MAKERERE UNIVERSITY

SOCIO-ECONOMIC AND GENDER-RELATED CHALLENGES EXPERIENCED BY TEENAGE MOTHERS IN ACCESSING HEALTHCARE SERVICES: A CASE STUDY OF WALUKUBA VILLAGE, MASESE, JINJA CITY

BY

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BASS

A DISSERTATION SUBMITTED TO THE COLLEGE OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF BACHELOR OF ARTS IN SOCIAL SCIENCES OF MAKERERE UNIVERSITY

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DECLARATION

I hereby declare that this research proposal is my own work and has never been presented for approval at any other university.

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APPROVAL

This research proposal has been submitted following my approval as the designated University Supervisor.

Signature: _____ **Date:** 17/09/2026

Dr. Richard Asaba Bagónza

DEDICATION

This dissertation is dedicated to my family for their love, encouragement and continued support throughout my academic journey. I also dedicate this work to all teenage mothers who continue to face social, economic and gender-related challenges while striving to protect their health, care for their children and build a better future for themselves.

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I dedicate this dissertation first and foremost to Almighty God for the gift of life, wisdom, strength, good health and grace that enabled me to pursue and complete my studies.

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LIST OF ABBREVIATIONS

Acronym	Full Meaning
ANC	Antenatal Care
CBO	Community-Based Organisation
CSDH	Commission on Social Determinants of Health
IDI	In-Depth Interview
IGA	Income-Generating Activity
KIIs	Key Informant Interviews
LC1	Local Council One
LMICs	Low- and Middle-Income Countries
NGO	Non-Governmental Organisation
NUSAF	Northern Uganda Social Action Fund
PNC	Postnatal Care
SAGE	Social Assistance Grants for Empowerment
SCT	Social Cognitive Theory
SDG	Sustainable Development Goal
SDH	Social Determinants of Health
UDHS	Uganda Demographic and Health Survey
VHT	Village Health Team
WHO	World Health Organization

ABSTRACT

Teenage mothers face multiple socio-economic and gender-related challenges that may limit their ability to access timely, affordable and respectful healthcare services. This study examined the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City. Specifically, the study explored financial challenges, social stigma and discrimination, gender norms and unequal power relations, the nature and adequacy of social support, and the coping strategies used by teenage mothers to overcome barriers to healthcare access. A qualitative case study design was employed, and data were collected through in-depth interviews with five teenage mothers aged 16–19 years residing in Walukuba Village. The data were analysed thematically to identify recurring patterns and experiences across participants.

The findings revealed that teenage mothers experienced significant financial barriers, particularly transport costs, the cost of medicines and medical supplies, limited personal income and dependence on relatives or male partners for healthcare expenses. Social stigma was experienced through family disappointment, community judgement, embarrassment and, in some cases, disrespectful treatment within healthcare settings. Gender norms placed greater responsibility for pregnancy, childcare and domestic work on teenage mothers, while fathers of the children often provided inconsistent support. Although teenage mothers were generally able to recognise when healthcare was needed, limited control over financial resources sometimes reduced their ability to seek care independently. Mothers, grandmothers, aunts, sisters and Village Health Team members were important sources of emotional, financial, practical and informational support, although such support was often inadequate. Teenage mothers coped by borrowing money, seeking help from relatives, keeping small savings, using informal income, consulting VHTs and sometimes visiting drug shops before seeking formal treatment.

The study concludes that healthcare access among teenage mothers is shaped by interconnected financial, social and gender-related factors rather than by the availability of health services alone. Improving access therefore requires interventions that address financial vulnerability, stigma, gender inequality, weak paternal responsibility and inadequate support systems. The study recommends strengthening adolescent-friendly healthcare services, family and paternal support, VHT services, economic empowerment, educational reintegration and community-based support programmes for teenage mothers. These measures would help improve timely, affordable, respectful and continuous healthcare access for teenage mothers and their children.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

This chapter introduces the study. It presents the background, problem statement, objectives, research questions and the significance of the study. It also defines the study's scope, the theoretical framework, the conceptual framework that guided the research, and the operational definition of key terms.

1.2 Background to the Study

Adolescent pregnancy is a globally recognized public health challenge that intersects profoundly with issues of gender inequality, poverty, education, and access to healthcare. According to the World Health Organization (WHO, 2023), approximately 21 million girls aged 15 to 19 years in low- and middle-income countries (LMICs) become pregnant each year, with roughly 12 million of these pregnancies resulting in live births. Globally, about 14% of adolescent girls have given birth before the age of 18, and the burden falls overwhelmingly on LMICs a prevalence estimated to be 95% higher than in high-income countries (Mizero et al., 2026). These pregnancies are rarely isolated events; they are embedded in complex socio-economic realities that shape not only the health trajectories of the young mothers themselves but also the outcomes of their children and the communities they inhabit.

Gender norms and unequal power relations also play an important role in shaping teenage mothers' access to healthcare services. In many communities, adolescent girls have limited control over financial resources, mobility and decisions concerning their bodies and healthcare, making them dependent on parents, guardians or male partners for permission, transport and money to seek care. This dependence may become more restrictive where a partner denies responsibility for the pregnancy, withdraws financial support or controls when and where the teenage mother can obtain treatment. Gender expectations may further place the responsibility for pregnancy, childcare and household work almost entirely on the girl, while the male partner faces fewer social consequences. Within healthcare settings, judgmental attitudes towards unmarried teenage mothers may reinforce shame and discourage timely care-seeking. Evidence indicates that restrictive gender norms, limited decision-making autonomy, provider bias and unequal access to finances can prevent adolescent girls from obtaining essential reproductive and maternal healthcare services (WHO, 2021, 2025). Studies from Sub-Saharan Africa similarly show that partner rejection, limited male involvement and exclusion of adolescent

mothers from household decision-making contribute to delayed or incomplete use of maternal healthcare services.

Financial constraints rank among the most prominent determinants of healthcare access among adolescent mothers in low-income settings. Even where services are nominally free, indirect costs such as transportation, food, accommodation during extended visits, and the purchase of prescribed supplements or medications often constitute insurmountable burdens for young women who lack independent income (Sully et al., 2020; Banke-Thomas et al., 2021). A systematic review by Oredipe et al. (2026) confirmed that adolescent mothers in LMICs most commonly lacked the financial resources necessary to cover transport costs, purchase prescribed medications, and maintain a balanced diet as recommended by health workers. Social stigma represents another well-documented yet persistently inadequately addressed barrier: provider attitudes, discriminatory remarks, and lack of confidentiality have been shown to erode young mothers's trust in health systems and deter them from seeking timely care (WHO, 2022; Patton et al., 2022). The absence of functional social support networks further compounds these challenges, with research demonstrating that teenage mothers with strong support systems exhibit significantly better antenatal care attendance and improved postnatal health-seeking behavior (Afulani et al., 2021; Bohren et al., 2022).

In Sub-Saharan Africa, where the burden of adolescent pregnancy is disproportionately concentrated, the consequences are particularly severe, encompassing elevated maternal mortality, increased infant morbidity, educational disruption, and sustained intergenerational cycles of poverty. Babies born to adolescent mothers in LMICs have a higher risk of stillbirth or death within the first few weeks of life compared to those born to mothers aged 20-29 years, and are more likely to experience preterm delivery, low birth weight, and higher mortality compared to those born to mothers aged 20-24 (Oredipe et al., 2026). Social stigma rooted in cultural norms around unmarried motherhood is particularly acute across the region. Research by Mizero et al. (2026) in Rwanda found that teenage mothers were subjected to stigma from families, friends, schools, churches, and even healthcare providers, generating feelings of shame, low self-esteem, and loneliness that actively discouraged care-seeking. The collapse of family support following an unplanned adolescent pregnancy, particularly where the partner is absent, creates profound social vulnerabilities that health systems across the continent are inadequately equipped to address.

Uganda stands among the countries most acutely affected by adolescent pregnancy in Sub-Saharan Africa. The Uganda Demographic and Health Survey (UDHS, 2022) reported that approximately 25% of girls aged 15 to 19 years in Uganda have either begun childbearing or are already pregnant with their first child. One out of four teenagers (15-19 years) in Uganda becomes pregnant, with rates being higher in rural (27%) than in urban Uganda (19%); in the Busoga region, 21% of 15-19-year-old teenagers have begun childbearing (Nabugoomu et al., 2020). The economic marginalization of teenage mothers is compounded by their premature withdrawal from formal education, a consequence that limits their long-term employability and economic autonomy. Evidence from Rwanda confirms that all teenage mothers in one qualitative study faced financial difficulties, with limited job opportunities causing severe hardship, and that the cost of accessing healthcare directly jeopardized maternal and child health outcomes even within a health insurance system (Mizero et al., 2026).

The situation is particularly concerning in communities such as Walukuba Village in Masese, Jinja City, where teenage mothers may experience interconnected socio-economic and gender-related challenges when seeking healthcare services. Although residents may access public and private healthcare facilities within Jinja City, teenage mothers may still face difficulties such as lack of money for transport, medicines and medical supplies, dependence on parents or male partners, limited decision-making power, stigma and inadequate social support. Studies from Uganda indicate that family encouragement and support in healthcare decision-making can facilitate care-seeking among teenage mothers, while poverty, negative community attitudes, harsh treatment by healthcare workers, shortages of medical supplies and limited adolescent-friendly services may discourage continued use of healthcare services (Nabugoomu et al., 2020). Unequal gender relations may further restrict teenage mothers' ability to make independent healthcare decisions, particularly where male partners deny responsibility for the pregnancy, withdraw financial assistance or control access to household resources. It is against this background of persistent socio-economic and gender-related barriers, together with limited context-specific evidence on the lived experiences of teenage mothers in Walukuba Village, that this study is situated. The study therefore explored the challenges teenage mothers experience in accessing healthcare services, the forms of support available to them and the coping strategies they use within their community.

1.2 Statement of the Problem

Teenage mothers require timely, affordable, respectful and adolescent-responsive healthcare services during pregnancy, childbirth and the postnatal period. They should be able to access

healthcare without discrimination based on their age, gender, marital status or motherhood status. Families, male partners, communities and healthcare providers are also expected to offer financial, emotional and informational support that enables teenage mothers to make informed healthcare decisions and continue using essential services. Namutebi et al. (2022) found that teenage first-time mothers in Uganda required health information, counselling, clinical monitoring, family reconciliation and connections to community-based support organisations during the postpartum period. These forms of support are important for protecting the health, dignity and decision-making autonomy of teenage mothers.

Despite the expected availability of supportive healthcare and social systems, teenage mothers in communities such as Walukuba Village, Masese, may experience interconnected socio-economic and gender-related barriers when seeking healthcare. Many teenage mothers lack independent income and depend on parents, guardians or male partners for transport, medicines, medical supplies and other healthcare-related expenses. This dependence may reduce their ability to decide when and where to seek care, particularly when male partners deny responsibility for the pregnancy, withdraw financial assistance or control access to household resources. Teenage mothers may also experience family rejection, community stigma, childcare burdens, school interruption and disrespectful treatment within healthcare settings. Cumber et al. (2022) found that pregnant adolescents in Uganda experienced financial difficulties, challenges in reaching health facilities, discrimination, disrespect from healthcare workers and inadequate privacy. Similarly, Nabugoomu et al. (2018), in a qualitative study conducted in Budondo Sub- County in Jinja District, identified pregnancy and childcare costs, harsh treatment, inadequate access to medicines and limited adolescent-tailored healthcare as major barriers affecting teenage mothers.

Although previous studies have documented financial constraints, stigma, inadequate social support and negative healthcare experiences among teenage mothers in Uganda, limited qualitative evidence explains how these challenges interact with gender norms and unequal power relations in Walukuba Village. The available literature does not adequately show how dependence on male partners and family members, limited control over financial resources, unequal responsibility for pregnancy and childcare, and restricted participation in healthcare decisions influence teenage mothers' access to services in this community. Without context-specific evidence, interventions may fail to address the social, economic and gendered realities shaping teenage mothers' healthcare-seeking experiences. This study therefore explored the

socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City. The findings may inform community-based, gender-responsive and adolescent-friendly interventions aimed at improving social support, respectful care and access to appropriate healthcare services.

1.3 Purpose of the Study

The purpose of this study was to explore the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City. The study soughtto generate an in-depth understanding of how financial constraints, social stigma, inadequate social support, gender norms and unequal power relations influence teenage mothers' healthcare-seeking experiences. It also examined the coping strategies teenage mothers use to overcome these barriers. By focusing on their lived experiences, the study is intended to provide context-specific evidence that may inform community-based, gender-responsive and adolescent-friendly interventions aimed at improving access to healthcare services among teenage mothers.

1.4 Research Objectives

1.4.1 General Objective

To explore the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City.

1.4.2 Specific Objectives

1. To explore the financial challenges experienced by teenage mothers when seeking healthcare services in Walukuba Village.
2. To examine how social stigma and discrimination influence the healthcare-seeking experiences of teenage mothers in Walukuba Village.
3. To assess how gender norms and unequal power relations within families, intimate relationships, communities and healthcare settings influence teenage mothers' access to healthcare services.
4. To explore the nature and adequacy of social support available to teenage mothers when seeking healthcare services.
5. To understand the coping strategies used by teenage mothers to overcome socio-economic and gender-related barriers to healthcare access.

1.5 Research Questions

1. What financial challenges do teenage mothers experience when seeking healthcare services in Walukuba Village?
2. How do social stigma and discrimination influence the healthcare-seeking experiences of teenage mothers in Walukuba Village?
3. How do gender norms and unequal power relations within families, intimate relationships, communities and healthcare settings influence teenage mothers' access to healthcare services?
4. What forms of social support are available to teenage mothers in Walukuba Village, and how adequate are they in facilitating access to healthcare services?
5. What coping strategies do teenage mothers use to overcome socio-economic and gender-related barriers to healthcare access?

1.6 Significance of the Study

This study is significant to teenage mothers in Walukuba Village because it documented the specific financial, social and gender-related challenges that affect their ability to seek and continue using healthcare services. By examining issues such as lack of money for transport and medicines, stigma, limited decision-making power, partner abandonment and inadequate family support, the study helps bring attention to the lived realities that are often overlooked in general maternal health programmes. The findings may support the development of interventions that respond more directly to the needs of teenage mothers within the community.

The study is useful to healthcare providers, Village Health Teams, community leaders, local organisations and Jinja City authorities. The findings may help these stakeholders understand how provider attitudes, lack of privacy, poor communication, unequal gender relations and weak social support systems discourage teenage mothers from seeking care. This evidence may guide the strengthening of adolescent-friendly services, community referral systems, counselling, family engagement and gender-responsive support programmes within Walukuba Village and surrounding communities.

The study is further contributes to the achievement of the Sustainable Development Goals. It is directly related to SDG 3 on Good Health and Well-Being because improving teenage mothers' access to antenatal, delivery, postnatal and general healthcare services can reduce

preventable maternal and child health risks. It also supports SDG 5 on Gender Equality by examining how unequal power relations, dependence on male partners, gender-based discrimination and limited decision-making autonomy affect teenage mothers' healthcare access. In addition, the study contributes to SDG 10 on Reduced Inequalities by drawing attention to the exclusion and disadvantages experienced by teenage mothers as a vulnerable group within the healthcare system. Academically, the study adds context-specific qualitative evidence on teenage motherhood, gender relations and healthcare access in Walukuba Village, and may provide a useful reference for future research and policy development.

1.7 Scope of the Study

1.7.1 Subject Scope

The study focused on the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services. It examined financial barriers, social stigma and discrimination, social support systems, gender norms, unequal power relations and the coping strategies used by teenage mothers. The study concentrated on the social, economic and gender factors influencing healthcare access rather than the clinical causes or medical outcomes of teenage pregnancy.

1.7.2 Geographical Scope

The study was conducted in Walukuba Village, located in Masese, Jinja City. Walukuba is an urban community with residents from different social and economic backgrounds and is served by both public and private healthcare facilities within Jinja City. The area was selected because it provides a suitable setting for examining the lived experiences of teenage mothers and the challenges they face when seeking healthcare services. Its community context enabled the researcher to explore how poverty, family relationships, social stigma, gender norms and available support systems influence healthcare access among teenage mothers.

1.7.4 Time Scope

The study focused on the experiences of teenage mothers who have sought healthcare services within the twelve months preceding data collection. Data collection is expected to take place between August and October 2026, while data analysis and report writing was completed between October and December 2026. Literature published mainly between 2016 and 2026 was reviewed to provide recent evidence and context for the study.

1.8 Theoretical Framework

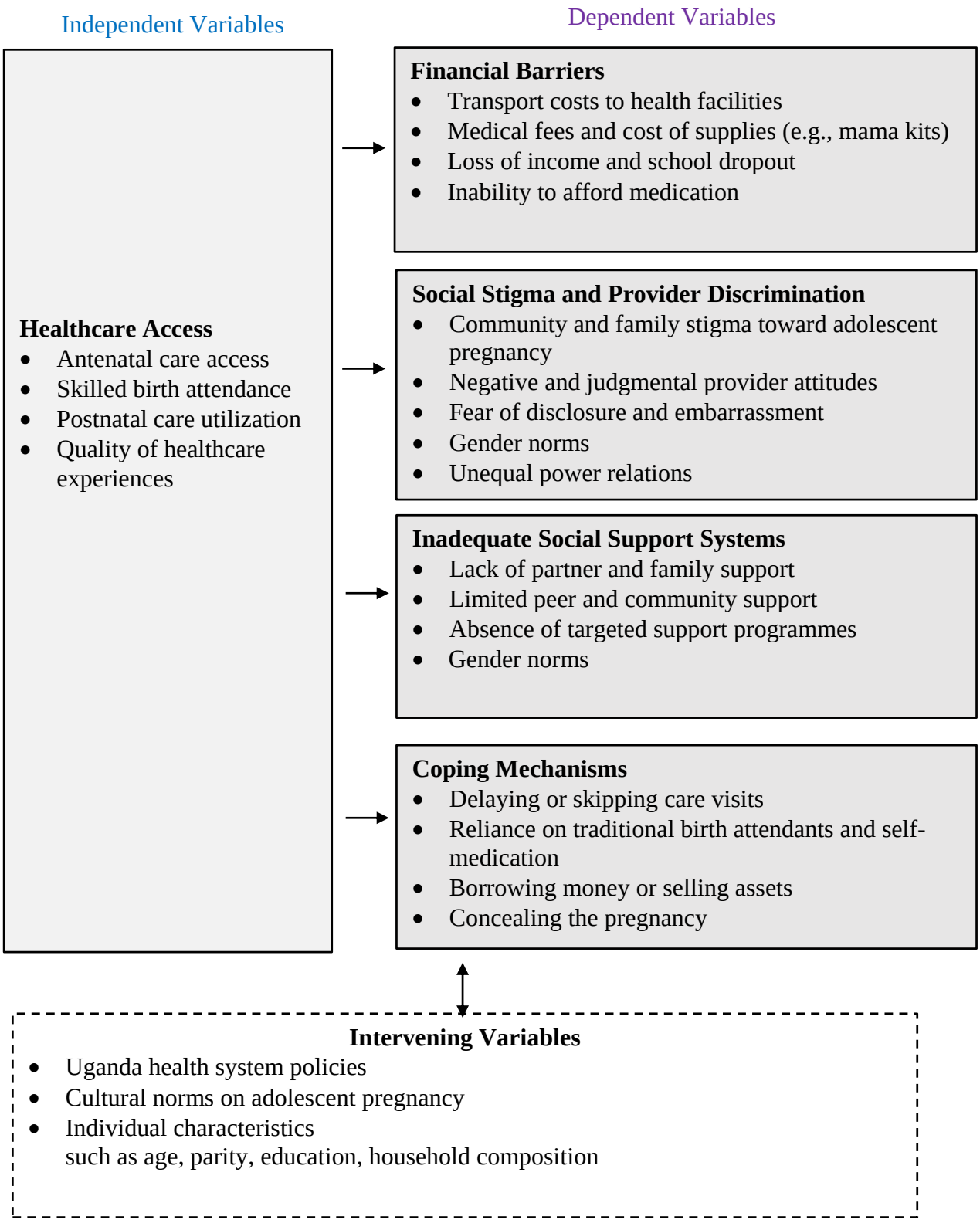
This study was anchored on the Social Determinants of Health (SDH) Framework, originally articulated by the World Health Organization's Commission on Social Determinants of Health (CSDH, 2008) and further developed by scholars including Marmot (2005) and Solar and Irwin (2010). The SDH Framework holds that health outcomes are not merely a product of individual biological or behavioral choices but are fundamentally shaped by the socio-economic conditions in which people are born, grow, live, work, and age. Structural determinants including income level, educational attainment, employment status, gender, and social class produce stratified social hierarchies that generate unequal distributions of power, resources, and opportunities, which in turn create differential exposures to health risks and differential capacities to access healthcare services. Applied to the present study, the SDH Framework provides an explanatory lens through which the healthcare access challenges of teenage mothers can be understood not as personal failings but as manifestations of deeper structural inequalities.

In addition to the SDH Framework, this study draws supplementary insights from Andersen's Behavioral Model of Health Services Utilization (Andersen, 1995). Andersen's model posits that healthcare utilization is a function of three interacting sets of factors: predisposing characteristics (demographic and social attributes that make individuals more or less likely to use health services), enabling resources (income, health insurance, and social support that facilitate or impede access), and need factors (perceived and evaluated health needs that motivate care-seeking). This model is particularly relevant for understanding the multi-dimensional nature of the barriers faced by teenage mothers, as it accounts for the interaction between personal characteristics (young age, gender, marital status), enabling resources (financial capacity, social support), and care-seeking behavior.

The study also draws on the Social Cognitive Theory (SCT) as applied by Nabugoomu et al. (2020) in their study of opportunities and challenges for teenage mothers in rural eastern Uganda. The SCT emphasizes the reciprocal interaction between personal factors (individual attitudes, self-efficacy, and knowledge), environmental factors (social, economic, physical, and health service environments), and health behaviors. This framework draws attention to how individual attitudes and self-efficacy interact with social and institutional environments to shape care-seeking decisions, and how changes at the individual or environmental level can reciprocally produce changes at the other. Together, the SDH Framework, Andersen's

Behavioral Model, and the Social Cognitive Theory provide complementary theoretical anchors that inform both the design of this study and the interpretation of its findings.

1.9 Conceptual Framework



Source: Adapted by the researcher (2026)

Figure 1: The Conceptual Framework

The conceptual framework presented in Figure 1 illustrates how socio-economic and gender-related challenges influence teenage mothers' access to healthcare services. In this study, the independent variables include financial barriers, social stigma and discrimination, inadequate social support, gender norms and unequal power relations. These factors may determine whether teenage mothers are able to seek care on time, afford healthcare-related costs, continue attending appointments and receive respectful and appropriate services.

Financial barriers include transport costs, the cost of medicines and medical supplies, loss of income and dependence on family members or male partners for healthcare expenses. Social stigma and discrimination refer to negative attitudes, judgment, rejection and disrespect experienced by teenage mothers within families, communities and healthcare settings. Inadequate social support includes limited emotional, financial and practical assistance from partners, parents, relatives, peers, community members and formal support programmes. Gender norms and unequal power relations relate to limited decision-making autonomy, unequal responsibility for pregnancy and childcare, dependence on male partners and restrictions on teenage mothers' ability to make independent healthcare decisions.

The dependent variable is access to healthcare services, reflected through timely care-seeking, affordability, continuity of care, availability of services and the quality of healthcare experiences. The framework also recognises coping strategies such as borrowing money, seeking support from relatives, relying on community networks, consulting Village Health Team members, using self-medication and delaying or skipping healthcare visits. Intervening factors such as age, education, marital status, household income, availability of nearby health facilities, health policies and community attitudes may strengthen or weaken the relationship between the identified challenges and healthcare access. For example, supportive family relationships may improve access to care, while restrictive gender norms and negative community attitudes may increase stigma and delay healthcare-seeking.

1.10 Operational Definitions of Key Terms

Teenage Mother: For the purposes of this study, a teenage mother refers to a girl or young woman aged between 13 and 19 years who is currently pregnant or has given birth to a child within the preceding twelve months and resides in the study community.

Healthcare Access: For the purposes of this study, healthcare access refers to the ability of a teenage mother to obtain the healthcare services she needs in a timely, affordable, respectful and dignified manner. It includes her ability to reach a health facility, pay for required services and medicines, receive appropriate care, continue attending recommended visits and use services without facing stigma, discrimination or gender-related restrictions.

Socio-Economic Challenges: Socio-economic challenges refer to the interrelated financial, social, and structural obstacles that hinder teenage mothers from accessing healthcare services. In this study, these challenges are operationalized across four dimensions: financial barriers (cost-related obstacles), social stigma and discrimination (attitudes and behaviors of providers and community members), social support inadequacy (absence or insufficiency of family, partner, peer, or institutional support), and coping deficits (where existing adaptive strategies are insufficient to overcome the identified barriers).

Financial Barriers: For the purposes of this study, financial barriers refer to cost-related challenges that prevent or discourage teenage mothers from seeking, reaching or continuing with healthcare services. These may include transport costs, the purchase of medicines and medical supplies, diagnostic or consultation fees, informal payments and loss of income or time from livelihood activities. They also include dependence on parents, guardians or male partners for money needed to obtain healthcare.

Social Stigma: Social stigma in this study refers to the negative social judgments, discriminatory attitudes, derogatory labeling, and exclusionary behaviors directed at teenage mothers by healthcare providers, community members, family, and peers on account of their adolescent pregnancy or motherhood status. Provider stigma specifically encompasses negative verbal and non-verbal behaviors exhibited by healthcare workers during clinical encounters that reduce the quality and dignity of care received by teenage mothers.

Social Support Systems: Social support systems are defined as the formal and informal networks of people and institutions that provide emotional, informational, instrumental, and financial assistance to teenage mothers to facilitate their access to healthcare. These include partners, parents, extended family, peer groups, community health workers, religious organizations, and formal social welfare and protection programmes.

Coping Mechanisms: For the purposes of this study, coping mechanisms refer to the behavioural, cognitive and social strategies that teenage mothers use to manage or overcome socio-economic and gender-related barriers to healthcare access. These may include borrowing money, seeking support from relatives, partners or community members, consulting Village Health Team members, relying on support groups, adjusting the timing of healthcare visits, using self-medication, or delaying care. Such strategies may be initiated individually or supported collectively through family and community networks.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section presents a systematic and critical review of existing literature pertaining to the socio-economic challenges faced by teenage mothers in accessing healthcare services, with particular emphasis on evidence drawn from global, Sub-Saharan African, and Ugandan contexts. The review is organized thematically in alignment with the five specific objectives of this study: financial barriers to healthcare access, social stigma and provider discrimination, social support systems, and coping mechanisms. Each thematic area is examined through a multi-layered lens, beginning with global evidence and progressively narrowing to the Sub-Saharan African and Ugandan contexts. The review culminates in a synthesis of identified research gaps that justify the present study. The literature reviewed spans peer-reviewed journal articles, policy documents, WHO and UN reports, national demographic surveys, and grey literature published primarily between 2014 and 2026, with seminal earlier works cited where theoretically foundational.

2.2 Financial Barriers to Healthcare Access among Teenage Mothers

2.2.1 Global Evidence on Financial Barriers

The relationship between poverty and restricted access to maternal healthcare is one of the most consistently documented findings in global health research. Across low- and middle-income countries (LMICs), financial barriers to healthcare manifest in multiple forms: user fees, out-of-pocket expenditures on medications and supplies, transportation costs to and from health facilities, and the indirect economic costs associated with time lost from productive activities (Sully et al., 2020). For adolescent mothers, these barriers are particularly acute because this population typically lacks financial autonomy, having been prematurely excluded from education and formal employment. The Guttmacher Institute's comprehensive analysis of sexual and reproductive health investment in LMICs found that financial barriers were among the leading reasons young women delayed or avoided antenatal care, and that the burden was disproportionately borne by the youngest and poorest women (Sully et al., 2020).

A systematic review by Oredipe et al. (2026), examining socioeconomic determinants and health system barriers to maternal healthcare access among teenage mothers across 15 peer-reviewed studies in LMICs, confirmed that adolescent mothers most commonly lacked the financial resources necessary to cover transport costs, purchase prescribed medications, and

maintain a balanced diet as recommended by health workers. Transportation costs emerged as the single most cited financial barrier for adolescents in peri-urban areas served by large referral hospitals. Banke-Thomas et al. (2021) found in a systematic review of out-of-pocket costs of maternal healthcare in Sub-Saharan Africa that even in countries with officially free maternity services, the actual costs incurred by women were substantial and constituted a major deterrent to care utilization, with the burden falling heaviest on economically disadvantaged women including adolescents. The concept of catastrophic health expenditure is particularly relevant to this context: teenage mothers who are financially dependent on families or partners are especially vulnerable, as they have no independent financial cushion to absorb healthcare costs (WHO, 2023).

2.2.2 Financial Barriers in Sub-Saharan Africa

In Sub-Saharan Africa, financial barriers to maternal healthcare are deeply intertwined with the broader architecture of poverty, gender inequality, and health system underfunding. Despite numerous government pledges and donor-supported initiatives to abolish user fees for maternal healthcare, evidence consistently demonstrates that the implementation of fee-free policies has been partial, inconsistent, and often accompanied by the substitution of formal fees with informal payments (Bohren et al., 2022). Gebremedhin et al. (2022) documented in a multi-country analysis that adolescent women were significantly more likely than adult women to report cost as a primary reason for not seeking antenatal care.

Mizero et al. (2026), in a qualitative study of 23 women who had undergone teenage pregnancy in Rwanda, found that the cost to access healthcare was high, directly jeopardizing health outcomes of mothers and babies. Despite the presence of a community health insurance system, the co-payment fee exerted financial burden, and the absence of insurance for those disowned by families made accessing healthcare financially impossible for some. The study documented cases where teenagers went to the health facility only when giving birth, having been unable to afford any antenatal care visits. The economic consequences of adolescent pregnancy extend well beyond immediate healthcare costs: premature school dropout effectively forecloses educational pathways and future income-earning opportunities, creating a sustained cycle of economic marginalization (Filippi et al., 2020). In Rwanda, all teenage mothers in Mizero et al.'s (2026) study faced financial difficulties, and their employment opportunities stopped as soon as they became pregnant, with community stigma further limiting their ability to find work.

Research by Nabugoomu et al. (2020) in eastern Uganda found that poverty rates in rural Uganda were high and contributed to families' inability to provide their daughters with much financial help. Challenges at the economic level included lack of money, lack of materials for handcrafts, no land for cultivation, high costs of agricultural inputs, and unprofitable markets. Additionally, teenage mothers failed to benefit from government agricultural programs because they were not established with homes and land for farming as required for eligibility. Afulani et al. (2021) in Ghana found that young mothers in the lowest economic quintile were three times less likely to complete the recommended minimum of four antenatal care visits compared to those in the highest quintile, underscoring the magnitude of financial stratification in care utilization.

2.2.3 Financial Barriers in Uganda

In Uganda specifically, financial barriers to healthcare access for teenage mothers operate within a context of widespread poverty, high youth unemployment, and persistent gaps in the implementation of free healthcare policies. The Uganda National Health Insurance Scheme remains in its nascent stages of development, leaving the majority of Ugandans, particularly vulnerable populations such as teenage mothers, without any formal financial risk protection mechanism. The UDHS (2022) reported that cost was among the major reasons cited by women aged 15 to 24 for not seeking skilled obstetric care. Transportation costs are particularly burdensome for teenage mothers living in low-income urban communities such as Walukuba Village in Masese, Jinja City, where limited household income and dependence on parents, guardians or male partners may affect their ability to reach healthcare facilities and meet other healthcare-related expenses.

Nalwadda et al. (2020) documented in a study of adolescent reproductive health in Uganda that financial dependence was a critical structural factor shaping young women's reproductive health decisions and behaviours, including their ability to access healthcare services independently. Financial barriers operated not only directly through inability to pay, but also indirectly through the negotiation of permission and resources within unequal power relationships. Nabugoomu et al. (2020) found that in rural eastern Uganda, lack of medicines in health centres was frequently reported and was compounded by suspected thefts at different supply-chain levels, forcing patients to purchase drugs privately at costs that were unaffordable for teenage mothers. In Walukuba Village, teenage mothers may similarly lack the resources needed to meet basic healthcare-related expenses and may depend on whatever financial

support parents, guardians, relatives or male partners are willing and able to provide. A critical evidence gap therefore remains regarding how financial dependence, transport costs, the purchase of medicines and limited control over household resources shape healthcare access among teenage mothers in Walukuba Village, Masese, Jinja City. This study is specifically designed to address that gap through an in-depth exploration of their lived experiences.

2.3 Social Stigma and Provider Discrimination

2.3.1 Conceptualizing Stigma in Healthcare Settings

Stigma, as theorized by Goffman (1963) in his foundational sociological work, refers to a deeply discrediting attribute that reduces an individual from a whole and complete person to a tainted and discounted one in the eyes of others. In healthcare contexts, stigma operates through a complex interplay of social attitudes, institutional norms, and individual behaviors that collectively construct certain groups as undeserving, irresponsible, or morally compromised. Link and Phelan (2001) expanded stigma theory to emphasize its structural dimensions, arguing that stigma involves the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination, and that its effects are most severe when the stigmatized person lacks the social and economic power to resist or counter the stigmatizing process. This framework is particularly applicable to teenage mothers, who bear the double stigma of youth and unsanctioned sexuality, and who typically lack the social capital to challenge stigmatizing treatment from healthcare providers or community members.

Within the healthcare literature, provider stigma has been identified as a critical determinant of care quality and utilization. The WHO (2022) has explicitly recognized provider stigma as a barrier to maternal health service utilization in LMICs and has called for the development of anti-stigma training programmes and accountability mechanisms within healthcare facilities. Research has documented that provider stigma operates through multiple mechanisms: verbal abuse and derogatory remarks, withholding of information and emotional support, reduced attentiveness and clinical thoroughness, breaches of confidentiality, and the attribution of negative patient characteristics based on group membership rather than individual circumstances (Bohren et al., 2022). For teenage mothers, who are already in a state of heightened emotional and physical vulnerability, encounters with stigmatizing providers can have severe consequences for their willingness to continue engaging with health services.

2.3.2 Stigma as a Barrier to Healthcare in Sub-Saharan Africa

Across Sub-Saharan Africa, social stigma associated with adolescent pregnancy is rooted in deeply entrenched cultural and religious norms that associate female honor with sexual purity, marital fidelity, and reproductive restraint. Teenage pregnancy particularly outside of formal marriage is experienced as a profound violation of social expectations, and teenage mothers are subject to various forms of social punishment including family exclusion, public shaming, withdrawal of educational support, and community ostracism (Nalwadda et al., 2020).

Mizero et al. (2026) documented in Rwanda that teenage pregnancy caused girls to face various types of discrimination and stigma leading to self-doubt and self-depreciation. As soon as their pregnancies became visible, participants expressed feeling ashamed and feared stigma from school and the community. Some pregnant girls were disowned by families, cast out of their homes, emotionally or physically abused, and rejected by friends, churches, and community members. Most strikingly, when seeking healthcare, some teenage mothers were criticized by healthcare providers during antenatal care visits: healthcare workers asked them intimidating questions, used harsh language, and laughed at them causing some not to return for care. This is consistent with findings by Oredipe et al. (2026), whose systematic review found that stigma, long waiting times, and lack of privacy in clinics discouraged young females from seeking reproductive healthcare, and that negative attitudes from healthcare workers significantly reduced service utilization among this group.

Bohren et al. (2022), in a qualitative evidence synthesis examining facility-based delivery across LMICs, found that adolescent women were significantly more likely than adult women to report verbal abuse, non-dignified care, and abandonment during labor and delivery. Studies from Kenya, Ghana, and Ethiopia have all documented teenage mothers reporting being called "irresponsible," "careless," or "stupid" by nurses and midwives, and of receiving less attentive care compared to adult patients. The cumulative effect is the erosion of young women's trust in health systems and a corresponding reduction in care-seeking behavior, with direct implications for maternal and infant health outcomes.

2.3.3 Stigma and Provider Discrimination in Uganda

In Uganda, social stigma surrounding teenage pregnancy is particularly intense, reflecting the confluence of conservative cultural norms, religious values, and gender-based power hierarchies. Nalwadda et al. (2020) documented that teenage mothers consistently cited fear of judgment and discrimination from community members and healthcare providers as a primary reason for delaying or avoiding facility-based care. Participants reported that nurses and

midwives at public health facilities frequently made derogatory remarks about teenage patients, questioned their life choices, and provided care in a manner that communicated disapproval and disrespect.

In eastern Uganda, Nabugoomu et al. (2020) found that medical staff were not adequately trained to provide adolescent-friendly services, and teenage mothers consequently received care that was not sufficiently tailored to their needs. Structural challenges such as understaffing, high patient loads and inadequate training further limited providers' ability to offer attentive, respectful and dignified care. Some service providers also reported low motivation because of poor or delayed remuneration. The physical environment of public healthcare facilities may further contribute to stigma where private and confidential consultation spaces are limited and sensitive questions are asked in the presence of other patients. These forms of provider-related stigma and institutional inadequacy remain insufficiently documented in relation to teenage mothers living in Walukuba Village, Masese. The present study therefore seeks to explore how provider attitudes, privacy, communication and the availability of adolescent-friendly services influence teenage mothers' access to healthcare.

2.4 Gender Norms and Unequal Power Relations in Healthcare Access

2.4.1 Conceptual Understanding of Gender Norms and Power Relations

Gender norms refer to socially constructed expectations regarding the roles, responsibilities and behaviour considered appropriate for women, men, girls and boys. These norms influence access to resources, household responsibilities, mobility, sexuality and participation in decision-making. In many societies, women and adolescent girls are expected to remain submissive, depend economically on men and seek approval from parents, partners or other family members before making important decisions. Such expectations can limit teenage mothers' autonomy and capacity to decide when, where and from whom to seek healthcare services. Unequal power relations occur when one individual or social group has greater control over resources, decisions and opportunities than another. Within families and intimate relationships, this may be reflected in male partners or older family members controlling household income, transport, healthcare expenditure and permission to visit a health facility.

Gender inequality can affect healthcare access through several interconnected pathways. Teenage mothers who lack control over financial resources may be unable to pay for transport, medicines, medical supplies or laboratory services without assistance from a partner or family

member. Their healthcare decisions may also be influenced by partners, parents, guardians and mothers-in-law, particularly where adolescent motherhood is associated with limited social status and economic dependence. Ganle et al. (2015) found that women's use of maternal healthcare services in Ghana was strongly influenced by husbands, mothers-in-law and other family members, sometimes leaving women with little authority over their own healthcare decisions. The study demonstrated that unequal household decision-making, economic marginalisation and gendered social power could delay or prevent women from obtaining skilled maternal healthcare.

Gender norms can also influence the distribution of responsibility for pregnancy and childcare. Teenage mothers may be expected to bear most of the physical, emotional and financial consequences of pregnancy, while male partners may face fewer social consequences or deny responsibility. This unequal allocation of responsibility may increase young mothers' dependence on their families and limit their ability to continue schooling, obtain employment or independently meet healthcare expenses. Community beliefs that associate respectable femininity with sexual restraint may further expose teenage mothers to blame and social judgment, while overlooking the roles of male partners, coercion and unequal sexual relationships. Consequently, gender norms do not merely shape individual attitudes; they influence the resources, choices and social support available to teenage mothers when they require healthcare.

2.4.2 Gender Norms and Healthcare Access in Sub-Saharan Africa

Across Sub-Saharan Africa, gender inequality remains an important determinant of maternal healthcare utilisation. Women and adolescent girls frequently have limited control over household income, mobility and reproductive decisions, particularly in settings where men are regarded as household heads and principal decision-makers. A multi-country analysis by Chol et al. (2019) found that women's autonomy, including participation in decisions concerning household income and major purchases, was associated with the use of maternal healthcare services across 31 Sub-Saharan African countries. Women with greater decision-making autonomy were generally better positioned to obtain antenatal care and skilled maternal health services than those who had little influence over household decisions.

The influence of gender inequality extends beyond individual households to community-level beliefs and expectations. Some communities tolerate male control over women's movements,

finances and reproductive choices, while expecting women to accept unequal relationships and domestic responsibilities. Singh et al. (2014) found that community-level gender inequality, including social norms that tolerated violence against women, negatively affected the utilisation of maternal healthcare services in rural Sub-Saharan Africa. Such norms may discourage women from challenging a partner's decision, requesting money for healthcare or travelling independently to a health facility. They may also normalise controlling behaviour and make it difficult for teenage mothers to disclose abuse, abandonment or lack of support.

Married and cohabiting adolescent mothers may experience particularly restricted autonomy because of the combined effects of young age, gender and economic dependence. Evidence from 13 Sub-Saharan African countries indicates that married adolescents' use of maternal healthcare is influenced by household living conditions and their ability to participate in decision-making. Adolescents with greater autonomy were more likely to utilise maternal healthcare than those whose decisions were mainly controlled by their husbands or other household members (Yaya et al., 2019).

Power relations also operate within healthcare settings. Healthcare providers possess institutional authority, medical knowledge and control over access to services. When providers hold judgmental attitudes towards adolescent pregnancy, teenage mothers may be blamed, humiliated or treated as irresponsible. This imbalance may prevent young mothers from asking questions, reporting mistreatment or demanding privacy and respectful care. Pregnant adolescents may therefore remain silent during consultations, accept inadequate treatment or avoid returning to facilities where they previously experienced disrespect. Gender-responsive healthcare must consequently address both household power relations and institutional practices that reduce adolescent mothers' voice and agency.

2.4.3 Gender Norms and Unequal Power Relations

In Uganda, gender norms are learned and reinforced through families, schools, religious institutions and communities from an early age. Girls are frequently expected to demonstrate obedience, sexual restraint and domestic responsibility, while boys may be allowed greater freedom of movement and sexual expression. Ninsiima et al. (2018), in a qualitative study conducted in western Uganda, found that restrictive gender norms significantly constrained adolescent girls' agency. Girls' movements were more closely controlled than those of boys, and responsibility for preventing pregnancy was largely placed on girls. These expectations

contributed to unequal sexual and reproductive power and increased girls' vulnerability to early pregnancy, coercion and limited participation in decisions affecting their lives.

Poverty may deepen these gender inequalities by increasing adolescent girls' dependence on male partners and older family members. Ninsiima et al. (2020) found that poverty interacted with unequal gender relations to restrict adolescent girls' ability to exercise their sexual and reproductive rights in western Uganda. Limited economic opportunities, dependence on others and inadequate services reduced girls' capacity to make independent decisions concerning relationships, pregnancy and reproductive healthcare. The study showed that adolescent girls' vulnerability could not be explained by poverty alone because it was intensified by unequal control over resources and gendered expectations regarding sexuality and obedience.

These inequalities may continue after a girl becomes pregnant or gives birth. Teenage mothers who lack their own income often depend on parents, guardians or male partners for transport and healthcare costs. Where a partner denies responsibility, withdraws support or controls household resources, a teenage mother may delay antenatal care, miss appointments or fail to obtain prescribed medicines. Pregnant adolescents in Uganda have reported difficulties reaching healthcare facilities and lack of financial assistance to obtain maternal health services. They have also described disrespect, discrimination and inadequate privacy within healthcare settings, conditions that reduce their willingness to seek and continue care (Atuhaire et al., 2022).

Unequal power may also prevent teenage mothers from openly communicating with healthcare providers. Because of their young age and socially stigmatised status, they may feel unable to question providers, request clarification or report disrespectful treatment. Providers may communicate directly with an accompanying parent, guardian or partner rather than involving the teenage mother in decisions about her own care. Such practices can further reduce her autonomy and reinforce the belief that adults or male partners have greater authority over her health. Family and community expectations may similarly discourage teenage mothers from seeking reproductive healthcare independently because doing so could be interpreted as disobedience or evidence of sexual activity.

Recent qualitative evidence on reproductive autonomy among adolescent girls in western Uganda also identifies economic dependence, unequal relationships and restrictive social expectations as barriers to decision-making concerning contraception, pregnancy and

childbirth. Reproductive autonomy involves the ability to make informed choices and exercise control over reproductive matters, yet adolescent girls' choices may be constrained by partners, parents, social norms and service-delivery environments (Alanyo et al., 2026).

Although existing Ugandan studies demonstrate that gender norms and unequal power relations affect adolescent girls' reproductive agency, financial independence and use of maternal healthcare, limited evidence focuses specifically on teenage mothers living in Walukuba Village, Masese. It remains unclear how decision-making within families and intimate relationships, control over financial resources, unequal childcare responsibilities, community expectations and interactions with healthcare providers shape their access to services. The present study addressed this gap by exploring teenage mothers' lived experiences and how gendered power relations influence their ability to seek, reach, afford and continue using healthcare services.

2.5 Social Support Systems and Healthcare Access

2.5.1 Theoretical Perspectives on Social Support

Social support theory, as developed by Cobb (1976) and subsequently elaborated by House (1981), posits that social relationships fulfill a critical health-protective function by providing individuals with the emotional, informational, instrumental, and appraisal resources necessary to manage health challenges and navigate complex systems. In the context of healthcare access, social support operates through multiple pathways: directly, by providing practical resources such as financial assistance, transportation, and childcare that facilitate care utilization; and indirectly, by buffering the psychological effects of stress, stigma, and social marginalization that otherwise deter care-seeking (Afulani et al., 2021). Research has consistently demonstrated that the presence of a supportive partner, family member, or peer during antenatal care visits significantly increases attendance rates, reduces anxiety during clinical encounters, and improves adherence to healthcare recommendations (Bohren et al., 2022; Agampodi et al., 2022).

2.5.2 Social Support and Adolescent Healthcare Access in Sub-Saharan Africa

Research across Sub-Saharan Africa has produced substantial evidence documenting the central role of social support in shaping healthcare utilization among teenage mothers. Afulani et al. (2021), in a study of perceived quality of antenatal care among adolescents in Ghana, found that teenage mothers who were accompanied by a family member or partner to antenatal

care visits reported significantly higher satisfaction with care and were significantly more likely to complete the full recommended course of antenatal visits compared to those who attended alone.

Family rejection following an unplanned adolescent pregnancy is a well-documented phenomenon in Sub-Saharan Africa that has severe consequences for healthcare access. Mizero et al. (2026) found in Rwanda that all interviewees stated their parents and siblings were primarily disappointed and angry following pregnancy disclosure: some were insulted, cast out of their homes, and emotionally or physically abused. Since teenage pregnancy is culturally portrayed as bringing a curse to the family in many communities, teenagers were criticized and sometimes physically removed from their homes. Almost unanimously, study participants reported that none of the men responsible for the pregnancies took any responsibility or offered any assistance — leaving teen mothers financially and emotionally strained and without the support needed to navigate healthcare systems. This pattern of paternal abandonment is consistent with findings from Nabugoomu et al. (2020) in Uganda, where blame cycles between families of pregnant teens and families of the baby's fathers constituted a significant social challenge associated with teenage pregnancy.

Conversely, where family support was present, it made a significant difference. Nabugoomu et al. (2020) found that in eastern Uganda, more than half of respondents reported that families and Village Health Teams (VHTs) supported teenage mothers by comforting, encouraging, and advising them about not losing hope, and helping them decide to deliver at health centers. Traditional birth attendants were also mentioned as having a kind and caring attitude toward teenage mothers, serving as an accessible and trusted alternative healthcare source in rural areas.

2.5.3 Social Support Systems in Uganda

In Uganda, the formal social support infrastructure available to teenage mothers remains limited and fragmented. The Government of Uganda operates a number of social protection programmes under the Ministry of Gender, Labour and Social Development, including the Social Assistance Grants for Empowerment (SAGE) programme and the Uganda Social Action Fund (NUSAF). However, these programmes have not been specifically designed or systematically extended to meet the healthcare and social support needs of teenage mothers in communities such as Walukuba Village, Masese. Civil society organisations have also developed community-based support initiatives, but these are often implemented in isolated

areas and may not consistently reach all teenage mothers who require assistance. As a result, many teenage mothers continue to depend mainly on family members, partners, peers, religious organisations and community health workers for financial, emotional and practical support when accessing healthcare services (Nalwadda et al., 2020; UDHS, 2022).

Nabugoomu et al. (2020) found that Village Health Teams played an important role in facilitating healthcare access among teenage mothers in eastern Uganda by encouraging them to seek care, providing advice on exclusive breastfeeding and accompanying them to health centres. However, the effectiveness of VHTs was constrained by understaffing, lack of payment, low motivation and negative attitudes from some parents and community members. Nalwadda et al. (2020) also documented that many teenage mothers experienced rejection or withdrawal of support from their immediate families after disclosing their pregnancies. In such circumstances, they often depended on older female relatives for emotional and practical assistance, although the adequacy of this support varied. A gap therefore remains between the potential contribution of VHTs and other community-based support systems and the actual support received by teenage mothers in Walukuba Village, Masese. This study seeks to explore the availability, accessibility and adequacy of these support systems within the study community.

2.6 Coping Mechanisms Employed by Teenage Mothers

2.6.1 Theoretical Perspectives on Coping

The concept of coping, as elaborated in the seminal work of Lazarus and Folkman (1984), refers to the cognitive and behavioral efforts made by individuals to manage the internal and external demands of transactions that are appraised as taxing or exceeding their resources. Lazarus and Folkman distinguished between problem-focused coping (efforts directed at altering the source of stress) and emotion-focused coping (efforts directed at regulating the emotional response to stress), arguing that individuals employ both types of coping simultaneously and selectively. More recent scholarship has expanded the coping framework to emphasize collective and community-level coping strategies alongside individual ones. Agampodi et al. (2022) highlighted the importance of social capital in enabling marginalized populations to collectively navigate healthcare barriers, arguing that community-level coping resources are often more sustainable and equitable than individually generated adaptive strategies.

2.6.2 Coping Strategies among Teenage Mothers in Sub-Saharan Africa

Research across Sub-Saharan Africa has documented a range of coping strategies employed by teenage mothers to overcome the financial, social, and institutional barriers they face in accessing healthcare services. At the financial level, teenage mothers commonly resort to informal borrowing from friends, relatives, and neighbors; participation in rotating savings and credit associations; sale of personal possessions; and, in some documented cases, transactional sexual relationships as a mechanism for generating healthcare-related income (Sully et al., 2020; Banke-Thomas et al., 2021). Mizero et al. (2026) found in Rwanda that some teen mothers joined cooperatives or support groups where they could save money, and a few managed to sell small items to generate income for healthcare and childcare costs. However, the same study found that support from NGOs and government organizations was inconsistent and not well-coordinated, so that granted support did not always reach the intended beneficiaries.

At the social and institutional level, teenage mothers across the region have been documented employing various strategies to navigate stigma and access care with reduced friction, including attending health facilities during times of lower patient volume, bringing trusted companions to advocate on their behalf during clinical consultations, and strategically building relationships with sympathetic community health workers who can serve as intermediaries between them and the formal health system (Filippi et al., 2020). The formation of peer support groups among teenage mothers has also been documented as a significant collective coping strategy in several Sub-Saharan African contexts, providing a combination of emotional support, information sharing, collective advocacy, and practical assistance that can meaningfully improve healthcare access and utilization outcomes.

2.6.3 Coping Mechanisms in the Ugandan Context

In Uganda, research on the coping strategies of teenage mothers in the context of healthcare access remains relatively sparse compared to the evidence on barriers, representing one of the specific gaps that this study seeks to address. Existing evidence suggests that teenage mothers in Uganda rely heavily on informal financial support from extended family networks, particularly grandmothers and aunts, as a primary mechanism for meeting healthcare costs (Nalwadda et al., 2020). Community-based savings groups and religious congregations have also been identified as sources of both material and emotional support for some teenage mothers in urban areas.

Nabugoomu et al. (2020) found that Village Health Teams played an important role as coping intermediaries for teenage mothers in eastern Uganda by encouraging them to attend health centres, facilitating referrals, providing health education on pregnancy danger signs and exclusive breastfeeding, and supporting positive healthcare decisions. Some families also assisted teenage mothers by providing and supervising income-generating activities such as mat and basket making, animal rearing and crop cultivation. In addition, organisations such as the SOUL Foundation offered vocational and agricultural training intended to strengthen their economic independence. However, the reach, consistency and quality of VHT and community-based support available to teenage mothers in Walukuba Village, Masese, have not been adequately documented. It is also unclear how teenage mothers in this community advocate for respectful treatment, respond to stigma or report discriminatory behaviour within healthcare settings. These gaps justify the present study's focus on the coping strategies and support systems used by teenage mothers when accessing healthcare services.

2.7 Summary of Literature and Identified Research Gaps

The reviewed literature reveals a growing body of evidence on the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services globally, across Sub-Saharan Africa and in Uganda. The evidence consistently identifies financial barriers, social stigma and provider discrimination, inadequate social support, restrictive gender norms, unequal power relations and limited coping options as important influences on healthcare access among teenage mothers. Studies by Oredipe et al. (2026), Mizero et al. (2026), Nabugoomu et al. (2020) and Nalwadda et al. (2020) provide valuable insights into the lived experiences of teenage mothers, particularly in relation to poverty, family rejection, provider attitudes, dependence on partners and the role of community-based support systems. These studies demonstrate the need for context-specific research that examines how such challenges are experienced within particular communities.

Several research gaps justify the present study. First, although financial barriers to maternal healthcare in Uganda are widely recognised, limited qualitative evidence explains how transport costs, medicines, medical supplies, loss of income and dependence on family members or male partners affect teenage mothers in Walukuba Village. Second, while stigma and discriminatory treatment have been documented in Uganda, little is known about how teenage mothers in this community experience judgment, rejection, disrespect and lack of privacy within families, communities and healthcare settings. Third, the availability and

adequacy of support from parents, partners, relatives, peers, Village Health Teams and community organisations have not been sufficiently explored in Walukuba Village. Fourth, existing studies provide limited attention to how gender norms and unequal power relations influence teenage mothers' control over resources, mobility, healthcare decisions and responsibility for pregnancy and childcare. Finally, the coping strategies used by teenage mothers in the study community to manage these barriers remain insufficiently documented.

The present study is designed to address these gaps through its five specific objectives and corresponding research questions. It explored financial challenges, social stigma and discrimination, gender norms and unequal power relations, the nature and adequacy of social support, and the coping strategies used by teenage mothers in accessing healthcare services. By focusing on the lived experiences of teenage mothers in Walukuba Village, Masese, the study contributed context-specific qualitative evidence that may inform gender-responsive, adolescent-friendly and community-based interventions aimed at improving healthcare access.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter presents the methodological approach that guided the study on the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City. It describes the research design, study area, study population, eligibility criteria, sample size and justification, sampling techniques, data collection methods and instruments, data collection procedures, trustworthiness of the study, data analysis, ethical consideration and study limitations. The methodology is designed to generate in-depth qualitative evidence that is consistent with the five specific objectives of the study.

3.1 Research Design

The study adopted a feminist phenomenological research design. This design was appropriate because the study sought to understand the lived experiences of teenage mothers in accessing healthcare services and how these experiences were shaped by gender, social and economic inequalities. Feminist phenomenology combines a focus on individuals' lived experiences with attention to the gendered power relations and social structures that influence those experiences. It therefore enabled the study to examine how financial dependence, social stigma, unequal childcare responsibilities, gender norms, partner relationships and limited decision-making power affected teenage mothers' access to healthcare services.

The feminist perspective was particularly relevant because teenage mothers occupy a socially vulnerable position in which their experiences may be influenced by age, gender, economic dependence and expectations surrounding pregnancy and motherhood. The design provided an opportunity for teenage mothers to express their experiences in their own words and placed their voices at the centre of the research process. Through in-depth interviews, the researcher explored how participants understood and experienced healthcare barriers, including dependence on family members or male partners for money, community judgement, unequal responsibility for childcare, inadequate social support and interactions with healthcare providers. This approach made it possible to understand not only the barriers participants encountered but also how unequal gender and power relations shaped their ability to respond to those barriers.

The phenomenological component enabled the researcher to identify common meanings, similarities and differences across the participants' lived experiences, while the feminist perspective supported a critical examination of the social and gender inequalities underlying those experiences. The design was therefore consistent with the study objectives, which focused on financial challenges, stigma and discrimination, gender norms and unequal power relations, social support and coping strategies. Although the findings were not intended to be statistically generalised to all teenage mothers in Uganda, the design generated detailed, context-specific insights into the experiences of teenage mothers in Walukuba Village and provided evidence that may inform gender-responsive and adolescent-friendly healthcare interventions.

3.2 Study Area

The study was conducted in Walukuba Village, located within the Walukuba–Masese area of Jinja City in Eastern Uganda, and is about 101 kilometers (63 miles) from Kampala Capital City. The area is an urban community characterised by low-income households, limited economic opportunities and varied access to public and private healthcare services. Teenage mothers in the area may seek antenatal, delivery, postnatal and general healthcare services depending on the availability of transport, affordability of care, support from family members or partners and their previous experiences with healthcare providers.

Walukuba Village was selected because it presents social and economic conditions that are relevant to the study. The area is associated with poverty, early school dropout and limited economic power among young girls, factors that may increase the vulnerability of teenage mothers. It also provides an appropriate setting for examining how transport costs, negative community attitudes, stigma, provider behaviour and inadequate social support influence access to healthcare. As a low-income urban community, Walukuba–Masese also enabled the study to generate insights into the particular experiences of teenage mothers in an urban setting, which may differ from those of teenage mothers living in rural areas.

3.3 Target Population

The target population for this study comprised teenage mothers residing in Walukuba Village, Masese, Jinja City. The study specifically focused on teenage mothers aged 13 to 19 years who were currently pregnant or had given birth within the preceding twelve months and had experience seeking, attempting to seek or accessing healthcare services during pregnancy, childbirth or the postnatal period.

Teenage mothers were selected because they were best positioned to provide first-hand accounts of the socio-economic and gender-related challenges they experienced when accessing healthcare services. Their experiences provided information on financial barriers, social stigma and discrimination, gender norms and unequal power relations, the nature and adequacy of social support available to them, and the coping strategies they used to overcome barriers to healthcare access.

3.4 Eligibility Criteria

The study included teenage mothers aged 13 to 19 years who resided in Walukuba Village, Masese, Jinja City. Eligible participants were either currently pregnant or had given birth within the preceding twelve months and had experience seeking, attempting to seek, delaying or accessing healthcare services during pregnancy, childbirth or the postnatal period. Participants were also required to be willing to participate voluntarily and provide informed consent or assent, as applicable.

Teenage mothers who did not reside in Walukuba Village, fell outside the required age range, or did not meet the pregnancy or childbirth criteria were excluded from the study. Teenage mothers who were severely ill, emotionally distressed at the time of data collection, unable to communicate effectively during the interview, or unwilling to provide informed consent or assent were also excluded.

3.5 Sample Size

The study involved a total of five teenage mothers from Walukuba Village, Masese, Jinja City. The participants were aged between 16 and 19 years and were selected because they had direct lived experience of pregnancy, motherhood and healthcare seeking. Four participants had already given birth and were caring for infants, while one participant was eight months pregnant at the time of the interview. To protect confidentiality, pseudonyms were used throughout the dissertation, and the names presented below do not represent the participants' real names.

Table 1: Characteristics of the Study Participants

Pseudonym	Age	Pregnancy/Motherhood Status	Education Level	Partner/Marital Status	Household/Family Situation	Main Livelihood
Sarah (TM01)	18	Mother of a 7-month-old baby	Left school in Senior Four after becoming pregnant	Not living with the baby's father	Lived with her mother, two younger siblings and her baby	Occasionally assisted her mother in selling tomatoes and onions
Amina (TM02)	17	Eight months pregnant with her first child	Left school in Senior Three	Not living with the baby's father; the father initially accepted the pregnancy but later questioned paternity and reduced support	Lived with her grandmother and younger cousin	No regular employment; occasionally earned money from washing clothes
Nabirye (TM08)	17	Mother of a 5-month-old baby	Left school in Senior Three	Not living with the baby's father; the father denied responsibility and provided no regular support	Lived with her maternal grandmother, cousins and her baby	Unemployed, with occasional domestic work and small food-preparation activities
Mariam (TM04)	16	Mother of a 10-month-old baby	Left school in Senior Two	Separated from the baby's father	Lived with her maternal aunt, the aunt's husband, cousins and her baby	Assisted her aunt in selling chapati and tea
Shakira (TM06)	19	Mother of an 8-month-old baby	Left school in Senior Four	Not cohabiting with the baby's father and described the relationship as unstable	Lived with her older sister and her baby	Sold second-hand clothes and small household items

The characteristics demonstrate important differences in the participants' circumstances. Mariam was the youngest participant at 16 years, while Shakira was the oldest at 19 years. Amina differed from the other participants because she was still pregnant, whereas the remaining four were already caring for infants. Educational attainment also varied, with participants having left school between Senior Two and Senior Four. Their family arrangements differed considerably: some depended mainly on mothers or grandmothers, while others lived with an aunt or older sister. Partner involvement was also inconsistent, ranging from separation and denial of responsibility to unstable and irregular support. Economic circumstances varied from having virtually no independent income to undertaking occasional informal work, with Shakira having comparatively greater personal income through her small

business. These differences enabled the study to capture a range of lived experiences relating to financial dependence, social support, gender relations and healthcare access.

The sample size was considered appropriate for a feminist phenomenological study because the purpose was to obtain rich and detailed accounts of teenage mothers' lived experiences rather than to produce statistically generalisable findings. The five in-depth interviews generated recurring and contrasting experiences related to financial challenges, social stigma and discrimination, gender norms and unequal power relations, social support and coping strategies. The variation in age, educational background, motherhood status, household arrangement, partner involvement and livelihood circumstances strengthened the study by allowing similarities and differences in participants' experiences to be examined in depth.

3.6 Sampling Techniques

The study used purposive sampling to select teenage mothers who had direct experience of the study problem. Participants were selected based on the established eligibility criteria, including being aged between 13 and 19 years, residing in Walukuba Village, and having experience seeking, attempting to seek or accessing healthcare services during pregnancy, childbirth or the postnatal period. Willingness to participate and share personal experiences was also considered during participant selection.

Purposive sampling was appropriate because it enabled the researcher to identify participants who could provide rich and relevant information on the socio-economic and gender-related challenges affecting healthcare access. The selected teenage mothers were therefore able to provide first-hand accounts of financial barriers, social stigma and discrimination, gender norms and unequal power relations, social support systems and the coping strategies they used when seeking healthcare services.

3.7 Data Collection Methods

The study used in-depth interviews as the main data collection method. In-depth interviews were conducted with the five teenage mothers to obtain detailed accounts of their experiences in accessing healthcare services. This method was appropriate because it allowed participants to describe their experiences freely and enabled the researcher to explore sensitive issues in greater depth.

The interviews focused on the main study themes, including financial barriers, social stigma and discrimination, gender norms and unequal power relations, the nature and adequacy of social support, and the coping strategies used by teenage mothers when seeking healthcare services. Probing questions were used where necessary to obtain clarification and richer descriptions of participants' experiences. The use of in-depth interviews therefore generated detailed first-hand information that directly addressed the objectives of the study.

3.8 Data Collection Instruments

The main data collection instrument used in the study was an in-depth interview guide for teenage mothers. The guide contained flexible, open-ended questions organised according to the five specific objectives of the study. It was designed to obtain detailed information on the financial challenges experienced by teenage mothers, social stigma and discrimination, gender norms and unequal power relations, the nature and adequacy of social support, and the coping strategies used when accessing healthcare services. The interview guide was aligned with the study objectives and conceptual framework and allowed the researcher to use probing questions where necessary to obtain clarification and deeper explanations from participants. The instrument was also designed to encourage teenage mothers to describe their experiences freely in their own words.

3.9 Data Collection Procedure

Before data collection commenced, the researcher sought permission from the Local Council One (LC1) leadership of Walukuba Village to conduct the study within the community. With the support of the LC1 leadership, eligible teenage mothers residing in Walukuba Village were identified and approached. Participants who met the inclusion criteria were informed about the purpose of the study and invited to participate voluntarily. The researcher explained the study procedures, confidentiality measures and participants' right to withdraw from the study at any time without any consequences. Interviews were scheduled at times and places that were convenient, private and safe for the participants.

In-depth interviews were conducted with the five teenage mothers using the interview guide. With the participants' permission, interviews were audio-recorded to ensure accurate capture of their responses, while notes were also taken to record relevant information arising during the interviews. The researcher used appropriate probing questions to obtain clarification and encourage participants to provide detailed descriptions of their experiences while maintaining a respectful and non-judgmental approach throughout the interviews.

After each interview, the researcher reviewed the notes and audio recordings to ensure completeness and accuracy. The recorded interviews were transcribed verbatim, and responses given in Luganda or another local language were translated into English while maintaining the original meaning of the participants' accounts. The completed transcripts were then organised and prepared for thematic analysis in accordance with the objectives of the study.

3.10 Validity and Reliability of Instruments

To ensure the trustworthiness of the study, the researcher applied measures that enhance credibility, dependability, confirmability and transferability of the findings. The data collection instruments were developed in line with the study objectives, research questions, literature review and conceptual framework, and were reviewed by the academic supervisor to ensure that they adequately address the areas under investigation. The interview guides were also be pre-tested with participants who have characteristics similar to those of the study participants but who were not be included in the final study. Feedback from the pre-test was used to revise unclear, repetitive, sensitive or leading questions before the main data collection begins.

Credibility was enhanced through careful probing during interviews, audio recording with participants' consent, accurate transcription and triangulation of information obtained from teenage mothers, healthcare providers, local leaders and non-participant observations. Dependability was promoted through consistent use of the interview guides and clear documentation of the data collection and analysis procedures. Confirmability was strengthened by ensuring that the findings are based on participants' accounts rather than the researcher's personal views, while transferability was supported through a clear description of the study setting, participants and research procedures.

3.11 Data management and Analysis

All audio recordings, interview notes and observation records were be labelled using identification codes rather than participants' names. Audio recordings were transcribed verbatim using Microsoft Word, while interviews conducted in Luganda or another local language was translated into English without altering the original meaning. Participant information and interview records were organised using Microsoft Excel, and all electronic files were stored in password-protected folders accessible only to the researcher.

The qualitative data was analysed using thematic analysis with the support of NVivo software. The researcher imported interview transcripts and observation notes into NVivo, read them

repeatedly, identify meaningful statements and assign codes to relevant information. Similar codes were then be grouped into categories and broader themes based on the study objectives, including financial barriers, social stigma and discrimination, gender norms and unequal power relations, social support and coping mechanisms.

Information obtained from teenage mothers, healthcare providers, local leaders and observation records was compared to identify similarities and differences across the data sources. Relevant participants' statements were presented as direct quotations to support the identified themes while maintaining confidentiality. The findings were then interpreted in relation to the research questions, conceptual framework and reviewed literature.

3.12 Ethical Considerations

The study observed the ethical principles of voluntary participation, informed consent, confidentiality, privacy, non-maleficence and respect for participants. Before data collection, the researcher was obtained an introductory letter from the Makerere University School of Social Sciences and present it to the relevant local authorities in Walukuba Village to seek permission to conduct the study. Participants were informed about the purpose of the study, the nature of their participation, the expected duration of the interviews, possible risks and benefits, and their right to withdraw from the study at any time without penalty.

Because the study involved teenage mothers, including participants below 18 years of age, additional safeguards were applied. Assent was obtained from teenage mothers who are minors, while permission was sought from a parent, guardian or legally authorised representative where applicable. Participants were not be forced to answer questions that make them uncomfortable and may pause or end the interview at any time. Interviews were conducted in private and safe settings to minimise the risk of embarrassment, stigma or unwanted disclosure.

Participants' names were not be recorded on interview guides, transcripts or observation forms. Identification codes were instead be used to protect their identities, and any information that could reveal a participant's identity was removed from the final report. Audio recordings, transcripts and field notes were securely stored in password-protected files and used only for academic purposes. Any participant who became emotionally distressed during an interview were allowed to stop, and where necessary, the researcher provided information on available counselling, healthcare or community support services.

3.13 Limitations of the Study

The study was limited by the sensitive nature of teenage pregnancy and healthcare experiences, which may make some participants reluctant to openly discuss issues such as stigma, financial hardship, partner support, gender relations and negative experiences with healthcare providers. Some healthcare providers and local leaders may also be cautious when discussing institutional weaknesses, provider attitudes or community practices. In addition, because the study involved a relatively small purposively selected sample from Walukuba Village, the findings may not be generalisable to all teenage mothers in Jinja City or Uganda.

To minimise these limitations, the researcher assured participants of confidentiality and anonymity, conduct interviews in private and safe settings, and use respectful and non-judgmental language during data collection. Participants were encouraged to share their experiences freely without pressure, while triangulation of information obtained from teenage mothers, healthcare providers, local leaders and non-participant observations were used to strengthen the credibility of the findings. Detailed description of the study setting and participants were also provided to enable readers to assess the relevance of the findings to similar contexts.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the integrated findings and their discussion. The results are drawn from in-depth interviews with five teenage mothers aged 16 to 19 years, including four mothers with infants and one participant who was eight months pregnant. The participants had varied educational, livelihood and household circumstances, but all had experienced disruption to education and varying levels of dependence on family members or partners for financial and social support. The findings are presented thematically in line with the study objectives. Each subsection presents a key finding, explains its significance, provides supporting evidence from participants, interprets the finding in relation to the study's theoretical perspective, links it to relevant literature, and discusses its implications for teenage mothers' access to healthcare services.

4.2 Financial Challenges

Financial challenges emerged as one of the most pervasive influences on teenage mothers' access to healthcare services in Walukuba Village. Although participants predominantly sought care from government health facilities because these were perceived as more affordable than private facilities, the interviews demonstrated that "free" or low-cost healthcare did not eliminate the financial burden associated with seeking care. Participants had to meet transport expenses, purchase medicines that were unavailable at health facilities, pay for some investigations and supplies, obtain food during prolonged facility visits, and prepare maternal and infant requirements such as baby clothes, soap and sanitary materials. These financial demands were particularly burdensome because the participants had either no employment or only unstable informal sources of income and therefore depended substantially on mothers, grandmothers, aunts, sisters and male partners. Financial hardship consequently influenced the timing of healthcare seeking, continuity of antenatal and postnatal visits, choice between formal facilities and drug shops, and participants' ability to act independently when they perceived a healthcare need. This pattern corresponds with evidence from Uganda and the wider Sub-Saharan African region demonstrating that financial constraints, transport costs and limited economic resources remain major enabling barriers to adolescent maternal healthcare utilisation (Nabugoomu et al., 2018; Mekonnen et al., 2019; Cumber et al., 2022; Tolossa et al., 2024; Muchemwa & Khozah, 2025).

Transport costs were particularly prominent in participants' accounts and frequently determined whether care could be sought immediately or had to be postponed Sarah, aged 18 years, explained that travelling to a healthcare facility became especially difficult when she was heavily pregnant or when she had to carry her sick child:

> *"Transport is one of the biggest problems. Sometimes I can walk, but when the baby is sick or when I was heavily pregnant, walking was difficult. A boda may ask for around three or four thousand shillings depending on where you are going, and you also need money to return."*

Her account shows that the financial burden was not necessarily generated by the clinical service itself but by the resources required to reach that service. Amina experienced the same difficulty more acutely when she developed severe abdominal pain at night while eight months pregnant. Her grandmother wanted her examined, but boda riders were charging more than usual at night, forcing the household to negotiate transport on credit with a rider known to the grandmother. Reflecting on that experience, Amina stated: *"I was relieved, but I kept thinking that if my grandmother had not known someone to transport us, I don't know what we would have done that night."*

These experiences support Cumber et al. (2022), whose qualitative study among pregnant adolescents in Uganda identified difficulty reaching health facilities and lack of financial support for transport as significant barriers. Similarly, Muchemwa and Khozah's (2025) scoping review identified both financial constraints and geographical accessibility as persistent barriers to adolescent maternal healthcare across Sub-Saharan Africa.

The significance of the transport finding is that physical proximity to healthcare services cannot be equated with effective access. A facility may geographically exist within reachable distance, but access remains constrained when a teenage mother lacks the money required to move from her household to that facility at the time care is needed. This finding is consistent with Andersen's Behavioral Model of Health Services Utilization, which distinguishes healthcare need from the enabling resources required to translate that need into actual service use. In the present study, participants were often able to recognise illness or understand that an appointment was necessary, but transport money determined whether recognition could be converted into timely healthcare utilisation. The broader literature supports this interpretation. Mekonnen et al. (2019), in a systematic scoping review of adolescent maternal healthcare utilisation in Sub-Saharan Africa, found that service use was shaped by interacting individual,

household and health-system factors rather than medical need alone, while Tolossa et al. (2024) similarly classified financial resources among the important enabling determinants of adolescent maternal-health utilisation.

The indepth-interview participants further demonstrated that seeking healthcare involved a range of indirect and out-of-pocket expenditures even when consultation itself was affordable. Mariam, aged 16 years, explained:

> *"Even when the health facility does not charge you for seeing the health worker, there are other costs. You need transport. Sometimes you need medicine from outside. Sometimes you need laboratory tests or supplies. Even food can become a problem because you may leave home early and stay at the health facility until afternoon."*

During pregnancy, her aunt had to purchase delivery requirements gradually because the household could not afford all the required items at once. Amina similarly described being instructed to obtain medicines outside the government facility and needing money for food during lengthy antenatal visits. Her grandmother sometimes ensured that she ate before leaving home because they could not afford to purchase food during the visit. These accounts indicate that financial access should not be measured solely through formal user fees. For economically vulnerable teenage mothers, relatively small expenses for transport, medicines, investigations, food and supplies accumulate and may become sufficiently large to disrupt care. Nabugoomu et al. (2018), in nearby Budondo Sub-county in Jinja District, similarly identified pregnancy and childcare costs, inadequate access to medicines, lack of income-generating skills and insufficient resources as important barriers confronting adolescent mothers. Mizero et al. (2024) also found that teenage mothers in Rwanda experienced substantial financial difficulty accessing healthcare despite many medical services being covered by community-based health insurance, demonstrating that formal coverage does not necessarily remove the wider economic burden of healthcare access.

Financial vulnerability was intensified by the participants' lack of independent and reliable income. Most depended on other household members to meet healthcare expenses, meaning that the ability to seek care was frequently linked to another person's willingness and capacity to provide money. Nabirye, aged 17 years, captured the emotional and practical consequences of this dependence when she stated:

> *"It makes you feel powerless. You can know that something is wrong, but if you do not have money, you cannot just decide to go. Sometimes I feel ashamed asking my grandmother because she is old and she is already looking after me and the baby."*

She further reported sometimes remaining silent about her own health problems because she did not want to create an additional expense for the household. Sarah, aged 18 years, expressed the same constraint more directly:

> "*It makes you feel like the decision is not completely yours. You can know that you need to go, but you first have to ask somebody. Sometimes they ask, 'Is it really serious?' or 'Can't you wait until tomorrow?' If it was my own money, I would just go*."

These accounts show that economic dependence was not simply a shortage of cash; it also reduced participants' autonomy by placing the implementation of healthcare decisions partly in the hands of people who controlled financial resources.

The relationship between economic dependence and healthcare autonomy is consistent with the Social Determinants of Health Framework, which argues that income, education, employment, gender and social position produce unequal distributions of resources, opportunities and power. In this perspective, the financial difficulties reported by the participants should not be reduced to individual inability to budget or earn money, but understood within the structural conditions surrounding teenage motherhood. Pregnancy had interrupted education, childcare constrained employment, and limited employment in turn maintained dependence on relatives and partners. Solar and Irwin (2010) argue that socioeconomic position shapes individuals' exposure to health risks and their access to resources necessary for protecting health, while the WHO Commission on Social Determinants of Health (2008) similarly emphasises that health inequalities are produced through unequal social and economic conditions. These theoretical propositions are strongly reflected in the present findings, where young age, interrupted schooling, insecure livelihoods and dependency converged to limit participants' practical freedom to seek healthcare. The finding is also consistent with Farih et al. (2026), whose analysis of more than 108,000 women across eight East African settings found financial barriers to healthcare to be disproportionately concentrated among economically disadvantaged and less-educated women.

The experience of Shakira provides an important contrast that further demonstrates the

relationship between personal income and healthcare autonomy. Unlike some participants who had virtually no personal income, Shakira sold second-hand clothes and small household items. When her baby developed fever, cough and difficulty breathing, the father advised her to wait until morning because he did not have money. However, Shakira had seven thousand shillings from a previous sale and was therefore able to act: *"I had about seven thousand shillings from selling a dress two days before, but I had planned to use that money to buy more stock. I used it for transport instead."* She later explained: *"That is why I try to keep some of my own money. Even if it is small, it gives me some independence."*

Shakira's experience suggests that personally controlled resources can strengthen healthcare decision-making because they reduce the need to wait for another person to recognise or finance a healthcare need. However, this independence was fragile: using money intended for business stock reduced her ability to reinvest, while expenditure on food, diapers and healthcare continually competed with business growth. Her experience therefore reveals a tension between immediate health protection and longer-term economic security.

This pattern demonstrates what may be described as a cycle of health-related economic vulnerability. Small-scale livelihood activities can create greater autonomy, yet unexpected healthcare expenditure can deplete the very resources that make future autonomy possible. Similar observations have been made elsewhere. Mizero et al. (2024) found that financial hardship remained a major challenge among teenage mothers even where some healthcare costs were formally covered, while Alanyo et al. (2025), in a qualitative study of teenage mothers in western Uganda, documented insufficient material support and called for economic support as part of broader interventions for teenage mothers. Nabugoomu et al. (2018) similarly identified home-based income-generating activities, employment opportunities and return to education as important needs of adolescent mothers in eastern Uganda. Together, these studies reinforce the interpretation that livelihood strengthening is not separate from healthcare access; rather, economic resources determine whether young mothers have the practical capacity to obtain healthcare when the need arises.

One of the most consequential effects of financial hardship was delayed, missed or modified healthcare seeking.

Nabirye, aged 17 years, reported:

> *"During pregnancy, I missed two antenatal appointments. One time we had no transport money. Another time my grandmother said she had to choose between buying food and giving me money to go for antenatal care. Because I was not feeling sick, I stayed home."*

The importance of this account lies in the nature of the trade-off being made. The household was not choosing healthcare over a discretionary expense; it was choosing between antenatal attendance and food. Sarah similarly missed an antenatal appointment and eventually attended almost two weeks later because her mother lacked money and the baby's father had stopped responding to her calls. Shakira also delayed a postnatal review because the baby appeared well and the available money was needed for food. These experiences are consistent with Tolossa et al. (2024), whose systematic review and meta-analysis concluded that adolescent maternal-health utilisation across Sub-Saharan Africa remains suboptimal and is affected by multiple enabling and contextual barriers. Mekonnen et al. (2019) similarly concluded that improving adolescent maternity-care utilisation requires interventions at individual, partner, community, provider and organisational levels rather than interventions that focus on adolescents alone.

Financial constraints also altered where participants initially sought healthcare. For illnesses perceived to be minor, several participants described using nearby drug shops because they appeared easier and cheaper than travelling directly to a health facility. Mariam explained: *"Sometimes you delay because you are trying to see if the problem can improve without spending much money. But that can also make you worried because you do not know whether waiting is making the problem worse."* Sarah and Nabirye described similar experiences in which drug shops were used before formal care, particularly where money for transportation was unavailable. This finding suggests that financial hardship affects not only utilisation but also the sequencing of healthcare: participants may first employ less costly or more accessible alternatives and move to formal healthcare only if symptoms persist or worsen. The 2025 scoping review by Muchemwa and Khozah likewise concluded that financial constraints interact with other access barriers to shape adolescent maternal service utilisation, while Cumber et al. (2022) observed that Ugandan adolescents require interventions that address both the health service environment and the social and economic circumstances affecting their ability to reach services.

The participants' narratives also challenge the tendency to interpret delayed attendance as evidence that teenage mothers are irresponsible or unconcerned about their health and that of

their children. Sarah explained this distinction clearly: *"Sometimes people think if you miss antenatal care or delay going to hospital, you are careless. But sometimes you know you need to go and you simply don't have transport money or somebody you depend on has refused to help."* This statement is analytically important because it separates motivation from capability. Participants frequently recognised that healthcare was needed, but structural and household economic constraints limited their capacity to act. The Social Determinants of Health perspective is particularly useful here because it shifts explanation away from blaming individual behaviour and towards understanding how socioeconomic position structures available choices. This distinction is also supported by recent systematic evidence showing that low adolescent utilisation of maternal services in Sub-Saharan Africa is produced by intersecting economic, social, geographical and health-system barriers rather than a simple lack of demand for healthcare (Tolossa et al., 2024; Muchemwa & Khozah, 2025).

Education and livelihood disruption further reinforced this financial vulnerability. Pregnancy had interrupted the education of all five participants, and none had stable formal employment. Nabirye, aged 17 years, explained:

> *"Because I have no education certificate and no skill, finding work is also difficult. Even if I got a job, I would need someone to remain with the baby. So pregnancy removed me from school, and motherhood is also making it difficult for me to start earning money. That is why I am still depending on other people for almost everything."*

Mariam similarly wanted to return to school or learn hairdressing or tailoring but faced the combined challenges of school fees, childcare and dependence on her aunt. Shakira's small business was constrained by the need to stay near her baby and by repeatedly diverting business capital to food, childcare and healthcare. These findings closely mirror Nabugoomu et al. (2018), who identified lack of academic qualifications, inadequate income-generating skills, employment needs and difficulty returning to school among adolescent mothers in eastern Uganda. More recent qualitative evidence from western Uganda similarly describes teenage motherhood as being accompanied by insufficient material support and disrupted future opportunities (Alanyo et al., 2025).

Taken together, the findings suggest a self-reinforcing pathway in which teenage pregnancy contributes to school interruption; reduced educational attainment limits access to stable

employment; limited employment produces low and insecure income; low income increases dependence on relatives and male partners; and dependence restricts timely and autonomous healthcare seeking. This relationship is consistent with Farih et al. (2026), who found that financial barriers to healthcare in East Africa were strongly patterned by socioeconomic disadvantage and educational attainment, and with Nabugoomu et al. (2018), who demonstrated the interrelationship between education, income-generating capacity and maternal-child health among teenage mothers in eastern Uganda. The same broader pattern is evident in Mizero et al. (2024), where teenage mothers' financial difficulties persisted alongside dependence on others, while Alanyo et al. (2025) documented insufficient material support among teenage mothers in western Uganda.

Overall, financial challenges among teenage mothers in Walukuba Village were therefore broader than an inability to pay medical fees. They consisted of interconnected constraints involving transport, medicines, investigations, delivery and childcare supplies, food, unstable or absent income, dependence on relatives and partners, school interruption, childcare responsibilities and depletion of small livelihood resources. These conditions shaped whether participants could act on healthcare needs immediately, maintain recommended appointments, purchase required medicines and exercise meaningful control over healthcare decisions. The findings substantially reinforce existing research from Uganda and Sub-Saharan Africa showing that adolescent maternal healthcare utilisation is shaped by financial and structural inequalities rather than availability of services alone (Nabugoomu et al., 2018; Mekonnen et al., 2019; Cumber et al., 2022; Tolossa et al., 2024; Mizero et al., 2024; Muchemwa & Khozah, 2025; Alanyo et al., 2025; Farih et al., 2026).

The findings have important practical implications. Improving healthcare access for teenage mothers requires interventions that address the broader economic conditions surrounding care rather than focusing exclusively on reducing formal facility fees. Transport assistance for vulnerable teenage mothers, consistent availability of essential medicines and maternal supplies, strengthened VHT referral mechanisms, linkage to social-protection programmes, vocational training, childcare support and opportunities for school re-entry could reduce economic dependence and strengthen healthcare autonomy. Small-business and livelihood interventions may also be valuable, but the experiences of participants such as Shakira demonstrate that livelihood support should be sufficiently sustained to withstand health-related shocks rather than simply providing very small income-generating activities. Such an

integrated approach is consistent with the conclusion of Nabugoomu et al. (2018) that adolescent-mother-and-child-friendly environments must address wider socioeconomic barriers, and with contemporary regional reviews calling for context-specific, multi-level responses to adolescent maternal healthcare access (Tolossa et al., 2024; Muchemwa & Khozah, 2025).

4.2 Social Stigma and Discrimination

Social stigma and discrimination emerged as another major influence on teenage mothers' healthcare-seeking experiences in Walukuba Village. Participants described stigma occurring at several interconnected levels: within families, among peers and former schoolmates, in the wider community, and within healthcare settings. Teenage pregnancy was frequently interpreted by others as evidence that a girl was stubborn, irresponsible, sexually undisciplined or had failed to listen to her parents. These judgments were not merely unpleasant social experiences; they shaped how participants viewed themselves, whether they disclosed their pregnancies, when they initiated antenatal care, how comfortably they communicated with healthcare providers and whether they felt able to challenge disrespectful treatment. Sarah, aged 18 years, described how community judgement affected her after becoming pregnant:

> *"Some people say girls who become pregnant young are stubborn or that they didn't listen to their parents. When I first became pregnant, some neighbours would look at me and start talking quietly. Sometimes you know they are talking about you even if you cannot hear everything. The negative comments can make you want to stay inside."*

Sarah's account demonstrates how negative community labelling created feelings of embarrassment and social withdrawal, illustrating how stigma could influence both teenage mothers' emotional wellbeing and their willingness to engage openly with people and services within the community.

The findings therefore demonstrate that stigma operated both as a social burden and as a practical barrier to healthcare access. This corresponds with Goffman's (1963) conceptualisation of stigma as a process through which an attribute becomes socially discrediting and reduces an individual's social standing. Link and Phelan (2001) further conceptualise stigma as involving labelling, stereotyping, separation, status loss and discrimination within conditions of unequal power. These theoretical ideas are particularly

relevant to teenage mothers because their age and pregnancy status expose them to moral judgement while simultaneously limiting their social power to resist that judgement.

At community level, participants commonly described being labelled as stubborn, badly behaved or responsible for destroying their own futures. Sarah, aged 18 years, explained:

> *"Some people say girls who become pregnant young are stubborn or that they didn't listen to their parents. When I first became pregnant, some neighbours would look at me and start talking quietly. Sometimes you know they are talking about you even if you cannot hear everything."*

She further explained that while some older women encouraged her, *"the negative comments can make you want to stay inside."* Mariam reported a similar experience, noting that teenage mothers were often assumed to have become pregnant because they were "badly behaved" or "moving with boys," even when community members did not know the circumstances surrounding the pregnancy. She recalled people near her home making remarks such as *"These girls of today start early,"* which she understood as being directed towards her. Shakira likewise observed that some community members described teenage mothers as stubborn and believed that pregnancy had "destroyed" the girl's future.

These findings illustrate what Goffman (1963) describes as a "spoiled identity," where a socially disapproved characteristic becomes the dominant lens through which an individual is viewed. The participants were no longer simply daughters, students or young women; pregnancy became a defining identity around which community judgement was organised. Link and Phelan's (2001) framework further helps explain how labels such as "stubborn," "careless" and "badly behaved" become stereotypes that justify social distancing and status loss. Recent evidence from eastern Uganda strongly supports this interpretation. Sakakibara et al. (2024), studying pregnant and recently delivered adolescents in rural eastern Uganda, found that pregnancy-related stigma was driven by social and gender norms and manifested through negative judgement, reduced social support and abuse, with consequences for psychosocial well-being and educational opportunities. Webb et al. (2023) similarly documented stigma, shame, family rejection and social exclusion among unmarried teenage mothers in rural Uganda, while Chemutai et al. (2020) found that adolescent mothers in eastern Uganda were often negatively treated by family and community members.

Family reactions were particularly influential because the household was ordinarily the participant's main source of financial, emotional and practical support. Several participants described anger and disappointment from parents or relatives when the pregnancy was disclosed. Sarah recalled: *"When my mother first found out, she was very angry. For some days she hardly talked to me normally. She kept asking me why I had wasted her money for school."* Nabirye similarly reported that her mother told her she had disappointed the family and that some relatives said she had brought shame to them. Her situation was further complicated when the father of her child denied responsibility, resulting in other people questioning whether she knew who the father was. She explained: *"I felt like I had to prove myself to people."* Shakira was also told by her mother that she had disappointed her after the family had struggled to keep her in school, while one aunt told her that she had "chosen to suffer."

The family responses reported in this study demonstrate that stigma can have particularly serious consequences when it originates within the same social networks on which teenage mothers depend for survival and healthcare access. Family disappointment may initially be expressed as anger or moral correction, but for a financially dependent adolescent, rejection can also threaten accommodation, food, childcare and money required for healthcare. Similar patterns have been documented elsewhere in Uganda. Webb et al. (2023) found that unmarried teenage mothers experienced intense family rejection and social exclusion, contributing to substantial psychosocial distress. Alanyo et al. (2025), studying teenage mothers in western Uganda, found teenage pregnancy to be associated with attempts to conceal pregnancy, strained family and partner relationships, social isolation and insufficient psychosocial support. Sakakibara et al. (2024) likewise identified withdrawal of social support as a manifestation of pregnancy-related stigma among adolescents in eastern Uganda. These findings suggest that stigma cannot be separated from the material conditions of healthcare access because the people capable of stigmatising a teenage mother may simultaneously control the support she requires to obtain healthcare.

School and peer relationships represented another important arena of stigma. Several participants described embarrassment, whispering, reduced contact with friends and fear of being seen by former classmates. Sarah recalled that a close school friend told another person that she had *"finished myself,"* after which she began avoiding places where she expected to meet former classmates. Nabirye reported: *"At school, I also felt ashamed. Some girls started laughing and whispering when they noticed my body changing. That is when I stopped going."*

Shakira similarly explained that some students stared and whispered about her pregnancy and that several friends stopped communicating with her after she became pregnant. These accounts indicate that educational disruption was not caused exclusively by pregnancy-related physical changes or financial constraints; the social environment of school also became increasingly difficult to navigate once pregnancy became visible.

This finding reinforces evidence that adolescent pregnancy stigma can contribute to educational exclusion and loss of future opportunities. Sakakibara et al. (2024) found that pregnancy-related stigma among Ugandan adolescents restricted access to educational and socioeconomic opportunities, while Webb et al. (2023) described teenage mothers' loss of schooling and career aspirations as a significant source of psychosocial distress. Alanyo et al. (2025) similarly documented concealment, isolation and disrupted aspirations among teenage mothers in western Uganda. Thus, stigma may indirectly intensify other healthcare barriers: withdrawal from school reduces educational attainment, lower educational attainment constrains livelihood opportunities, and reduced earning capacity reinforces financial dependence. Social stigma therefore operates within a wider cycle of socioeconomic vulnerability rather than as a purely psychological experience.

One of the clearest healthcare consequences of stigma was concealment of pregnancy and delayed initiation of antenatal care. Sarah explicitly connected fear of social judgement to late ANC attendance: *"That is one reason I delayed starting antenatal care. I was afraid of meeting people who knew me and being seen sitting with pregnant women. I used to wear loose clothes."* Nabirye similarly stated: *"I delayed antenatal care partly because I did not want people to see me. I also feared health workers asking about the baby's father because by then he had already started denying the pregnancy. I did not want to explain that story to strangers."* Shakira also delayed antenatal attendance because she did not want people to see her at the clinic and feared healthcare workers asking about her age.

The consistency of this finding across participants is important because it demonstrates a direct pathway between stigma and healthcare utilisation: anticipated judgement encouraged concealment; concealment delayed disclosure; and delayed disclosure contributed to late ANC initiation. This closely mirrors the findings of Achieng et al. (2025) among pregnant adolescents living in a Nairobi informal settlement. Their study found that internalised and interpersonal stigma pushed adolescent girls into secrecy and contributed to delayed ANC initiation and fragmented engagement with maternal healthcare. Some participants deliberately

attempted not to be seen attending clinics because they feared judgement associated with being pregnant while young and still of school-going age. Erasmus et al. (2020) similarly found in South Africa that adolescent pregnancy was constructed as deviant, irresponsible and shameful, creating fear of reactions from families, communities, schools and healthcare facilities and contributing to nondisclosure and delayed ANC. Cumber et al. (2022) likewise found discrimination and disrespect to be important barriers to maternal-health service utilisation among pregnant adolescents in Uganda.

Social Cognitive Theory provides an additional useful interpretation of this relationship. The theory emphasises reciprocal interaction among personal factors, environmental conditions and behaviour. In the present findings, community judgement constituted an environmental factor that contributed to personal feelings of shame and fear, which in turn influenced the behavioural decision to conceal pregnancy or postpone ANC. At the same time, supportive family members sometimes disrupted this process. Sarah's mother eventually told her that hiding would not protect the baby, while Nabirye's grandmother insisted that she attend healthcare despite her fear of being seen. This demonstrates the reciprocal character proposed by Social Cognitive Theory: the same social environment that can reinforce avoidance can, through supportive relationships, also strengthen health-promoting behaviour. Achieng et al. (2025) similarly found that while stigma contributed to delayed ANC, supportive parents, relatives and healthcare providers facilitated attendance by counselling and accompanying pregnant adolescents.

Stigma did not end when participants reached the healthcare facility. The interviews revealed experiences of provider judgement, particularly through comments about age, schooling, marital status and pregnancy. Sarah described one antenatal encounter in which a health worker asked her age and then remarked, *"At your age, what were you looking for?"* in front of other women. Sarah reported that some patients laughed and that she felt so embarrassed that she simply wanted the examination to end. Nabirye described a similarly painful experience after explaining that the father of her child was not supporting her. According to Nabirye, the health worker responded: *"You girls choose these men, and later you come here alone."* Nabirye explained: *"That comment really hurt me because I was already struggling with being abandoned. After that, I avoided asking her questions."*

Shakira also recalled being told during ANC, *"You young girls want to become women before your time."* The comment was made in front of other people, leaving her ashamed.

These experiences are consistent with provider stigma described in the wider literature. Cumber et al. (2022) found that pregnant adolescents in Uganda experienced discrimination, disrespect and lack of privacy within maternal-health services. Onukwugha et al. (2022), examining unmarried adolescents' reproductive and maternal-health service experiences in Uganda and Nigeria, found that adolescents could face discrimination based on age and marital status and reported impolite and judgemental treatment from service providers. Nabugoomu et al. (2018) identified harsh treatment and inadequate adolescent-tailored communication among the barriers experienced by adolescent mothers in eastern Uganda. More broadly, Muchemwa and Khozah (2025) concluded that stigma and provider attitudes remain significant barriers to maternal-health access among adolescents across Sub-Saharan Africa. These similarities suggest that the experiences reported in Walukuba are not isolated interpersonal incidents but reflect wider institutional challenges in providing adolescent-sensitive maternal healthcare.

Importantly, however, participants did not describe all healthcare providers negatively. This distinction should be maintained because the findings demonstrate substantial variation in provider behaviour. Sarah recalled a midwife during childbirth who spoke calmly to her while she was frightened and repeatedly guided her through what she needed to do. Nabirye likewise described a supportive midwife during delivery who reassured her and guided her through labour. Shakira reported both a judgmental antenatal encounter and a contrasting family-planning consultation in which the health worker respectfully explained available methods and informed her that she had a right to choose. She summarised the variation simply: *"So it depends on the person."* This variation is analytically significant because it indicates that provider behaviour can operate either as a barrier or as a facilitator. Achieng et al. (2025) similarly found that condescending provider attitudes discouraged ANC attendance, whereas respectful communication, privacy and confidentiality enabled engagement with services.

Respectful provider interactions may therefore counteract some of the stigma teenage mothers encounter in families and communities. Conversely, healthcare-based judgement can reinforce the same negative labels already experienced outside the facility. Goffman's stigma theory is particularly useful here because the healthcare encounter may either reproduce a socially discredited identity or temporarily suspend it by treating the teenage mother first as a patient deserving dignity and care. Link and Phelan's (2001) emphasis on power is equally relevant. Healthcare providers possess institutional authority, clinical knowledge and control over services, while teenage mothers may be young, economically dependent and socially

stigmatised. This power imbalance means that even comments a provider regards as advice or discipline may have a strong silencing effect. The proposal's literature similarly notes that provider stigma can operate through derogatory remarks, reduced emotional support, inadequate communication and breaches of confidentiality, with consequences for continued service utilisation.

Privacy and confidentiality were closely connected to the experience of stigma. Participants were particularly uncomfortable when questions concerning the father of the child, sexual activity or family planning could be overheard by other patients. Sarah, aged 18 years, explained:

> *"Sometimes you are asked questions where other patients are nearby. You may not want to answer properly. For example, questions about the baby's father or family planning are personal. If many people can hear, I just give a short answer. When I am inside a room with one health worker, I can explain more freely."*

Nabirye similarly reported that she felt uncomfortable discussing family planning or the father's denial of responsibility where others could hear, whereas she could speak more openly when alone with the provider. Shakira, aged 19 years, also stated:

> *"If they ask about family planning, sexual activity or the baby's father, I may not want to explain everything. When the health worker takes time to speak privately, I feel more comfortable and I give more information."*

These accounts demonstrate that privacy is not merely a question of comfort but influences the completeness of information exchanged during clinical encounters. Where teenage mothers anticipate that sensitive information may be overheard, they may shorten answers, withhold relevant information or avoid raising concerns altogether. This potentially compromises communication and the quality of care. Cumber et al. (2022) identified inadequate privacy as a significant barrier among pregnant adolescents in Uganda, while Achieng et al. (2025) found privacy and confidentiality to be important facilitators of ANC attendance in Kenya. Onukwugha et al. (2022) likewise highlighted gaps between youth-friendly policy and adolescents' actual experiences of reproductive and maternal-health services in Uganda and Nigeria. The implication is that adolescent-friendly healthcare requires not only technically

competent treatment but consultation environments in which teenage mothers can disclose information without fear of public exposure or moral judgement.

Another important manifestation of stigma was participants' tendency to remain silent when they experienced disrespect. Nabirye stated: *"Usually I remain quiet. I do not feel confident enough to argue with a health worker."* She explained that she had never formally reported mistreatment because she did not know where to report and feared meeting the same provider again. Sarah similarly explained: *"Usually I keep quiet. I have never reported a health worker. You fear that maybe next time you come, the same person will be there."* She added that she might have changed facilities after being embarrassed during ANC if another affordable option had been available. Shakira also reported that most young mothers remained silent because they feared that complaining could cause providers to treat them worse during subsequent visits.

This silence reflects the interaction between stigma and unequal institutional power. Link and Phelan (2001) argue that stigma is most consequential when those who label and stereotype possess greater social power than those being labelled. In these interviews, teenage mothers were dealing with healthcare workers whom they perceived as older, more knowledgeable and institutionally authoritative. Remaining silent therefore functioned as a strategy for protecting continued access to care, even though it left disrespectful behaviour unchallenged. Nabirye further explained elsewhere that when a health worker was harsh she sometimes said "yes" even when she did not fully understand, because she feared appearing troublesome. Such silence has potential clinical implications because a patient who does not ask for clarification may leave without fully understanding treatment, danger signs, medication or follow-up instructions.

The present findings therefore demonstrate that stigma operates through a sequence of mutually reinforcing mechanisms. Community and family judgement create shame and fear; shame contributes to concealment and social withdrawal; concealment can delay antenatal attendance; healthcare-based judgement reinforces fear and discourages questions; inadequate privacy reduces disclosure; and institutional power encourages silence rather than reporting. This pattern closely resembles findings from Sakakibara et al. (2024), who conceptualised adolescent pregnancy stigma in Uganda as a multilevel process shaped by social norms and unequal autonomy, and Achieng et al. (2025), who showed that stigma operated across intrapersonal, interpersonal and organisational levels to delay ANC in an informal urban

settlement. Erasmus et al. (2020) similarly demonstrated that defining adolescent pregnancy as irresponsible and shameful encouraged nondisclosure and avoidance of care, while Muchemwa and Khozah (2025) identified stigma as one of the persistent barriers affecting adolescent maternal-health service accessibility across Sub-Saharan Africa.

At the same time, the findings reveal important protective influences. Supportive mothers, grandmothers and other female relatives frequently encouraged participants to prioritise their own health and that of their babies despite community judgement. Kind midwives and respectful providers also gave participants confidence to continue engaging with healthcare. These positive experiences are important because they show that stigma is neither inevitable nor uniformly experienced. It can be interrupted through supportive interpersonal relationships and adolescent-responsive healthcare environments. This is consistent with Chemutai et al. (2020), who recommended continuous counselling and adolescent-focused maternal-health support in Uganda, and with Achieng et al. (2025), who found supportive parents and healthcare providers to be important facilitators of ANC use. Webb et al. (2023) further recommended community-based empowerment and sensitisation approaches to counter the social exclusion and psychosocial harm associated with unmarried teenage motherhood.

Overall, social stigma and discrimination in Walukuba Village extended beyond isolated negative comments. They constituted a broader social process through which teenage pregnancy was associated with moral failure, irresponsibility and lost future potential. These meanings affected relationships with parents, relatives, peers, former schoolmates, community members, other patients and healthcare providers. The consequences included emotional distress, social withdrawal, concealment of pregnancy, delayed ANC, reduced willingness to disclose sensitive information, fear of asking questions and silence in response to disrespect. The findings strongly correspond with Ugandan and regional studies documenting pregnancy-related stigma, family rejection, social isolation, provider judgement, inadequate privacy and delayed healthcare seeking among adolescent mothers (Chemutai et al., 2020; Cumber et al., 2022; Onukwugha et al., 2022; Webb et al., 2023; Sakakibara et al., 2024; Alanyo et al., 2025; Achieng et al., 2025; Muchemwa & Khozah, 2025).

The implications of these findings are therefore both community-based and health-system based. At community level, interventions should challenge narratives that portray teenage mothers as morally failed or undeserving, while engaging parents, peers, religious leaders, VHTs and local leaders in promoting supportive responses after pregnancy has occurred.

Family counselling may be particularly important because family acceptance can determine whether a teenage mother has the confidence and material support needed to continue healthcare. Within health facilities, adolescent-responsive training should emphasise respectful language, non-judgmental communication, confidentiality, private consultation and direct involvement of teenage mothers in discussions concerning their own care. Facilities should also establish clear and confidential feedback or complaints mechanisms that young patients can use without fearing retaliation. Such approaches would respond to the central finding that teenage mothers do not simply require healthcare services to be physically available; they require environments in which seeking those services does not expose them to additional shame, humiliation or loss of dignity.

4.3 Gender Norms and Unequal Power Relations

Gender norms and unequal power relations emerged as important influences on teenage mothers' healthcare access in Walukuba Village. Participants consistently described a social environment in which pregnancy rapidly transformed the expectations placed on a girl: she was expected to stop behaving like a child, assume responsibility for the baby, undertake domestic work, remain closer to home and become accountable for the child's health and wellbeing. At the same time, the boys or men responsible for the pregnancies were perceived to experience considerably fewer disruptions to their education, employment, movement and social lives. Unequal power was also evident in control over financial resources and healthcare decisions. Although most participants reported that nobody explicitly prohibited them from seeking healthcare, their dependence on parents, older relatives or male partners meant that the person controlling transport or treatment money could effectively determine whether care was obtained immediately, delayed or sought from a cheaper source. Gender inequality therefore operated through the unequal distribution of responsibility, resources and decision-making power rather than solely through explicit restrictions. This corresponds with the conceptual framing of the study, which identifies gender norms as socially constructed expectations concerning appropriate roles and responsibilities for women and men, and unequal power relations as differences in control over resources, decisions and opportunities.

A dominant gender norm emerging from the participants' narratives was the expectation that pregnancy immediately transformed a teenage girl into an adult caregiver regardless of her age, experience or readiness.

Sarah, aged 18 years, explained:

> *"People expect her to accept responsibility for the baby. If you become pregnant, people say you are now a woman and you should stop behaving like a child. You are expected to care for the baby, wash clothes, cook and help at home."*

Mariam, aged 16 years, described the transition as particularly abrupt because she had still understood herself primarily as a student before pregnancy:

> *"People expect you to suddenly behave like an adult. They tell you that since you have a baby, you are no longer a child. You are expected to know how to feed the baby, wash clothes, cook, stay home and behave responsibly. For me, I was still used to being a student. Suddenly everyone expected me to know how to raise a baby."*

Nabirye similarly observed that even at 16 or 17 years of age a teenage mother was expected to know how to care for her child and was blamed when the baby was dirty, sick or crying.

These accounts demonstrate how motherhood was gendered as an immediate and almost total responsibility of the girl. The expectations were not limited to providing physical care for the baby but extended to domestic labour, behavioural restrictions and social maturity. The findings align with Ninsiima et al. (2018), whose qualitative work in western Uganda found that girls were socialised towards obedience, sexual restraint and domestic responsibility, while boys were often granted greater freedom of movement and sexual expression. The findings can also be interpreted through the Social Determinants of Health Framework because gender operates as a structural determinant that influences access to resources, opportunities and power. Once pregnancy occurred, the participants experienced gender not simply as a personal identity but as a set of expectations that reorganised their education, labour, mobility and caregiving responsibilities. These changes ultimately affected their capacity to seek healthcare independently.

The inequality became particularly visible when participants compared their experiences with those of the fathers of their children. Sarah, aged 18 years, stated:

> *"The girl gets more blame. When I became pregnant, many questions were directed at me. People asked why I allowed it to happen. The baby's father continued working and going out normally. Nobody could look at him and know that he had made someone pregnant."*

She added that even when the father failed to provide, the responsibility for meeting the baby's needs remained with her and her mother. Amina expressed the same disparity more concisely: *"The girl suffers more. Everyone can see that you are pregnant. You stop school and people talk about you. For the man, he can continue his life. If he denies the pregnancy, sometimes there is nothing the girl can do."* Mariam similarly reported that while she stopped school and moved away from her mother's home, the father of her child continued "moving around normally" and did not experience comparable social consequences.

Nabirye's account demonstrates the persistence of this inequality after childbirth:

> *"The girl carries the pregnancy. Everyone sees it. She may stop school, lose friends and stay home. The man can continue working and moving around normally. In my case, he even denied responsibility, but I am the one who remained with the baby. When the baby is sick, I am the one looking for money. When the baby cries at night, I am the one awake."*

Shakira made a comparable observation, explaining that after delivery the baby remained mainly with the mother and that if the father refused financial support, the mother still had to find a way to provide food and treatment. The consistency of these narratives shows that pregnancy and parenting consequences were not distributed equally between girls and male partners. The teenage mother experienced the visible pregnancy, educational interruption, day-to-day childcare, night-time caregiving, healthcare seeking and continuing obligation to meet the child's needs, while paternal responsibility was more negotiable and, in some cases, could be withdrawn almost entirely.

This finding supports previous literature showing that gender norms shape the distribution of reproductive and caregiving responsibility. The study's literature review notes that teenage mothers may be expected to bear most physical, emotional and financial consequences of pregnancy while male partners face fewer social consequences or may deny responsibility altogether. Alanyo et al. (2026), in western Uganda, similarly found that adolescent girls' reproductive autonomy was constrained by relational and structural factors, including parental and partner control, financial dependence and limited ability to implement personal decisions. Cumber et al. (2022) further emphasised the importance of stronger male involvement in adolescent maternal healthcare in Uganda. The implication is that interventions focusing solely on educating or counselling teenage mothers risk reinforcing the same gender imbalance by

placing responsibility for successful pregnancy, childcare and healthcare utilisation almost exclusively on the girl.

The participants' household responsibilities further demonstrated how gender norms translated into practical barriers to healthcare. Sarah reported: *"If I have my baby and my mother has gone to work, I may also be responsible for preparing food for my brothers. Sometimes you postpone things because you cannot just leave. Also, when I need healthcare for myself, I first think about who will remain with the baby."* Amina explained that before attending healthcare appointments she often tried to complete cooking, cleaning and other domestic work first, which sometimes caused her to arrive later than planned. Mariam similarly described planning healthcare visits around washing, sweeping, cooking and assisting with her aunt's business, adding that seeking care for herself was especially difficult because she frequently had to carry the baby with her.

Shakira, aged 19 years, explained:

> *"I take care of the baby most of the time. I also help my sister with cooking, washing and other work at home. If I want to go to the health facility for myself, I first have to find someone to stay with the baby or carry her with me. That makes it harder to seek care for my own health."*

Nabirye reported that she sometimes delayed seeking healthcare for herself because there was nobody available to remain with the baby. These findings reveal that childcare was not merely an additional responsibility but could directly compete with the teenage mother's own healthcare needs. The same young women who were expected to recognise illness and ensure their babies received treatment were also required to arrange childcare before obtaining treatment for themselves. This creates the possibility that maternal health needs become secondary to the needs of the infant and household.

The gendered allocation of unpaid care work observed in this study reflects a broader pattern in which women and girls carry disproportionate responsibility for domestic labour and caregiving. Within the present context, this burden is intensified by participants' young age and lack of alternative childcare arrangements. Teshale et al. (2025), in a systematic qualitative synthesis covering 81 studies and 4,816 participants from East Africa, found that maternal healthcare access was shaped by interconnected interpersonal barriers, including limited family support, communication challenges and lack of decision-making autonomy, alongside

community-level gender disparities. The current findings add an important teenage-mother perspective to this evidence: care responsibilities do not simply consume time but can determine whether the mother herself attends healthcare, arrives on time or postpones treatment altogether.

Unequal power relations were also evident in healthcare decision-making. The findings did not suggest that teenage mothers were entirely excluded from decisions. In fact, participants frequently identified health problems first because they spent the most time with their babies. However, recognising that care was required did not necessarily mean having the power to implement the decision. Shakira explained: *"Mostly I make the first decision because I am the one with the baby. I can see when she is sick. But money affects the final decision. If I need transport or medicine and I have no money, then I have to involve my sister or the baby's father."* Mariam similarly stated: *"I also make decisions myself, especially if I feel something is wrong with the baby. But because I depend on my aunt financially, I cannot completely separate the decision from her."* Nabirye described her grandmother as having considerable influence because she controlled financial resources and had greater experience; if the grandmother advised waiting because money was unavailable, Nabirye sometimes had little alternative.

This distinction between identifying a healthcare need and having the resources to act on it is central to understanding power in the present study. Power did not always take the form of explicit permission or prohibition. Rather, it operated through control over enabling resources. Nabirye captured this directly when she stated: *"So even without someone saying, 'You cannot go,' lack of control over money can still prevent you from going when you want."* Mariam reached the same conclusion after the father of her baby advised her to wait until morning rather than use a private clinic for a feverish child: *"So sometimes someone does not have to say, 'You are not allowed to go.' If they control the money, their decision can still affect what you do."* These are particularly important findings because they show that measuring autonomy only by asking who "makes the decision" may underestimate the power of resource control. A teenage mother may nominally make the decision but remain unable to implement it.

This interpretation is supported by wider evidence on healthcare decision-making autonomy. Aragaw et al. (2023), analysing 24,135 young women aged 15–24 years across 11 East African countries, found that almost one-third lacked autonomy in healthcare decision-making. Education, employment, household wealth and age were significantly associated with greater

autonomy, with younger, poorer and unemployed women particularly disadvantaged. Gebeyehu et al. (2022), in a systematic review and meta-analysis of more than 100,000 women in low- and middle-income countries, likewise found that education and income were positively associated with maternal-health decision-making autonomy. Chol et al. (2019) found across 31 Sub-Saharan African countries that women's participation in household financial decisions was associated, although variably across countries, with maternal healthcare utilisation. These studies reinforce the conclusion that economic resources and decision-making authority are closely intertwined, particularly for young women.

Male-partner support also revealed important dimensions of power and instability. Although the fathers were not always directly involved in household healthcare decisions, their willingness to provide money could influence whether and when healthcare was obtained. Sarah reported that nobody had explicitly prevented her from seeking healthcare, but when the father delayed or refused to send money, healthcare was indirectly delayed. On one occasion, he advised waiting until morning rather than attending a more expensive private clinic, and because Sarah lacked her own money, she had to wait. Shakira described an even clearer connection between relationship dynamics and healthcare resources: *"When we are getting along, he helps more. When we quarrel, support reduces. That is one of the things I dislike because support for the baby should not depend on our relationship."* She also reported that he sometimes attempted to influence which healthcare facility she used because he considered some facilities too expensive.

Amina's experience involved more complete withdrawal: the father had largely stopped supporting her and had even told her that attending antenatal care repeatedly was a waste of money because women had historically delivered without many visits. Nabirye's partner denied responsibility for the child and sometimes questioned paternity when she requested assistance, while Mariam described the father as unreliable and felt that she carried the emotional burden of caring for the sick baby largely alone. These accounts demonstrate a gendered asymmetry in which paternal support could be conditional, delayed or withdrawn while maternal responsibility remained continuous. The baby's illness could not be postponed because of relationship conflict, yet access to money sometimes depended on precisely those relationship dynamics.

Alanyo et al. (2026) similarly found that parental and partner control, financial dependence and limited self-efficacy constrained adolescent girls' reproductive autonomy in western Uganda

and recommended household economic empowerment, parenting support and continued access to education. Matovu et al. (2025), studying more than 2,000 adolescent girls and young women in Uganda, also demonstrated limitations in reproductive decision-making autonomy: among current contraceptive users, only a minority reported making contraceptive decisions independently. Although contraceptive decision-making differs from decisions about treatment for a sick child, both findings highlight the broader challenge adolescent girls face in translating personal preferences into autonomous reproductive and healthcare choices.

Power relations were also evident within healthcare settings. Participants frequently described themselves as less confident when communicating with older health workers, particularly when providers appeared impatient, harsh or judgmental. Nabirye stated: *"Sometimes I just say yes even when I do not fully understand because I do not want them to think I am disturbing them. I think being young makes it harder because you feel that older people know more and you should just listen."*

Mariam similarly explained that when a provider appeared annoyed she feared asking too many questions and sometimes left without fully understanding the information provided, later asking her aunt for clarification. Amina reported becoming quiet when health workers were impatient, while Shakira explained that she had become more confident after childbirth but still spoke more openly only when the provider was respectful.

This demonstrates that unequal power in healthcare is not limited to household relations. Healthcare providers possess institutional authority, medical knowledge and control over clinical information, while teenage mothers occupy a relatively low-power position because of age, limited education and the stigma associated with adolescent pregnancy. The study's literature review similarly argues that these power differences can discourage young mothers from questioning providers, seeking clarification or reporting mistreatment. Teshale et al. (2025) identified lack of decision-making autonomy and poor provider-client interactions among the multilevel barriers affecting maternal healthcare in East Africa. The implication is that adolescent-friendly healthcare should not merely provide services to teenage mothers but actively create opportunities for them to speak, ask questions and participate in decisions concerning their own bodies and their children.

Taken together, the findings demonstrate that gender norms and unequal power relations shaped healthcare access through several mutually reinforcing pathways. Teenage mothers were expected to assume immediate adult responsibility for pregnancy and childcare, while

fathers could continue education, work and social life with comparatively fewer consequences. Domestic work and childcare reduced participants' time and flexibility for seeking healthcare, particularly healthcare for themselves. Economic dependence meant that mothers could recognise a healthcare need but still lack the resources required to act, while paternal financial support could be conditional on relationship dynamics. Within healthcare facilities, differences in age and institutional authority sometimes discouraged participants from questioning providers or participating confidently in clinical discussions. The findings therefore support the argument that healthcare autonomy is not simply an individual characteristic; it is produced within relationships and social structures that determine who controls resources, whose judgement is treated as authoritative and whose responsibilities are considered unavoidable.

The findings are broadly consistent with evidence from Uganda and Sub-Saharan Africa demonstrating the relationship between gender inequality, reproductive autonomy and maternal healthcare utilisation (Ninsiima et al., 2018; Ninsiima et al., 2020; Chol et al., 2019; Yaya et al., 2019; Cumber et al., 2022; Gebeyehu et al., 2022; Aragaw et al., 2023; Matovu et al., 2025; Teshale et al., 2025; Alanyo et al., 2026). Aragaw et al. (2023) particularly demonstrate the importance of age, education and employment for healthcare decision-making autonomy among young East African women, while Alanyo et al. (2026) provide recent Uganda-specific qualitative evidence that financial dependence, parental and partner control and restrictive social expectations constrain adolescent reproductive autonomy. The present study extends these observations by showing how the same inequalities operate after teenage pregnancy through childcare responsibilities, control of healthcare resources, conditional partner support and reduced confidence in institutional interactions.

Addressing these gender-related barriers therefore requires interventions at household, community and health-system levels. Families and partners should be sensitised to recognise teenage mothers as legitimate participants in healthcare decisions rather than passive dependants. Fathers should be encouraged and held accountable for consistent financial and caregiving responsibility, rather than involvement being dependent on the state of their relationship with the teenage mother. Economic empowerment, return-to-school programmes, vocational opportunities and childcare support could increase teenage mothers' practical capacity to make and implement healthcare decisions. Within healthcare facilities, providers should communicate directly and respectfully with teenage mothers, confirm their understanding, invite questions and support informed participation in decisions about maternal,

child and reproductive healthcare. Such interventions would respond to the central finding that improving healthcare access requires not only making services available, but also strengthening teenage mothers' power to decide, obtain resources and act on healthcare needs.

4.4 Social Support Systems and Healthcare Access

Social support emerged as a major protective factor in teenage mothers' ability to access and continue using healthcare services in Walukuba Village. Across the five interviews, participants described receiving different combinations of emotional, financial, informational and practical assistance from mothers, grandmothers, aunts, sisters, male partners, friends, neighbours, religious community members and Village Health Team (VHT) members. However, the availability and adequacy of this support varied considerably. Older female relatives emerged as the most dependable source of support, frequently providing accommodation, food, transport money, childcare, accompaniment to health facilities and emotional encouragement. In contrast, support from the fathers of the children was generally described as inconsistent or absent. VHTs played a particularly important informational role by advising participants about pregnancy danger signs, immunisation, family planning and when illness required formal healthcare. Formal organisational support, however, was largely absent from participants' experiences. These findings correspond with the study's definition of social support systems as formal and informal networks providing emotional, informational, instrumental and financial assistance that facilitates healthcare access.

The importance of social support can be understood through Social Support Theory, developed by Cobb (1976) and House (1981), which proposes that social relationships protect health by providing emotional reassurance, information, material resources and practical assistance. In relation to healthcare access, support can operate directly by providing transport, money, childcare and accompaniment, or indirectly by reducing fear, stress, stigma and isolation that might otherwise discourage care-seeking. The literature reviewed for this study similarly indicates that supportive partners, family members and peers can improve antenatal attendance, reduce anxiety and facilitate adherence to healthcare recommendations (Afulani et al., 2021; Bohren et al., 2022; Agampodi et al., 2022). The findings from Walukuba strongly reflect this multidimensional understanding because participants did not describe support as one single resource. Rather, the most useful supporters were those capable of combining money, practical care, information and emotional encouragement.

Older female relatives were the most consistent source of support across the interviews. Sarah identified her mother as the person on whom she depended most: *"My mother supports me the most. My aunt also helps when things are difficult. The baby's father provides some money, but not consistently."* She explained that her mother provided almost everything she needed, including accommodation, food, transport money, childcare and advice. The importance of her mother was also evident when Sarah experienced disrespect during antenatal care. Rather than allowing the incident to stop her from returning, her mother encouraged her to continue attending because the health of Sarah and her baby was more important than the provider's negative remarks. Sarah later stated:

> *"My mother also encourages me. She was very angry when I first became pregnant, but after some time she accepted the situation and told me that I should concentrate on raising the baby well and think about returning to school in future."*

Sarah's experience demonstrates that family relationships were not necessarily supportive from the moment pregnancy was disclosed. Initial anger, disappointment and conflict could gradually be replaced by acceptance and practical assistance. This transition is analytically important because the same family relationship that initially contributed to emotional distress later became the participant's strongest healthcare resource. Social support should therefore not be understood as a fixed characteristic that is either present or absent; it may evolve over the course of pregnancy and motherhood. This observation corresponds with evidence reviewed in the proposal showing that family rejection is common following adolescent pregnancy but that family acceptance and encouragement can substantially improve teenage mothers' ability to cope and utilise healthcare services. Nabugoomu et al. (2020), for example, found in eastern Uganda that families encouraged teenage mothers, comforted them and supported positive healthcare decision-making, including encouraging facility delivery.

Grandmothers performed a similarly central role for Amina and Nabirye. Amina described her grandmother as her primary supporter during pregnancy: *"My grandmother gives me food, accommodation, transport money and sometimes goes with me. My mother sends money occasionally. The VHT gives advice and has explained danger signs in pregnancy."* The grandmother's involvement went beyond financial assistance. She encouraged Amina to attend healthcare, accompanied her when necessary and helped interpret when symptoms required urgent attention. In an earlier incident when Amina developed severe abdominal pain at night,

her grandmother actively searched for transport and negotiated with a boda rider who agreed to be paid later. Thus, the grandmother operated as both an economic resource and a healthcare decision-making facilitator.

Nabirye's grandmother played an almost identical role. Nabirye explained: *"My grandmother is the main person. My mother also helps when she can. My aunt has helped with money before. The VHT woman also gives us advice. The baby's father is not someone I can depend on."* She further stated that her grandmother provided food, accommodation, transport money, childcare and accompaniment when the baby was seriously ill. These findings show the importance of intergenerational female support within households. Where biological mothers were unavailable or living elsewhere, grandmothers assumed both caregiving and economic responsibilities for the teenage mother and her child. This informal redistribution of care enabled participants to remain connected to healthcare even where support from male partners was absent.

The prominence of mothers, grandmothers, aunts and sisters is consistent with findings from Ugandan research indicating that extended family networks frequently become the principal safety net for teenage mothers. The proposal notes that where teenage mothers experience partner withdrawal or household instability, they often depend on older female relatives for emotional and practical assistance, although the adequacy of that support varies according to the resources available within the household (Nalwadda et al., 2020; Nabugoomu et al., 2020). Namutebi et al. (2022) similarly found that teenage first-time mothers in Uganda required counselling, health information, family reconciliation and linkages to community-based organisations during the postpartum period. The present findings therefore reinforce the view that families are not peripheral actors in adolescent maternal healthcare; they are often the practical infrastructure through which healthcare becomes possible.

Mariam's experience further illustrates the importance of extended family when relationships with parents become strained. Following conflict with her mother after the pregnancy was discovered, her aunt allowed her to move into her household and became the main source of support. Mariam stated: *"My aunt is the main person. She has supported me from pregnancy until now. My mother has also started helping more than before. We are now speaking better, and sometimes she sends some money or buys clothes for the baby."* Her aunt provided accommodation, food, transport money, childcare and emotional support and sometimes held the baby so Mariam could rest or assist with work. This support also enabled healthcare

utilisation. When money for treatment was unavailable, the aunt sometimes borrowed from people she knew through her small business and prioritised facility attendance when the baby appeared seriously ill.

Mariam's account demonstrates what Social Support Theory describes as instrumental support: practical assistance that enables an individual to manage a stressful or demanding situation. The aunt did not simply offer emotional encouragement; she created the material conditions under which Mariam could access healthcare. At the same time, Mariam's dependence produced feelings of guilt because her aunt also had children and limited income. She explained: *"Emotionally, I feel supported by my aunt. Financially, it is not enough because her income is small and she has her own family. Sometimes I worry that I am becoming a burden to her."* This highlights an important distinction between the presence of social support and its adequacy. A teenage mother may have a loving and committed relative but still experience healthcare barriers if that relative is economically constrained.

Shakira's experience provides further evidence of this distinction. Her older sister was her strongest supporter, providing accommodation, childcare, food and occasional money, while her mother and the baby's father also helped intermittently. Shakira described the support network as fragmented rather than absent: *"It helps, but it is not always enough. My sister has her own responsibilities. The baby's father is not consistent. My mother also has other children. So sometimes everyone helps a little, but there can still be a gap."* This account shows that multiple supporters do not necessarily produce adequate support when each supporter possesses limited resources or provides assistance only occasionally. The practical effectiveness of a support network therefore depends on its consistency and capacity, not merely on the number of people involved.

This finding is important because it challenges a simple binary categorisation of teenage mothers as either "supported" or "unsupported." In Walukuba, several participants were surrounded by relatives who cared about them, yet healthcare was still delayed because those relatives lacked transport money, medicine money or sufficient income. Social support therefore interacted closely with poverty. A family could provide emotional reassurance while remaining unable to eliminate material barriers to healthcare. The proposal's Social Support Theory framing explicitly recognises this distinction between emotional, informational and instrumental support. The findings suggest that the health benefits of supportive relationships

are strongest when emotional encouragement is combined with concrete resources that allow the teenage mother to act.

Another important pattern concerned the comparatively limited and inconsistent support received from fathers of the children. Across the interviews, partner support was generally less dependable than support from female relatives. Sarah explained that the baby's father contributed money only irregularly and was not substantially involved in physical childcare. Amina felt that responsibility had fallen unfairly on her grandmother and family, stating: *"I also feel the baby's father should help. It is not fair that everything remains with my family."* Nabirye described the father of her child as someone she could not depend on at all, particularly because he had denied responsibility. Mariam reported occasional assistance but explained that there was no predictable amount or regular pattern of contribution.

Shakira received somewhat more partner support than some other participants, but it was conditional and unstable. She explained that the father sometimes provided money or bought items for the baby, but support could decrease after disagreements between them. This meant that assistance necessary for the baby's health was vulnerable to fluctuations in the adult relationship. Such findings reveal that paternal support often functioned as supplementary rather than foundational support. Teenage mothers therefore built their healthcare strategies primarily around female relatives because those relationships were more dependable, even where the relatives themselves were economically disadvantaged.

The pattern is consistent with literature from Uganda and Sub-Saharan Africa showing that partner abandonment or inconsistent male involvement can significantly weaken adolescent mothers' financial and emotional support systems. The proposal notes that Nabugoomu et al. (2020) documented family conflict and blame between families of teenage mothers and families of the men responsible for pregnancies, while research from other African settings has shown that withdrawal of paternal responsibility leaves teenage mothers and their families to absorb the financial and emotional consequences. Cumber et al. (2022) consequently recommended stronger male involvement in adolescent maternal health services because financial and social support from partners can influence healthcare utilisation.

The findings therefore suggest that partner involvement should not be interpreted simply as physical accompaniment to a clinic. Meaningful involvement includes regular financial contribution, emotional support, recognition of paternal responsibility, participation in

childcare and responsiveness when a mother reports that a child requires medical attention. Where these dimensions are absent, the burden shifts to the teenage mother and her extended family. This has direct implications for community interventions: encouraging paternal responsibility may reduce the disproportionate pressure currently placed on mothers, grandmothers, aunts and sisters.

Village Health Team members emerged as another important source of support, particularly through information and referral advice. Sarah explained that the VHT helped distinguish illnesses that could be monitored from those requiring formal healthcare: *"The VHT gives advice. She has told me when the baby's condition needs a health worker instead of just buying medicine."* Amina similarly reported that the VHT explained pregnancy danger signs and advised her about antenatal care. Nabirye stated that the VHT provided information about immunisation, infant feeding and when to attend a health facility. Mariam also received guidance on immunisation, family planning and when her baby required treatment. Shakira reported that the VHT helped her understand symptoms that should not be ignored.

The consistency of these accounts across all five participants indicates that VHTs occupy a particularly valuable position between households and formal healthcare services. They provide accessible information without requiring the mother first to pay transport costs or navigate a potentially intimidating facility environment. Their role appears particularly important where participants have limited healthcare knowledge or are uncertain about symptom severity. This finding closely corresponds with Nabugoomu et al. (2020), who found in eastern Uganda that VHTs encouraged teenage mothers to attend health centres, facilitated referrals, provided advice about breastfeeding and pregnancy danger signs, and supported positive healthcare decision-making. The same study found that family and VHT support helped teenage mothers maintain hope and encouraged health-facility delivery.

Social Cognitive Theory also helps explain the importance of VHTs. The theory emphasises reciprocal interaction between individual knowledge and self-efficacy, the social environment and health behaviour. VHTs potentially strengthen both knowledge and confidence while altering the immediate social environment around the teenage mother. For example, a mother who is unsure whether a child's symptoms warrant formal treatment may gain confidence to attend after speaking to a trusted VHT. In this way, informational support can translate into healthcare behaviour even where the VHT does not provide direct clinical treatment.

However, the evidence also indicates that VHT support cannot substitute for financial assistance. Participants consistently described VHTs as providers of advice rather than money. This distinction matters because knowing that healthcare is necessary does not automatically resolve transport or medicine costs. The proposal similarly notes that although VHTs have substantial potential to facilitate adolescent maternal healthcare, their effectiveness may be constrained by limited resources, inadequate motivation, lack of remuneration and weak coordination. Strengthening VHT systems therefore requires more than expecting community volunteers to provide additional counselling. They need adequate training, referral information, communication support and clear links with healthcare facilities and community organisations.

Participants also reported smaller but meaningful contributions from neighbours, friends and religious communities. Amina received baby clothes from a woman at church, while Mariam described women near her aunt's business who occasionally provided baby items or short-term childcare. Shakira's former school friends primarily provided emotional encouragement, which she valued because *"sometimes it helps just to have someone to talk to."* Sarah similarly reported encouragement from women at church, although she had not received regular healthcare-related material support. These accounts demonstrate that community support may take relatively small forms, yet these contributions can reduce emotional isolation and occasionally provide material resources.

Emotional support is especially important given the stigma and rejection documented in Section 4.2. Social Support Theory proposes that supportive relationships can buffer the psychological effects of stressful experiences and social marginalisation. In the present study, relatives and friends often reassured teenage mothers that their lives had not ended because of pregnancy. This type of encouragement appeared to help participants continue caring for their children, attend healthcare despite embarrassment and maintain aspirations for future schooling or skills development. Emotional support should therefore not be treated as secondary to financial support. It serves a different but complementary function by strengthening motivation and resilience.

Nevertheless, one of the clearest findings was the limited availability of formal support programmes. None of the five participants reported being enrolled in a formal teenage-mother support programme that consistently provided financial, counselling or healthcare-access assistance. Sarah had heard of organisations assisting young mothers but had not joined one. Amina reported some assistance from church members and a VHT but no formal organisation

or teenage-mother group. Mariam stated: *"I have not received support from an NGO or a formal teenage-mother group. I have heard people say some organisations help young mothers with skills training, but I do not know where to find them."* Shakira similarly reported that she had heard of groups supporting young mothers but was not part of one.

This represents an important gap between the potential existence of social programmes and participants' actual access to them. A service cannot function as a support system if intended beneficiaries do not know it exists, do not understand eligibility requirements or cannot access it. The proposal similarly observes that formal support for teenage mothers in Uganda remains fragmented. Government social-protection programmes are not specifically designed around teenage mothers' healthcare needs, while civil-society initiatives often operate only in selected locations and may not reach all eligible young mothers. Consequently, teenage mothers continue to rely mainly on informal family and community networks. This finding is also consistent with Namutebi et al. (2022), who identified a need for healthcare providers to link teenage first-time mothers with counselling, life-skills programmes and community-based organisations.

The absence of reliable formal support is significant because informal support systems can fail precisely when families themselves are poor. Participants' mothers, grandmothers, aunts and sisters were frequently the people who "found a way," yet those relatives also faced other household responsibilities. Sarah explained that although she was grateful for her mother's help, *"financially it is still not enough because my mother does not earn much. She also has other children."* Nabirye worried that her grandmother was using resources required by her own household to care for Nabirye and the baby. Mariam worried about becoming an additional burden to an aunt who already had her own children. These experiences demonstrate that informal family solidarity can protect healthcare access while simultaneously shifting economic strain from the teenage mother to another economically vulnerable household member.

The findings therefore reveal both the strength and fragility of informal support. Families were often remarkably adaptive: they borrowed money, provided accommodation, accompanied teenage mothers, cared for babies and helped interpret healthcare advice. Yet these strategies depended on household resources that were already limited. A single supportive grandmother or aunt could prevent a teenage mother from being completely excluded from healthcare, but she could not necessarily remove transport costs, guarantee medicines or finance long-term

education and childcare. This may explain why participants consistently distinguished between being emotionally supported and being financially secure.

Participants consequently identified a broader package of support that would improve healthcare access. Amina suggested transport support, baby supplies, counselling and opportunities to return to school or learn vocational skills. Mariam emphasised transport assistance, information about counselling and support programmes, vocational training and respectful healthcare. She argued that skills such as hairdressing, tailoring or small-business management could provide teenage mothers with income that would reduce dependence on others for healthcare decisions. Shakira similarly proposed transport support, skills training, small-business assistance, counselling for teenage mothers and their families, stronger paternal responsibility and respectful healthcare environments.

These recommendations show that participants understood social support in broad terms. What they desired was not simply charity or occasional financial assistance but a pathway towards greater stability and independence. Their preferred forms of support combined immediate healthcare access, such as transport assistance, with longer-term interventions such as education, skills training and livelihood development. This aligns with Nabugoomu et al. (2020), who identified income-generating opportunities alongside family and community support as important opportunities for improving teenage mothers' maternal and child health in eastern Uganda. It also corresponds with Namutebi et al. (2022), who recommended stronger linkages between teenage mothers, healthcare services, continuing education, life-skills programmes and community organisations.

Taken together, the findings demonstrate that social support was one of the strongest factors protecting teenage mothers from complete exclusion from healthcare. Mothers, grandmothers, aunts and sisters provided the most dependable combination of financial, practical and emotional assistance; VHTs provided accessible health information and referral guidance; neighbours, friends and religious community members offered occasional material and emotional assistance; and fathers provided varying but generally inconsistent financial support. However, the adequacy of these networks was limited by household poverty, competing family responsibilities, unreliable paternal involvement and the absence of accessible formal teenage-mother programmes. Social support therefore mitigated the barriers identified in earlier sections but rarely eliminated them entirely.

The findings are consistent with the broader literature showing that social support facilitates healthcare utilisation among adolescent mothers through accompaniment, encouragement, information, childcare and material assistance (Afulani et al., 2021; Bohren et al., 2022; Agampodi et al., 2022; Nabugoomu et al., 2020; Nalwadda et al., 2020; Namutebi et al., 2022). At the same time, the Walukuba findings demonstrate that supportive relationships alone cannot overcome structural poverty. The effectiveness of support depends on whether supporters possess the material, informational and institutional resources necessary to translate concern into action.

The implications are therefore clear. Interventions should strengthen rather than replace the informal support networks that teenage mothers already rely upon. Family counselling and reconciliation may help parents and relatives move from initial anger towards supportive involvement. Fathers should be encouraged to provide consistent financial, emotional and childcare support rather than occasional assistance only during emergencies. VHTs should receive adequate training, facilitation and referral information to strengthen their role as community-to-facility intermediaries. Healthcare facilities should actively link teenage mothers to available counselling, social welfare, education and livelihood programmes rather than assuming that families can meet all their needs. Finally, structured peer-support groups for teenage mothers could provide a safe environment for sharing health information, emotional support and information about available services. Strengthening these interconnected systems would reduce dependence on a single overstretched family member and create a more reliable network through which teenage mothers can access timely, respectful and continuous healthcare.

4.5 Coping Strategies Used to Overcome Healthcare Barriers

The findings revealed that teenage mothers used several coping strategies to manage the financial, social and healthcare-related barriers they experienced. These strategies included seeking assistance from family members, borrowing money, using personal savings and informal earnings, consulting Village Health Team members, using nearby drug shops, seeking assistance from male partners, avoiding confrontation with disrespectful healthcare providers, drawing motivation from motherhood, maintaining future aspirations and relying on prayer. Although some of these strategies enabled participants to obtain healthcare, others provided only temporary relief or sometimes created additional risks.

4.5.1 Seeking Assistance from Family Members

Seeking assistance from family members was the most common and dependable coping strategy across the five interviews. When participants lacked money for transport, medicines or other healthcare expenses, they commonly approached the female relative who was already providing day-to-day support. Mothers, grandmothers, aunts and sisters therefore functioned as important sources of financial, practical and emotional assistance.

Sarah, aged 18 years, explained: *"First I talk to my mother. If we don't have money, we may call my aunt or the baby's father. My mother has borrowed from neighbours before."* Amina, aged 17 years, similarly stated: *"I first talk to my grandmother. If we don't have money, she may call my mother or borrow from someone."*

These experiences show that teenage mothers frequently depended on existing family networks to mobilise resources when healthcare needs arose. Family assistance therefore acted both as a social-support mechanism and as an informal source of emergency healthcare financing.

4.5.2 Borrowing Money

Borrowing money was another important coping strategy, particularly when household resources were exhausted. Participants borrowed from relatives, neighbours or other people within their social networks to meet urgent transport, medicine or treatment expenses.

Nabirye, aged 17 years, explained: *"Borrowing helps you today but creates another problem tomorrow. My grandmother has borrowed for healthcare and then struggled to buy food afterwards."* Mariam, aged 16 years, similarly stated: "*Borrowing helps at that moment, but later it creates another problem because the money has to be repaid."*

Borrowing therefore enabled participants to respond to immediate healthcare needs, but it was not a sustainable solution. Repayment obligations sometimes reduced the money available for food and other household needs. This demonstrates that a coping strategy may be effective in the short term while increasing economic vulnerability later.

4.5.3 Using Personal Savings and Earnings from Informal Livelihood Activities

Some teenage mothers attempted to keep small amounts of money from informal livelihood activities so that they could respond more quickly when healthcare was needed. Small personal savings reduced their dependence on relatives and male partners and provided them with some degree of financial autonomy.

Sarah, aged 18 years, explained: *"Keeping even a small amount of money from selling vegetables has helped too. If I have five or ten thousand shillings saved, I feel safer because I know I can at least start the journey to seek care."* Shakira, aged 19 years, similarly explained: *"Having some personal income has helped me a lot. Even if the business is small, I feel better when I have my own money."*

Although personal income increased independence, participants sometimes had to use money intended for business investment to pay healthcare expenses. This meant that healthcare expenditure could weaken the small livelihood activity from which future healthcare funds were expected to come. Personal savings were therefore useful but remained limited by participants' generally low and unstable incomes.

4.5.4 Consulting Village Health Team Members

Participants also consulted Village Health Team members when they were uncertain about whether an illness required immediate formal healthcare. VHTs provided health information and helped teenage mothers distinguish between minor conditions and symptoms that required prompt referral to a healthcare facility.

Mariam, aged 16 years, explained: *"The VHT advice has also helped because sometimes I do not know whether something is dangerous. She can tell me that a baby with certain symptoms should be taken to the health facility quickly."*

VHT consultation therefore functioned as an important informational coping strategy. It helped teenage mothers and their families make decisions about when limited financial resources should be used to seek formal healthcare. However, VHT advice did not eliminate financial barriers such as transport and medicine costs, meaning that informational support needed to be accompanied by practical and financial support.

4.5.5 Using Nearby Drug Shops for Minor Illnesses

Some participants used nearby drug shops when an illness was considered minor or when the cost of travelling to a formal healthcare facility was difficult to meet. Drug shops were viewed as easier, faster and sometimes cheaper to access.

Sarah, aged 18 years, explained: *"For minor sickness, sometimes I first go to the drug shop because it is easier and cheaper. If the baby doesn't improve, I look for money to go to the health facility."*

Although this strategy enabled participants to obtain some form of treatment quickly, it also carried risks. Several participants reported eventually seeking formal healthcare after medicines obtained from drug shops failed to improve the child's condition. Drug-shop use could therefore delay appropriate diagnosis and treatment. This coping strategy demonstrates how financial hardship may lead teenage mothers to first choose the least costly or most accessible healthcare option rather than the most appropriate one.

4.5.6 Seeking Financial Support from Male Partners

Teenage mothers also attempted to obtain financial assistance from the fathers of their children, particularly when they needed money for transport, medicines or child healthcare. However, this strategy was frequently described as unreliable because some fathers delayed sending money, failed to fulfil promises or provided support inconsistently.

Amina, aged 17 years, explained: *"Waiting for the baby's father also wasted my time before. I used to think he would eventually help, but now I don't depend on him."*

Participants gradually adjusted their coping strategies after repeatedly experiencing unreliable paternal support. Some reduced their dependence on the fathers and instead approached mothers, grandmothers, aunts or other relatives. This shows that coping strategies were not fixed but changed according to participants' previous experiences and perceptions of which sources of support were dependable.

4.5.7 Remaining Silent, Avoiding Confrontation and Seeking Alternative Healthcare Providers

Participants also developed coping strategies for dealing with stigma, harsh communication and disrespectful treatment within healthcare settings. Rather than openly confronting healthcare workers, participants commonly remained silent, discussed the experience later with a trusted relative, avoided a particular provider or attempted to seek assistance from another healthcare worker.

Amina, aged 17 years, explained: *"I normally keep quiet. I don't think I would report unless something very serious happened. I remind myself that I went there for my health and the baby's health. If one worker is rude, I try not to let that stop me from going back."*

Silence and avoidance helped participants minimise confrontation and continue accessing healthcare despite negative experiences. However, these strategies did not address the underlying problem of disrespectful treatment. Remaining silent may therefore have protected immediate healthcare access while allowing inappropriate provider behaviour to remain unreported.

4.5.8 Drawing Motivation from Motherhood

Participants frequently identified their children as an important source of emotional strength and motivation to overcome healthcare barriers. Despite financial hardship, stigma and difficult healthcare experiences, responsibility for their babies encouraged them to continue searching for ways to obtain healthcare. Sarah, aged 18 years, stated: "*My baby is the biggest reason. When I look at her, I know she depends on me. Even when I feel ashamed or don't have enough money, I try to find a solution."* Nabirye, aged 17 years, similarly explained: *"My baby gives me strength. Even if I am tired or ashamed, I know he has nobody else who is responsible for him every day."*

Motherhood therefore operated not only as a source of responsibility but also as an emotional coping resource. Participants reframed their circumstances around the need to protect their children's health, which strengthened their determination to seek solutions when barriers arose.

4.5.9 Maintaining Future Educational and Economic Aspirations

Future aspirations were another coping mechanism identified among participants. Some teenage mothers continued hoping to return to school, acquire vocational skills, establish businesses or become financially independent. These aspirations helped them maintain a sense that teenage pregnancy had not permanently ended their opportunities for personal development.

Nabirye continued to express a desire to return to school or obtain vocational skills, while Mariam hoped to become economically independent so that she could support her child without continually depending on relatives. Shakira's small business similarly provided her with confidence that she could gradually become more independent.

Maintaining future goals therefore served as a form of personal-growth coping. It enabled participants to construct an identity beyond teenage motherhood and provided motivation to continue addressing the difficulties associated with healthcare access, education and economic dependence.

4.5.10 Prayer and Spiritual Coping

Prayer was also used by some participants as a way of managing stress, uncertainty and emotional difficulties. Although prayer did not directly provide money for transport, medicines or childcare, it helped some teenage mothers maintain hope during difficult circumstances. Sarah, aged 18 years, explained: *"I also pray. Sometimes when things are difficult, believing that my situation can improve helps me not to give up."*

Mariam also reported using prayer to manage stress and maintain hope that her circumstances would eventually improve. Prayer therefore functioned mainly as an emotion-focused coping mechanism that helped participants regulate fear, disappointment and uncertainty while continuing to search for practical solutions.

Overall, the findings demonstrate that teenage mothers in Walukuba Village used a combination of financial, social, informational, behavioural and emotional coping strategies. They sought family assistance, borrowed money, used savings and informal earnings, consulted VHTs, used nearby drug shops, contacted male partners, avoided confrontation with disrespectful providers, drew motivation from their children, maintained future aspirations and

relied on prayer. However, the effectiveness of these strategies varied considerably. Some strategies, particularly family support, personal savings and VHT advice, facilitated healthcare access, while others such as borrowing, waiting for unreliable partners and relying on drug shops could create additional financial or health-related risks. The findings therefore demonstrate that coping should not be interpreted as evidence that the barriers experienced by teenage mothers had been resolved. Rather, many of the strategies represented attempts to manage persistent structural challenges such as poverty, financial dependence, stigma and inadequate formal support.

This chapter presented and discussed the findings on the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village. The findings showed that financial difficulties were a major barrier, particularly transport costs, the cost of medicines and other healthcare-related needs, limited personal income and dependence on family members or partners. Social stigma and discrimination also influenced healthcare-seeking through community judgement, family disappointment, embarrassment, fear of being seen and, in some cases, disrespectful treatment within healthcare facilities. Gender norms further placed disproportionate responsibility for pregnancy, childcare and household work on teenage mothers, while fathers of the children often experienced fewer social consequences and provided inconsistent support. These inequalities reduced teenage mothers' autonomy, particularly where access to healthcare depended on another person controlling the money required for transport or treatment.

Despite these challenges, teenage mothers demonstrated considerable resilience by relying on mothers, grandmothers, aunts, sisters, VHTs and other informal networks for financial, emotional, informational and practical support. They also used coping strategies such as borrowing money, keeping small savings, using income from informal work, consulting VHTs, seeking cheaper care from drug shops and drawing motivation from their children, prayer and future aspirations. However, some coping strategies, particularly borrowing, waiting for unreliable partners, delaying care and initially using drug shops, sometimes created additional financial or health risks. Overall, the findings indicate that improving healthcare access for teenage mothers requires more than the physical availability of services. It requires addressing financial vulnerability, stigma, unequal gender relations, limited decision-making power and gaps in formal support while strengthening family, community and health-system mechanisms that promote timely, respectful and dignified healthcare.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the conclusions and recommendations arising from the findings of the study on the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City. The conclusions are drawn from the major findings discussed in Chapter Four. The chapter also presents practical recommendations aimed at improving teenage mothers' access to timely, affordable, respectful and appropriate healthcare services.

5.2 Summary

This study examined the socio-economic and gender-related challenges experienced by teenage mothers in accessing healthcare services in Walukuba Village, Masese, Jinja City. The findings reveal that healthcare access is shaped by interconnected financial, social and gender-related factors, including transport and medicine costs, lack of independent income, dependence on relatives and male partners, social stigma, unequal childcare responsibilities, limited decision-making power and inadequate formal support systems. Although healthcare services may be available, teenage mothers do not always have the financial resources, social support or autonomy required to access them promptly and consistently. Mothers, grandmothers, aunts, sisters and Village Health Team members emerged as important sources of financial, emotional, practical and informational support, while support from fathers of the children was often inconsistent. Teenage mothers also demonstrated resilience through borrowing, small savings, informal livelihood activities, VHT consultations and family support; however, some coping strategies, including delayed care, reliance on drug shops and waiting for unreliable financial assistance, sometimes created additional risks. The study therefore concludes that improving healthcare access among teenage mothers requires interventions that go beyond increasing the availability of health services to address the wider economic, social and gender inequalities influencing their ability to use those services. Recommendations emphasise respectful and adolescent-friendly healthcare, stronger family and paternal support, economic and educational empowerment, strengthened VHT services, reduction of community stigma and improved linkage to formal support programmes. Overall, the study contributes to understanding how poverty, gender relations, social support and healthcare experiences interact in shaping teenage mothers' access to care and highlights the need for coordinated action at

household, community and health-system levels to ensure that teenage mothers and their children can obtain timely, affordable, respectful and appropriate healthcare.

5.3 Conclusions

The findings of this study demonstrate that financial vulnerability remains a fundamental barrier to healthcare access among teenage mothers in Walukuba Village. Although government healthcare services are generally available and perceived as more affordable, teenage mothers still face substantial indirect costs involving transport, medicines, laboratory investigations, delivery requirements, food during facility visits and other maternal and child-care expenses. These costs become particularly restrictive because most teenage mothers have no stable independent income and depend on mothers, grandmothers, aunts, sisters or male partners for financial assistance. Financial dependence therefore limits not only the ability to pay for healthcare but also the ability to decide independently when and where healthcare should be sought. A teenage mother may recognise that she or her child requires treatment but still have to wait for another person to provide transport money or agree that the health problem is serious enough to justify expenditure. The study therefore concludes that the availability of healthcare services does not automatically translate into meaningful access when teenage mothers lack the economic resources required to reach and use those services.

The economic challenges experienced by teenage mothers are further reinforced by interruption of education and limited livelihood opportunities. Pregnancy resulted in participants leaving school, while childcare responsibilities subsequently made it difficult to return to education or obtain stable employment. This creates a reinforcing cycle in which teenage pregnancy contributes to school interruption, reduced education limits employment opportunities, limited employment produces low income, and low income increases dependence on family members and partners for healthcare. Although some participants engaged in small informal activities such as selling vegetables, washing clothes or selling second-hand items, these sources of income were unstable and easily depleted by healthcare, childcare and household expenses. The study therefore concludes that financial barriers to healthcare cannot be addressed only through free consultation services. Improving teenage mothers' healthcare access also requires interventions that strengthen education, livelihood opportunities, childcare support and economic independence.

Social stigma and discrimination also remain powerful influences on teenage mothers' healthcare experiences. Teenage pregnancy was frequently associated with ideas of stubbornness, irresponsibility, disobedience and failure to complete education. Such attitudes were expressed through family disappointment, community gossip, negative comments from peers and, in some cases, judgmental treatment by healthcare providers. The study found that fear of being seen and judged contributed to concealment of pregnancy and delayed initiation of antenatal care among some participants. Stigma therefore operates beyond emotional distress; it influences concrete healthcare behaviour by making teenage mothers reluctant to disclose pregnancy, attend facilities openly, ask questions or discuss sensitive reproductive-health issues. Although several participants also reported respectful and supportive healthcare workers, the persistence of judgmental comments and inadequate privacy shows that healthcare environments can either reduce or reinforce the stigma teenage mothers already experience within their communities.

The study further notes that gender norms place a disproportionate share of the consequences of teenage pregnancy and parenthood on girls. Teenage mothers were expected to become responsible adults immediately, take primary responsibility for childcare, perform domestic work and ensure that their babies were fed, clean and treated when sick. In contrast, the fathers of the children were generally able to continue working, socialising and moving freely, while some provided irregular support or denied responsibility altogether. This unequal distribution of responsibility means that teenage mothers carry the visible, social, emotional and practical consequences of pregnancy while paternal responsibility may remain negotiable. The expectation that the mother must always find a solution when the baby requires healthcare reinforces gender inequality and increases dependence on female relatives when fathers fail to contribute consistently.

Unequal power relations were also evident in healthcare decision-making. The study found that teenage mothers were often the first people to identify when they or their babies required healthcare because they spent the most time with their children. However, identifying the need for care did not necessarily mean having the power to implement the decision. Control over transport money, medicine costs and other healthcare resources gave relatives or partners considerable influence over whether care was obtained immediately or delayed. Importantly, teenage mothers were rarely directly told that they were forbidden from seeking healthcare. Instead, power operated indirectly through economic dependence. A person who controlled the

money could influence the timing and choice of healthcare without explicitly denying permission. The study therefore concludes that healthcare autonomy should not be understood only in terms of who verbally makes a decision, but also in terms of who controls the resources required to act on that decision.

The study also concludes that social support is one of the strongest protective factors enabling teenage mothers to continue accessing healthcare. Mothers, grandmothers, aunts and sisters emerged as the most reliable supporters, providing accommodation, food, transport money, childcare, healthcare advice, accompaniment and emotional encouragement. Their involvement frequently prevented complete exclusion from healthcare when teenage mothers had no independent resources. However, the support provided by these female relatives was itself constrained by poverty and competing household responsibilities. A grandmother or aunt may be willing to support a teenage mother but still lack the money required for transport or medicines. The study therefore identifies an important difference between the presence and adequacy of social support. Teenage mothers may be emotionally supported while remaining financially vulnerable.

Support from the fathers of the children was comparatively less reliable. Although some fathers occasionally provided money or purchased items for their children, participants generally could not depend on this assistance consistently. In some cases, support reduced following disagreements between the teenage mother and the father, while in others the father questioned paternity or withdrew involvement altogether. This places additional pressure on the teenage mother's family and reinforces the gendered distribution of childcare responsibility. The study therefore concludes that stronger paternal responsibility is necessary not only as a social or moral obligation but also as an important component of healthcare access. Fathers' consistent participation in financial support, childcare and healthcare decisions could reduce the burden currently carried by teenage mothers and their female relatives.

Village Health Teams also emerged as an important link between teenage mothers, households and formal healthcare services. VHTs provided information about antenatal care, immunisation, family planning, infant feeding, danger signs and when symptoms required formal treatment. Their accessibility allowed teenage mothers to seek advice before committing scarce household resources to transport or treatment. However, VHT support was mainly informational and could not resolve financial barriers such as transport and medicine costs. Similarly, participants reported little or no direct support from formal teenage-mother

programmes, NGOs or organised support groups. The study therefore concludes that the current support system is heavily dependent on informal family and community networks, while structured formal support remains limited or insufficiently accessible.

Teenage mothers nevertheless demonstrated considerable resilience and resourcefulness in responding to healthcare barriers. They borrowed money, sought assistance from relatives, retained small savings, used earnings from informal activities, consulted VHTs, contacted fathers of their children and sometimes used nearby drug shops when formal healthcare appeared unaffordable. Their children were also an important source of motivation, with participants explaining that responsibility for the baby's wellbeing encouraged them to continue seeking healthcare despite financial hardship, stigma and disrespect. Prayer, encouragement from relatives and aspirations to return to school or obtain vocational skills also helped participants maintain hope and cope with their circumstances.

However, the study concludes that not all coping strategies are equally safe or sustainable. Borrowing may enable immediate healthcare access but create debt and reduce money available for food or business. Waiting for an unreliable partner to send money can delay treatment. Using drug shops as a cheaper first option may postpone appropriate care when illness is more serious than initially assumed. Spending small-business capital on healthcare may solve an immediate medical problem but reduce future income. Remaining silent when healthcare workers behave disrespectfully may prevent confrontation but leaves discriminatory behaviour unchallenged. These findings demonstrate that coping should not be confused with the absence of barriers. Teenage mothers are often coping precisely because formal systems have failed to provide adequate economic, social and institutional protection.

Overall, the study concludes that teenage mothers' healthcare access in Walukuba Village is shaped by an interconnected system of financial vulnerability, social stigma, gender inequality, unequal power relations, inadequate formal support and reliance on informal coping strategies. These factors do not operate independently. School interruption contributes to low income; low income produces dependence; dependence reduces healthcare autonomy; gender norms place greater childcare responsibility on teenage mothers; stigma reduces confidence and willingness to seek care; and limited formal support forces families to rely on borrowing and other short-term solutions. At the same time, supportive female relatives, VHTs, personal resilience and small sources of income demonstrate that these barriers can be reduced when teenage mothers have supportive relationships and some control over resources. Improving healthcare access

therefore requires coordinated interventions at household, community and health-system levels that address both the immediate barriers to care and the broader social and economic conditions that produce teenage mothers' vulnerability.

5.4 Recommendations

Based on the findings and conclusions of the study, the following recommendations are proposed to improve healthcare access among teenage mothers in Walukuba Village, Masese, Jinja City.

5.4.1 Healthcare Providers

Healthcare providers should strengthen adolescent-friendly and respectful healthcare services for teenage mothers. Young mothers should be treated without judgement, humiliation or negative comments related to their age, pregnancy or relationship status. Healthcare workers should communicate in a supportive manner, allow teenage mothers to ask questions and involve them directly in decisions concerning their own health and that of their children.

Health facilities should also improve privacy and confidentiality, particularly when discussing sensitive issues such as family planning, sexual relationships, partner involvement and reproductive health. Where possible, consultations involving sensitive information should be conducted away from other patients. Healthcare providers should also explain treatment instructions in simple language and confirm that teenage mothers have understood the information provided before they leave the facility.

Health workers should routinely identify teenage mothers who are experiencing financial hardship, family rejection, partner abandonment or other social challenges and refer them to available social workers, VHTs, counsellors or community support programmes. Clear and confidential mechanisms should also be established through which teenage mothers can report disrespectful treatment without fear of retaliation.

5.4.2 Parents and Extended Family Members

Parents, grandparents, aunts, sisters and other relatives should provide continued emotional, financial and practical support to teenage mothers. Although teenage pregnancy may initially cause disappointment within families, rejection and prolonged blame may worsen healthcare delays, emotional distress and dependence. Families should therefore prioritise the health and wellbeing of the teenage mother and her child while supporting her to rebuild her future.

Family members should encourage timely antenatal, postnatal and child-health attendance and assist with transport, childcare and healthcare decisions where necessary. However, support should not remove the teenage mother's voice in decisions concerning her own healthcare. Teenage mothers should gradually be encouraged to participate independently in decisions and develop confidence in communicating with healthcare providers.

Families should also support teenage mothers who wish to return to school, undertake vocational training or participate in safe income-generating activities. Strengthening their educational and economic opportunities would reduce long-term dependence and improve their ability to meet healthcare costs independently.

5.4.3 Fathers of the Children and Male Partners

Fathers of children born to teenage mothers should be actively encouraged to take consistent financial, emotional and caregiving responsibility. This can be promoted through family counselling, community dialogues and male-involvement sessions conducted by healthcare workers, Village Health Teams, religious leaders and local leaders. These sessions should clearly explain fathers' responsibilities towards the health and welfare of both the teenage mother and the child and emphasise that paternal responsibility should continue regardless of whether the relationship with the teenage mother remains intact.

Healthcare facilities should also encourage male partners to participate in antenatal, postnatal and child-health education where appropriate. Involving fathers in these services can help them understand the costs of pregnancy, childbirth, immunisation, treatment and everyday childcare, while also promoting shared decision-making and caregiving. Families should involve fathers early in discussions about the pregnancy and the child's needs rather than contacting them only during financial emergencies. Positive examples of responsible fatherhood within the community can also be used during sensitisation activities to challenge the perception that pregnancy and childcare are solely the responsibility of the girl.

Where fathers repeatedly refuse to provide support or deny responsibility, local leaders and relevant community structures should facilitate family mediation and follow-up to encourage them to fulfil their parental obligations. Where informal mediation fails, teenage mothers and their families should be informed about available child-protection and legal mechanisms through which support for the child may be pursued. Combining sensitisation, counselling, community accountability and formal mechanisms would provide a stronger approach to encouraging fathers to take responsibility than relying on voluntary support alone.

5.4.4 Village Health Teams

Village Health Team members should be strengthened to continue serving as an accessible link between teenage mothers and formal healthcare services. VHTs should receive regular training on adolescent maternal health, pregnancy danger signs, newborn and child-health conditions, family planning, respectful communication and referral procedures.

VHTs should conduct targeted follow-up of vulnerable teenage mothers, especially those who have missed antenatal or postnatal appointments, lack family support or face financial barriers. They should provide clear information about when a health problem requires immediate referral rather than self-medication or treatment from a drug shop.

The Ministry of Health and local authorities should also improve facilitation and logistical support for VHTs. Their role should not depend entirely on unpaid personal effort if they are expected to provide consistent health education, referral and follow-up within the community.

5.4.5 Community and Religious Leaders

Community and religious leaders should conduct regular sensitisation aimed at reducing stigma against teenage mothers. Community messages should discourage labelling teenage mothers as careless, stubborn or morally failed and instead promote supportive responses that encourage them to seek healthcare and continue education or skills development.

Religious leaders, local council leaders and other influential community members should encourage families to support teenage mothers rather than isolate or reject them. They should also promote greater accountability among fathers and challenge social norms that place almost all responsibility for pregnancy and childcare on girls.

Community leaders should further help connect teenage mothers to VHTs, counselling services, healthcare facilities, vocational programmes and any existing organisations that provide support to young mothers.

5.4.6 Government and Local Authorities

Government and local authorities should strengthen social-protection mechanisms that specifically respond to the needs of vulnerable teenage mothers. Transport assistance, emergency healthcare support and access to essential maternal and child-health supplies should be considered for teenage mothers from economically disadvantaged households.

Healthcare facilities serving communities such as Walukuba should maintain adequate supplies of essential medicines and maternal-health commodities so that teenage mothers are not routinely required to purchase prescribed medicines outside government facilities. Reducing out-of-pocket expenditure would directly address one of the major barriers identified by the study.

Government should also strengthen implementation of school re-entry policies for teenage mothers and expand access to affordable vocational training. Teenage mothers who are unable to immediately return to formal education should have opportunities to acquire practical skills that can support safe and sustainable income generation.

5.4.7 Non-Governmental and Community-Based Organisations

NGOs and community-based organisations should develop or expand programmes specifically targeting teenage mothers. Such programmes should combine healthcare referral, counselling, psychosocial support, livelihood training, childcare assistance and educational reintegration rather than addressing only one aspect of their vulnerability.

Peer-support groups should be established within communities so that teenage mothers can share experiences, receive health information and obtain emotional encouragement from others facing similar circumstances. These groups could also serve as platforms for linking teenage mothers to VHTs, healthcare workers and livelihood programmes.

Organisations offering support should improve community awareness about where their services are located and how teenage mothers can access them. The study found that some

participants had heard about programmes for young mothers but did not know how to find or join them.

5.4.8 Economic Empowerment of Teenage Mothers

Economic empowerment should be treated as an important component of improving healthcare access among teenage mothers. Government programmes, non-governmental organisations, community-based organisations and local leaders should support the establishment of income-generating activities (IGAs) specifically targeting teenage mothers. These may include tailoring, hairdressing, catering, poultry keeping, small-scale retail businesses, crafts and other locally viable activities that can generate regular income. Support should go beyond skills training to include start-up capital, equipment, business mentorship and basic financial-management education so that teenage mothers are able to establish and sustain their own livelihoods.

The IGAs should be designed in ways that recognise the childcare responsibilities of teenage mothers. Community-based activities, flexible training schedules and childcare support would enable mothers to participate without having to leave their babies unattended for long periods. Where possible, teenage mothers could also be organised into small groups or savings associations through which they can undertake joint businesses, access revolving funds and support one another in maintaining their livelihood activities.

Savings initiatives should also be encouraged to help teenage mothers gradually build emergency funds for transport, medicines and other healthcare-related expenses. However, savings alone may not be sufficient where incomes are very low and unstable. Economic empowerment interventions should therefore combine IGAs, start-up support, savings opportunities and linkage to existing social-protection programmes. Strengthening teenage mothers' ability to earn and control their own income would reduce dependence on relatives and male partners and improve their capacity to make timely healthcare decisions for themselves and their children.

5.4.9 Teenage Mothers

Teenage mothers should be encouraged to seek antenatal, postnatal and child-health services promptly and to follow recommended appointment schedules as far as possible. They should make use of VHTs and qualified healthcare providers when uncertain about pregnancy or child-

health danger signs rather than relying solely on self-medication or repeated drug-shop treatment.

Teenage mothers should also be encouraged to participate actively in healthcare consultations, ask questions where information is unclear and request privacy when discussing sensitive reproductive-health concerns. Where they experience disrespectful treatment, they should be informed about available complaints or support mechanisms rather than feeling that silence is their only option.

Finally, teenage mothers should be encouraged to pursue opportunities for education, vocational training and safe income generation. Their transition to motherhood should not be interpreted as the end of their educational or economic future. Strengthening confidence, knowledge and economic independence would improve both their wellbeing and their capacity to make timely healthcare decisions for themselves and their children.

5.5 Further Research

Further research should be conducted using larger samples of teenage mothers drawn from different communities in Jinja City and other parts of Uganda to determine whether the financial, social, gender-related and healthcare-access challenges identified in Walukuba Village are similar in other settings. The present study focused only on teenage mothers and therefore captured their lived experiences without directly obtaining the perspectives of other actors who may influence healthcare access. Future studies should therefore broaden the participant base to include fathers of the children, parents and guardians, Village Health Team members, healthcare workers, local leaders and representatives of organisations supporting teenage mothers.

Future researchers should also consider using additional qualitative methods such as key informant interviews (KIIs) with healthcare providers, VHTs, local leaders and programme staff, as well as focus group discussions with selected community members where appropriate. These methods could provide complementary perspectives on provider attitudes, community norms, paternal responsibility, referral systems and the availability of support services. Further studies may also examine how teenage mothers' experiences change over time from pregnancy through childbirth and the postnatal period, particularly in relation to education, employment, economic independence and healthcare autonomy. Intervention-based research is also recommended to assess the effectiveness of transport support, adolescent-friendly healthcare

services, peer-support groups, VHT follow-up, family counselling, male-partner involvement, vocational training and economic empowerment in improving timely, affordable and respectful healthcare access among teenage mothers.

REFERENCES

Achieng, A., Ajayi, A. I., & Kabiru, C. W. (2025). "Trying not to be seen": A qualitative study exploring adolescent girls' experiences seeking antenatal care in a Nairobi informal settlement. *BMJ Open, 15*(6), e093696. doi:10.1136/bmjopen-2024-093696

Alanyo, L. G., Masereka, E. M., Pebolo, P. F., & Kimera, E. (2025). Photo-voicing experiences of teenage mothers with teenage pregnancy and motherhood in Western Uganda. *PLOS ONE, 20*(11), e0335413. doi:10.1371/journal.pone.0335413

Alanyo, L. G., Vindevogel, S., Kimera, E., Atuyambe, L. M., & Bilsen, J. (2026). Barriers and facilitators of reproductive autonomy of adolescent girls in western Uganda: A qualitative inquiry. *Sexual and Reproductive Health Matters, 33*(1), 2683272. doi:10.1080/26410397.2026.2683272

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1–10.

Aragaw, F. M., Teklu, R. E., Belay, D. G., Negash, W. D., Fetene, S. M., Alemu, T. G., Eshetu, H. B., Fentie, E. A., Shewarega, E. S., & Asmamaw, D. B. (2023). Individual and community level predictors of women's autonomy in health care decision-making among youth in East African countries: A multilevel analysis. *BMJ Open, 13*(6), e066975. doi:10.1136/bmjopen-2022-066975

Banke-Thomas, A., Ayomoh, F. I., Abejirinde, I. O. O., Banke-Thomas, O., Eboreime, E. A., & Ameh, C. A. (2021). Cost of utilising maternal health services in low- and middle-income countries: A systematic review. *International Journal of Health Policy and Management, 10*(9), 564–577. doi:10.34172/ijhpm.2020.104

Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014). Facilitators and barriers to facility-based delivery in low- and middle-income countries: A qualitative evidence synthesis. *Reproductive Health, 11*, 71. doi:10.1186/1742-4755-11-71

Chemutai, V., Nteziyaremye, J., & Wandabwa, G. J. (2020). Lived experiences of adolescent mothers attending Mbale Regional Referral Hospital: A phenomenological study. *Obstetrics and Gynecology International, 2020*, 8897709. doi:10.1155/2020/8897709

Chol, C., Negin, J., Agho, K. E., & Cumming, R. G. (2019). Women's autonomy and utilisation of maternal healthcare services in 31 Sub-Saharan African countries: Results from the

demographic and health surveys, 2010–2016. *BMJ Open, 9*(3), e023128. doi:10.1136/bmjopen-2018-023128

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, *38*(5), 300–314.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications.

Cumber, S. N., Atuhaire, C., Namuli, V., Bogren, M., & Elden, H. (2022). Barriers and strategies needed to improve maternal health services among pregnant adolescents in Uganda: A qualitative study. *Global Health Action, 15*(1), 2067397. doi:10.1080/16549716.2022.2067397

Erasmus, M. O., Knight, L., & Dutton, J. (2020). Barriers to accessing maternal health care amongst pregnant adolescents in South Africa: A qualitative study. *International Journal of Public Health, 65*(4), 469–476. doi:10.1007/s00038-020-01374-7

Farih, O. A., Mohamed, S. H., Abdillahi, A. M., Abokor, A. H., Ali, M. A., Muse, A. H., & Abdikarim, H. (2026). Financial barriers and inequalities in healthcare access across East Africa: Evidence from demographic and health surveys. *Frontiers in Reproductive Health, 7*, 1730560. doi:10.3389/frph.2025.1730560

Filippi, V., Chou, D., Ronsmans, C., Graham, W., & Say, L. (2016). Levels and causes of maternal mortality and morbidity. In R. E. Black, R. Laxminarayan, M. Temmerman, & N. Walker (Eds.), *Reproductive, maternal, newborn, and child health: Disease control priorities* (3rd ed., Vol. 2, pp. 51–70). The International Bank for Reconstruction and Development/The World Bank.

Ganle, J. K., Obeng, B., Segbefia, A. Y., Mwinyuri, V., Yeboah, J. Y., & Baatiema, L. (2015). How intra-familial decision-making affects women's access to, and use of maternal healthcare services in Ghana: A qualitative study. *BMC Pregnancy and Childbirth, 15*, 173. doi:10.1186/s12884-015-0590-4

Gebeyehu, N. A., Gelaw, K. A., Lake, E. A., Adela, G. A., Tegegne, K. D., & Shewangashaw, N. E. (2022). Women decision-making autonomy on maternal health service and associated factors in low- and middle-income countries: Systematic review and meta-analysis. *Women's Health, 18*, 17455057221122618. doi:10.1177/17455057221122618

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Hackett, K., Lenters, L., Vandermorris, A., LaFleur, C., Newton, S., Ndeki, S., & Zlotkin, S. (2019). How can engagement of adolescents in antenatal care be enhanced? Learning

from the perspectives of young mothers in Ghana and Tanzania. *BMC Pregnancy and Childbirth, 19*, 184. doi:10.1186/s12884-019-2326-3

House, J. S. (1981). *Work stress and social support*. Addison-Wesley.

Kish, L. (1965). *Survey sampling*. John Wiley & Sons.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385. doi:10.1146/annurev.soc.27.1.363

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 365*(9464), 1099–1104.

Matovu, J. K. B., Amongin, D., Akulume, M., Tuhebwe, D., Murungi, I., & Wanyenze, R. K. (2025). Contraception decision-making autonomy among adolescent girls and young women in Uganda. *npj Women's Health, 3*, 14. doi:10.1038/s44294-025-00066-y

Mekonnen, T., Dune, T., & Perz, J. (2019). Maternal health service utilisation of adolescent women in sub-Saharan Africa: A systematic scoping review. *BMC Pregnancy and Childbirth, 19*, 366. doi:10.1186/s12884-019-2501-6

Mizero, D., Dusingize, M. I., Shimwa, A., Uwimana, A., Waka, T. Y., & Wong, R. (2024). Assessing the experiences of teenage mothers in accessing healthcare in Rwanda. *BMC Public Health, 24*, 2309. doi:10.1186/s12889-024-19769-z

Mizero, D., Shimwa, A., Dusingize, M. I., Uwimana, A., Yohannes, T., & Wong, R. (2026). Exploring the lived socioeconomic experiences of teen mothers in Rwanda. *Reproductive Health, 23*, 60. doi:10.1186/s12978-026-02278-0

Muchemwa, G., & Khozah, M. Y. (2025). Accessibility and barriers to maternal health services for adolescents in Sub-Saharan Africa: A scoping review. *Therapeutic Advances in Reproductive Health, 19*, 26334941251403814. doi:10.1177/26334941251403814

Nabugoomu, J., Seruwagi, G. K., Corbett, K., Kanyesigye, E., Horton, S., & Hanning, R. (2018). Needs and barriers of teen mothers in rural Eastern Uganda: Stakeholders' perceptions regarding maternal/child nutrition and health. *International Journal of Environmental Research and Public Health, 15*(12), 2776. doi:10.3390/ijerph15122776

Nabugoomu, J., Seruwagi, G. K., Corbett, K., Horton, S., & Hanning, R. (2020). Perceived opportunities and challenges of family and community members in supporting teen mothers in rural Eastern Uganda. *African Journal of Reproductive Health, 24*(3), 88–100. doi:10.29063/ajrh2020/v24i3.10

Nalwadda, G., Mirembe, F., Byamugisha, J., & Faxelid, E. (2010). Persistent high fertility in Uganda: Young people recount obstacles and enabling factors to use of contraceptives. *BMC Public Health, 10,* 530. doi:10.1186/1471-2458-10-530

Namutebi, M., Kabahinda, D., Mbalinda, S. N., Nabunya, R., Nanfuka, D. G., Kabiri, L., Ngabirano, T. D., & Muwanguzi, P. A. (2022). Teenage first-time mothers' perceptions about their health care needs in the immediate and early postpartum period in Uganda. *BMC Pregnancy and Childbirth, 22*, 743. doi:10.1186/s12884-022-05062-7

Ninsiima, A. B., Leye, E., Michielsen, K., Kemigisha, E., Nyakato, V. N., & Coene, G. (2018). "Girls have more challenges; they need to be locked up": A qualitative study of gender norms and the sexuality of young adolescents in Uganda. *International Journal of Environmental Research and Public Health, 15*(2), 193. doi:10.3390/ijerph15020193

Ninsiima, A. B., Michielsen, K., Kemigisha, E., Nyakato, V. N., Leye, E., & Coene, G. (2020). Poverty, gender and reproductive justice: A qualitative study among adolescent girls in Western Uganda. *Culture, Health & Sexuality, 22*(sup1), 65–79. doi:10.1080/13691058.2019.1660406

Nove, A., Matthews, Z., Neal, S., & Camacho, A. V. (2014). Maternal mortality in adolescents compared with women of other ages: Evidence from 144 countries. *The Lancet Global Health, 2*(3), e155–e164. doi:10.1016/S2214-109X(13)70179-7

Onukwugha, F., Agaba, P., Hayter, M., & Orton, B. (2022). Unmarried adolescents' experiences of using reproductive and maternal health services in Nigeria and Uganda: A qualitative study. *Social Sciences, 11*(5), 203. doi:10.3390/socsci11050203

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K., … Viner, R. M. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet, 387*(10036), 2423–2478. doi:10.1016/S0140-6736(16)00579-1

Sakakibara, K., Murray, S. M., Arima, E. G., Ojuka, C., & Familiar-Lopez, I. (2024). Exploring pregnancy-related stigma experiences among adolescents in rural Uganda. *Journal of Adolescence, 96*(7), 1581–1589. doi:10.1002/jad.12364

Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health: Social determinants of health discussion paper 2 (Policy and practice).* World Health Organization.

Sully, E. A., Biddlecom, A., Darroch, J. E., Riley, T., Ashford, L. S., Lince-Deroche, N., Firestein, L., & Murro, R. (2020). *Adding it up: Investing in sexual and reproductive health 2019*. Guttmacher Institute.

Teshale, M. Y., Bante, A., Belete, A. G., Crutzen, R., Spigt, M., & Stutterheim, S. E. (2025). Barriers and facilitators to maternal healthcare in East Africa: A systematic review and qualitative synthesis of perspectives from women, their families, healthcare providers, and key stakeholders. *BMC Pregnancy and Childbirth, 25*, 111. doi:10.1186/s12884-025-07225-8

Tolossa, T., Gold, L., Dheresa, M., Turi, E., Yeshitila, Y. G., & Abimanyi-Ochom, J. (2024). Adolescent maternal health services utilization and associated barriers in Sub-Saharan Africa: A comprehensive systematic review and meta-analysis before and during the Sustainable Development Goals. *Heliyon, 10*(15), e35629. doi:10.1016/j.heliyon.2024.e35629

Uganda Bureau of Statistics. (2023). *Uganda Demographic and Health Survey 2022*. Uganda Bureau of Statistics.

Wang, X., & Cheng, Z. (2020). Cross-sectional studies: Strengths, weaknesses, and recommendations. *Chest, 158*(1 Suppl.), S65–S71. doi:10.1016/j.chest.2020.03.012

Webb, L., Kyaddondo, D., Ford, T., Bergqvist, A., & Cox, N. (2023). Psychosocial health in adolescent unmarried motherhood in rural Uganda: Implications for community-based collaborative mental health education, and empowerment strategies in the prevention of depression and suicide. *Transcultural Psychiatry, 60*(3), 537–551. doi:10.1177/13634615221147361

World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the Commission on Social Determinants of Health*. World Health Organization.

World Health Organization. (2021). *Assessing and supporting adolescents' capacity for autonomous decision-making in health care settings: A tool for health-care providers*. World Health Organization.

World Health Organization. (2023). *Global health estimates: Leading causes of death and disability*. World Health Organization.

World Health Organization. (2024). *Adolescent pregnancy*. World Health Organization.

APPENDICES

APPENDIX I: IN-DEPTH INTERVIEW GUIDE FOR TEENAGE MOTHERS

Study title

Socio-Economic and Gender-Related Challenges Experienced by Teenage Mothers in Accessing Healthcare Services: A Qualitative Case Study of Walukuba Village, Masese, Jinja City

Purpose of the interview

This interview seeks to understand the socio-economic and gender-related challenges experienced by teenage mothers when accessing healthcare services. It will explore financial challenges, stigma and discrimination, social support, gender norms and power relations, and the coping strategies teenage mothers use when seeking healthcare.

Target participants

Teenage mothers aged 13–19 years who are currently pregnant or have given birth within the preceding twelve months and reside in Walukuba Village.

Estimated duration

Approximately 40–60 minutes.

Interview identification information

Participant code: _____

Date of interview: _____

Place of interview: _____

Start time: _____

End time: _____

Language used: _____

Name/code of interviewer: _____

Permission to audio-record obtained: Yes [ ] No [ ]

Instructions to the interviewer

1. Conduct the interview in a private, quiet and safe place.
2. Introduce yourself and explain the purpose of the study in simple language.
3. Confirm that informed consent or assent and, where applicable, permission from a parent or guardian have been obtained.

4. Remind the participant that participation is voluntary and that she may decline to answer any question or stop the interview at any time.
5. Do not express judgment, blame, surprise or disagreement with the participant's responses.
6. Ask one question at a time and allow the participant enough time to respond.
7. Use neutral probes such as:
    - Please tell me more about that.
    - How did that happen?
    - How did that make you feel?
    - Can you give me an example?
    - What happened after that?
    - How did it affect your decision to seek healthcare?
    - What support did you receive?
8. Do not pressure the participant to disclose experiences of violence, abuse or other sensitive matters.
9. Pause the interview when the participant becomes uncomfortable or distressed. Ask whether she would like to continue, take a break or stop.
10. Record relevant non-verbal observations and field notes without including information that could directly identify the participant.

Opening statement

Thank you for agreeing to participate in this interview. I am interested in learning about your experiences as a teenage mother and the challenges you may have faced when seeking healthcare services. There are no right or wrong answers. Everything you share will be treated confidentially and used only for academic purposes. You may choose not to answer any question, and you may stop the interview at any time.

Before we begin, do you have any questions?

May we proceed with the interview?

Yes [ ] No [ ]

Section A: Participant Background

1. **Please tell me a little about yourself.**

   Possible probes: Age, current pregnancy or motherhood status, age of the baby, current

living arrangements, school attendance, employment or income-generating activities, relationship status.

2. **Please tell me about the healthcare services you have needed during pregnancy, childbirth or after delivery.**

   Possible probes: Antenatal care, delivery services, postnatal care, family-planning services, child immunisation, treatment when the mother or baby became sick, counselling or mental-health support.

3. **Where do you usually go when you or your baby needs healthcare?**

   Possible probes: Public health facility, private clinic, pharmacy or drug shop, traditional healer or birth attendant, Village Health Team member, other sources of care.

4. **Please describe a recent experience when you needed to seek healthcare for yourself or your baby.**

   Possible probes: What led to the decision to seek care, who helped make the decision, means of transport used, what happened at the facility, whether the required care was received.

Section B: Financial Challenges

Objective One: To explore the financial challenges experienced by teenage mothers when seeking healthcare services

5. **What financial challenges have you experienced when seeking healthcare services?**

   Possible probes: Transport costs, consultation charges, medicines, laboratory tests, medical supplies or mama kits, food while attending a facility, childcare costs, informal payments.

6. **How do you usually obtain money for healthcare-related expenses?**

   Possible probes: Parents or guardians, male partner or father of the child, relatives, friends or neighbours, personal work or business, borrowing, savings groups, community organisations.

7. **Have you ever delayed, missed or stopped seeking healthcare because you did not have enough money?**

   Possible probes: Service required, length of delay, alternatives used, consequences for the mother or baby.

8. **How does depending on another person for money affect your ability to seek healthcare?**

Possible probes: Need to ask for permission, refusal to provide money, delays in receiving money, another person choosing the health facility, effect on independence.

9. **In what ways have pregnancy or motherhood affected your education, employment or ability to earn money?**

   Possible probes: Leaving or interrupting school, loss of employment, difficulty finding work, childcare responsibilities, dependence on others, loss of personal income.

Section C: Social Stigma and Discrimination

Objective Two: To examine how social stigma and discrimination influence teenage mothers' healthcare-seeking experiences

10. **How are teenage mothers generally viewed or treated in this community?**

    Possible probes: Treatment by parents and relatives, male partners, friends and peers, neighbours, religious leaders, community leaders.

11. **Have you personally experienced blame, rejection, embarrassment or unfair treatment because of becoming pregnant or having a child at a young age?**

    Possible probes: What happened, who was involved, emotional effects, influence on where or when healthcare was sought.

12. **Please describe how healthcare workers have treated you when you sought care.**

    Possible probes: Respectful or disrespectful communication, judgmental questions or comments, shouting or harsh language, being ignored, receiving less attention than older mothers, supportive or caring treatment.

13. **Have you ever worried that healthcare workers or other patients would judge you because of your age?**

    Possible probes: Delaying or avoiding care, choosing another facility, hiding the pregnancy or motherhood, attending with another person for support.

14. **How would you describe the privacy and confidentiality provided when you seek healthcare?**

    Possible probes: Whether sensitive questions were asked privately, whether other patients could hear, freedom to speak openly, fear that information would be shared without permission.

Section D: Gender Norms and Unequal Power Relations

Objective Three: To assess how gender norms and unequal power relations influence teenage mothers' access to healthcare services

15. **In your community, what is generally expected of a girl who becomes pregnant or has a child while still a teenager?**

Possible probes: Expected behaviour, household work, childcare, schooling, marriage or relationships, obedience to parents or partners, responsibility for the pregnancy.

16. **How are teenage mothers treated compared with the boys or men responsible for their pregnancies?**

    Possible probes: Who is blamed, who carries responsibility for the baby, who experiences social consequences, whether the father is expected to provide support, what happens when he denies responsibility.

17. **Who usually makes decisions about whether, when and where you seek healthcare?**

    Possible probes: The teenage mother herself, parent or guardian, male partner, older relative, healthcare provider, joint decision-making.

18. **Have you ever been prevented, discouraged or delayed from seeking healthcare by a family member or partner?**

    Possible probes: Refusal to provide money, refusal to give permission, restricting movement, choosing the facility on the participant's behalf, preventing family-planning use, controlling healthcare information.

19. **How does your relationship with the father of the child affect your ability to access healthcare?**

    Possible probes: Financial support, emotional support, accompaniment to health facilities, participation in decisions, denial of responsibility, abandonment, controlling behaviour.

20. **Do household work and childcare responsibilities affect your ability to seek healthcare?**

    Possible probes: Lack of childcare, inability to leave home, missed appointments, tiredness or lack of time, need for permission from household members.

21. **When speaking with healthcare workers, do you feel able to ask questions and participate in decisions about your own care?**

    Possible probes: Whether explanations are given directly, decisions made by adults without involvement, ability to disagree or request another option, whether the participant feels respected as a mother and patient.

Section E: Social Support

Objective Four: To explore the nature and adequacy of social support available to teenage mothers

22. **Who provides you with support when you need healthcare?**

    Possible probes: Parents or guardians, male partner, older female relatives, friends or peers, neighbours, religious groups, Village Health Team members, community leaders, non-governmental organisations.

23. **What kinds of support do you receive?**

    Possible probes: Money, transport, childcare, emotional encouragement, healthcare information, accompaniment to facilities, assistance obtaining medicines, referral to services.

24. **How adequate is the support you receive in meeting your healthcare needs?**

    Possible probes: Reliable support, insufficient support, missing support, withdrawal of support, effects of inadequate support on healthcare access.

25. **Have you ever received support from a Village Health Team member, healthcare worker, community organisation, religious organisation or teenage-mother support group?**

    Possible probes: Type of assistance provided, how the service was identified, ease of access, usefulness of the support, areas for improvement.

26. **What additional support would make it easier for teenage mothers to access healthcare?**

    Possible probes: Financial assistance, transport, childcare, counselling, peer-support groups, skills training, family mediation, adolescent-friendly healthcare services.

Section F: Coping Mechanisms

Objective Five: To understand the coping strategies used to overcome socio-economic and gender-related barriers

27. **What do you usually do when you face difficulties accessing healthcare?**

    Possible probes: Borrowing money, asking relatives or friends for help, seeking support from a partner, contacting a VHT member, changing healthcare facilities, rescheduling visits, seeking treatment from a pharmacy or drug shop, self-medication, delaying or skipping care.

28. **Which coping strategies have helped you most?**

    Possible probes: Reasons the strategy was helpful, who provided support, whether it enabled receipt of required care, whether the strategy would be used again.

29. **Which strategies have not worked well or have created additional difficulties?**

    Possible probes: Increased debt, delayed treatment, inappropriate medication, conflict with family or partners, stigma or embarrassment, health complications.

30. **How do you respond when you experience disrespect, stigma or discrimination in a healthcare setting?**

    Possible probes: Remaining silent, reporting the incident, asking another person to speak on the participant's behalf, changing facilities, avoiding future visits, seeking help from a community leader or VHT member.

31. **What personal strengths, beliefs or sources of encouragement help you continue seeking healthcare?**

    Possible probes: Concern for the baby, advice from relatives, religious faith, previous positive healthcare experiences, personal determination, peer encouragement.

Closing statement

Thank you for your time and for sharing your experiences. The information you have provided is important for understanding the challenges faced by teenage mothers. Your responses will remain confidential and will be used only for academic purposes.

Before we finish, how are you feeling after discussing these experiences?

APPENDIX V: INFORMED CONSENT AND ASSENT FORM FOR STUDY PARTICIPANTS

Study Title

Socio-Economic and Gender-Related Challenges Experienced by Teenage Mothers in Accessing Healthcare Services: A Qualitative Case Study of Walukuba Village, Masese, Jinja City

Introduction

You are invited to participate in this study because you have information relevant to the experiences of teenage mothers in accessing healthcare services. Before agreeing to participate, please read or listen to the information below.

Purpose of the Study

The purpose of the study is to explore the financial, social and gender-related challenges experienced by teenage mothers when accessing healthcare services.

Study Procedures

Participation will involve an individual interview lasting approximately 30–60 minutes. With your permission, the interview may be audio-recorded. You may refuse to be recorded and still participate in the study.

Voluntary Participation

Participation is voluntary. You may refuse to answer any question or withdraw from the study at any time without penalty.

Risks and Benefits

Some questions may make you uncomfortable because they concern personal, family or healthcare experiences. You may skip such questions or stop the interview. There may be no direct benefit to you, but the findings may help improve understanding of the challenges teenage mothers face.

Confidentiality

Your name will not be included in the interview notes, transcripts or final report. A participant code will be used instead. The information collected will be stored securely and used only for academic purposes.

Consent for Participants Aged 18 Years and Above

I confirm that the purpose and procedures of the study have been explained to me. I understand that participation is voluntary and that I may withdraw at any time. I freely agree to participate.

Participant's name: _____

Signature or thumbprint: _____

Date: _____

Permission to audio-record: Yes [ ] No [ ]

Researcher's name: _____

Researcher's signature: _____

Date: _____

Assent for Participants Below 18 Years

The study has been explained to me in a language I understand. I know that I may refuse to answer any question or stop the interview at any time. I freely agree to participate.

Participant's name: _____

Age: _____

Signature_____

Date: _____

Parent or Guardian Permission

I confirm that the study has been explained to me. I understand that participation is voluntary, and I give permission for the teenage mother named above to participate.

Parent or guardian's name: _____

Relationship to participant: _____

Signature: _____

Date: _____

Researcher's signature: _____