and was diagnosed with a latent stage of labour and quickly progressed to active labour while at the health facility (level IV). Her primary grievance regarding childbirth was the requirement to pay for the necessary supplies for her care, along with experiencing physical and verbal abuse. Among the 14 interviews conducted, Mia's childbirth experience stood out as particularly troubling to me.

Isabella was the youngest participant. She was a 15-years-old at the time of the interview and she had already terminated her schooling before she conceived. She was formally married to her teen husband and this was their first pregnancy and childbirth experience. She had a spontaneous vaginal birth and she didn't report any complications such as perineal tears. On the day of the interview, we could feel the social support Isabella had as we were surrounded by her close relatives as we sought permission to speak to her in-depth. The lure of speaking to the young teen mother was certainly there and we had much anticipation about her birth experiences. However, we never got as much information as we desired and she was somewhat shy.

Taylor was a 17-year-old mother who had completed her primary level of education. She was cohabiting with her spouse and she earned her living through tailoring. Taylor was the first participant who had some income-generating skills as a way of earning a living. She gave birth in a level IV health centre to a baby girl by spontaneous vaginal birth. Taylor was eloquent during our conversation. She was okay with how she was treated during childbirth and didn't have much information to share with me. The interview was cordial and it ended on a good note.

The 10th interview was with **Campbell**, a 19-year-old mother cohabiting with her spouse and earning a living through farming. She gave birth to her second child, a baby boy in a level III health centre. Having already experienced childbirth in a public health facility, Campbell was familiar with the process. During the interview, rainfall prompted us to seek shelter in Campbell's home before proceeding. Once inside, the warmth of the house encouraged Campbell to openly discuss her birth experience, aligning well with the study's objectives.

Amelia was an 18-year-old mother who had no formal education. She was separated from her husband at the time of the interview and she earned her living through farming. Amelia gave birth to her second child in

a level IV health centre. She had a spontaneous vaginal birth to a healthy baby boy weighing 2.5 Kilograms. She went to the hospital on a motorcycle and she was accompanied by her sister to the hospital. Amelia was an orphan who lacked social support although she was coping somewhat well.

Ella was our second young participant at 16 years of age. She stopped schooling at primary level six when she conceived. At the time of the interview, she was cohabiting with her spouse and she was dependent on the spouse for a living. Her labour pain started at night and she was taken to the hospital in the morning and gave birth to her first child the following day. She had a normal vaginal birth without complications in a III health centre. The interview with Ella was enjoyable as she was free and comfortable throughout the interview.

Scarlett was an 18-year-old mother who had completed primary-level education. She was cohabiting with her spouse and her main source of income was farming. She started feeling labour pain on Thursday evening and went to the hospital at 17:00 hours and she gave birth to her first child at 24:00 hours. She gave birth to a baby girl in a health center level IV through a normal vaginal birth. The interview environment was conducive as we sat comfortably under a big mango tree as Scarlett recollected and shared her birth experience passionately.

Our final interview was with **Susan**, an 18-year-old mother who completed primary-level education. At the time of the interview, she was cohabiting with her spouse and her main source of income was farming. She gave birth to a healthy baby girl through a normal vaginal birth in a level IV health centre. This was her first birth experience and she had mixed experiences about her care at the health facility. The interview environment was well prepared as we sat outside away from the rest of Susan’s family members. This was the last interview and I had plenty of experience interviewing adolescent mothers and this interview went very well.

Appendix 6.3: Thematic Map of Adolescents' Experiences of Care During Childbirth

ODES/EXTRACTS	SUB-THEME	THEME	OVERARCHING THEME
She told me nothing that would make me have problems with her, IDI 02	**Effective Interaction**	**Effective Communication**	**Adolescents' Mixed Fortunes During Facility-Childbirth**
We were even interacting well with joy, IDI 12			
Our conversation was going on well, IDI 12			
She was humble while talking to me and was not rude, IDI 13			
They were talking calmly to me, IDI 13			
She was interacting well with me, IDI 11			
They kept telling me even the time I was giving birth they told me that I should push the baby, IDI 11	**Provision of Information**		
said progress is still long, IDI 13			
I was told there was progress and I was asked to be walking around, IDI 03			
Hum, even how they treated me showed they were respecting me, IDI 11	**Respectful Care**	**Dignity and Respect**	
There was maximum respect, IDI 12			
I was not slapped, IDI 11			
They never shouted at me and they also never slapped me, IDI 13			
They were treating me well, IDI 14			
She started being friendly to me during my pregnancy, IDI 02	**Friendly Care**		
They showed me love, IDI 12			
They treated me very well up to the time that I gave birth, IDI 02			
she loved me at a higher level and wished me a safe delivery, IDI 05			
I would see and tell those people were liking me, IDI 12			
I was given a warm welcome, P014, IDI 01	**Hospitality**	**Supportive Care During Childbirth**	
I was welcomed well, IDI 14, IDI 12			
When I reached the nurse welcomed me, IDI 02			
she received me so well, IDI 05			
They received me without shouting at me, IDI 15			
I was examined and told I was about to give birth, IDI 14	**Encouragement**		

She said I should persevere I will give birth that it's a boy, IDI 11			
The nurse told me that my childbirth would be okay without any complications and also said that young girls are giving birth without complications compared to old women, IDI 05			
She also encouraged me to exercise by helping me to walk around, IDI 02			
"One important thing that I know is the nurse [midwife] was on my side. She delivered me well and made my childbirth very easy without any problem, IDI 05	**Partnership with Adolescents**		
The nurse was there [during labour and childbirth] and she waited to receive the baby, IDI 12			
The nurse was with me up to the time I gave birth. She even cleaned me up, IDI 13			
On getting inside [labour suite], I went straight on bed and both of them [midwives] were inside and I gave birth straight away, IDI 06			
At some point when I would feel like falling down the nurse [midwife] would support me, IDI 02			
My neighbor who is a traditional birth attendant went with me and was present in the labour suite, IDI 14	**Companionship During Labour and Childbirth**		
When I was pushing the baby, there were three people, the nurse [midwife], my sister-in-law, and my mother-in-law, IDI 12			
They were helping me [mother-in-law and neighbor] to wash clothes, cook, boil tea, and drink water, IDI 01			
My mother-in-law and even Jasper [husband] went along with us [transported her to hospital], IDI 05			
She was allowed [inside the labour suite]. It was my husband who was not in [the labour suite] because he seemed to be having some fear, IDI 05			
Immediately I reached, they took me to the examination room, I was examined and told I was about to give birth, IDI 14	**Timely Care**		
She examined me immediately without wasting time, IDI 05			

I went straight to the nurse who examined me and said the baby was on its way, IDI 06			
The labour suit and the general ward even the compound looking clean, IDI 02	**Clean Labour Suite and Ward**	**Health Facility Hygiene**	
The facility was clean even the beds were clean, IDI 08			
Inside the ward was clean, IDI 09			
The place where I got services from was clean, IDI 14			
Where I delivered from was clean, IDI 11			
The hospital was clean and even the labour suite was clean, IDI 03			
The labour suite didn't have any issues, it was clean, IDI 05			
The place was generally clean like the labour suite, the floor was clean because immediately someone delivered the place would be cleaned up, and even the toilets, IDI 12			
The washrooms were generally clean like the bathroom and toilet, P001	**Clean Toilets and Bathroom**		
The place was generally clean […] even the toilets, bathrooms, IDI 12			
… but bathrooms were okay, IDI 05			
The bathrooms were being used well and was clean, IDI 03			
The bathroom was okay, IDI 13			
The toilet was clean as they had cleaned it, IDI 11			
The toilet was good, IDI 14			
Hmmmm, she gave me a very terrible slap on my thigh and my thigh got paralysed instantly, IDI 07	**Physical Abuse**	**Disrespect and Abuse**	
I was slapped like twice even and my step mother was just there looking, IDI 04			
….and she was painfully touching me, IDI 04			
They then told me that if I pushed so hard and my uterus got torn it would be my own problem, IDI 07	**Verbal Abuse**		
They said that I should open up my vagina well because they are not the ones who inserted my husband's penis into my vagina, IDI 07			
Mm, I was also told I should go back to school that I am still young to be in marriage, IDI 01			

Aaaa, she wasn't treating me well because the abusive languages she was using were heavy, IDI 10			
I am not the one who told you get pregnant while you are still young, IDI 06			
Mm, the midwife quarreled at me, IDI 04			
… [midwife] put the baby on the weighing scale and left, IDI 04	**Neglect and Abandonment**		
The nurse [midwife] came when the baby's head was already out then she came and cut the cord, IDI 04			
I started pushing the baby behind the house [within the health facility, IDI 07			
I delivered alone and the nurse received the baby, IDI 01			
She left me to push the baby alone as she was busy working at the table while telling me I should push the baby she waited until after I delivered and she even took too long to clean up the blood, IDI 03			
The labour suit was not yet open so I delivered at the door, IDI 10			
The nurse said I can decide to leave you and then she walked away saying that is not how people should go the hospital, IDI 04			
By the time I reached [for childbirth], the nurse [midwife] wasn't around and other people opened the door for us, IDI 07			
She instructed me to lay and lift up my legs of which I did but at one point I pushed and then my energy got depleted, IDI 07	**Non-Consented Care**		
They just started the procedure, nurse [midwife] came and inserted her hands in you, IDI 05			
Nurse [midwife] came and inserted her hands in my vagina [without seeking my consent], IDI 05			
I wasn't given any opportunity to ask even a single question and the way I was treated I could hardly ask any question, IDI 07	**Disempowerment**		
Mm, but I did not ask for anything even I didn't respond to her, IDI 03			
I just listened as she talked, IDI 01			
He told me I should name my child after him, IDI 11			
I did not tell her. I was fearing she would shout at me, IDI 05			

What they do is they detain your book (discharge forms) and they are given back after delivering the said items or money, IDI 07	**Bribery and Extortion**		
Everyone was paying for the card [discharge form] and if you had not paid you would not be given the card, IDI 12			
When we were leaving the hospital, we were told to pay Ugx. 13,0000 (USD 3.6). We pleaded saying there was no money and we gave Ugx. 10,000 (USD 2.70), IDI 07			
My husband gave me some money. They asked for Ugx. 3,000 (USD 0.8) and they said if that money was not there then we would not be discharged when we gave that Ugx. 3000 (USD 1), we were discharged, IDI 10			
They asked for some money and I think they were given Ugx. 15.000 (USD 4.2), IDI 12			
Hmm, they just give back your discharge form [after you have paid some money] and then you go and register your child and then get vaccination after which you are free to get back, IDI 07			
Everyone was paying for the card [discharge form] and if you have not paid you would not be given the card, IDI 12			
All the gloves that were used are the ones we bought, we bought four pairs, IDI 07			
I gave them a bucket of washing power and two rolls of toilet papers [as requested], IDI 14			
She was asking for detergent, washing soap and then my mother in-law bought, IDI 02			
They also asked for detergent but we had bought it and this old woman who was taking care of me picked from the paper bag and gave it to them, IDI 10			
The toilets and bathrooms were not clean at all, I had no choice but to bath in it like that, IDI 10	**Dirty Toilets and Bathrooms**	**Health Facility Constraints**	
Inside the ward was clean but the toilets and bathrooms were all not cleaned, IDI 09			
The hospital was clean but the toilet was not okay, inside was very dirty with very bad smell, the floor had a lot of very dirty stuffs,			

the bathroom had visible human feces making it very difficult for women like us who had just given birth to bathe from inside, IDI 07			
It is the toilets that sometimes could be dirty in that you find feces and urine on the floor and no one bothers to clean it and the bathrooms sometimes were very dirty, you could find that those women who have just delivered have bathed and their blood flooded on the floor, IDI 02			
Sometimes if you go to bath you find blood on the floor they have not cleaned and then the toilets you find cotton dumped and other dirty things, IDI 04			
"In the toilets some people would dump blood out not in the pit which was not good. It is only the toilets that women would dump blood on the floor though some would throw in the pit, IDI 03			
It was the bathroom that was not clean and was unbearable. Some people would go in there and dump in cotton wool soaked in blood, they wouldn't throw it in the pit, IDI 14			
"It was the toilets that were dirty, IDI 05			
It was never clean [toilet and bathroom], ever since I started going for antenatal, there was no single day that I found it clean, IDI 02			
Water wasn't just put off but there seemed to be a problem with the line. Water was being collected from Amach complex and was far, IDI 14	**Unstable Water Supply**		
Sometimes there would be no water most especially if the borehole breaks down, IDI 02			
There is water, we would collect water from the other side of the hospital [outside the hospital] where people are detained, IDI 07			

Appendix 6.4: Maama Kit

The Maama Kit consists of basic supplies that are required at childbirth such as sterile gloves, plastic sheets, cord ligature, razor blades, tetracycline, cotton, soap and sanitary pads.

Appendix 6.5: Thematic Map of Drivers of Adolescents' Experiences and Care During Childbirth

CODES/EXTRACTS	SUB-THEME	THEME	OVERARCHING THEME
I had bought enough clothes for the baby and the things [items required during birth like petticoats, knickers, basin, maama-kit] I had were enough, IDI 10	**Possession of Birthing Necessities**	**Basis for Favorable Treatment**	**Drivers of Adolescents' Mixed Experiences During Facility-Childbirth**
I had all the requirements like the maama kit, the scan result, the basin and baby's clothes, IDI 13			
I had 9 pieces of baby's sheets and maama kit, IDI 14			
She liked me because she said that if a woman is going to deliver you have to be clean. I had bathed, my clothes were clean, IDI 05	**Neatness and Cleanliness**		
I went while I was smart. I had gone when I had bathed and my clothes were clean, IDI 13			
I was also clean because I would go and bath and my clothes were being washed all the time, IDI 12			
And you need to go when you are smart when you have washed your clothes, IDI 14			
It is because when you are still young, they assume you are unable to give birth, IDI 04	**Being Young**	**Basis for Mistreatment**	
Maybe they also looked at me as being young, IDI 10			
Some people go when they have enough things like for me I went with nothing even without the baby's sheets but I had bought only a few, IDI 11	**Lack of Birthing Necessities**		
I went without clothes, IDI 04			
They judge you according to the items you have carried along to the hospital, IDI 07			
They don't accept if you have not scanned [obstetric scan], IDI 07			
We didn't have any luggage, nothing to use to examine me and the nurse [midwife] said I can decide to leave you and then she walked away, IDI 04			
If he [the midwife] is being hard on you it means you are not well prepared, IDI 10			
I even don't know, sometimes they could have seen how I am that's why they treated me like that, IDI 11	**Perceived Low Social Status**		
That I was dirty like a mad person [unkempt], IDI 04			
They treat people according to how you are, if they see you are of some [high] class then they fairly treat you but if they see you are of low class they treat you harshly, IDI 07			

Maybe she saw the way I was, maybe I looked different from others that go to her. Maybe she saw me and looked down on me, IDI 06			
Whatever I was told to do, I did and the way they instructed to push the baby I also did, and walking around I did walk because the time I was examined and told you are not far from giving birth don't go far I then stayed in one place inside there, I was told stand around from inside, I stood like that until I gave birth, IDI 11	**Passive Compliance**	**Mechanisms to Cope with Mistreatment**	
It is only that when you are told to do something and then you follow into details, IDI 11			
If you are given instructions you need to follow, and sometimes if you are called maybe to check on your weight on a scale or that you are going to be examined then you need to hurry because if you delay, they get angry, IDI 14			
I was following the instructions being given, if the nurse [midwife] says don't bend I would not bend, if she tells me to walk, I would as well walk, P013			
What you are told to do, do it, if you are given what to eat, eat it. If they are taking good care of you, giving you water to bath and you are bathing there is no problem, IDI 12			
I was not disturbing them or even misbehaving I was just walking around and not crying, IDI 01	**Calm Demeanour**		
I did not tell her I was fearing she would shout at me, IDI 03			
I was so calm without any issues [not disturbing the midwife], IDI 05			
My character and lifestyle make people admire me in terms of socialising, IDI 02	**Relational Skills**		
If you go to the hospital, you should know how to relate with the health workers, IDI 12			
All you need is to be respectful, IDI 14			