MOTHERHOOD IN ADOLESCENCE:

VOICES FROM THE MARGINS

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This is report presents the results of a survey on the experiences of young mothers in Iganga (rural) and Kawempe (urban low-income locale) in Uganda. The project was implemented between April 2021 and November 2024. Contact the Principal investigator for more information at doriskakuru@uvic.ca or visit our website: https://onlineacademiccommunity.uvic.ca/cmv/

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
GPS	Global Positioning System
HIV	Human Immunodeficiency Virus
NGO	Non-Government Organisation
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
UBOS	Uganda Bureau of Statistics

Executive Summary

This groundbreaking study was conducted by scholars at the University of Victoria, Canada, Makerere University, and Nascent Research and Development Organisation (NRDO-U). The report presents findings from a survey conducted in Bulamagi Sub County, Iganga district, and Kawempe Division, Kampala City, among girls aged 10-19.

The study aimed to investigate the complex interplay of gendered, generational, structural, and cultural forces that shape the experiences of young motherhood in rural and urban Uganda. The results show that young mothers in the age range of 10-19 require targeted supports to overcome barriers to accessing services, information and products about Sexual and Reproductive Health and Rights (SRHR).

METHODS

We utilized a cross-sectional survey design and a participatory youth peer research approach to research. The data collection questionnaire was translated into local languages and administered via the KoBo Toolbox platform. Data was collected by young mothers or girls who have been pregnant or are parenting a child. Data were analyzed using STATA 5.0, which facilitated the analysis of descriptive statistics and a test of independence using Pearson's Chi-square test.

SNAPSHOT OF THE DATA

Prevalence of young motherhood

- There were more young mothers in Iganga than in Kawempe. Slightly more than a quarter (28%) of the girls who completed the survey in Kawempe and almost half of those in Iganga (47.4%) have ever been pregnant, although not all of them carried the baby to term.
- Most of the young mothers met the men who made them pregnant at their (girls') home, and many of the men were 1–6 years older.
- The age at which girls first got pregnant did not significantly differ between Kawempe and Iganga.
- Most girls (53.9%) in Kawempe and (74.4%) in Iganga were supported by their mothers during pregnancy.
- The biggest fear expressed about teenage pregnancy was being a burden to family members (51% in Kawempe and 21% in Iganga). About 51% of the girls in Iganga were terrified about the possibility of being dismissed from home after getting pregnant.

Perceptions about Young Motherhood

- About 20% of the young mothers in Kawempe and 46.7% of those in Iganga were not particularly proud of being young mothers.
- Community perceptions of young motherhood were rated as 'bad' by 35.5% of the respondents in Kawempe and 40.7% in Iganga.

Access to SRHR Information, products and services

- Parents are the primary source of information (53.9% for Kawempe and 36.2% for Iganga).
- Over half of the girls who have ever been pregnant (62.6% in Kawempe and 52.7% in Iganga) wish they knew how to avoid unwanted pregnancy.
- Girls as young as 10 are sexually active, and some of them become pregnant.
- Girls who completed the survey need help accessing menstrual hygiene products, including underwear.
- Some young mothers got pregnant after having sex to meet a one-time financial need (15% in Kawempe and 5.5% in Iganga).

Access to SRHR Services

- Access to antenatal services by young mothers was characterized by long wait times, and 56% experienced challenges at the health facility.
- Of the young mothers who delivered at a healthcare facility, only 37.9% were satisfied with the services, and 20.9% were very satisfied.
- More girls in Kawempe than Iganga are within 30 minutes of walking distance to public health facilities, primary school, secondary school and police station.
- Many girls (60%) left school between the ages of 14 and 16 due to a lack of school fees and other requirements (63.8%), the COVID-19 lockdown (31.5%), pregnancy (14.3%), and other reasons.

Adolescent SRH Rights

- At least 30% of the girls who completed the survey in Kawempe underwent pregnancy tests, and 3.4% were subjected to virginity tests, while in Iganga, it was 9.6% for pregnancy tests and 2.6% for virginity tests.
- Some girls who completed the survey do not believe they have the right to report forced sex and physical

violence perpetrated by a boyfriend, partner, or husband.

Contraceptive use and antenatal services:

- About 72% of the girls do not use contraceptives, and those who are users start between the ages of 17 and 19 years of age.
- Injections accessed from health centers are the most utilized contraceptive method.
- Nearly one-third of the respondents said they find it impossible to access a condom.

CALL TO ACTION

This report represents a crucial step in addressing the SRHR concerns of girls 10-19 who are/have ever been pregnant or are parenting a child. We challenge researchers to investigate further the magnitude of barriers to accessing SRHR services, information and products among young people under 19 years of age and possible remedies from the perspective of young people. Our study was conducted in only two sites in Uganda. It would be interesting to understand the SRHR experiences of girls aged 10-19 years in in more Ugandan districts. Specifically, more research is required about the unique needs of girls aged <15 who become pregnant or mothers. They merit particular attention because they are under-researched, and their perspectives are missing in exiting scholarly knowledge.

We call upon legislators, policymakers, advocates, allies, civil society, and local leaders to devise and implement interventions to prevent teenage pregnancy focused on the family. These could include sensitizing parents/caregivers about how to keep girls safe from defilement and sexual violence in the home. More interventions could aim at changing the social norms that perpetuate teenage pregnancy-related stigma.

We challenge the relevant Ugandan government ministries to fully equip prepubescent girls with information about menstruation and how to prevent unwanted pregnancy since our results show that girls as young as 10 years are sexually active and some are using contraceptives.

We urge the central and local governments to alleviate period poverty forthwith. Alleviating period poverty will boost efforts to prevent unwanted teenage pregnancy since some girls get pregnant to meet a one-time financial need, including menstrual hygiene products.

Further, we call upon the central and local governments to ensure that health facility staff and services are adolescent-friendly. We recommend more research about the strategies for providing antenatal and postnatal services for young mothers to thrive in a context where available facilities are made for adults.

Lastly, we suggest that adolescent girls be equipped with more information about their SRHR rights. We strongly call upon the parliament of Uganda to outlaw virginity tests and pregnancy checks in schools since such practices constitute sexual violence and violate human rights.

Résumé Analytique

Cette étude révolutionnaire a été menée par des chercheurs de l'Université de Victoria, au Canada, de l'Université de Makerere et de Nascent Research and Development Organisation. Le rapport présente les résultats d'une enquête menée dans le sous-comté de Bulamagi, dans le district d'Iganga et dans la Division de Kawempe, ville de Kampala, auprès de filles âgées de 10 à 19 ans.

L'étude visait à examiner l'interaction complexe des forces sexospécifiques, générationnelles, structurelles et culturelles qui façonnent les expériences de la jeune maternité dans les zones rurales et urbaines de l'Ouganda. Les résultats montrent que les jeunes mères âgées de 10 à 19 ans ont besoin d'un soutien ciblé pour surmonter les obstacles à l'accès aux services, à l'information et aux produits relatifs à la santé et aux droits sexuels et génésiques (SRHR).

MÉTHODES

Nous avons utilisé une enquête transversale et une approche participative de la recherche par les jeunes. Le questionnaire de collecte de données a été traduit dans les langues locales et administré via la plateforme KoBo Toolbox. Les données ont été collectées par des jeunes mères ou des filles qui ont été enceintes ou qui élèvent un enfant. Les données ont été analysées à l'aide de STATA 5.0, ce qui a facilité l'analyse des statistiques descriptives et un test d'indépendance à l'aide du test du chi-carré de Pearson.

APERÇU DES DONNÉES

Prévalence de la jeune maternité:

- Les jeunes mères sont plus nombreuses à Iganga qu'à Kawempe. Un peu plus d'un quart (28%) des filles qui ont répondu à l'enquête à Kawempe et près de la moitié de celles d'Iganga (47,4%) ont déjà été enceintes, même si toutes n'ont pas mené leur grossesse à terme.
- La plupart des jeunes mères ont rencontré les hommes qui les ont mises enceintes à leur domicile (celui des filles), et beaucoup d'entre eux étaient âgés de 1 à 6 ans de plus qu'elles.
- L'âge auquel les filles sont tombées enceintes pour la première fois ne diffère pas significativement entre Kawempe et Iganga.
- La plupart des filles (53,9%) à Kawempe et (74,4%) à Iganga ont été soutenues par leur mère pendant leur grossesse.
- La plus grande crainte exprimée à propos de la grossesse chez les adolescentes était d'être un fardeau pour les membres de la famille (51% à Kawempe et 21% à Iganga). Environ 51% des filles d'Iganga étaient terrifiées à l'idée d'être renvoyées de chez elles après leur grossesse.

Perceptions de la jeune maternité

- Environ 20% des jeunes mères de Kawempe et 46,7% de celles d'Iganga n'étaient pas particulièrement fières d'être jeunes mères.
- Les perceptions communautaires de la jeune maternité ont été jugées « mauvaises » par 35,5% des personnes interrogées à Kawempe et 40,7% à Iganga.

Accès à l'information, aux produits et aux services en matière des droits de la sante sexuelle et reproductive (SRHR)

- Les parents sont la première source d'information (53,9% à Kawempe et 36,2% à Iganga).
- Plus de la moitié des filles qui ont déjà été enceintes (62,6% à Kawempe et 52,7% à Iganga) souhaiteraient savoir comment éviter une grossesse non désirée.
- Des filles de 10 ans sont sexuellement actives et certaines d'entre elles tombent enceintes.
- Les filles qui ont répondu à l'enquête ont besoin d'aide pour accéder aux produits d'hygiène menstruelle, y compris les sous-vêtements.
- Certaines jeunes mères sont tombées enceintes après avoir eu des rapports sexuels pour répondre à un besoin financier ponctuel (15% à Kawempe et 5,5% à Iganga).

Accès aux services de santé sexuelle et reproductive

- L'accès des jeunes mères aux services prénatals était caractérisé par de longs délais d'attente, et 56% d'entre elles ont rencontré des difficultés dans l'établissement de santé.
- Parmi les jeunes mères qui ont accouché dans un établissement de santé, seules 37,9% étaient satisfaites des services, et 20,9% étaient très satisfaites.
- Plus de filles à Kawempe qu'à Iganga se trouvent à moins de 30 minutes de marche des établissements de santé publique, de l'école primaire, de l'école secondaire et du poste de police.

- De nombreuses filles (60%) ont quitté l'école entre 14 et 16 ans en raison de l'absence de frais de scolarité et d'autres exigences (63,8%), du confinement COVID-19 (31,5%), de la grossesse (14,3%) et d'autres raisons.

Droits des adolescents en matière de santé sexuelle et reproductive

- Au moins 30% des filles qui ont répondu à l'enquête à Kawempe ont subi des tests de grossesse et 3,4% des tests de virginité, tandis qu'à Iganga, ce chiffre était de 9,6% pour les tests de grossesse et de 2,6% pour les tests de virginité.
- Certaines filles qui ont répondu à l'enquête ne pensent pas avoir le droit de dénoncer les rapports sexuels forcés et les violences physiques perpétrées par un petit ami, un partenaire ou un mari.

Utilisation de contraceptifs et services prénataux

- Environ 72% des filles n'utilisent pas de contraceptifs, et celles qui en utilisent commencent entre 17 et 19 ans.
- Les injections obtenues dans les centres de santé constituent la méthode contraceptive la plus utilisée.
- Près d'un tiers des personnes interrogées ont déclaré qu'il leur était impossible d'avoir accès à un préservatif.

APPEL À L'ACTION

Ce rapport représente une étape cruciale dans la prise en compte des préoccupations en matière des droits de la sante sexuelle et reproductive des filles de 10 à 19 ans qui sont/ont été enceintes ou qui élèvent un enfant. Nous invitons les chercheurs à étudier plus avant l'ampleur des obstacles à l'accès aux services, informations et produits SRHR chez les jeunes de moins de 19 ans, ainsi que les solutions possibles du point de vue des jeunes. Notre étude n'a été menée que dans deux sites en Ouganda. Il serait intéressant de comprendre les expériences des filles âgées de 10 à 19 ans en matière de SRHR dans un plus grand nombre de districts ougandais. Nous appelons les législateurs, les décideurs, les défenseurs, les alliés, la société civile et les dirigeants locaux à concevoir et à mettre en œuvre des interventions visant à prévenir les grossesses chez les adolescentes en mettant l'accent sur la famille. Il pourrait s'agir de sensibiliser les parents/soignants à la manière de protéger les filles de la défloration et de la violence sexuelle à la maison.

D'autres interventions pourraient viser à modifier les normes sociales qui perpétuent la stigmatisation liée aux grossesses précoces. Nous demandons aux ministères ougandais compétents de fournir aux filles prépubères des informations sur la menstruation et sur la prévention des grossesses non désirées, car nos résultats montrent que des filles de 10 ans sont sexuellement actives. Nous demandons instamment au gouvernement central et aux autorités locales de réduire immédiatement la pauvreté liée aux règles. La réduction de la pauvreté menstruelle renforcera les efforts de prévention des grossesses non désirées chez les adolescentes, car certaines filles tombent enceintes pour répondre à un besoin financier ponctuel, notamment en ce qui concerne les produits d'hygiène menstruelle. En outre, nous demandons au gouvernement central et aux autorités locales de veiller à ce que le personnel et les services des établissements de santé soient adaptés aux adolescents.

Nous recommandons de mener davantage de recherches sur les stratégies permettant de fournir des services prénatals et postnatals aux jeunes mères afin qu'elles puissent s'épanouir dans un contexte où les installations disponibles sont conçues pour les adultes. Enfin, nous suggérons que les adolescentes soient mieux informées sur leurs droits en matière de santé sexuelle et reproductive. Nous demandons instamment au parlement ougandais d'interdire les tests de virginité et les contrôles de grossesse dans les écoles, car ces pratiques constituent des violences sexuelles et violent les droits de l'homme.

1 INTRODUCTION

Adolescent childbearing is a global concern, affecting 41 per 1000 girls aged 15–19 years, mainly in the global south (UNFPA, 2023). UNICEF defines it as pregnancy among girls aged between 13–19 years (Mezmur et al., 2021). The African Committee of Experts on the Rights and Welfare of the Child calls teenage/young motherhood a public health emergency on the continent (ACERWC, 2022). According to a recent Uganda demographic and health survey, the teenage pregnancy rate fluctuated between 24% and 25% over the last two decades (Uganda Bureau of Statistics (UBOS), 2024).

Research on teenage/young mothers in Uganda has previously used adult-centric methodologies without the active participation of young people (ACERWC, 2022; Kakuru, 2022; Mambo et al., 2022; Nyakato et al., 2024). Apart from the work of Kamusiime (2024), while youth peer research is emerging on the continent, it barely involves teenage/young mothers/pregnant and parenting girls. Young people are in the best position to generate valuable evidence for improving their well-being, yet their exclusion from knowledge production is apparent (Cummings, 2024).

The complex combination of girls' experiences of adolescence and motherhood implies that they have unique perspectives which can best be captured through engaging peers who understand what being young and pregnant could look like. The existing scholarly literature highlights the varied challenges young mothers face, including those related to childbirth, stigma, societal rejection, limited education and income-generating opportunities, among others (ACERWC, 2022; Kakuru, 2022; Kamusiime, 2024; Nyakato et al., 2024). There is a paucity of knowledge about their resilience and agency in navigating social exclusion.

This report presents findings from a cross-sectional quantitative study conducted in Bulamagi Sub County, Iganga district, and Kawempe Division, Kampala Capital City Authority (KCCA) among girls aged 10–19. The survey was led by young mothers aged 15–19 years. Different scholars have used different terms to refer to young mothers. SmithBattle et al. (2020) have used the terms adolescent pregnancy or adolescent mothers, all of which mean "immoral" pregnancy in the Ugandan context. We, instead, adopt the term young mothers in this report to refer to girls below 19 years who have ever been pregnant (including currently pregnant) or are parenting a child. The study aimed to investigate the complex interplay of gendered, generational, structural, and cultural forces that shape young motherhood experiences and how young mothers navigate social definitions to enjoy their sexual reproductive and health rights (SRHR).

Key areas of investigation include access to information and knowledge about SRHR; societal perceptions and attitudes towards young motherhood; availability and accessibility of SRHR products and services; and challenges faced during pregnancy, childbirth, and postpartum periods.

By centring the voices of marginalized adolescent girls, this research sought to build a foundation for more effective research and advocacy skills to facilitate their negotiation for access to SRHR information, services, and products with relevant stakeholders.

The following specific objectives guided the study:

1. To examine young mothers' access to SRHR information and knowledge.
2. To identify societal perceptions about young motherhood.
3. To investigate young mothers' access to SRHR products and services.
4. To identify the challenges faced and the existing supports during pregnancy, childbirth, and postpartum periods.

Figure 1: Cartoon Image of some of the girls who collected data

The findings of this study provide valuable insights into the complex realities of young motherhood in urban (Kawempe) and rural (Iganga) settings. The results offer a nuanced picture of the similarities and differences in the SRHR experiences or girls in the age range of 10-19 living in a typical Ugandan rural or poor urban context. This research contributes to the growing literature on adolescent SRHR in Sub-Saharan Africa (Chandra-Mouli et al., 2015; Yakubu & Salisu, 2018). By examining these issues, we aim to inform evidence-based strategies for improving the lives and rights of pregnant and parenting girls in Uganda. The findings of this study have important implications for policy development, program design, and intervention strategies aimed at supporting adolescent mothers and promoting their SRHR.

In the following sections, we present a detailed analysis of the data collected, highlighting key themes and patterns that emerged from the study. The report concludes with recommendations for future research, policy, and practice to address the unique needs of young mothers in Uganda and promote their sexual and reproductive health and right

2 METHODOLOGY AND APPROACH

2.1 Study Area and Design

The study was conducted in Bulamagi Sub-County Iganga district and Kawempe Division Kampala Capital City ensuring a broad representation of girls aged 10 – 19 years. Kawempe is categorized as an urban area while Iganga is a rural area. Notably, despite being categorized as an urban area, Kawempe is one of Kampala's poor urban locales, where people with the lowest incomes live. We adopted a participatory cross-sectional survey design for this study.

2.2 Sample size determination

According to the population projections by UBOS (2023), Kawempe division and Iganga district have a total of 49,752 and 18,900 girls aged 10–19 years, respectively, on which the sampling was based. We followed the formula of Krejcie and Morgan (1970), wherein 380 participants are recommended for a population size of 50,000 and 377 participants for a population of 20,000.

Figure 2: Location of Iganga and Kampala

2.3 Recruitment

In our study, we used simple random sampling to identify the study participants. The youth peer researchers (YPRs) canvassed door-to-door to recruit survey participants. The starting point (center point) was the Local Council 1 (LC1) office, and the first home was the closest to the LC1 office. The YPRs moved to all homes until they met a boundary, such as a road. They would then move right until they reached the targeted number of girls aged 10-19.

Age (10–19 years), residence in the study area and being female were the only inclusion criteria factors. We aimed to include everyone in the age bracket regardless of their motherhood or pregnancy experiences or lack thereof. For households with more than one adolescent girl, we used the manual lottery method to select one. The YPR wrote the girls' names in that household on a paper (ballot) and put the papers in a basket. The YPR then requested the parent or caregiver to choose a name/paper. The selected name would be the representative for that household.

2.4 Data Collection

Quantitative data was collected in November 2022 using a structured questionnaire administered face-to-face to girls aged 10–19 years. The KoBoToolbox (Kobo, n.d.), an open-source tool for mobile data collection, was used to capture several data types, including GPS data (latitude, longitude and altitude) to identify a specific household uniquely.

The research instrument/questionnaire was co-designed and co-piloted by members of the research team and the YPRs. After that, the digital questionnaire was set up on

the KoBo Toolbox platform. The questionnaire was uploaded on the smart mobile devices used to collect data. We trained YPRs on how to use the KoBo Toolbox and they collected all the data.

Figure 3: A picture of one girl collecting data from a peer

2.5 Data Management and Analysis

We used the KoBo Toolbox platform to build the data collection forms, collect data on mobile devices and instantly send the data from the field to the server. We downloaded data from the server in the form of .xls, csv, and other supported formats for analysis. We later exported the survey data into STATA 5.0 to facilitate further analysis, including descriptive statistics and a test of independence using Pearson's Chi-square test. With data presented in various forms and patterns, deductions, interpretations and conclusions were drawn about the study variables.

2.6 Ethical Considerations

The authors include cisgender, adult women and adolescent girls (15-19) whose names are undisclosed for ethical reasons. Authors DK and MKM are based in Canada while the rest of the team members live in Uganda. While conducting this research we aimed to center the young mothers as knowers and knowledge co-creators and we continuously reflected on the differences in age and formal education levels between the YPRs, study participants and adult researchers, particularly during the data analysis process. The research was approved by the Makerere University School of Social Sciences Research ethics committee (protocol number MUSS-2021-76), the University of Victoria (protocol number 21-0233), and the Uganda National Council for Science and Technology (registration number SS1114ES).

Throughout the research, we adhered to guidelines set out by the UNCST, Canada's Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and UNICEF's Ethical Research Involving Children. For example, we obtained written informed consent and assent from all the caregivers and adolescents respectively. Throughout the process of data collection, we made deliberate efforts to protect YPRs and their peers from harm. For example, the YPRs were always accompanied by an adult member of the research team to ensure their safety. We also had a trained youth counsellor on call in case any adolescent experienced difficult emotions and required support. The YPRs and their peers were compensated for their time according to the requirements of the Makerere University School of Social Sciences Research Ethics committee and the UNCST.

3 FINDINGS

This chapter presents the findings of the survey, and the detailed summary table is available on the project website (see Kakuru et al., 2024a). The chapter presents the demographic characteristics, experiences of young motherhood, young mothers' access to SRHR information and knowledge, and access to SRHR services and products. Figure 4 shows the age of the girls who participated in the study.

3.1 Demographic characteristics

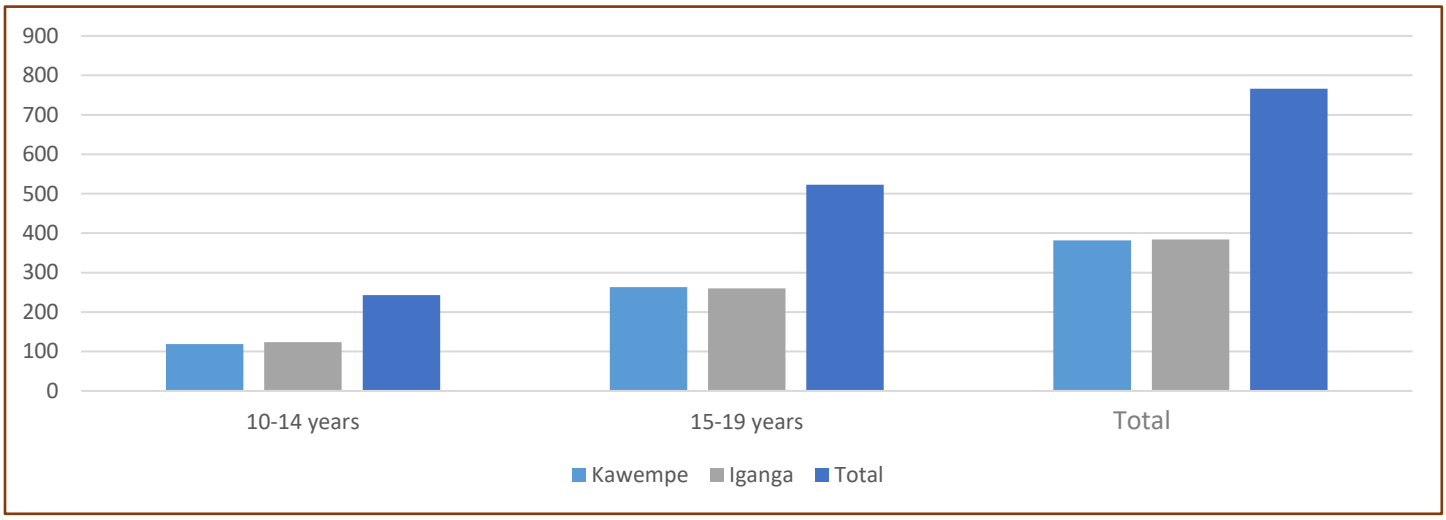


Figure 4: Study Participants by Age

In total 766 girls aged 10 - 19 were interviewed (98.7% from Iganga district and 95.8% from Kawempe division). The average age and median age were 16.5 and 17 years of age in Kawempe and Iganga respectively. Most of the girls who responded to the survey were in the 15-19 age group as shown in Figure 4.

Table 1 shows that girls aged between 17-18 years in both study sites and the youngest participants were from Iganga district.

Age in years	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
10	27	7.1	10	3	37	5
11	20	5.2	19	5	39	5
12	23	6.0	22	6	45	6
13	21	5.5	43	11	64	8
14	28	7.3	30	8	58	8
15	48	12.6	34	9	82	11
16	44	11.5	42	11	86	11
17	59	15.4	94	24	153	20
18	80	20.9	89	23	169	22
19	32	8.4	1	0	33	4
	382	100.0	384	100	766	100

Table 1: Participants by age and district

Our data suggests that Iganga and Kawempe have more adolescents aged 10–19 when compared with the national average population that stands at 13.3% for ages 10-14 and 10.8% for ages 15-19 (including males) according to UBOS (2024). Additionally, we found that 546 of the 766 girls who responded to the survey were single (71%), about 20% were either married or living with one partner, about 5% were in a polygamous marriage and 4% were separated.

3.1.1 Education status

The findings show that all respondents had ever attended school, with 39.4% and 62.2% for Kawempe and Iganga, respectively, completing primary (P5–P7), 38.0% in Kawempe and 22.8% in Iganga had lower completed secondary (S1–S4), 3.8% in Kawempe and 0.3% in Iganga had completed upper secondary school (S5–S6). Table 2 shows a significant difference

in education between Kawempe and Iganga at 5% level of significance (p<0.05) according to Pearson's Chi-square test (P<0.001).

Highest level of education	Kawempe	Iganga	Total
Pre-primary school	0	0.3	0.1
Lower primary (P1-P4)	18.9	14.4	16.6
Upper primary (P5-P7)	39.4	62.2	50.9
Lower secondary (S1-S4)	38	22.8	30.3
Upper secondary (S5-S6)	3.8	0.3	2

Table 2: Highest level of education completed

P =primary level, S=Secondary level

Since all the girls were aged between 10-19 years, it is not surprising that only a few have completed high school as illustrated in Figure 5.

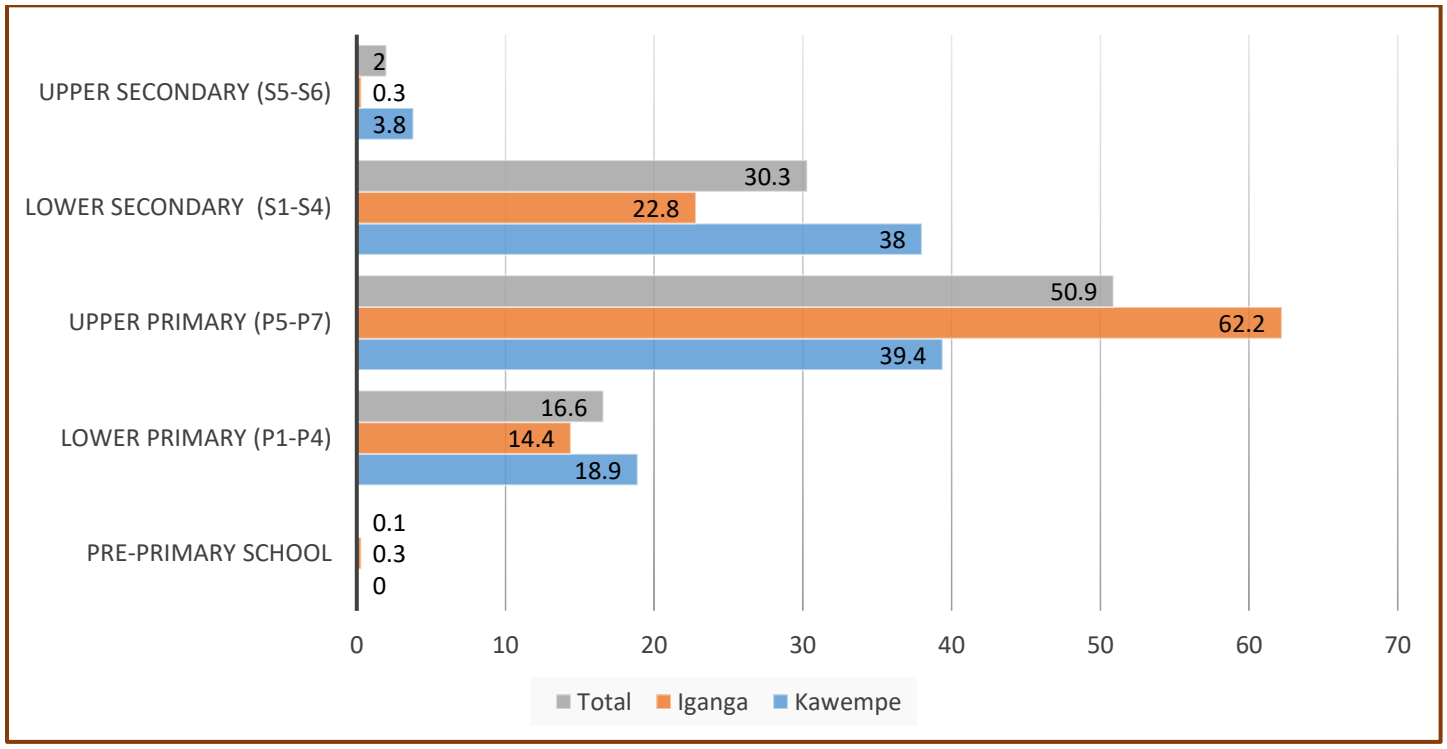


Figure 5: Rural-Urban (Iganga-Kawempe) Comparison of the Highest Level of Education Completed

However, since Uganda has implemented Universal primary education since 1997, one would expect girls aged 10-19 to be able to read and write. However, we found that almost three-quarters (70.2%) of the girls who responded to the survey in Kawempe, compared with 41.9% of those in Iganga, can read or write a sentence in the local language. On the other hand, 18.6% of in Kawempe, compared with 37.8% in Iganga, cannot read and write a sentence in the local language. It also emerged that 9.9% of the participants in Kawempe and 30.5% in Iganga cannot read and write a sentence in English as shown in Table 3.

	Read and write		Total	Read only		Total	Write only		Total	Cannot read and write		Total
	Kawempe	Iganga		Kawempe	Iganga		Kawempe	Iganga		Kawempe	Iganga	
Can read and write a sentence in a local language	70.2	41.9	56.0	6.5	14.3	10.4	4.7	6.0	5.4	18.6	37.8	28.2
P-value	p<0.001											
Can read and write a sentence in English	80.4	51.8	66.1	4.2	10.9	7.6	5.5	6.8	6.1	9.9	30.5	20.2
P-value	p<0.001											

Table 3: Respondents' self-assessment in reading and writing

At a 5% level of significance, this finding implies a significant difference in literacy according to Pearson's Chi-square test ($p<0.05$). Table 3 gives a summary of respondents' literacy ratings.

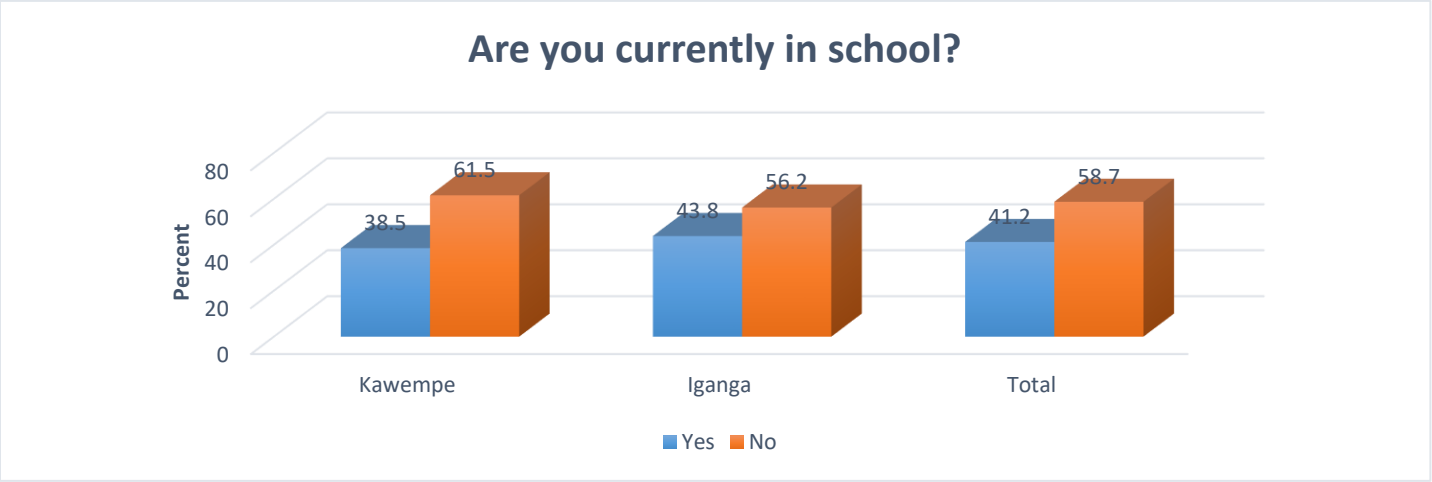


Figure 6: Girls in school at the time of data collection

According to our data, more than half of the girls who completed the survey were not in school at the time of data collection as shown in Figure 6. Our analysis yielded a Pearson's Chi-square value of 0.141 ($p=0.141$), which implies that there is no significant difference in the percentage of girls in school in Iganga and Kawempe.

Reasons for Leaving School

The findings show that slightly more than a third (38.5%) of the girls who responded to the survey in Kawempe and 43.8% of those in Iganga were still in school. Almost half (53.5.%) of the respondents in Kawempe and 66.8% in Iganga dropped out between the ages of 14 and 16. The average age of leaving school was 14.6 and 15 years for Kawempe and Iganga, respectively.

Question/Options	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Age of leaving school (n = Kawempe, 228; Iganga, 214)						
10 – 13 Years	60	26.3	37	17.3	97	22.0
14 – 16 Years	122	53.5	143	66.8	265	60.0
17 – 19 Years	46	20.2	34	15.9	80	18.1

Question/Options	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Average	14.6		15.0		14.8	
P-value	p = 0.014					
Reason for leaving school (Multiple, n = Kawempe, 228; Iganga, 214)						
Graduated	2	0.9	3	1.4	5	1.1
Domestic work	10	4.4	4	1.9	14	3.2
Forced marriage	2	0.9	3	1.4	5	1.1
Early marriage	11	4.8	14	6.5	25	5.7
Other work	14	6.1	3	1.4	17	3.9
Pregnancy	24	10.5	39	18.2	63	14.3
COVID-19 lockdown	78	34.2	61	28.5	139	31.5
Sex work	2	0.9	5	2.3	7	1.6
Illness /health-related challenges	9	4.0	5	2.3	14	3.2
Lack of school fees and scholastic materials	159	69.7	123	57.5	282	63.8
Menstruation-related challenges	10	4.4	3	1.4	13	2.9
Large classes	2	0.9	0	0.0	2	0.5
Other (Mother died, father refused, father died, I got tired)	18	7.9	9	4.2	27	6.1
P-value	p = 0.022					

Table 4: Age of leaving school and reasons for leaving school

As shown in Table 4, the primary reason for school dropout is a lack of school fees and learning materials such as stationery (69.7% in Kawempe and 57.5% in Iganga). At a 5% level of significance (according to the Pearson Chi-square test), there was no significant difference in the number of girls currently attending school between Kawempe and Iganga ($p>0.05$). However, there was a significant difference in the age at which girls leave school and the reasons for leaving school ($p<0.05$). See Table 4 for further details.

Our findings show that 23 girls in Kawempe and 17 in Iganga dropped out of school to get married, although Article 31 of the Constitution of Uganda states that marriage should only be entered into by people aged 18 and above (Republic of Uganda, 1995). Moreover, our findings show that about 1% of the girls who dropped out of school were forced to get married, which violates Article 31 (3) of the constitution of Uganda (Republic of Uganda, 1995). We were particularly interested in challenges related to sexual and reproductive health (SRHR). We found that some reasons for dropping out of school were indeed SRHR-related. These include menstruation, pregnancy, engagement in sex work, early marriage and forced marriage. These factors suggest a strong need to address these issues at the grassroots, local government and central government levels.

3.2 Experiences of Young Motherhood

One of the objectives of the survey was to investigate the societal perceptions of young motherhood. We explored girls' experiences of pregnancy and age at first pregnancy, circumstances that led to pregnancy, realization of pregnancy, young mothers' perceptions of teenage pregnancy, support after pregnancy, child caregiving, young mothers' perceptions about young motherhood, and societal perceptions about young motherhood.

3.2.1 Experiences of pregnancy and age at first pregnancy

We sought data about motherhood experiences in terms of whether the girls had ever been pregnant or had a child. We found that almost two-thirds (63.3%, n=485) of the girls who completed the survey have never had a child.

Question/Options	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Number of children ever had						
Never had a child	279	73.0	206	53.7	485	63.3
Currently pregnant	9	2.4	21	5.5	30	3.9

Question/Options	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
One child	64	16.8	119	31.0	183	23.9
Two or more	19	5.0	19	5.0	38	5.0
Miscarried	4	1.1	2	0.5	6	0.8
Pregnancy terminated	5	1.3	6	1.6	11	1.4
Baby died (after birth)	2	0.5	11	2.9	13	1.7
P-value	p<0.001					
Who takes care of your child (n=Kawempe, 83; Iganga, 154)						
Self	29	34.9	42	23.6	71	27.2
Father of the child	38	45.8	51	28.7	89	34.1
My mother	8	9.6	32	18.0	40	15.3
My grandmother	4	4.8	10	5.6	14	5.4
The child's father's family member /relative	0	0.0	11	6.2	11	4.2
Others (refugee camp/other relative)	4	4.8	32	18.0	36	13.8
P-value	p<0.001					

Table 5: Number of children and who is taking care of the child

Of the 221 (28.9%) who had children, 34.1% of the children were taken care of by the child's father, while 15.3% were taken care of by the girls on their own. There was a significant difference in the number of children ever born and the caretaker between Kawempe and Iganga at a 5% level of significance according to Pearson's Chi-square test (p<0.001). Table 5 provides details regarding the number of children and who is taking care of the child.

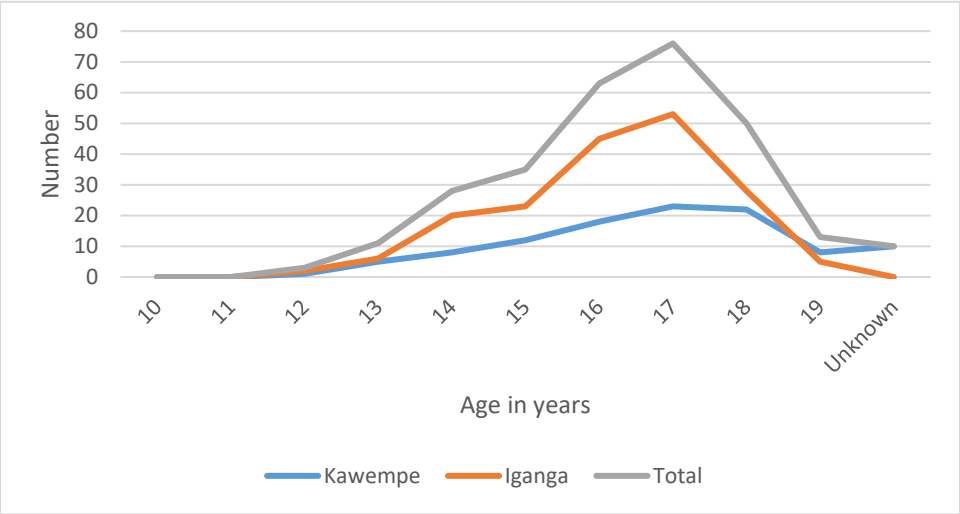
Slightly more than a quarter (28.0%, n=107) of the girls who completed the survey in Kawempe and almost a half of those in Iganga (47.4%) have ever been pregnant although not all of them carried the baby to term.

Age at first pregnancy	Kawempe	Iganga	Total	Percent
10	0	0	0	0
11	0	0	0	0
12	1	2	3	1
13	5	6	11	4
14	8	20	28	10
15	12	23	35	12
16	18	45	63	22
17	23	53	76	26
18	22	28	50	17
19	8	5	13	4
Unknown	10	0	10	3
Total	**107**	**182**	**289**	**100**

Table 6: Age at first pregnancy

The average age at first pregnancy was 16.5 years and 16.2 years for Kawempe and Iganga respectively. Our analysis shows that there was no significant difference in age at first pregnancy (p>0.05) between the rural and urban site. The youngest age at first pregnancy was 12 years (n=1 Kawempe, 2 Iganga) as shown in Table 6.

The number of girls who had ever been pregnant in Iganga was on average higher than that in Kawempe as illustrated in Table 6 and Figure 6.



However, there was a significant difference in ever-pregnant girls and circumstances behind pregnancy between Kawempe and Iganga ($p<0.05$).

Figure 7: Age at first pregnancy

3.2.2 Circumstances that led to pregnancy

As illustrated in Table 7 the findings show that 43.0% of the girls who had ever been pregnant in Kawempe and 74.7% in Iganga became pregnant through mutual sexual relationship. However, the rest of the girls got pregnant due to reasons related to sexual violence such as rape, coerced sex, sex work, and forced/early marriage.

Causes of pregnancy (*Multiple, n=Kawempe, 107, Iganga, 182*)	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Mutual sexual relationship	46	43.0	136	74.7	182	63.0
Rape or sexual exploitation	3	2.8	19	10.4	22	7.6
Coerced or pressured into sex	24	22.4	11	6.0	35	12.1
Sex work	4	3.8	3	1.7	7	2.4
One-time financial need	16	15.0	10	5.5	26	9.0
I was married when I got pregnant	18	16.8	6	3.3	24	8.3
Failed contraceptive	17	16.0	1	0.6	18	6.2
Under influence of alcohol	2	2.0	0	0.0	2	0.7
Other (Bad situation, because of my parents, I wanted to)	5	4.7	0	0.0	5	1.8
P-value	p<0.001					

Table 7: Circumstances that best define the cause of the pregnancy

Our findings show that being coerced or pressured into sex (35%) was the second largest cause of pregnancy among the girls who completed the survey. This was followed by one-time financial need (26%), early marriage (24%), and rape or sexual exploitation (22%). This finding is particularly disturbing given that per the Ugandan 2007 Penal Code Act 8 amendment, any person who performs a sexual act with another person under 18 years commits defilement which is a sexual offence (Republic of Uganda, 2007). Utilizing that definition of defilement, therefore, the survey participants who got pregnant due to consensual sex were sexually defiled or violated. This suggests that 100% of the girls who completed the survey and had ever had sex experienced sexual violence or defilement.

3.2.3 Realization of pregnancy

The survey participants were asked about how they found out they were pregnant. Almost half of those who completed the survey (48.6%) in Kawempe and almost three-quarters (73.5%) of those in Iganga found out that they were pregnant when they missed periods.

Options	Kawempe		Iganga		Total	
	No.	%	No.	%	No	%
I missed my period	52	48.6	134	73.6	186	64.4
I was tested at school	7	6.5	12	6.6	19	6.6
I was tested at health facility	28	26.2	28	15.4	56	19.4
I took a home pregnancy test	13	12.2	2	1.1	15	5.2
Other symptoms (vomiting, headache)	7	6.5	6	3.3	13	4.5
P-value	p<0.001					

Table 8: How girls found out that they were pregnant

Others (6.6%) learned that they were pregnant through pregnancy tests or examinations conducted at schools and 5.2% procured home testing kits. According to Pearson's Chi-square test, there was a significant difference in access to home pregnancy test kits ($p<0.05$) between Kawempe and Iganga, as shown in Table 9 and Figure 8.

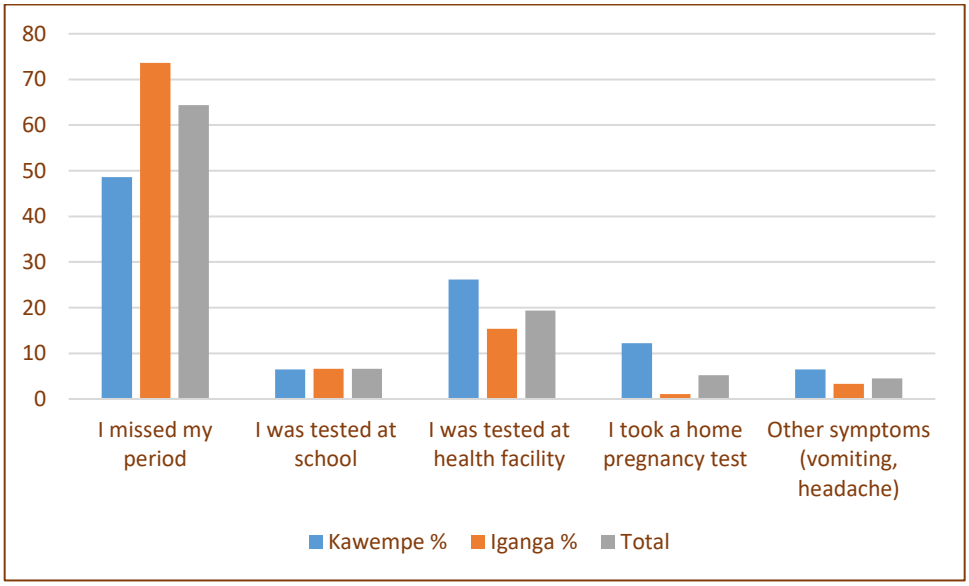


Figure 8: How girls found out they were pregnant (%)

3.2.4 Young mothers' perceptions of teenage pregnancy

We asked the girls who completed the survey to enumerate their biggest fears about being young and pregnant. Slightly more than half (51.1%) of the girls in Kawempe and 21.0% in Iganga said that being pregnant early is annoying and makes them a burden to their family members.

Options	Kawempe (%)	Iganga (%)
Annoying and being a burden to my family members	51.1	21.0
Risk of being dismissed from school	10.6	15.9
Risk of being dismissed from home	19.2	51.1
Risk of being forcefully married off	6.4	5.1
Risk of being excommunicated from the religious institution	1.1	0.0
Being a single mother	10.6	2.8
Discrimination	3.2	1.1
Being stigmatized	4.3	4.6
Not being financially stable	8.5	0.0
Others	7.5	3.4
P-value	p<0.001	

Table 9: Biggest fears about being pregnant (%, multiple responses)

In Kawempe, 19.2% feared being dismissed from home compared with 51.1% in Iganga. Those who mentioned being dismissed from school were 10.6% in Kawempe and 15.9% in Iganga as shown in Table 9. There was a significant difference in the fears of teenage pregnancy between Kawempe and Iganga ($p<0.05$).

3.2.5 Support after pregnancy

According to the data collected, most of the support was provided by family members. Almost half (53.9%) of the girls who were mothers in Kawempe and almost three quarters (74.4%) in Iganga were supported by their mothers followed by their fathers at 11.0% and 5.7% in Kawempe and Iganga respectively as shown Table 10. There was no significant difference among people who offered support to girls after finding out they were pregnant (p>0.05) according to the Pearson Chi-square test as shown in Table 10.

People who provided support (Multiple responses)	Kawempe (%)	Iganga (%)
Father	11.0	5.7
Mother	53.9	74.4
Brother	6.6	5.1
Sister	7.7	4.0
Aunt	5.5	2.3
Uncle	3.3	0.6
Neighbor	5.5	0.6
Health care personnel	3.3	2.8
Others (Social worker, LC 1, Police)	8.0	18.7
P-value	p = 0.121	

Table 10: People who supported young mothers after finding out the pregnancy

Although the findings in Table 9 show that 51% of the young mothers felt that they became a burden to family members, according to Table 10, they (family members) provided most of the support. The findings might suggest that community members outside the young mothers' families are not keen on providing support and are likely to dismiss them from school and religious institutions.

3.2.6 Child caregiving

We asked the girls who were mothers to enumerate all the people who were involved in taking care of their children. As illustrated in Figure 9, most of the girls mentioned that the fathers of the children were involved although they did not support them when they discovered the pregnancy. About 35% of the young mothers in Kawempe and 23% of those in Iganga took care of their babies independently. There was a significant difference between Kawempe and Iganga child caregiving supports based on p<0.001 as illustrated below.

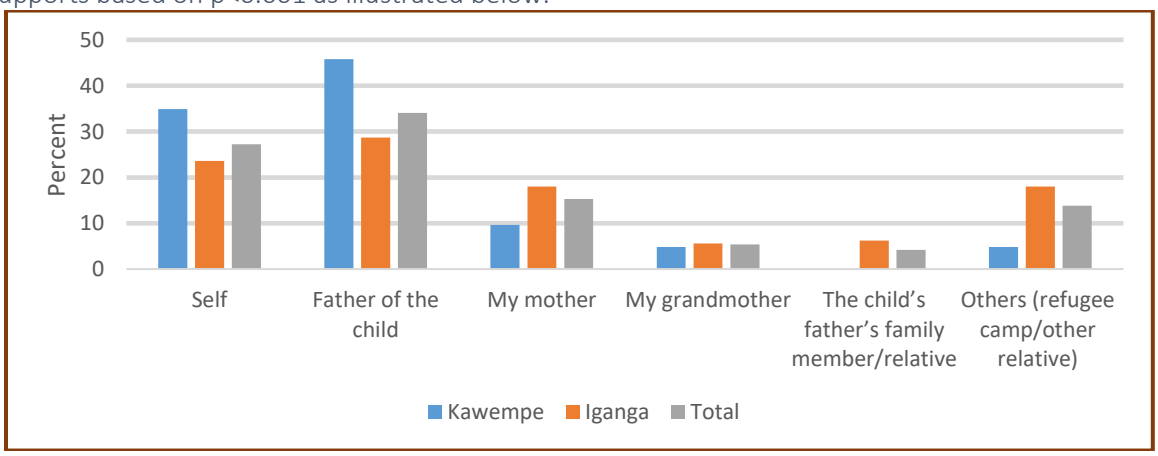


Figure 9: People who participate in child caregiving

3.2.7 Young mothers' perceptions about young motherhood

Considering that family members provided most of the support and yet the girls had significant fears about pregnancy, we asked the girls who had ever been pregnant to describe their feelings about being a young mother. Almost a third (34.6%) in Kawempe and 3.9% in Iganga felt respected, 20.6%. However, 37% (46.7% in Iganga and 20.6% in Kawempe) felt ashamed, and 19% felt bad. Overall, 23.2% felt good or proud. See Table 11.

Options	Kawempe (%)	Iganga (%)	Total (%)
I feel good because I was not forced	31.8	20.9	24.9
I feel good /proud	31.8	18.1	23.2
I feel ashamed	20.6	46.7	37.0
I feel bad	19.6	18.7	19.0
I feel sad and lonely	20.6	11.5	14.9
I feel worthless	13.1	7.7	9.7
I feel mature	17.8	4.4	9.3
I feel respected	34.6	3.9	15.2
Other (fear, need help)	1.9	5.0	3.8
P-value	p<0.001		

Table 11: How girls felt about being a young mother

There was a significant difference in how young motherhood in Kawempe and Iganga was experienced ($p<0.05$) at 5% level of significance according to the Pearson's Chi-square test. Figure 6 below illustrates the differences in how the girls felt when they learned they were pregnant. More girls felt respected in Kawempe (34%) compared with Iganga (3.9%). Regarding shame, more girls in Iganga had a feeling of shame (46.7%) compared with Kawempe.

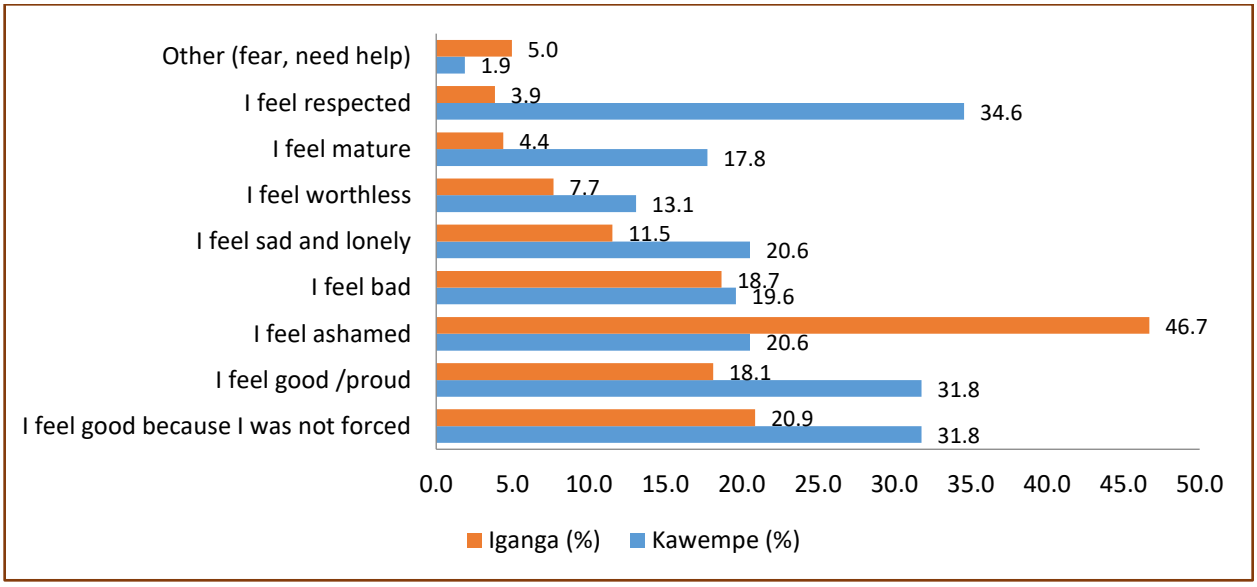


Figure 10: How girls felt about being a young mother

It is possible that some of the girls who feel good got pregnant from a mutual sexual relationship. While others might feel proud of themselves for successfully navigating the lack of necessary support and resources amidst social norms that stigmatize young motherhood.

3.2.8 Societal perceptions of young motherhood according to girls aged 10-19

We asked the girls who had ever been pregnant to rate their family and community members' perceptions of young motherhood on the scale from very good to terrible. Figures 11 and 12 illustrate the girls' ratings of their family and

community members' perceptions of young motherhood. Most of the respondents rated community perceptions as very bad or terrible, while the ratings of family perceptions varied according to study sites.

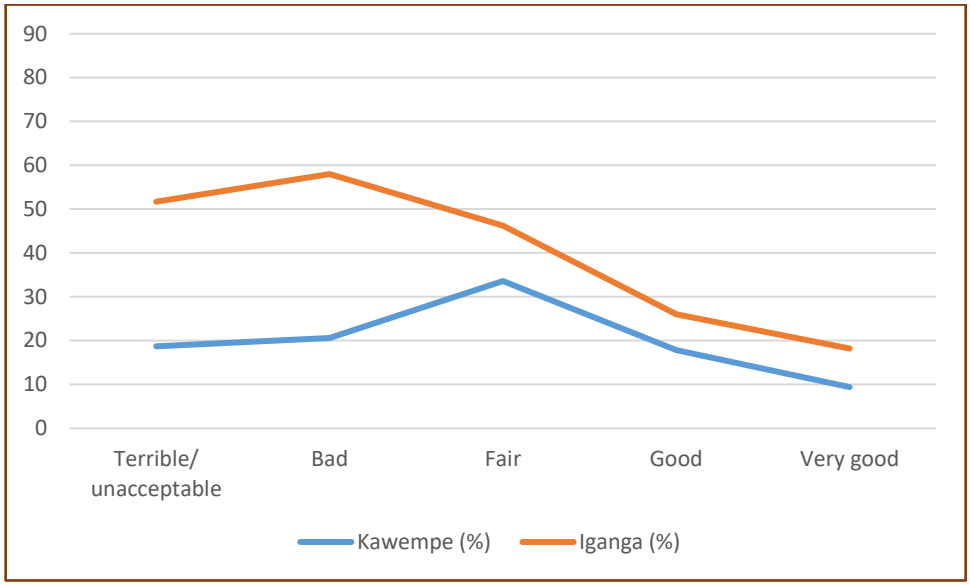


Figure 11: Family members' perceptions of young motherhood (%)

The ratings of family members in Iganga are worse than those of Kawempe. Our analysis yielded a Pearson Chi-square value of $p<0.001$, which indicates a highly statistically significant relationship between the ratings of the family members' perceptions of young motherhood in Kawempe compared with Iganga. Since Iganga is a homogenous rural society, it may be characterized by stronger social norms around girlhood and motherhood, leading to more negative perceptions about young motherhood. Kawempe, on the other hand, is characterized by a more heterogeneous social structure, in which family members might be not as strongly opposed to young motherhood as those in Iganga.

Regarding community perceptions, 7.5% and 12.1% of the girls in Kawempe and Iganga rated them as very good, respectively, while 21% of the ratings in Kawempe and 15.4% in Iganga considered them as terrible/unacceptable as illustrated in Figure 12.

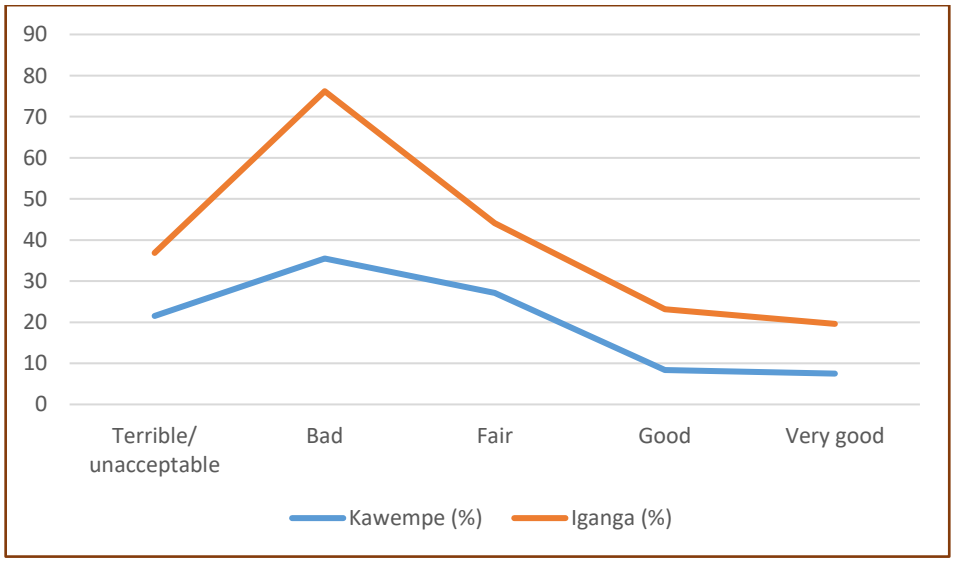


Figure 12: Community members' perceptions of young motherhood (%)

Our analysis of community members perceptions in Iganga and Kawempe yielded a Pearson Chi-square value of 0.065 (p>0.05), which implies that although the differences in community members perceptions are not statistically significant.

3.3 Access to Information and Knowledge

3.3.1 Girls' Sources of SRHR Information

Regarding access to SRHR information and knowledge, we found that slightly more than half (53.9%) of the girls in Kawempe compared with 36.2% in Iganga accessed information from parents followed by health workers (37.2% versus 28.9). We note that there is a significant difference in access to information from social media in Kawempe (n=41) compared with Iganga (n=9) as shown in Table 12.

Girls' sources of SRHR information (multiple responses)	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Parents	206	53.9	139	36.2	345	45.0
Pamphlet	14	3.7	26	6.8	40	5.2
Educational movies	24	6.3	11	2.9	35	4.6
Mass media	41	10.7	35	9.1	76	9.9
Internet/Social media	41	10.7	9	2.3	50	6.5
Teachers	126	33.0	85	22.1	211	27.6
School clubs	54	14.1	99	25.8	153	20.0
Health workers	142	37.2	111	28.9	253	33.0
Siblings	37	9.7	16	4.2	53	6.9
Friends	62	16.2	61	15.9	123	16.1
Counsellors	53	13.9	11	2.9	64	8.4
Other (Neighbors, NGOs, husband, on phone, none, Aunt, Jaja [grandparent])	27	7.1	83	21.6	110	14.4
P-value	p<0.001					

Table 12: Sources of SRH information (multiple responses)

Our findings show that there was a significant difference in ways of accessing information about SRHR between Kawempe and Iganga (p<0.05).

3.3.2 Gaps in young mothers' pregnancy-related information before they became pregnant

The girls who completed the survey and had ever been pregnant were asked to describe the types of information they wish they had before they became pregnant. Although parents, teachers, and health workers were mentioned among the providers of SRHR information, our results show that adolescent girls who had ever been pregnant wished they knew how to avoid pregnancy, sexual violence and forced/early marriage.

We asked girls who had ever been pregnant to itemize what they wished they knew before getting pregnant. Our findings show that more than half of the girls who had ever been pregnant (62.6% in Kawempe and 52.8% in Iganga) wished they knew how to avoid pregnancy, and 26.2% in Kawempe and 29.1% in Iganga wished they knew the do's and don'ts of first pregnancy. At least 25% and 14 % of the young mothers in Iganga and Kawempe wished they knew how to avoid sexual violence. Additionally, 18.1% and 15% in Iganga and Kawempe, respectively, wished they knew how to avoid forced marriage as illustrated in Figure 12.

Our analysis yielded a Pearson Chi-square value of p = 0.002 suggesting a significant relationship in the differences in what girls in Kawempe and Iganga wished they knew. The findings might suggest that girls <19 in Iganga are more prone to sexual violence and forced marriage compared to their counterparts in Kawempe.

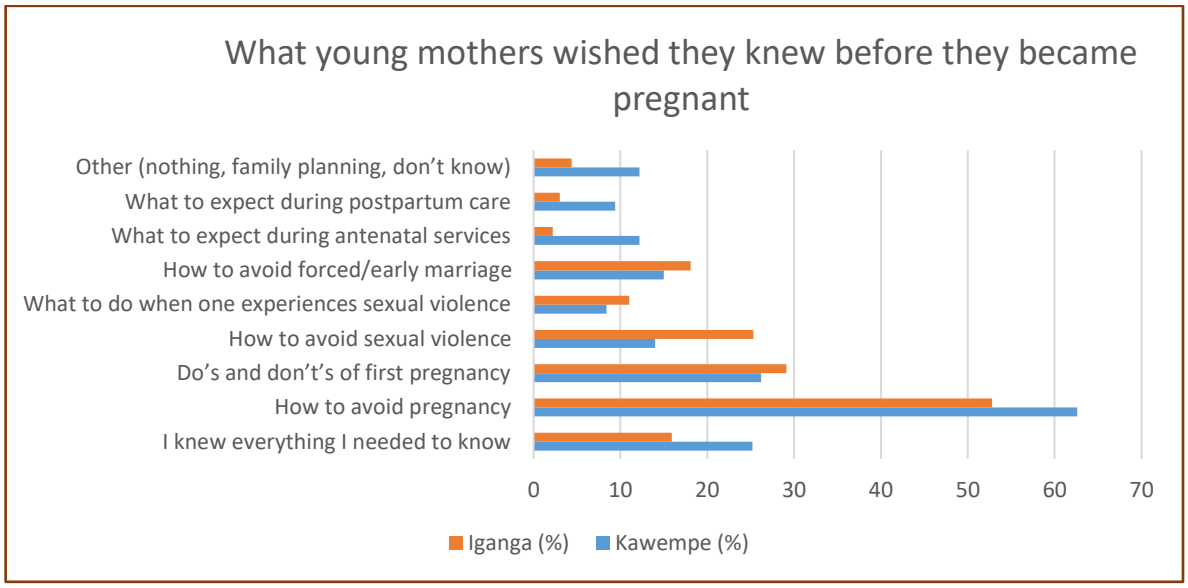


Figure 13: What girls <19 wished they knew before getting pregnant (%)

3.3.3 Discussion of Sexual and Reproductive Health issues with Fathers

The girls who completed the survey were asked about their relationship with their fathers. Of the girls who still had fathers who were alive, 27.6% in Kawempe and 48.8% in Iganga lived with them. Of those who lived with their fathers, 13.6% in Kawempe and 10.3% in Iganga had discussed reproductive health-related matters with them. Figure 14 illustrates the findings on how easy it is for the girls to discuss SRHR matters with their fathers.

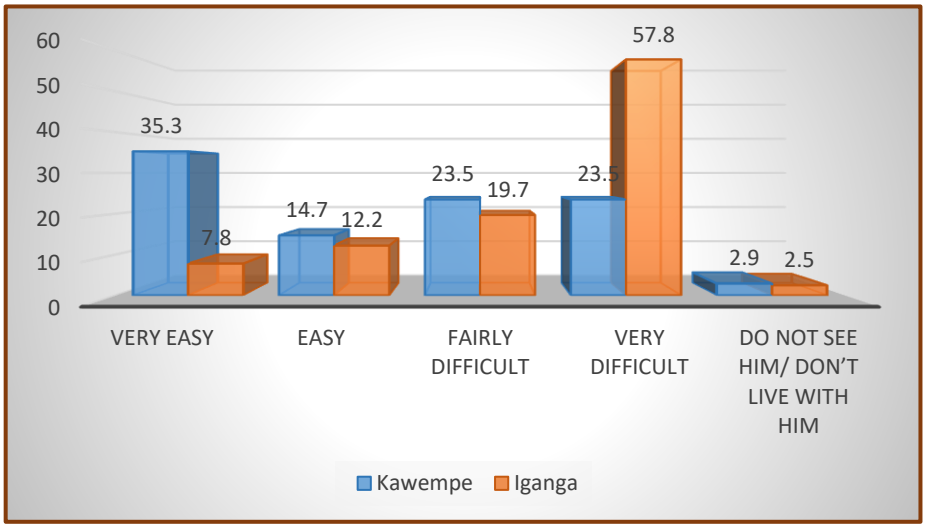


Figure 14: How difficult or easy it is to talk with fathers about SRHR

When asked how easy or difficult it is to discuss with fathers the issues of sexual and reproductive health, 35.3% in Kawempe and 7.8% in Iganga said that it is easy while 23% versus 57.8% reported that it is very difficult, as shown in Figure 14. The issues discussed with the fathers include HIV 79.4% in Kawempe and 57.6% in Iganga, pregnancy (58.8% in Kawempe, 24.2% in Iganga), abstinence (35.2% in Kawempe and 39.4% in Iganga), and others as shown in Figure 15.

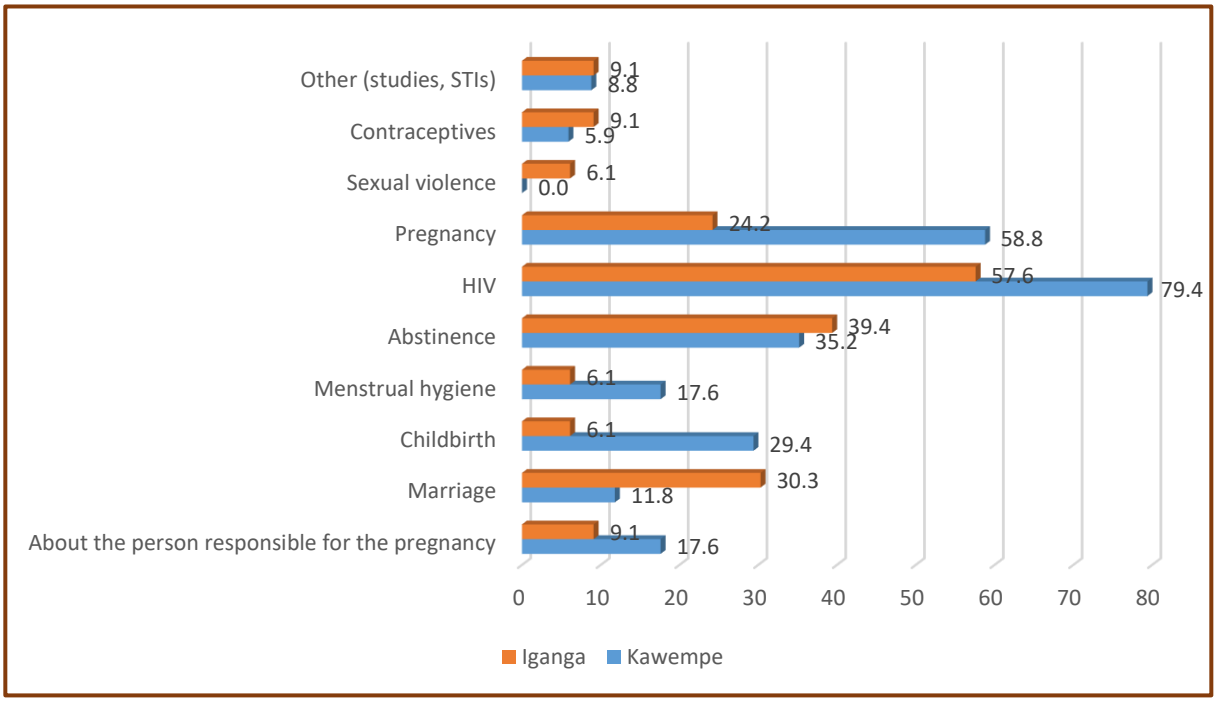


Figure 15: Issues discussed with the fathers (%, multiple responses)

Our findings show that the topic HIV prevention and abstinence were the most discussed topics while sexual violence and contraceptives were the least discussed with fathers. We found that 16.4% in Kawempe and 29.7% Iganga think that it is a taboo to talk about reproductive health with men as summarized in Table 13.

Which option best describes your experience of talking about reproductive health with your father? (n=Kawempe, 250; Iganga, 320)	Kawempe		Iganga	
	No.	%	No.	%
It is taboo to talk about reproductive health matters with men	41	16.4	95	29.7
My religion or cultural practices forbid me to have these conversations	18	7.2	30	9.4
My father thinks it is not proper to discuss reproductive health matters with girls	39	15.6	26	8.1
I'm afraid to talk with my father about sexuality and reproductive health because he'll think I'm mature and ready to get married	45	18.0	64	20.0
I'm afraid to talk with my father about sexuality and reproductive health because he'll punish me	28	11.2	34	10.6
I'm uncomfortable and embarrassed to talk to my father	43	17.2	51	15.9
I prefer to discuss dating, and relationship matters with people who are not related to me, such as friends, teachers, and neighbors	9	3.6	5	1.6
My father is ill-prepared to have these conversations with me and often shares inaccurate information with me	4	1.6	7	2.2
I have open conversations about menstruation, healthy relationships, sexually transmitted infections, consent, contraception, etc., with my father and know my questions and concerns will be kept confidential	23	9.2	8	2.5

Table 13: Girls experiences of talking about SRHR with fathers

Many girls feel uncomfortable discussing SRHR with their fathers or male figures, citing cultural or personal barriers. This suggests that while parents may be a source of initial SRHR information, they often provide only superficial guidance rather than in-depth, valuable knowledge.

3.3.4 Discussion of Sexual and Reproductive Health issues with Mothers

Eighty percent of the girls in Kawempe and 89.3% in Iganga have mothers who are still living. Of these, 58.8% in Kawempe and 60.9% in Iganga lived with their mothers in the same household, and 58.5% in Kawempe and 60.9% in Iganga had discussed SRHR issues with their mothers.

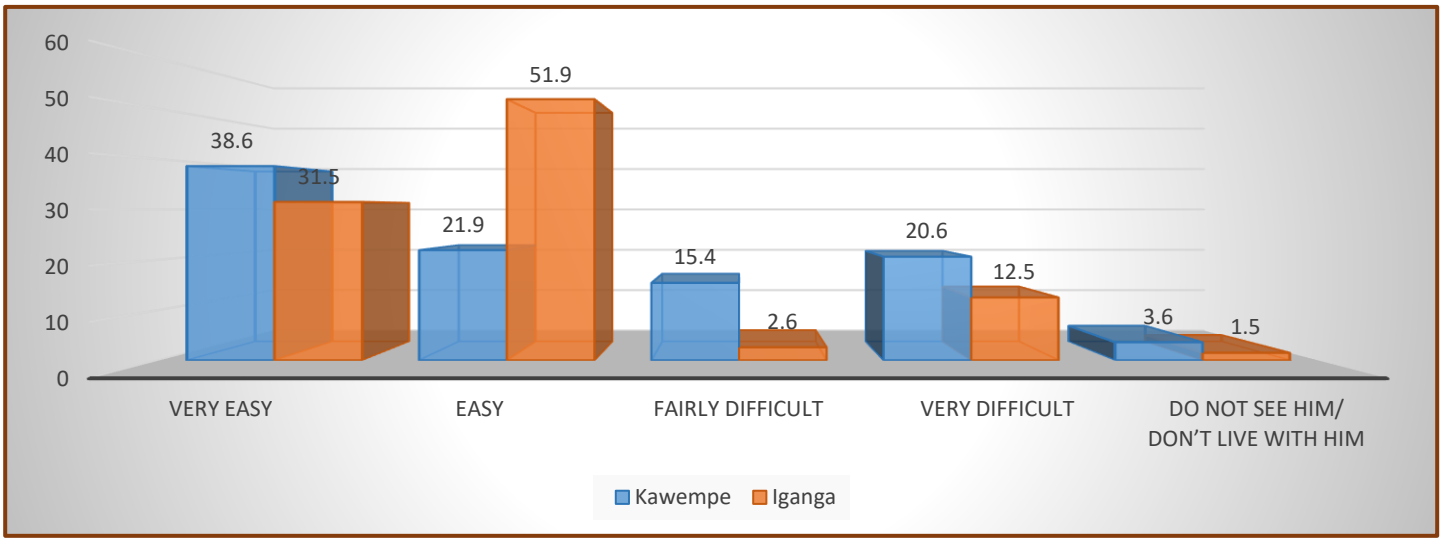


Figure 16: How difficult or easy it is to talk with mothers about SRHR

When asked how easy it was to discuss SRHR issues with their mother, 20.6% in Kawempe and 12.5% in Iganga said it was very difficult to discuss SRHR issues with their mothers. In comparison, 38.8% versus 31.5% in Iganga said it was very easy. See Figure 16. These findings show that girls in Iganga found it easier to discuss SRHR matters with their mothers than with their fathers. Additionally, when we compare responses regarding how easy it is for girls in Iganga and Kawempe to discuss SRHR with their mothers, our data shows that it is easier for girls in Iganga than those in Kawempe, as illustrated in Figure 11. While there is a significant difference in how easy or difficult it is for girls in Iganga to discuss SRHR matters with fathers (very difficult) and mothers (easy), for Kawempe, the girls find it almost equally difficult to speak with either parent. The issues discussed with mothers include HIV (82.7%), pregnancy (55.9%) and others as shown in Figure 17.

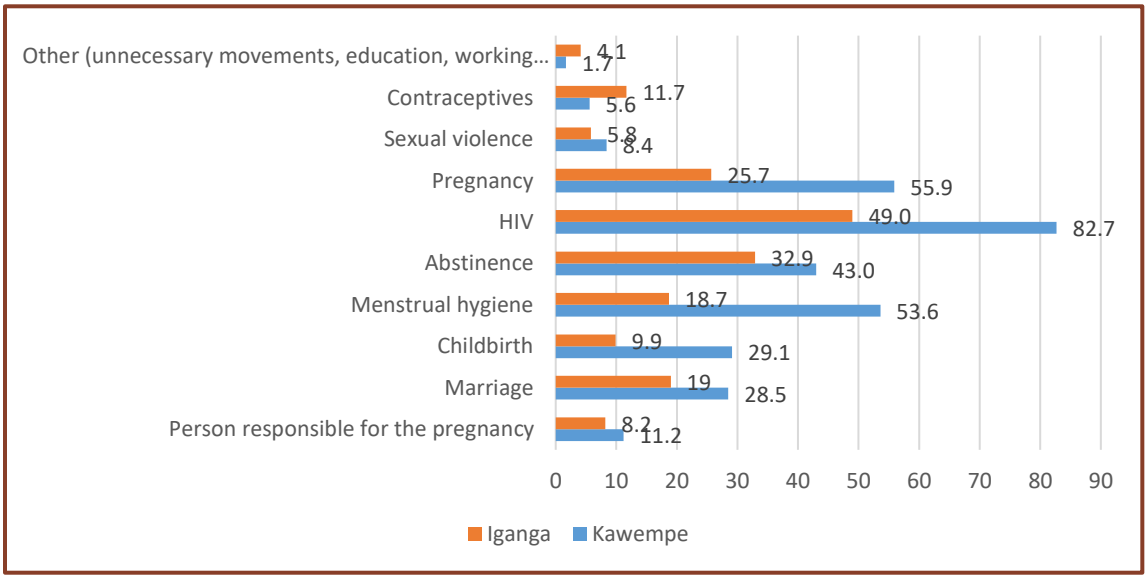


Figure 17: Issues discussed with mothers

Our data shows that most mothers discussed HIV, pregnancy, abstinence, menstrual hygiene and marriage with their daughters. Topics of contraception and sexual violence are not among the top discussed areas, although young mothers identified them among the issues, they wish they had more information about before getting pregnant. When asked about experiences of discussing SRHR issues with mothers, most of the girls who completed the survey (42.5% in Kawempe compared to 17.5% in Iganga) said that they have open conversations about menstruation, healthy relationships, sexually transmitted infections, consent, contraception with their mother and knew that their questions and concerns were being kept confidential. However, 4.6% in Kawempe and 13.1% in Iganga said that it is taboo or immoral to talk about topics related to sexual reproductive health. The findings are summarized in Table 14.

Experience talking about reproductive health with mothers (n=Kawempe, 306; Iganga, 343)	Kawempe		Iganga	
	No.	%	No.	%
It is taboo or immoral to talk about reproductive health	14	4.6	45	13.1
My religion or cultural practices forbid me to have these conversations	6	2.0	26	7.6
I'm afraid to talk with my mother about sexuality and reproductive health because she'll think I'm mature and ready to get married	38	12.4	45	13.1
I'm afraid to talk with my mother about sexuality and reproductive health because she'll punish me	39	12.7	52	15.2
I think my mother wanted to talk to me about sex-related issues, but thought the conversation could prompt me to experiment with sex	24	7.8	56	16.3
I prefer to discuss dating, and relationship matters with people who are not related to me, such as friends, teachers, and neighbours	23	7.5	20	5.8
My mother is ill-prepared to have these conversations with me and often shares inaccurate information with me	11	3.6	14	4.1
I have open conversations about menstruation, healthy relationships, sexually transmitted infections, consent, contraception, etc. with my mother and know my questions and concerns will be kept confidential	130	42.5	60	17.5
My mother didn't explicitly talk about reproductive health with me. Instead, she talked about broader issues related to hygiene, education, morality, housekeeping, and dress code for girls	21	6.9	25	7.3

Table 14: Girls' experiences of discussing SRHR topics with mothers

It should be noted that although most mothers discussed SRHR issues with their girls, almost half 49% in Kawempe and 42.4% in Iganga started to discuss these issues as late as 14 years, as shown in Figure 18. Also, 17(11%) in Kawempe and 3% in Iganga started discussing with the girls aged 16 and above.

We found that 24.1% of Kawempe and 28.8% of Iganga respondents said that they discuss these issues almost daily, and 22.2% of Kawempe and 8.5% of Iganga respondents said they only discuss SRHR issues with their mothers once a year as illustrated in Figure 18. It should be noted that even though most mothers discussed SRHR issues with their girls, almost half (49% in Kawempe and 42.4% in Iganga) started to discuss these issues as late as 14 years, as shown in Figure 9. Also, 17 (11%) in Kawempe and 3% in Iganga discuss with the girls aged 16 and above.

We found that 24.1% of Kawempe and 28.8% of Iganga respondents said that they discuss these issues almost daily, and 22.2% of Kawempe and 8.5% of Iganga respondents said they only discuss SRHR issues with their mothers at least once a year as illustrated in Figure 18.

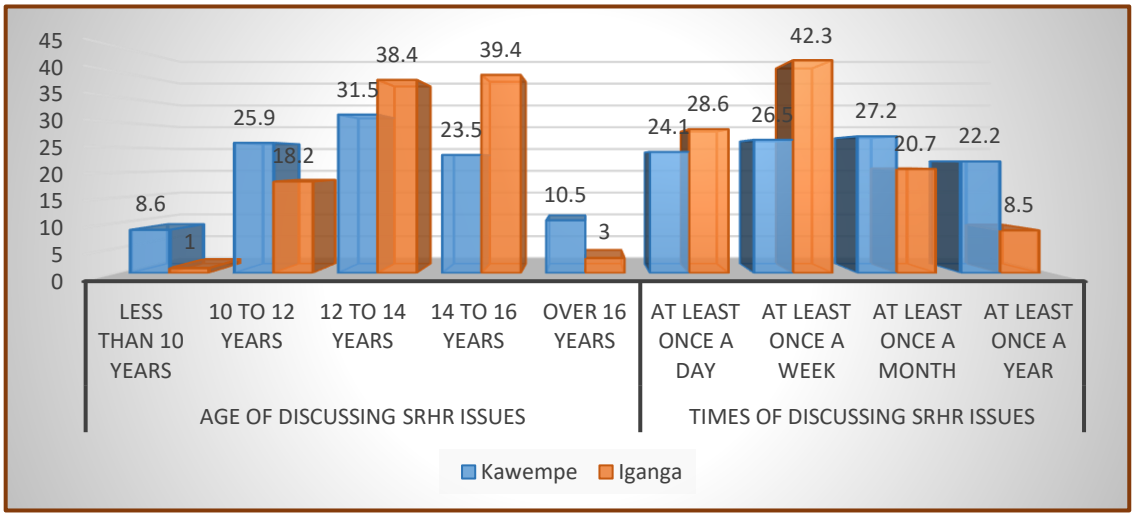


Figure 18: Age and times of discussing SRHR issues with mothers (%)

3.3.5 SRHR lessons provided outside the home

When asked about other sources of SRHR information outside their homes, the girls who responded to the survey mentioned that they received information from schools, health facilities, and community members. Our data show that most of the girls in Kawempe (60.7%), compared with 36.7% in Iganga, had lessons about SRHR from schools, followed by health facilities (42.7% for Kawempe and 36.7% for Iganga), and communities (31.9% for Kawempe and 25.0% for Iganga). However, 14.7% of Kawempe and 18.5% of Iganga respondents reported never having SRHR-related lessons. The most discussed topics in Kawempe were sexually transmitted infections (STIs) including AIDS and HIV prevention (72.1%), followed by abstinence (58.6%) and being faithful (30.4%). In comparison, for Iganga, it was correct and consistent use of condoms (53.0%) followed by contraceptives (32.3%), as shown in Table 15.

Question/Options	Kawempe		Iganga	
	No.	%	No.	%
Where has she had lessons/information on SRHR? (*Multiple responses*)				
Never	56	14.7	71	18.5
At school	232	60.7	141	36.7
Church/Mosques	28	7.3	35	9.1
Community	122	31.9	96	25.0
Hospitals/Health centers	163	42.7	141	36.7
NGOs	48	12.6	24	6.3
Others (radio, VHTs, mother, friends, father, Aunt)	33	8.6	49	12.8
Topics covered in those lessons (multiple; n=Kawempe, 326; Iganga, 313)				
Adolescent sexuality	93	28.5	24	7.7
STIs, including AIDS and HIV prevention	235	72.1	77	24.6
Abstinence	191	58.6	76	24.0
Being faithful	99	30.4	53	16.9
Correct and consistent use of condoms,	49	15.0	166	53.0
Medical male circumcision,	11	3.4	15	4.8
Treatments approved by the ministry of health	24	7.4	7	2.2
Risky sexual practices (sex without a condom)	16	4.9	11	3.7
Reporting physical and sexual violence	20	6.1	18	5.8
Contraceptives	68	20.9	101	32.3
Care during pregnancy	19	5.8	3	1.1
Young motherhood stigma	4	1.2	5	1.6
Puberty (body changes, period),	8	2.4		

Question/Options	Kawempe		Iganga	
	No.	%	No.	%
Gender norms	8	2.4	5	1.6
Personal care and hygiene	47	14.4	6	1.9
Nutrition	18	5.5	1	0.3
Alcohol and substance use	7	2.1	2	0.6
Harmful and unlawful traditional practices and their effects (genital mutilation, early marriages, etc.)	11	3.4	1	0.3
Unsafe abortions and post-abortion care services	15	4.6	3	1.1
Child abuse	29	8.9	33	10.5

Table 15: Where they have had SRHR lessons from and the topics covered

Of those who received information at school, 60.1% for Kawempe and 37.7% for Iganga, 60.1% got it from the senior woman teacher, 55.5% in Kawempe, and 50.2% in Iganga received it from the school nurse, and others as shown in Figure 19.

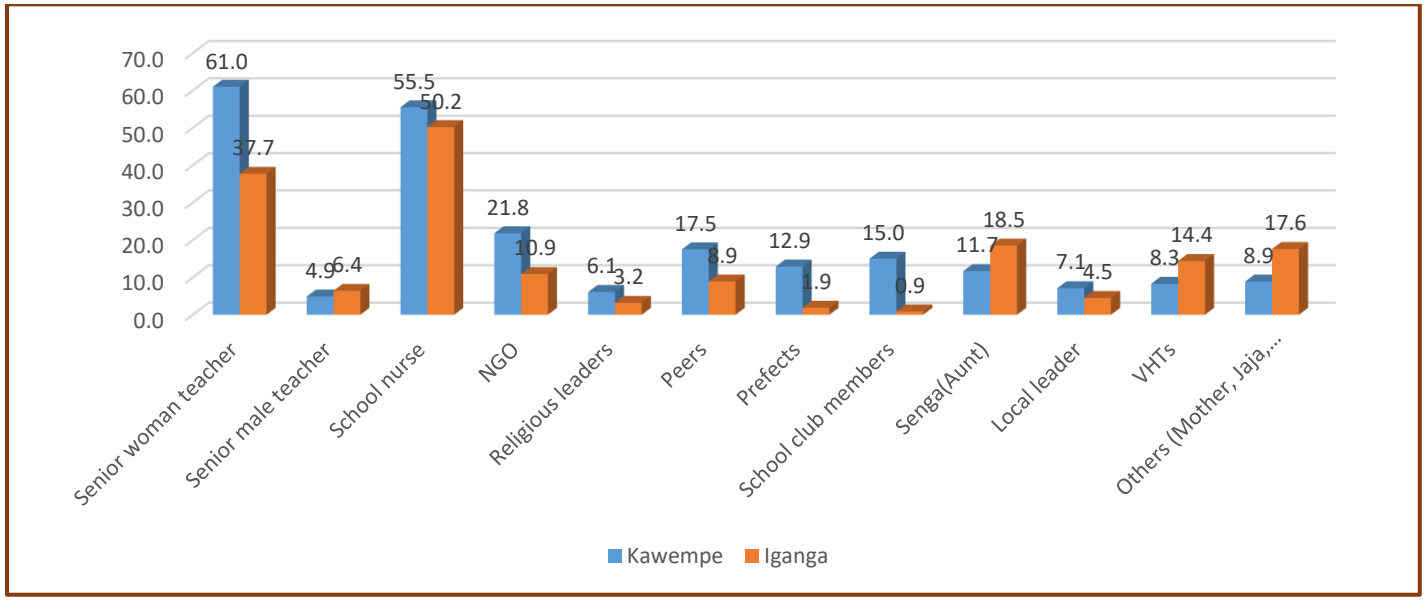


Figure 19: Who gave SRHR information at school (%, multiple responses)

3.4 Knowledge and Attitudes on Sexual and Reproductive Health Rights (SRHR)

3.4.1 Perceptions about getting pregnant, contraceptives and sexual rights

Respondents were asked for their perceptions about critical areas, including HIV prevention, pregnancy and contraceptives and other SRHR issues. Most of the girls who completed the survey (90%) believe that girls and women have the sole responsibility of protecting themselves from unwanted pregnancy.

> **Some of the girls who completed the survey believe that pregnancy can be avoided through having sex while standing, bathing immediately after sex or taking Panadol.**

Panadol is a locally available over-the-counter pain reliever. Table 16 shows the girls' perceptions of methods for preventing pregnancy.

Methods used by girls to prevent unwanted pregnancy	Kawempe	Iganga	Total
It is a responsibility of girls/women only to protect themselves from unwanted pregnancy	95.3	85.3	90.4
You cannot get pregnant if you use contraceptives	65.2	46.3	55.9
You cannot get pregnant if have sex while standing	2.4	17.7	9.9
You cannot get pregnant if you bathe immediately after having sex	4.5	10.9	7.6
You cannot get pregnant if use condoms	77.0	71.9	74.5
You cannot get pregnant the first time you have sex with a new boyfriend	1.3	1.6	1.5
You cannot get pregnant if you spend a short time in the act	1.6	0.8	1.2
You cannot get pregnant if take Panadol before or after having sex	7.4	8.7	8.0
P-value	p<0.001		

Table 16: Girls' perceptions about methods for preventing unwanted pregnancy (%, multiple responses)

The findings show that there is a significant difference in the beliefs about strategies to prevent unwanted pregnancy among girls in Kawempe and Iganga who completed the survey.

3.4.2 Perceptions about getting HIV prevention

Regarding HIV prevention, there was no significant difference in perceptions held by girls in both study sites as illustrated in Table 18.

Perceptions about HIV prevention	Kawempe	Iganga	Total
Young people should protect themselves from HIV/AIDS	93.5	87.8	90.6
Someone can protect him/herself from HIV/AIDS by having sexual relations with one uninfected, faithful partner	26.4	36.7	31.6
Someone can protect him/herself from HIV/AIDS by abstaining from sex	51.3	54.4	52.9
Someone can protect him/herself from HIV/AIDS by bathing immediately after having sex	2.1	5.2	3.7
Someone can protect him/herself from HIV/AIDS by using condoms only during the first sexual encounter	11.5	29.4	20.5
Someone can protect him/herself from HIV/AIDS by using condoms consistently	34.6	35.9	35.3
Someone can protect him/herself from HIV/AIDS by not sharing a plate of food with an infected person	13.1	4.4	8.8
Someone can protect him/herself from HIV/AIDS by (not sharing sharp instruments, doesn't know)	28.8	7.8	18.3
It is the girls' duty to protect themselves from HIV	91.4	75.0	83.2
P-value	p<0.001		

Table 17: Girls' perceptions about HIV prevention (% multiple responses)

Some girls (3.7%) believe that bathing immediately after sex can protect one from acquiring HIV, and 20.5% believe it is not possible to get HIV during the first sexual encounter.

This is a surprising finding given that HIV was the topic mostly discussed by mothers of nearly 83% of the girls who completed the survey in Kawempe and 49% of those in Iganga. Additionally, nearly 58% in Iganga and 79.4% in Kawempe said it was the topic mostly discussed with fathers.

3.4.3 Girls' perceptions about reproductive rights

To further investigate the perceptions about SRHR, we asked participants about their beliefs about physical and sexual violence. The data shows that on average, 50% of the girls who completed the survey (24% for Kawempe and 76.2% for Iganga), believe men should beat their wives. Although 74% also believe women have the right to refuse sex with the husband or partner, 66% also believe they should not report forced sex by a boyfriend or husband. The results are summarized in Table 18.

Perceptions about sexual and reproductive rights	Kawempe	Iganga	Total
When a boyfriend beats his girlfriend or husband beats his wife and can justify why he beat her, it is not okay	31.1	56.9	44.0
Sometimes I think men/boyfriends should discipline their wives/girlfriends	24.0	76.2	50.1
Sometimes I think even women/girls should discipline their husbands/wives	23.5	64.6	44.0
Women have the right to refuse sex, even with their husband or partner	82.6	66.7	74.6
You can refuse sex with your boyfriend or girlfriend when he/she wants to, but you do not want	84.4	57.9	71.2
I think it is right for you to have sex against your will	19.8	12.2	16.0
If a boyfriend/husband forces you to have sex when you do not want, you should not report him	69.9	63.0	66.5
P-value	p<0.001		

Table 18: Girls' perceptions about sexual and reproductive rights (% multiple responses)

> **These findings show a gap in adolescent girls' awareness of sexual rights especially the rights to refuse unwanted sex, report forced sex or report physical violence perpetrated by a partner or husband.**

While our data (see Table 7) show that most of the young mothers (74.7%) got pregnant while in a mutual sexual relationship, it is unknown whether their pregnancies were a result of forced sex or not since many believe forced sex during a relationship should not be reported. The findings might also suggest that unless adolescent girls are equipped with information about their SRHR, they will continue to suffer from unwanted sex as the pregnancy prevention rhetoric continues.

3.5 Young Mothers' Access to SRHR Products and Services

3.5.1 Access to Selected Social Service points

Schools and health center staff were mentioned among the sources of adolescent SRHR information (see Table 12). Respondents were asked to estimate the time in minutes taken to walk to and back from the nearest social service points including health facilities, schools, and police stations. At a 95% level of significance, the Pearson's Chi-square test shows a significance difference in access to selected service points between rural and urban areas (p<0.05). Table 19 presents a summary of the responses (KWP = Kawempe; IGA = Iganga).

	Less than half an hour (%)		Half an hour to 1 hour (%)		1 to 2 hours (%)		More than 2 hours (%)		*P*
Service point	KWP	IGA	KWP	IGA	KWP	IGA	KWP	IGA	
Public health facility	53.7	23.7	33.3	26.3	12.6	46.4	0.5	3.7	<0.001
Private health facility	89.0	58.1	8.1	28.7	2.9	12.8	0.0	0.5	<0.001
Public primary school	47.9	41.2	35.6	31.5	16.2	25.5	0.3	1.8	0.002
Private primary school	79.3	44.5	14.4	28.9	6.3	25.5	0.0	1.0	<0.001

Service point	Less than half an hour (%)		Half an hour to 1 hour (%)		1 to 2 hours (%)		More than 2 hours (%)		*P*
	KWP	IGA	KWP	IGA	KWP	IGA	KWP	IGA	
Public Secondary school	37.2	17.7	39.5	24.0	21.2	51.3	2.1	7.0	<0.001
Private Secondary school	58.7	22.9	25.9	24.0	15.2	43.8	0.3	9.4	<0.001
Police station	61.5	30.0	28.0	24.5	10.5	40.9	0.0	4.7	<0.001
P: Pearson's Chi-square p-value									

Table 19: Time taken to walk to and from selected nearest social service points

More girls in Kawempe than Iganga are within 30 minutes of walking distance to public health facilities, primary school, secondary school and police station. We also found that more girls are closer to a private facility compared with a public service point in both study sites. For example, 22.9% in Iganga are within 30 minutes walking distance to a private secondary school compared with 17.7% who are within 30 minutes walking distance to a public-school secondary school. We note a similar pattern in Kawempe and across all the service points that are both privately and publicly provided. Such long walking distances present a barrier to accessing education and other reasons for leaving school, as shown in Table 4.

3.5.2 Medical examinations, tests and other SRHR services received at school

The girls who completed the survey mentioned that they had been subjected to 'medical examinations' at school as one of the SRHR services. The study respondents were asked to itemize the different medical services they received from school and Figure 20 illustrates the findings.

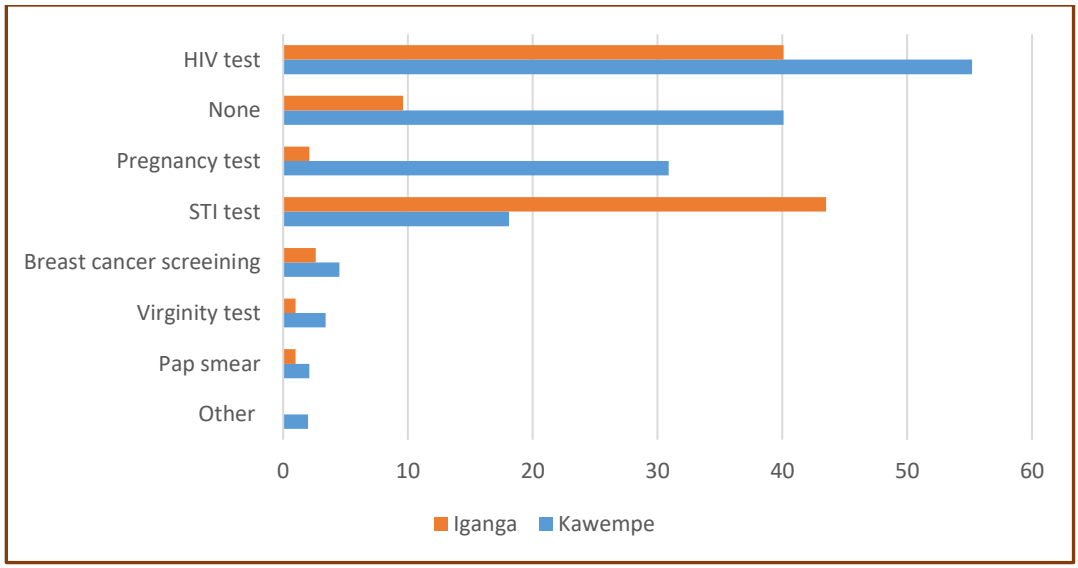


Figure 20: Medical examinations/tests done at school (%)

As shown in Figure 20, the SRHR services received from school include HIV, STI and cancer screening tests. Forty percent (40.1%) of the girls in Kawempe and Iganga said they did not undergo medical examination/ screening at school. However, 55.2% of the respondents in Kawempe and 43.5% in Iganga were tested for HIV.

> **We also note some invasive body and sexual surveillance practices such as pregnancy checks and virginity tests were conducted at schools. Our data show that only 89.5% of the girls who completed the survey in Kawempe and 82.2% of those in Iganga who were subjected to 'medical examinations' gave their consent.**

Past studies have identified pregnancy checks conducted at school for the purpose of excluding pregnant girls from school (Sotonye-Frank, 2024) although government guidelines say otherwise (see MOES, 2020). Our findings confirm those of Kakuru (2024), who attributes the pervasion of sexual surveillance of the bodies of adolescent girls to adultism entrenched in social norms as well as oppressive child protection legislation.

3.5.3 Menstrual Hygiene Products

Age at menarche (%)	Kawempe	Iganga	Total
10 to 13	22.2	11.0	15.3
14 to 16	18.1	42.4	33.2
17 to 19	59.7	46.6	51.6
Total	**328**	**326**	**654**
Mean	13.1	13.4	13.3
Median	13	13	13

Table 20: Age at Menarche

The average and median age at menarche for Kawempe was 13.1 and 13 years, respectively, which was similar for Iganga at 13.4 and 13 years, respectively. Of those who had started menstruation, 22.2% in Kawempe and 11.0% in Iganga were aged between 10 to 13 years respectively.

The majority (67.4%) in Kawempe used disposable sanitary pads compared to the majority in Iganga (60.4%) who used pieces of cloth. There was a significant difference in age at starting menstruation and type of menstrual hygiene products used between Kawempe and Iganga ($p<0.05$) according to Pearson's Chi-square test, as shown in Figure 21 and Table 20.

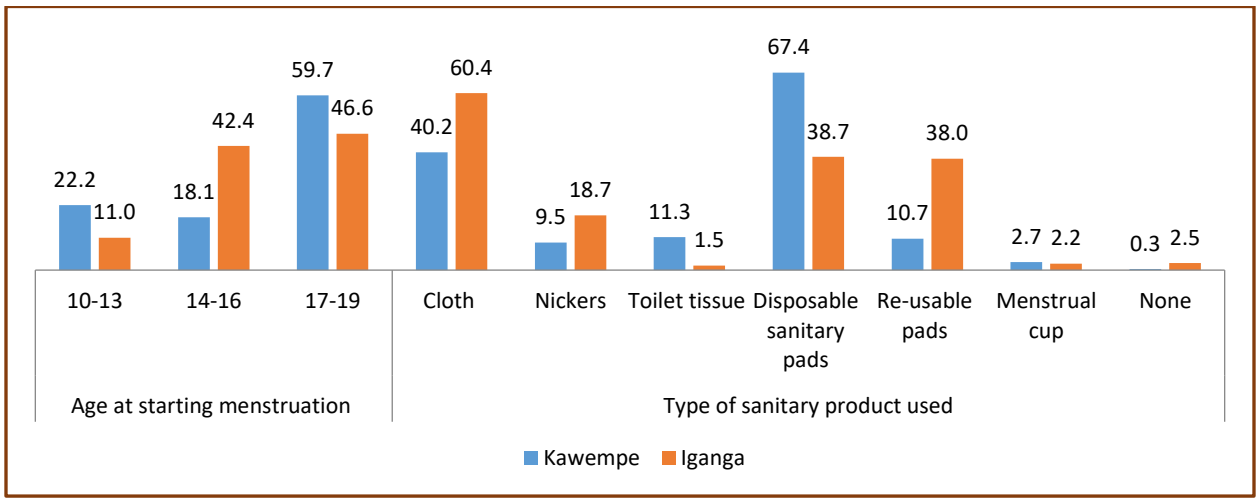


Figure 21: Age at menarche and type of menstrual hygiene products used (%)

The girls who completed the survey were asked to specify how they accessed menstrual hygiene products. We found that most of the girls (about 59%) in both Kawempe and Iganga accessed menstrual hygiene products from parents, followed by self, 28.2% in Kawempe and 20.2% in Iganga, and then school 5.5% in Kawempe and 10.1% in Iganga as shown in Figure 18.

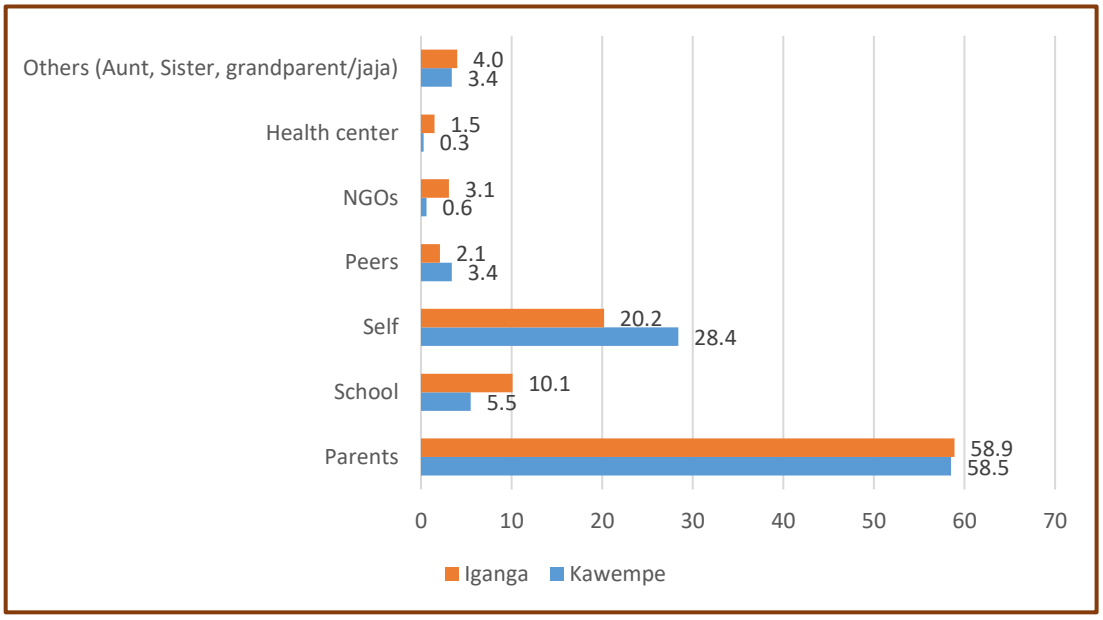


Figure 22: Source of Menstrual Hygiene Products

Our analysis shows that the 28% who provide their own products are likely the owns who do not use disposable sanitary pads which are received from parent, schools, health centers, or NGOs. There was no significant difference in access to menstrual hygiene products by girls in Kawempe and Iganga.

3.5.4 Challenges associated with menstruation

We asked respondents about their menstruation-related challenges. The majority (83.8% in Kawempe and 78.2% in Iganga) of the girls reported that they experienced abdominal pain or discomfort. Other challenges include a lack of products (25.9% versus 9.5%), and irregular periods (8.2% versus 6.8%) for Kawempe and Iganga respectively.

Challenges associated with menstruation differed significantly between Kawempe and Iganga, respectively ($p<0.005$), as indicated in Table 21.

Challenges	Kawempe	Iganga	Total
Lack of products	25.9	9.5	17.7
Abdominal pain	83.8	78.2	81.0
Shame/Stigma	7.6	5.5	6.6
Missing classes	6.7	4.6	5.7
Irregular period	8.2	6.8	7.5
Lack of privacy	11.6	2.5	7.0
Lack of water	6.1	3.4	4.7
Lack of underwear	6.4	4.6	5.5
Lack of soap	7.9	5.5	6.7
Other (back pain, body weakness)	16.8	13.5	15.1
P-value	p<0.001		

Table 21: Challenges associated with menstruation (%, multiple responses)

As illustrated in Table 21 and Figure 23, a higher proportion of girls in Kawempe than those in Iganga had menstruation-related challenges.

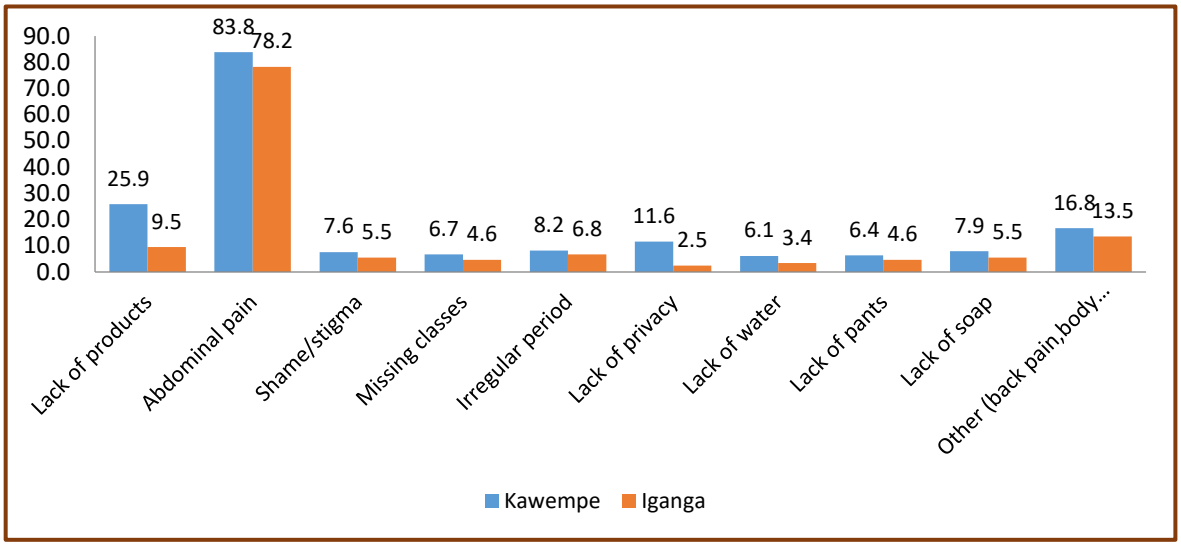


Figure 23: Girls' menstruation-related challenges

3.5.5 Use of Contraceptives

About nineteen percent (18.9%) of the girls in Kawempe and 30.7% in Iganga had started using contraceptives by the time of the interview as illustrated in Figure 22. Our analysis shows a significant difference between contraceptive usage among girls below 19 years in in the two study sites ($p<0.001$).

Of those who had started using contraceptives, 22.2% in Kawempe compared to 11.0% in Iganga started as early as 10 to 13 years of age, 18.1% in Kawempe and 33.2% in Iganga started between 14 and 16 years, and 59.7% in Kawempe and 51.6% in Iganga between 17 and 19 years with an average of 16.2 years as shown in Table 24.

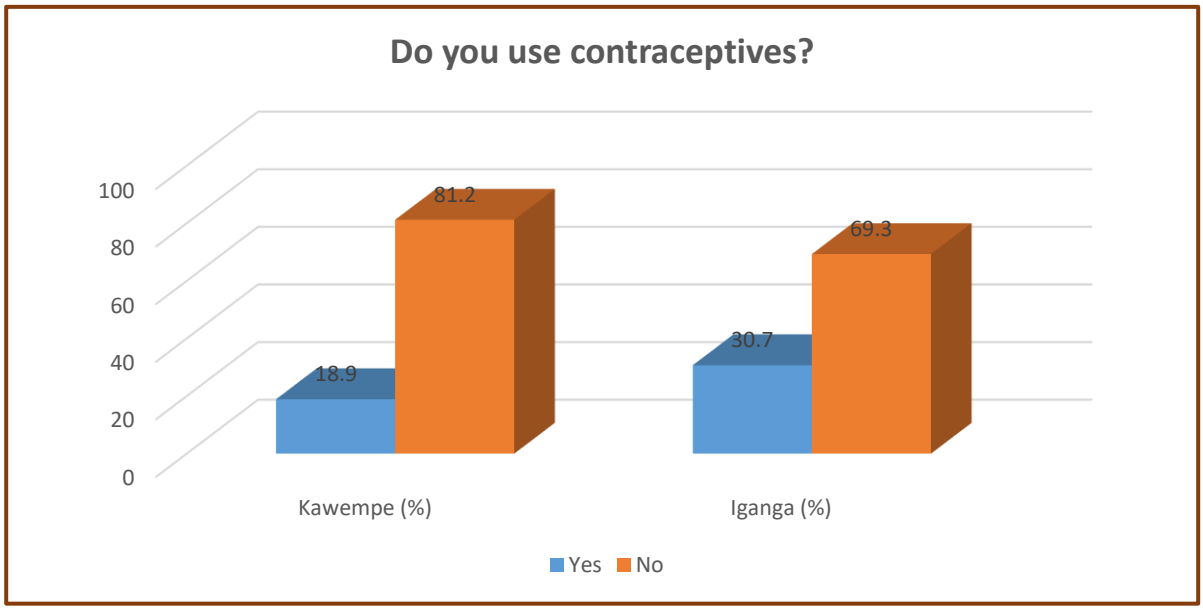


Figure 24: Contraceptive usage among girls aged 10-19 years

Age at first contraceptive use	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%

10-13	16	22.2	13	11.0	29	15.3
14-16	13	18.1	50	42.4	63	33.2
17-19	43	59.7	55	46.6	98	51.6
P-value	p = 0.001					

Table 22: Contraceptive use and age at first contraceptive use

The methods used include herbs, injections, moon beads, withdrawal, Intra-uterine device (IUD) implants and pills as shown in Table 23. The majority (65.3% vs 69.5% in Iganga) of the girls were using injections and condoms (26.4% versus 10.2% in Iganga).

Kind of contraceptives methods used (multiple responses)	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Herbs or traditional medicines	7	9.7	12	10.2	19	10.0
Condoms	19	26.4	12	10.2	31	16.3
Injections	47	65.3	82	69.5	129	67.9
Moon-beads	1	1.4	0	0.0	1	0.5
Withdrawal	7	9.7	0	0.0	7	3.7
IUD	11	15.3	15	12.7	26	13.7
Other (Implants, pills)	7	9.7	8	6.8	15	7.9
P-value	p = 0.003					

Table 23: Types of contraceptive methods used

Most of the girls in Kawempe were encouraged by partners (31.9%) and peers (30.6%), while those of Iganga were encouraged mainly by mothers (39.0%) and self (26.3%). About 65% in Kawempe and 42.4% in Iganga said they got the contraceptives from health centers, and 19.4% versus 35.6% in Kawempe and Iganga, respectively, got them from their parents. Kawempe and Iganga differed significantly in the kind of contraceptive methods used and who encouraged the girl to use contraceptives ($p<0.05$) see Table 23 for more details.

Questions/Options	Kawempe		Iganga		Total	
	No.	%	No.	%	No.	%
Who encouraged her to use contraceptives (multiple responses)						
Mother	19	26.4	46	39.0	65	34.2
Father	1	1.4	1	0.9	2	1.1
Teacher	9	12.5	16	13.6	25	13.2
Peers	22	30.6	27	22.9	49	25.8
Forced	6	8.3	3	2.5	9	4.7
Self	20	27.8	31	26.3	51	26.8
Partner	23	31.9	9	7.6	32	16.8
Other (Heard on radio, friends, health workers, sister)	6	8.3	19	16.1	25	13.2
P-value	p = 0.012					
How she accesses contraceptives (multiple responses)						
Parents	14	19.4	42	35.6	56	29.5
School	9	12.5	26	22.0	35	18.4
Self	12	16.7	20	17.0	32	16.8
Peers	14	19.4	30	25.4	44	23.2
NGOs	4	5.6	6	5.1	10	5.3

Health center	47	65.3	50	42.4	97	51.1
Other (VHT, sister)	1	1.4	8	6.8	9	4.7
P-value	p = 0.233					

Table 24: Method used, who encouraged her and how the method was accessed

3.5.6 Access to condoms

We asked the girls about how easy it is for them to access a condom at a local shop or drug store (if one has money) or ask for one at the health center. Almost a third (35.5%) in Kawempe and 36.2% in Iganga said it was impossible, while 9.2% of those in Kawempe and 18.8% in Iganga said it was very easy, as shown in Figure 25. It is not surprising that adolescents in the study sites find it impossible to access condoms given the social norms and marginalizing SRH policies that exist in Uganda.

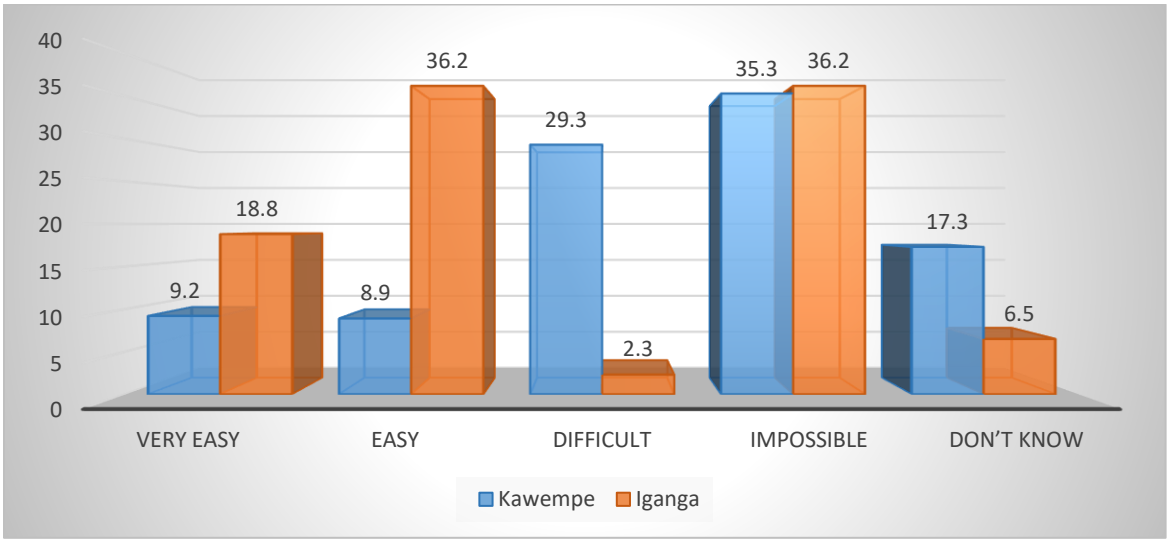


Figure 25: How Easy it is to access condoms (%)

3.5.7 Access to Antenatal Care (ANC)

Of the girls <19 who reported having ever been pregnant, 70.1% in Kawempe and 89.6% in Iganga reported that they accessed antenatal services. Most young mothers in Kawempe (62.7%) accessed immunization services, followed by STI testing and treatment and counselling both at (56.0%). In Iganga, 44.2% accessed regular clinical visits (at least one per month), 42.3% went for STIs testing and treatment and 36.2% received immunization services. There was a significant difference in access to antenatal services and the kind of antenatal services accessed between Kawempe and Iganga ($p<0.05$), as shown in Table 25.

Question/Options	Kawempe		Iganga		Total	
	No	%	No	%	No	%
Accessed antenatal services (Multiple responses)						
Yes	75	70.1	163	89.6	238	82.4
No	32	29.9	19	10.4	51	17.7
P-value	p<0.001					
Kind of antenatal services accessed (Multiple responses)						
Regular clinical visits (at least one per month)	40	53.3	72	44.2	112	47.1
STIs testing and treatment	42	56.0	69	42.3	111	46.6
Information about how to ensure a healthy pregnancy, labor and delivery, and breastfeeding	15	20.0	21	12.9	36	15.1

Ultrasound to check if the baby was growing well	31	41.3	10	6.1	41	17.2
Immunization	47	62.7	59	36.2	106	44.5
Mama kit	11	14.7	32	19.6	43	18.1
Counselling	42	56.0	26	16.0	68	28.6
Other (Weight check)	1	1.3	0	0.0	1	0.4
P-value	p<0.001					

Table 25: Kind of antenatal services did you access? (Multiple responses)

Our data show that 21.3% of the girls in Kawempe were extremely satisfied and 28% were very satisfied with ANC services, compared to 37.4% and 25.8% in Iganga who were extremely satisfied and very satisfied respectively. Twelve percent in Kawempe and 7.4% in Iganga were not at all satisfied, as shown in Figure 26.

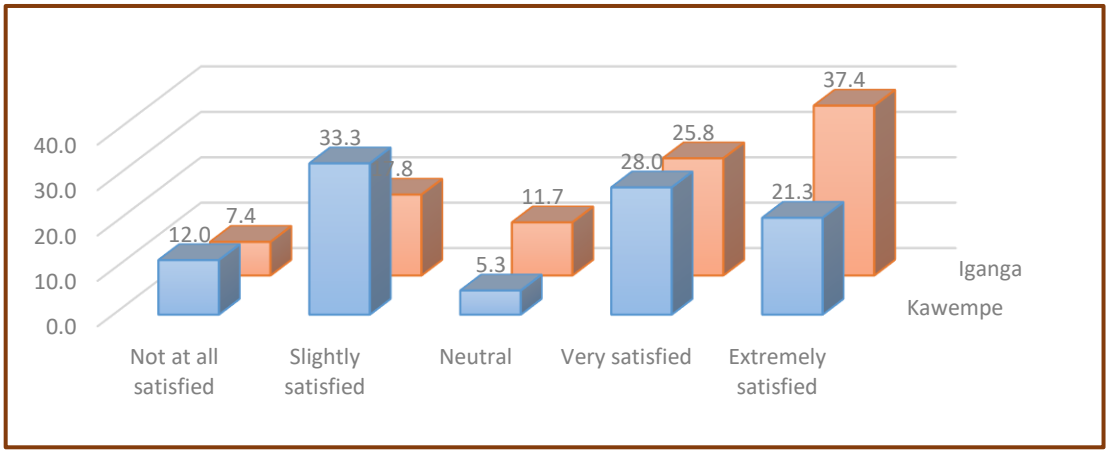


Figure 26: Experience at the health care facility during ANC visit

Long queues (50.7% versus 24.7% for Iganga), which may also be related to long waiting times (41.3% versus 27.5% for Iganga), were reported as a major challenge in accessing services during pregnancy. Others include rude and judgmental service providers (42.7% versus 3.3% for Iganga) and expensive services (28.0% in Kawempe versus 24.7% for Iganga). The rest of the challenges are shown in Table 26.

Major challenges in accessing services during pregnancy (Multiple, n=Kawempe, 75; Iganga, 182)	Kawempe		Iganga	
	No.	%	No.	%
Services are not available in my community	17	22.7	35	19.2
Services are available but expensive	21	28.0	45	24.7
Healthcare facility staff were not youth-friendly	20	27.0	28	15.4
Long waiting time /long queues	69	92	95	52.2
Lack of privacy	6	8.0	4	2.2
Rude and judgemental service providers	32	42.7	6	3.3
Providers that lacked training for and in understanding adolescent ad young women's reproductive needs	4	5.3	7	3.8
The overall quality of services was poor	5	6.7		
Mistrust of the health workers	3	4.0	3	1.6
Household financial status	8	10.6	7	3.3
Lack of transport	7	18.7	44	24.0

*Table 26: Major challenges in accessing services during pregnancy (*Multiple responses*)*

The data show that young mothers' challenges in accessing ANC during pregnancy include lack of these services in the community and the cost of accessing them. Table 27 summarizes the reasons for not seeking ANC services during pregnancy (32 respondents for Kawempe and 19 respondents for Iganga).

Reasons for not seeking antenatal services (multiple, n=Kawempe, 32; Iganga, 19)	Kawempe		Iganga	
	No.	%	No.	%
I didn't know where to go or who to talk to	21	65.6	3	15.7
I preferred to go to a traditional herbalist than a health worker	11	34.4	2	10.5
Services were unavailable in my village	10	31.3	4	21
Services were too expensive	3	9.4	6	31.6
Healthcare facility staff were not youth-friendly	2	6.3	3	15.7
Long queues	2	6.3	1	5.3
Rude and judgemental service providers	3	9.4	4	21
My family forbade me to leave the house to preserve their reputation	1	3.2	0	
Other (No money, aborted/terminated the pregnancy)	7	21.9	0	

Table 27: Reasons for not seeking ANC services during pregnancy (n=32, multiple responses)

Most of the girls in both study sites mentioned long waiting times or long queues as the biggest challenge they faced in accessing services or reasons why they decided not to access antenatal services during pregnancy as summarized in Table 27.

3.5.8 Labor and Delivery

Of the girls who delivered (68.3% for Kawempe and 77.6% for Iganga) from public health facilities, 14.4% for Kawempe and 17.6% in Iganga delivered from private health facilities, 11.5% for Kawempe and 4.8% for Iganga delivered from home. In terms of satisfaction with services at health care facilities, 29% and 16% in Kawempe were very satisfied and extremely satisfied, respectively, compared with 37.9% and 20.9% for Iganga, as shown in Figure 17, 12% vs 14% for Iganga not at all satisfied with the services related to labor and delivery.

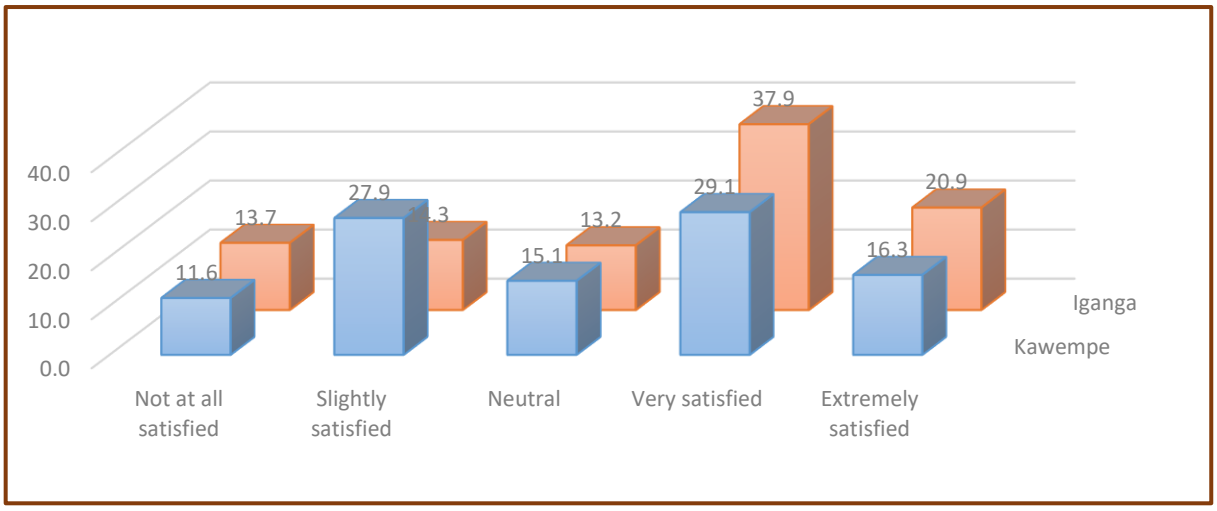


Figure 27: Experience at the health care facility during labor and delivery (%)

In Kawempe and Iganga, many young mothers face challenges during labor and delivery at healthcare facilities. Specifically, 45.3% of Kawempe young mothers and 56.0% of those in Iganga reported difficulties. The most common issues included excessive bleeding (51.3% in Kawempe and 62.7% in Iganga) and a lack of essential necessities (43.6% in Kawempe and 8.8% in Iganga). A summary of the challenges faced during labor and in the postpartum period, and the reasons for not seeking postpartum services are in Table 28.

Question/Options	Kawempe		Iganga	
	No.	%	No.	%
Challenges faced during labor and delivery. (*Multiple,* n=Kawempe, 39; Iganga, 102)				
Baby died	1	2.6	17	16.7
Excessive bleeding	20	51.3	64	62.7
Harsh treatment	16	41.0	6	5.9
Lack of necessities	17	43.6	9	8.8
Lack of privacy	10	25.6	11	10.8
High costs	7	17.9	8	7.8
Other (excessive bleeding, too much pain)	5	12.8	16	15.7
Kind of postpartum services accessed (Multiple, n=Kawempe, 65; Iganga, 148)				
Mom and baby health check (1 to 4 appointments up to 6 weeks after birth)	33	50.8	104	70.3
STIs testing and treatment for the newborn	20	30.8	31	20.9
Breastfeeding education	34	52.3	21	14.2
Immunization	50	76.9	43	29.1
Nutrition counselling	28	43.1	7	4.7
Counselling	21	32.3	16	10.8
Reasons for not seeking postpartum services (*Multiple,* n=Kawempe, 42; Iganga, 34)				
I didn't know where to go or who to talk to	30	73.8	5	14.7
I preferred to go to a traditional herbalist than a health worker	9	21.4	7	20.6
Services were unavailable in my village	14	33.3	10	29.4
Services were too expensive	13	31.0	4	11.8
Healthcare facility staff were not youth-friendly	3	7.1		
Long queues	6	14.2	3	8.8
Rude and judgmental service providers	6	14.2		
Providers that lacked training for and in understanding adolescent and young women's reproductive needs	1	2.4		
Other (Aborted)	2	4.8	8	23.5

Table 28: Types of postpartum services accessed and why services were not accessed

We asked respondents about the challenges faced in the process of accessing services after delivery. The findings show that long waiting time was mentioned by 41.5% in Kawempe and 20.3% in Iganga. Relatedly, long queues were mentioned by 40.0% of the girls in Kawempe and 11.1% in Iganga. Other challenges include rude and judgmental service providers (33.8% for Kawempe and 7.1% of Iganga), services not being available in the community (32.3% for Kawempe and 24.7% for Iganga), and available services are expensive (26.4% for Kawempe and 26.4% for Iganga), as summarized in Table 29.

Question/Options	Kawempe		Iganga	
	No.	%	No.	%
Major challenges in accessing services after delivery (Multiple, n=Kawempe, 65; Iganga, 182)				
Services are not available in my community	21	32.3	45	24.7
Services are available but expensive	19	29.2	48	26.4
Healthcare facility staff were not youth-friendly	8	12.3	26	14.3
Long waiting time	27	41.5	37	20.3
Long queues	26	40.0	21	11.5
Lack of privacy	10	15.4	9	4.9
Rude and judgemental service providers	22	33.8	13	7.1
Providers that lacked training for and in understanding adolescent and young women's reproductive needs	8	12.3	3	1.6
The overall quality of services was poor	3	4.6	2	1.1
Mistrust of the health workers	7	10.8	3	1.6
Household financial status	8	12.3	2	1.1
Lack of transport	16	24.6	43	23.6

Table 29: Major challenges in accessing services after delivery (Multiple)

3.5.9 Experiences with abortion/pregnancy termination

Although adolescent girls in Uganda are excluded from accessing induced abortion services, a quarter (25.2%) of the girls in Kawempe and 29.1% in Iganga said that they knew someone who had terminated their pregnancy. The procedures used to terminate the pregnancy include support from a health care professional (70.4% for Kawempe and 18.9% for Iganga), use of pills of different kinds (22.2% for Kawempe and 20.8% for Iganga), use of herbs and taking strong tea (both at 18.5% for Kawempe and 15.1% for Iganga), and others, as shown in Table 30.

Question/Options	Kawempe		Iganga	
	Number	Percent	Number	Percent
Knows anyone who has terminated their pregnancy (n=Kawempe, 107; Iganga, 182)				
Yes	27	25.2	53	29.1
No	80	74.8	129	70.9
Procedure did they use to terminate the pregnancy (n=Kawempe, 27; Iganga, 53)				
Support of a health care professional	19	70.4	10	18.9
Herbs	5	18.5	31	58.5
Sharp instrument	1	3.7	16	30.2
Pills	6	22.2	11	20.8
Taking strong tea	5	18.5	8	15.1
Drinking laundry detergent			2	3.8
Other methods (Doesn't remember)	4	14.8	6	9.8

Table 30: Procedure used to terminate the pregnancy (Multiple)

At least 70% of the girls in Kawempe and nearly 19% in Iganga who completed the survey mentioned that their peers sought services of a trained health care professional to terminate pregnancy. However, we note that some girls relied on 'unsafe' methods such as sharp instruments, taking pills, and laundry detergent to terminate unwanted pregnancy. We conducted an in-depth examination of the abortion experiences of girls aged 10-18 during the qualitative aspect of our research and details are described by Kakuru et al. (2024b). This finding speaks to the importance of revisiting the laws that govern young people's access to information, services and products as far as unwanted pregnancies are concerned.

4 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 Summary

4.1.1 Prevalence of Young motherhood:

The study findings show that there were more young mothers in Iganga (n = 182) than Kawempe (n = 97). We also found that most of the girls who completed the survey in Kawempe were young mothers who became pregnant between the ages of 17-19 (54.6%), while in Iganga the most affected age bracket was 14-16 (48.4%). Kawempe had more young mothers in the age bracket of 10-13 (6.2%) compared with Iganga (4.4%). This special group of young mothers is under-researched despite their unique human rights and health concerns (UNFPA, 2022).

Most of the young mothers met the men who made them pregnant at their (girls') homes and most of these men were 1–6 years older. These findings suggests that girls in rural areas are more susceptible to adolescent pregnancy, and they should be prioritized in SRHR policy development and implementation. The findings also suggest that unfortunately the home does not offer 100% safety for girls <19. Recent research conducted in Uganda found that more girls got pregnant during the COVID-19 lockdown than pre-Covid era (Batiibwe et al., 2023; Musinguzi et al., 2022).

Although Uganda has a wealth of child protection policies and programs, our findings show that all the young mothers who completed the survey got pregnant due to defilement, rape, coerced sex, and financial needs, all of which imply that there is a gap in the enforcement of the available child protection laws. A study conducted by Gopal et al. (2020) in Uganda recommends involving men through a bottom-up approach integrating local social norms and structures.

4.1.2 Perceptions about Young Motherhood

Regarding the perceptions of young mothers and young motherhood by the society, the findings show that 20% of the girls who completed the survey and were young mothers in Kawempe and 46.7% of those in Iganga were not exactly proud of being a young mother. Concerning their relatives' perceptions, 33.6% of the respondents in Kawempe who were young mothers rated their relatives' perceptions as 'fair' while for Iganga, 37.4% rated their relatives' perceptions as 'bad.' In comparison, most of the young mothers in both study sites rated community perceptions as 'bad' (35.5% for Kawempe and 40.7% for Iganga).

The findings also show that most of the support for young mothers was provided by the family members—especially mothers. This is not a surprising finding and points to the need for more interventions aimed at changing the social norms that perpetuate teenage pregnancy-related stigma. Since adults are also the front-line workers in health care, child and youth care, and social work, and they are ultimately the key policy implementers, and their perceptions matter in the combat for the prevention of teen pregnancy.

4.1.3 Access to SRHR Information

Regarding access to SRHR information, the findings show that in both study sites, parents were the major source of information (53.9% for Kawempe and 36.2% for Iganga), which explains why they also provide most of the support to young mothers. We asked the girls who completed the survey and were young mothers to identify the kind of information they wished they had before they got pregnant. Over half (62.6% in Kawempe and 52.7% in Iganga) wished they knew how to avoid pregnancy. This finding underscores the importance of providing girls from the age of 10 onward with this crucial information.

While the social and religious norms underpin the existing systems and mechanisms that determine the messages and practices for preventing adolescent pregnancy with emphasis on abstinence, the findings of this study demonstrate that girls as young as 10 are sexually active and some of them become pregnant.

4.1.4 Access to SRHR Products

In terms of access to SRHR products, the findings also show that girls who completed the survey struggle to access menstrual hygiene products including basics such as underwear. Most of the girls use washable pieces of cloth (40% in Kawempe and 60.4% in Iganga), followed by disposable pads (67% in Kawempe and 38.7% in Iganga). This might suggest that girls in Iganga face more challenges in accessing disposable sanitary pads compared with those in Kawempe. The challenges in accessing menstrual hygiene products have been linked to adolescents' involvement in transactional sex at the risk of getting pregnant (Phillips-Howard et al., 2015).

Our data reveals a disturbing trend: some young mothers in Kawempe (15%) and Iganga (5.5%) reported becoming pregnant after engaging in transactional sex to meet basic financial needs, including access to feminine hygiene products. This underscores the critical need to address period poverty and ensure that adolescent girls are safe from exploitation due to lack of essential menstrual health products

4.1.5 Access to SRHR Services

Another aspect of SRHR access that we explored was girls' access to services. The young mothers mentioned that antenatal services either did not exist in their communities, were too expensive for them, or their access was characterized by long waiting times that presented a barrier for them. Only 37.9% of the young mothers who delivered at a health care facility were satisfied with the services and 20.9% were very satisfied.

The young mothers (56%) said they experienced challenges at the health care facility. The challenges faced included losing the baby, excessive bleeding, harsh treatment from health care providers, lack of necessities, lack of privacy, and high costs. The findings suggest that the atmosphere at the health care facilities is not adolescent friendly. For example, the high costs and long queues present as unique barriers for young mothers, which older women might find easier to navigate.

4.1.6 Adolescent SRH Rights

Our research reveals alarming violations of adolescent girls' rights. Notably, some schools in our study locations engage invasive and traumatic body surveillance practices. These include forced medical examinations and virginity tests, which involve intrusive and abusive procedures, such as digital penetration. Such actions are unacceptable and highlight the need for urgent protection of girls' rights and dignity.

Only 40% of the girls who completed the survey in both study sites were not exposed to these examinations at school. In Kawempe 30.9% underwent pregnancy tests and 3.4% were subjected to virginity tests, while in Iganga it was 9.6% for pregnancy tests and 2.6% for virginity tests. Other tests conducted included pap smear, STI test, HIV test, and breast cancer examination. Although 89.5% and 82.2% of those who underwent the tests and physical examinations in Kawempe and Iganga said they consented to the examinations, there are outstanding questions about the kind of consent that was obtained and the process for obtaining such consent. Kakuru (2024) contends that virginity testing done in schools is a form of body intrusion. According to McClelland and Fine (2013), adolescent body surveillance, which is a form of sexual violence, which makes it a felony according to Ugandan laws.

Additionally, our analysis shows that some girls who completed the survey do not believe they have the right to report forced sex and physical violence perpetrated by a boyfriend, partner, or husband. Some of them do not believe they have a right to refuse sex from a husband or partner. These findings suggest that adolescent girls in the study area should be equipped with more information about their SRHR.

4.2 Conclusions

The study reveals critical issues around adolescent pregnancy and SRHR in Kawempe and Iganga, Uganda. The findings emphasize young girls' marginalization and the significant social and institutional challenges they face. Findings show higher rates of pregnancy among girls aged 14-19 in Iganga compared to Kawempe, pointing to the influence of rurality on adolescent pregnancy rates. Despite parental involvement as the main source of SRHR information, and the supports provided by parents, many girls lacked essential knowledge to prevent unwanted pregnancy.

The challenges related to accessing menstrual hygiene products are widespread, with some girls improvising with makeshift products. These barriers indicate the pervasive menstrual injustice which further exacerbates the risk of transactional sex and, consequently, adolescent pregnancies and young motherhood. Intrusive, illegal and abusive practices in schools, such as virginity testing and other examinations, infringe on adolescent girls' SRHR. The consent-seeking processes for these tests are questionable, as some girls may feel compelled to comply due to the adultist nature of school rules and policies. Furthermore, inadequate SRHR

services and unfriendly health facilities hinder young mothers' ability to access necessary antenatal and postnatal care. Many reported a dissatisfaction with antenatal services, citing high costs, long waiting times, and poor treatment from healthcare workers.

The systemic shortcomings indicate that health facilities are not designed with the unique needs of young mothers in mind, leading to a failure in addressing adolescent SRHR. The study also underscores the prevailing cultural and religious norms that perpetuate stigmatization of young mothers. A significant percentage of respondents expressed shame, while community perceptions were overwhelmingly negative. Most of the supports young mothers received came from immediate family members, particularly their mothers, underscoring the critical role families play in the lives of young mothers in these communities. Moreover, many girls do not recognize their right to refuse sex or report forced sexual encounters, indicating a critical gap in awareness of SRHR and bodily autonomy.

The findings call for more robust interventions targeting adolescents' knowledge of their SRHR and efforts to change social norms around teenage motherhood. This includes equipping girls with knowledge and skills to assert their rights, promoting safer and more respectful sexual and reproductive health services, and addressing the broader socio-economic factors that contribute to early pregnancy, such as poverty and inequities in educational access. Ultimately, the research points to an urgent need for policymakers to prioritize adolescent SRHR in rural areas like Iganga and poor urban communities like Kawempe. Effective enforcement of child protection laws, as well as improved access to SRHR products and services, is essential to reduce teenage pregnancies and improve the well-being of young mothers. By involving local communities and addressing the socio-cultural norms that perpetuate teenage pregnancy, Uganda can make significant strides in supporting adolescent girls in their SRHR and needs.

4.3 Recommendations

Based on the study findings and their analysis, we make the following recommendations

- More research should be conducted on how to improve child protection strategies within the home to prevent incidences of defilement at the family level.
- Efforts should be made to sensitize family and community members about the importance of providing care for pregnant teens and their babies
- A bottom-up approach to engaging men in teenage pregnancy prevention interventions is urgently recommended.
- There is an urgent need for research about the most culturally appropriate strategies for providing SRHR information to prepubescent girls in a context where young people are excluded from unwanted pregnancy prevention discourse regardless of the consequences on their wellbeing and that of their children. We recommend research about the best practices for ensuring adolescent girls' access to SRH products including menstrual hygiene products in a sustainable manner to eradicate period poverty and foster menstrual justice.
- There is need for research about effective strategies for providing antenatal and postnatal services for young mothers to thrive in a context where available facilities target adult women.
- Although a lot of research has been conducted about adolescent SRHR in Uganda, there still exists a gap in how to enforce existing laws and the appropriate strategies for equipping young people with SRHR information and knowledge.
- Pregnancy checks, vaginal screening and virginity tests in schools should be outlawed as they are dehumanizing and are a form of sexual violence.

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Kawempe Youth[1].

Iganga Youth[2].

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[2] Fatuma Naigaga; Fauza Babirye; Hanifa Nambogwe; Shamila Nakaziba; Doreen Nangobi; Aisha, Nabuyaga; Mercy Nabirye; Apophia Munawala; Miria Namusobya; and Zam, Namuluuta

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