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SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY**

**WOMEN'S EXPERIENCES OF EMERGENCY POST-ABORTION CARE AT
KAWEMPE NATIONAL REFERRAL HOSPITAL, UGANDA**

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DECLARATION

I declare that this dissertation is my original work, prepared from the study data and supporting materials available to me, and that all sources consulted have been duly acknowledged. This work has not been submitted for any other degree at this or any other university.

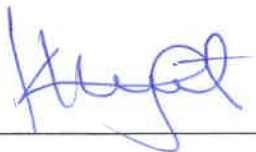
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LIST OF ABBREVIATIONS

EPAC	Emergency post-abortion care
IDI	In-depth interview
KNRH	Kawempe National Referral Hospital
SEM	Socio-Ecological Model
SSA	Sub-Saharan Africa

OPERATIONAL DEFINITION

Abortion	The loss of a pregnancy, whether spontaneously or by induction, before viability (Currently 26 weeks of gestation in Uganda).
Emergency post-abortion care (EPAC)	Immediate, life-saving clinical and supportive care delivered to women presenting with acute abortion-related complications such as haemorrhage, sepsis, shock, retained products of conception, uterine trauma, or severe pain, requiring stabilisation and urgent intervention.
Women's experiences	What women directly go through during the EPAC encounter, including clinical interactions, communication, pain control, waiting times, provider behaviour, consent processes, emotional responses, privacy, and perceived dignity.
Women's reproductive age	Women aged 18 to 45 years.

ABSTRACT

Background

Post-abortion care (PAC) encompasses emergency treatment, counselling, contraceptive services, and referral linkages. The emergency component of PAC, which is Emergency post-abortion care (EPAC), is a life-saving service for women presenting with acute abortion-related complications such as haemorrhage, sepsis, retained products of conception, and severe pain. In Uganda, where abortion is legally restricted and socially stigmatised, women's experiences of care are shaped not only by clinical urgency but also by fear, moral vulnerability, provider interactions, and structural health system constraints. While EPAC is essential for survival, there is limited evidence on how women interpret and evaluate their care experiences in referral hospital settings in Uganda.

Objective

To explore women's experiences of emergency post-abortion care at Kawempe National Referral Hospital, Uganda.

Methods

A qualitative phenomenological design was employed. Eligible participants varied in age, parity, education, and socio-economic background. Sixteen in-depth interview transcripts from women who had received EPAC at KNRH in March and April 2026 were analysed thematically. The transcripts were analysed thematically using an inductive approach. The Socio-Ecological Model guided interpretation across individual, interpersonal, and facility levels. Rigour was ensured through iterative coding, constant comparison, and close engagement with participants' narratives.

Findings

Women's experiences of EPAC were complex and often contradictory. Six themes were identified: (1) survival and physical relief as the immediate measure of good care; (2) pain, fear, and emotional distress during treatment; (3) reassurance and support as buffers against vulnerability; (4) dignity under pressure: communication and privacy in EPAC; (5) structural barriers across the pathway of care; and (6) experiences beyond discharge: incomplete recovery and uncertainty. Care

was frequently evaluated through the lens of survival and physical relief, with many participants describing rapid stabilisation, supportive providers, and timely intervention. Although many participants described survival and physical stabilisation positively, these accounts frequently co-existed with intense procedural pain, fear of death, dismissive communication, compromised privacy, delays, financial burden, and inadequate follow-up after discharge. Experiences extended beyond discharge, with ongoing physical symptoms, uncertainty about recovery and fertility, and variable follow-up support.

Conclusion

EPAC at KNRH was experienced not only as a clinical intervention but as a complex encounter shaped by bodily vulnerability, interpersonal dynamics, and system-level constraints. While life-saving care was often delivered successfully, women's experiences of care were evaluated through a broader lens that included dignity, communication, pain management, timeliness, and continuity of care. Strengthening EPAC, therefore, requires a shift toward more consistent, patient-centred approaches that integrate clinical effectiveness with respectful care, improved triage, enhanced counselling, and clearer post-discharge support systems/mechanisms.

CHAPTER ONE: INTRODUCTION

1.1 Background

Post-abortion care (PAC) encompasses emergency treatment, counselling, contraceptive services, and referral linkages (WHO, 2022). The emergency component of PAC, which is the Emergency post-abortion care (EPAC), involves urgent clinical management of women presenting with acute abortion-related complications such as haemorrhage, sepsis, retained products of conception, shock, or severe pain (Bridwell *et al.*, 2022). Unlike routine reproductive health services, EPAC is delivered in time-critical contexts where rapid stabilisation and life-saving intervention are prioritised. However, while the primary clinical objective is survival, the quality of care is not determined solely by technical outcomes. Increasingly, global evidence recognises that women evaluate care through a broader perspective, including communication, dignity, privacy, emotional support, and timeliness (Kruk and Leslie, 2017; WHO, 2017).

Globally, unsafe abortion continues to be a major cause of maternal morbidity and mortality, especially in low- and middle-income countries. It is estimated that nearly half of all abortions happen under unsafe conditions, resulting in complications that require emergency medical intervention (WHO, 2022; Ganatra *et al.*, 2025). In such settings, EPAC acts as a vital entry point into the health system, often making the difference between life and death. However, research consistently shows that survival alone does not guarantee a positive care experience. Women often report fear, confusion, lack of information, and perceived mistreatment, even when clinical management is technically effective (Baum *et al.*, 2021; Ouedraogo *et al.*, 2023).

In Sub-Saharan Africa (SSA), these challenges are compounded by health system constraints, including limited resources, high patient volumes, and workforce shortages. Studies across the region demonstrate that women's experiences of post-abortion care are shaped not only by the availability of services but also by how those services are delivered. Respectful communication, pain management, and privacy protections have been identified as critical determinants of perceived quality, yet these elements are often inconsistently implemented in overstretched public health settings (Mutua *et al.*, 2015; Kumah, 2025).

In Uganda, the context of EPAC is further shaped by restrictive abortion laws and strong social stigma surrounding abortion and pregnancy loss (Paul *et al.*, 2014; Cleeve, 2019). These factors influence both health-seeking behaviour and how women interpret their care experiences. Women may delay seeking care due to fear of judgment or legal consequences, and upon presentation, may carry feelings of guilt, anxiety, or shame. These emotional and social dimensions interact with the clinical encounter, shaping how care is experienced, remembered, and evaluated (Paul *et al.*, 2014; Ganatra *et al.*, 2025).

KNRH, one of Uganda's busiest public maternity facilities, receives a high volume of women presenting with abortion-related emergencies. Care is delivered within a setting characterised by heavy patient load, resource limitations, and the need for rapid clinical decision-making. Within this environment, women's experiences are not uniform. Some report prompt attention, reassurance, and effective treatment, while others encounter delays, inconsistent communication, and structural barriers such as the cost of scans or medications. Evidence from related obstetric care at KNRH has shown that even when clinical care is effective, women may still experience poor communication and emotional neglect (LoPoni *et al.*, 2025).

Importantly, women's experiences of EPAC are not confined to the moment of clinical intervention. Many arrive at KNRH after navigating multiple lower-level facilities that may lack essential resources such as blood, equipment, or trained personnel. These pathways often involve repeated referrals and delays before definitive care is reached, which can worsen the clinical condition and shape perceptions of care (Atuhairwe *et al.*, 2021). As a result, women's experiences are constructed not only within the referral hospital but also through the broader health system through which they move (Mutua *et al.*, 2015; Kumah, 2025).

Furthermore, the EPAC experience extends beyond discharge. Women may continue to experience physical symptoms, uncertainty about recovery, concerns about future fertility, and varying levels of social support or stigma within their communities. Previous studies have shown that post-abortion care experiences influence not only immediate recovery but also future health-seeking behaviour and trust in the health system (Lythgoe *et al.*, 2021; Udho *et al.*, 2025).

Despite EPAC's central role in maternal health, much of the existing research in Uganda has focused on clinical outcomes, service availability, and utilisation patterns. While these approaches provide important insights, they offer a limited understanding of how women themselves interpret and make meaning of their care experiences, particularly in emergency contexts. Without this perspective, quality improvement efforts risk prioritising technical performance while overlooking the relational, emotional, and structural factors that shape patient experience (Oluka, 2014).

This study, therefore, sought to explore women's experiences of EPAC at KNRH through a qualitative lens, recognising that high-quality care must integrate both clinical effectiveness and patient-centred experience.

1.2 Problem statement

EPAC is a life-saving intervention for women presenting with abortion-related complications such as haemorrhage, infection, and retained products of conception. While these interventions are effective in preventing mortality, evidence shows that clinical success does not necessarily translate into a positive care experience (Kruk and Leslie, 2017).

Globally and in SSA, women receiving post-abortion care frequently report fear, inadequate communication, poor pain management, and perceived disrespect, even when treatment outcomes are medically successful (Baum *et al.*, 2021; Ouedraogo *et al.*, 2023). In Uganda, these challenges are compounded by restrictive abortion laws, stigma, and health system constraints such as overcrowding, delays, and resource limitations (Paul *et al.*, 2014; Kumah, 2025).

There remains a significant gap in understanding how women who receive EPAC in Uganda actually experience, interpret, and evaluate that care. Existing research in Uganda has predominantly focused on service availability, utilisation rates, and clinical outcomes, with limited attention to the lived experiences of women during and after emergency treatment (Izugbara *et al.*, 2020; Jackline *et al.*, 2024; Anena and Auma, 2025). This evidence gap is particularly notable at the national referral hospital level, where patient volumes, clinical urgency, and system pressures create distinct care conditions.

At KNRH, one of Uganda's busiest maternity facilities, EPAC is a high-volume service delivered within a high-pressure environment that prioritises rapid stabilisation. The gynaecological emergency unit receives approximately 16 women with abortion-related complications each day, of whom an estimated 6 (approximately 38%) require EPAC, equivalent to around 180 EPAC cases per month (PAC register–KNRH, 2025), representing a substantial and concentrated burden of EPAC need within a single national referral facility. In such settings, women may have survived life-threatening conditions yet still experienced care as confusing, painful, or lacking in dignity. Additionally, many women reach KNRH only after navigating multiple lower-level facilities due to a lack of essential services, which further shapes their experiences of care (Mutua *et al.*, 2015).

This study, therefore, sought to explore women's experiences of EPAC at KNRH. Without this evidence, it is difficult to design interventions that move beyond technical provision to address the full spectrum of what women need during abortion-related emergencies.

1.3 Aim and objectives

1.3.1 Aim

This study aimed to explore women's experiences of emergency post-abortion care at Kawempe National Referral Hospital, Uganda.

1.3.2 Specific objectives were

- A. To explore women's experiences of clinical care, provider interactions, and health system conditions during EPAC at KNRH.

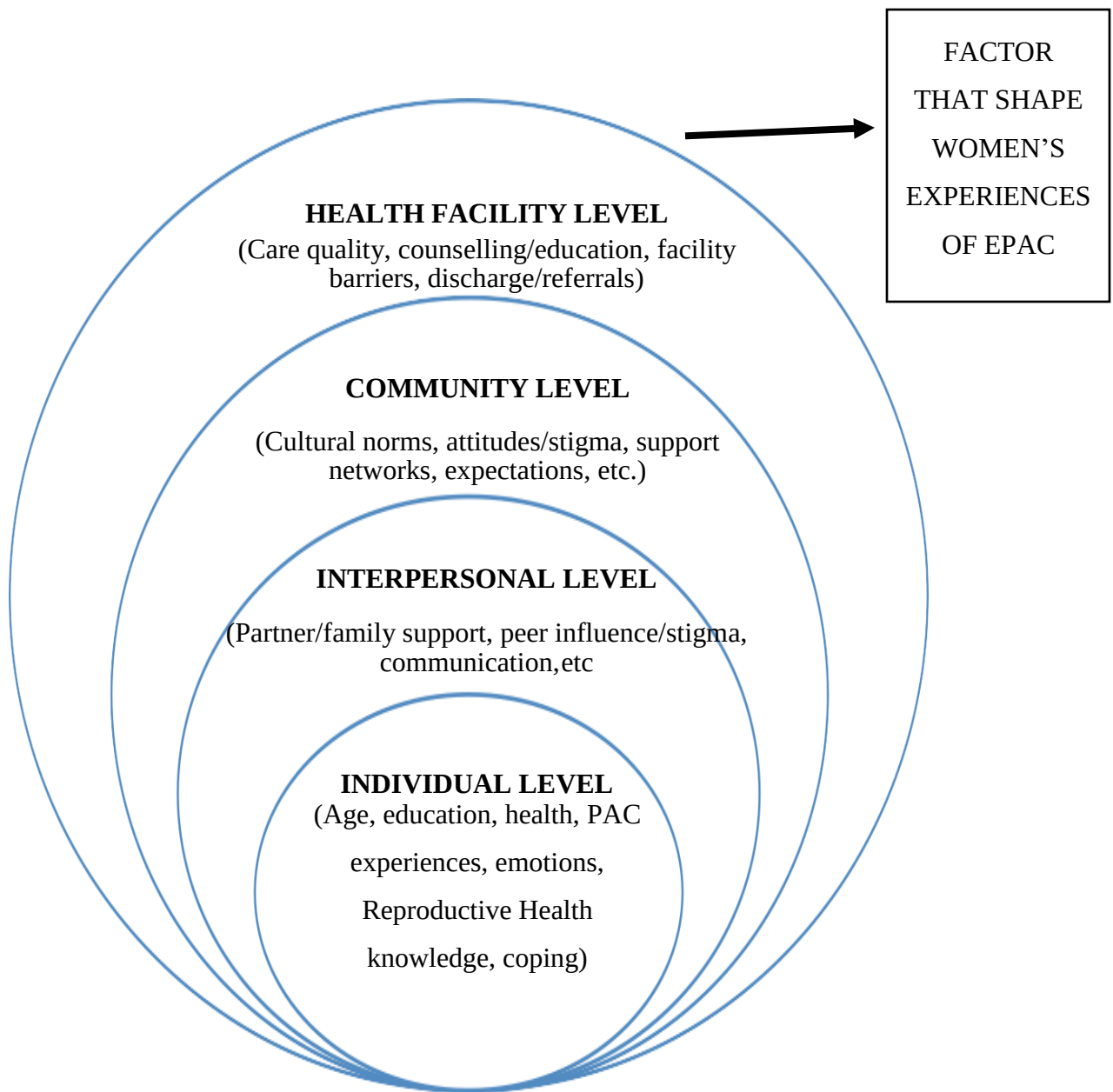
1.4 Theoretical orientation

This study was guided by the Socio-Ecological Model (SEM) originally developed by Bronfenbrenner and later applied to health behaviour and health service research by Stokols (1996) and Schölmerich and Kawachi (2016). The SEM holds that human experiences and behaviours are shaped not by a single factor in isolation, but by the interaction of influences operating at multiple nested levels: the individual, the interpersonal, the community (or facility), and the broader societal context.

This framework was chosen because it is particularly well-suited to examining the complexity of women's experiences of emergency reproductive care. Women do not experience EPAC purely as individuals responding to a clinical procedure; they experience it through the combined effects of their own bodily vulnerability and prior expectations, the attitudes and behaviour of the healthcare providers around them, the organisational conditions of the facility in which care is delivered, and the wider social meanings attached to abortion and pregnancy loss in their communities.

In this study, the SEM was employed as an interpretive lens rather than a rigid coding framework. Themes inductively generated from participants' narratives were subsequently organised and interpreted using the SEM to illustrate how individual, interpersonal, facility, and social factors interacted to shape women's experiences. This approach enabled a more analytically comprehensive account of EPAC that goes beyond describing what happened to explaining why women experienced it as they did.

Fig 1: The Social Ecological Model of factors influencing women's experience.



CHAPTER TWO: LITERATURE REVIEW

2.1 Global and regional perspectives on EPAC

EPAC encompasses the clinical, emotional, and social dimensions of managing abortion-related complications. Globally, it is recognised as an essential component of reproductive health services, particularly in low- and middle-income countries where unsafe abortion remains prevalent (WHO, 2022). Research across multiple countries has demonstrated that women's experiences of EPAC are determined not only by clinical effectiveness but also by the quality of provider interactions, the degree of pain management, the protection of privacy, and the responsiveness of services to emotional needs (Baum *et al.*, 2021, 2023; Ganatra *et al.*, 2025).

A WHO qualitative evidence synthesis by Ganatra *et al.* (2025) on women's experiences of facility-based abortion care identified consistent themes across diverse settings: the importance of respectful communication, non-judgmental provider attitudes, adequate pain management, and privacy. Women in this synthesis described technical competence as necessary but not sufficient for a positive care experience. The affective and relational dimensions of care were equally important. These findings are echoed in multi-country qualitative work by Baum *et al.* (2023), which emphasised that dignity, empathy, information provision, and emotional support are core domains of abortion care quality from the client perspective.

Qualitative evidence from diverse settings shows that women assess post-abortion care not only by clinical outcomes but also by the way they are treated during care. Women consistently report valuing clear explanations, respectful communication, and emotional reassurance from healthcare providers (Baum *et al.*, 2021, 2023). However, studies also document persistent gaps, including inadequate information, limited involvement in decision-making, and experiences of disrespect or judgment, particularly in restrictive settings (Ouedraogo *et al.*, 2023; Muga *et al.*, 2024).

In SSA, studies have documented that women's experiences of post-abortion care are shaped by facility-level constraints, provider attitudes, and social stigma (Mutua *et al.*, 2015; Ouedraogo *et al.*, 2023; Kumah, 2025). Ouedraogo *et al.* (2023) found that women in Kenya experienced disrespectful communication as a form of moral judgment, particularly in public-sector facilities.

Muga *et al.* (2024) reported that across Burkina Faso, Kenya, and Nigeria, limited equipment, inadequate provider preparedness, and weak service systems were major barriers to quality post-abortion care. Izugbara *et al.* (2020), in a systematic review of SSA, concluded that while service availability has improved in some settings, access, quality, affordability, and readiness remain highly uneven. Coast *et al.* (2025) further showed in a narrative review that women's abortion-related experiences are embedded within broader social and moral contexts, particularly where laws are restrictive or stigma is high, and that these wider contexts shape women's interpretations of clinical interactions with providers.

Studies from East Africa more broadly show that social stigma, referral challenges, structural delays, and provider behaviour shape women's experiences of abortion-related care. In Tanzania, women's interpretations of post-abortion care quality encompassed both clinical outcomes and service-quality factors such as waiting time, provider interaction, and information provision (Baynes *et al.*, 2019; Baum *et al.*, 2021; Muga *et al.*, 2024).

Importantly, the legal and social context surrounding abortion shapes how care is experienced. In settings where abortion is legally restricted or socially stigmatised, women may anticipate judgement or blame, which can affect both care-seeking behaviour and interactions with providers (Coast *et al.*, 2025; Ganatra *et al.*, 2025). This highlighted the need to view post-abortion care not only as a medical service but also as a socially embedded experience.

2.2 EPAC in Uganda and similar contexts

In Uganda, post-abortion care is delivered within a health system characterised by high demand, limited resources, and significant structural constraints. Studies have shown that barriers such as delayed presentation, service costs, and limited availability of essential supplies continue to affect access to care (Oluka, 2014; Paul *et al.*, 2014).

Although efforts have been made to improve access to post-abortion care services, challenges remain in ensuring consistent quality across facilities. Research in Ugandan settings indicates that women may receive technically adequate care yet still experience gaps in communication, emotional support, and information provision (Oluka, 2014). These findings suggest that the

quality of care cannot be fully understood through clinical indicators alone. Additionally, abortion stigma, shaped by restrictive laws and strong cultural and religious norms, continues to influence both care-seeking behaviour and how women interpret interactions with providers (Paul *et al.*, 2014; Cleeve, 2019).

Evidence from comparable emergency obstetric contexts at KNRH further highlights these concerns. Women undergoing emergency procedures have reported fear, a lack of information, and emotional neglect, despite successful clinical outcomes (LoPoni *et al.*, 2025). These findings are highly relevant to EPAC, where women are often physically unstable and emotionally distressed, and therefore particularly sensitive to the way care is delivered.

Stillman *et al.* (2023) showed that women's abortion experiences in Uganda were characterised by both physical suffering and emotional pain, while Kabunga *et al.* (2023) highlighted the added complexity for women living with HIV in northern Uganda, where fear, stigma, and moral conflict overlapped with the physical dimensions of care.

In addition, stigma surrounding abortion in Uganda continues to shape women's experiences. Fear of disclosure, social judgement, and legal ambiguity can delay care-seeking and influence how women interpret providers' behaviour (Paul *et al.*, 2014). These factors underscore the importance of examining EPAC within its broader social and legal context.

2.3 Gap in the literature

Although existing studies provide valuable insights, several important gaps remain in the evidence base. First, much of the available research in Uganda has focused on service availability, utilisation, and clinical outcomes, with limited attention to women's lived experiences, particularly in emergency settings (Izugbara *et al.*, 2020; Jackline *et al.*, 2024; Anena and Auma, 2025). This leaves a gap in understanding how women interpret care as more than mere survival.

Second, existing studies in Uganda often assess quality using patient satisfaction measures, which may not fully capture the complexity of women's experiences. Satisfaction scores can mask underlying issues, such as fear, confusion, or perceived disrespect, particularly in contexts where

expectations of care are low, and women may not feel empowered to express dissatisfaction (Oluka, 2014).

Third, there is limited research examining how women's experiences are shaped across multiple levels of influence simultaneously, including individual emotional responses, interactions with providers, facility organisation, and the broader social context of stigma and legal restriction. Without this multi-level perspective, it is difficult to identify the most impactful points for improvement (Izugbara *et al.*, 2020; Baum *et al.*, 2021).

Finally, there is limited qualitative evidence focused specifically on EPAC at the national referral hospital level in Uganda, where patient volumes, clinical urgency, and system pressures are particularly high.

2.4 Contribution of the study

This study addressed these gaps by providing an in-depth qualitative exploration of women's experiences of EPAC at KNRH, Uganda's busiest public maternity facility. By centring women's own narratives, the study moved beyond clinical outcomes to examine how care is experienced, interpreted, and evaluated across the full trajectory from hospital arrival through post-discharge recovery.

Guided by the Socio-Ecological Model (Schölmerich and Kawachi, 2016), the study offered a multi-level understanding of how individual-, interpersonal-, facility-, and community-level factors interact to shape women's experiences. In doing so, it provided context-specific evidence to inform patient-centred improvements in emergency reproductive healthcare in Uganda and similar resource-constrained referral settings across SSA.

CHAPTER THREE: METHODS

3.1 Study design

This study employed a qualitative phenomenological design. Phenomenology is a methodological approach concerned with understanding the lived experiences of individuals who have directly encountered a particular phenomenon (Creswell and Poth, 2018). This design was appropriate because the study sought to explore how women experienced, interpreted, and made meaning of EPAC, rather than to quantify outcomes or measure the prevalence of specific experiences. The phenomenological approach enabled an in-depth exploration of the physical, emotional, and social dimensions of women's EPAC experiences, capturing aspects of care quality that are not accessible through quantitative methods alone.

3.2 Study setting

The study was conducted at KNRH in Kampala, Uganda, specifically within the gynaecological emergency unit, where women with abortion-related complications are assessed, managed, and reviewed. KNRH is one of Uganda's busiest public maternity facilities and serves as a national referral centre for obstetric and gynaecological emergencies. The gynaecological emergency unit receives approximately 16 women with abortion-related complications each day, of whom an estimated 6 (approximately 38%) require EPAC, equivalent to around 180 EPAC cases per month (PAC register–KNRH, 2025). is offered for free, and Out-of-pocket payments are made for ultrasound scans, radiological investigations, and/or the purchase of drugs needed but currently out of stock or unavailable at the facility. EPAC is offered every day of the year, and services are available 24 hours each day. EPAC services are delivered by doctors and nurses who range from senior consultants to student health workers undergoing medical training. This setting was appropriate for the study because it allowed exploration of EPAC experiences within a real-world referral context characterised by clinical urgency and significant system pressures, making it directly relevant to policy and practice in Uganda.

3.3 Study population and data source

The study analysed sixteen in-depth interview transcripts from women who had received EPAC at KNRH. Participants ranged in age from 18 to 45 years and represented diverse socio-demographic and reproductive backgrounds, including variation in marital status, educational attainment, occupation, and parity. This diversity broadened the range of perspectives captured and enabled the examination of women's experiences across different personal and social circumstances.

The data source consisted of in-depth interviews, which provided rich, detailed first-person narratives of women's experiences from the onset of complications through hospital care and recovery. In-depth interviews are particularly suited to exploring sensitive topics such as abortion-related care, as they allow participants to share experiences in their own words and at their own pace.

3.4 Sampling strategy

A purposive sampling with maximal variation was used to select participants with direct experience of EPAC. The participants had been discharged within the preceding 14 days. Participants were required to be clinically stable at the time of recruitment, to have provided informed consent, and to be willing and able to participate in an interview conducted in either English or Luganda. The 14-day post-discharge window was specified to allow participants sufficient time for initial physical recovery and reflection on their experience, whilst minimising the risk of significant recall bias. This window also ensured that women were not approached during the acute treatment period, thereby protecting their well-being and clinical care from interference (Bourret *et al.*, 2025). This approach is appropriate in qualitative research where the aim is to obtain information-rich cases rather than statistically representative samples (Creswell and Poth, 2018).

The dataset reflected variation across key characteristics such as age, parity, and socio-economic status, allowing exploration of different experiences rather than a single homogeneous narrative.

Sampling was guided by the principle of data saturation, in which data collection continued until no new codes, categories, or themes emerged from additional transcripts, indicating that the dataset

had reached sufficient analytical completeness (Guest, Namey and Chen, 2020). The sixteen transcripts were assessed as providing sufficient depth and variation to support meaningful thematic analysis, with saturation evident as codes and categories became consistent and repetitive across the later transcripts. No substantively new experiences or perspectives appeared in the final interviews, confirming that the dataset was analytically adequate for this study.

3.5 Data collection

Data were collected through semi-structured in-depth interviews following a two-stage recruitment process. In the first stage, women who had received EPAC at the gynaecological emergency unit of KNRH were identified by the clinical team at the point of confirmed discharge. Their contact details were obtained, and they were assigned a scheduled review appointment date, in keeping with standard post-discharge clinical practice at the unit. Interviews were deliberately not conducted at the point of discharge. Women at discharge are often physically weak, emotionally distressed, and under time pressure to leave the facility; approaching them at that point would have risked participant burden, compromised data quality, and potentially interfered with clinical care (Creswell and Poth, 2018; Ganatra *et al.*, 2025). The two-week review visit has been used as the preferred recruitment point in comparable qualitative studies of post-abortion care, as it provides a structured clinical window during which women are more physically stable and better able to reflect on and articulate their experiences (Bourret *et al.*, 2025). In the second stage, on or around the scheduled review date, the research team contacted participants to confirm their planned arrival time at the hospital. Upon arrival for their review appointment, women who met the eligibility criteria were approached by a trained research assistant, given a verbal explanation of the study, and offered time to consider participation before written informed consent was obtained. Only those who gave informed consent were interviewed. Of the women approached during the study period, eight declined to participate, citing time constraints, disinterest, or other personal concerns. During March and April 2026, the sixteen women who consented were interviewed in a consultation room at the gynaecological emergency unit of KNRH, prioritising privacy and minimising disruption to their recovery. The interview guide covered the following thematic areas: the pathway to care and first presentation; reception, triage, and waiting; admission and initial assessment; treatment and procedural experience; privacy and dignity during care; provider

communication and information-giving; pain and emotional responses; support received from partner, family, and community; challenges encountered during and after treatment; and experience after discharge, including follow-up and recovery.

Interviews were conducted in English or Luganda, according to participant preference, to ensure comfort and accurate expression of experiences. All interviews were audio-recorded and subsequently transcribed verbatim for analysis. Back-translation procedures were applied where applicable to ensure accuracy of interpretation.

3.6 Data analysis

The transcripts were read repeatedly to develop familiarity with the data. Meaningful units of text were identified, coded, and grouped into categories based on similarities and patterns across participants' accounts. Themes were generated inductively through thematic analysis to capture the data's underlying meaning, moving iteratively between participants' language and broader interpretive concepts. Constant comparison across transcripts was used throughout to identify both common patterns and divergent experiences (Guest, Namey and Chen, 2020).

The SEM was applied as an interpretive lens at later stages of analysis to organise findings by the level at which they operated: individual, interpersonal, facility, and community. This use of the SEM as an organising framework, rather than a deductive coding template, allowed themes to remain grounded in participants' narratives while being situated within a theoretically coherent multi-level account of the factors shaping women's experiences.

3.7 Rigour and trustworthiness

Rigour was ensured by applying Lincoln and Guba's (1985) criteria for trustworthiness in qualitative research: credibility, dependability, and transferability. Credibility was enhanced through immersion in the transcripts and close, iterative engagement with participants' own words. Dependability was ensured through consistent application of the coding framework across all sixteen transcripts and systematic documentation of analytical decisions. Transferability was supported by providing detailed descriptions of the study setting, participant characteristics, and analytical process, enabling readers to assess the relevance of findings to comparable contexts.

Transparency was also maintained by deliberate attention to both positive and negative experiences, including contradictions within individual accounts, to avoid selective reporting. Illustrative quotations were selected to represent the breadth of experiences rather than only the most positive or negative accounts.

3.8 Ethical considerations

This study addressed a sensitive reproductive health topic and involved secondary analysis of interview data from women who had experienced abortion-related complications. Confidentiality was prioritised throughout the analysis. Participant identities were not included in the transcripts; instead, participants were identified by anonymised codes. The analysis was conducted with careful attention to preserving participants' dignity and avoiding unnecessary exposure of personal or identifying information. The study was conducted in accordance with the ethical principles governing research with human subjects.

CHAPTER FOUR: FINDINGS

4.1 Participant characteristics

This chapter presents findings from the analysis of sixteen in-depth interview transcripts from women who had received EPAC at KNRH. The participants ranged in age from 18 to 45 years and represented diverse social and reproductive backgrounds, including variation in marital status, educational attainment, occupation, and parity. This diversity broadened the range of perspectives captured and enabled the examination of women's experiences across different personal and social circumstances. The participants were selected during March and April 2026. Table 1 presents the socio-demographic characteristics of the study participants.

Table 1: Socio-demographic characteristics of participants (March 2026 – April 2026)

Characteristic	Category	Frequency (n=16)
Age (years)	18–24	3
	25–34	7
	35–45	6
Marital status	Married	9
	Not married (single/unmarried)	7
Education level	Primary	4
	Lower secondary	6
	Upper secondary	4
	Post-secondary (certificate/institute)	2
Occupation	Housewife/Unemployed	6
	Informal employment (business, farming, restaurant, tailoring)	7
	Formal employment	3
Number of children	0	4
	1–2	6
	3–4	4
	5+	2

4.2 Overview of findings

Between March and April 2026, we interviewed sixteen women who had received EPAC services at KNRH. Sixteen in-depth interview transcripts were included in the final analysis, each containing sufficiently detailed narratives on care pathways, treatment experiences, communication, emotional responses, social support, challenges, and post-discharge experiences. Transcripts were read repeatedly for familiarisation, coded iteratively, and compared across cases to generate sub-themes, categories, and themes.

From the analysis, six themes emerged. Theme one covered women's experience of survival and physical relief as the immediate measure of good care. Theme two covered pain, fear, and emotional distress during treatment. Theme three covered reassurance and support as buffers against vulnerability. Theme four covered dignity under pressure, specifically communication and privacy during EPAC. Theme five covered structural barriers across the care pathway. Theme six covered experiences beyond discharge, including incomplete recovery and uncertainty.

Based on the findings, the factors shaping women's experiences of EPAC at KNRH were identified using the Socio-Ecological Model. The individual-level factors shaping women's experiences included bodily pain, fear of death, and concerns about future fertility. At the interpersonal level, provider reassurance, respectful or dismissive communication, and family support were the key influences. Facility-level factors included triage and waiting times, privacy arrangements, availability of blood and medicines, referral processes, and continuity of care after discharge. At the broader social level, abortion-related stigma and fear of judgment shaped both care-seeking and recovery. Table 2 summarises all themes, sub-themes, and corresponding meaning units.

Table 2: Overview of themes, sub-themes, and meaningful units/codes

Theme	Sub-theme	Meaningful units (codes)
Survival and physical relief as the immediate measures of good care	Physical stabilisation and symptom relief	Bleeding stopped, pain reduced, improvement, felt saved
	Rapid emergency response	Attended quickly, rushed to help, prioritised, and took emergency action
	Survival is the minimum threshold of acceptable care	Gratitude for survival, recovery despite distress, care judged by outcome
Pain, fear, and emotional distress during treatment	Procedural pain and bodily suffering	Painful evacuation, instruments feared, severe discomfort, helplessness
	Fear of death and acute uncertainty	Fear of dying, shock, severe bleeding, anxiety, uncertainty
	Emotional conflict and self-judgment	Guilt, regret, self-blame, internal distress
Reassurance and support as buffers against vulnerability	Provider reassurance and emotional calming	Comfort, counselling, encouragement, calming words
	Family and social support	Transport, money, cooking, caregiving, and the presence of relatives
	Absence of support	Being alone, abandonment, dependence, and emotional isolation
Dignity under pressure: communication and privacy in EPAC	Respectful communication and explanation	Welcomed, informed, listened to, spoken to well
	Dismissive or judgmental communication	Rude language, blame, harsh tone, not listened to
	Privacy preserved or violated.	Curtain used, exposure during procedure, embarrassment, and many observers.

Table 2 continued: Overview of themes, sub-themes, and meaningful units/codes

Theme	Sub-theme	Meaningful units (codes)
Structural barriers across the pathway of care	Delays and waiting under emergency conditions	Long waits, delayed review, bleeding while waiting
	Overcrowding and limited resources	Many patients, a lack of blood, staff shortage, and shortages
	Financial burden within care	Paying for a scan, buying medicines, borrowing money
	Referral and transfer challenges	Moved between facilities, no blood, delayed definitive care.
Experiences beyond discharge: incomplete recovery and uncertainty	Persistent symptoms after discharge	Ongoing pain, bleeding, weakness, and possible infection
	Limited follow-up and continuity gaps	No review, no follow-up call, no check-up
	Fertility and reproductive uncertainty	Future pregnancy concerns, fear about fertility, unanswered questions.
	Social support, silence, and stigma after discharge	Selective disclosure, support from family, fear of judgment

4.3 Relief and survival after crisis

For most women, the first and most immediate meaning of EPAC was survival. Participants often described care as "good" when it produced recognisable bodily improvement, especially relief from pain, reduced bleeding, or a sense that the condition had been controlled in time. In the context of emergency complications, clinical recovery formed the earliest and strongest basis for women's judgments of care.

Some participants explicitly linked positive evaluation of care to physical improvement after treatment. These accounts suggest that women initially interpreted care in terms of symptom relief and the restoration of bodily stability. Where treatment stopped visible deterioration, women often viewed this as evidence that health workers had done what was necessary.

"They worked on me very well... they focused on me being fine. The doctors kept checking on me, and when I was told I could go home, I felt like a different person

from the one who had come in. I was really happy with the way they treated me."
(IDI_16, 23 years)

"When I went to the hospital, I was feeling lower abdominal pain with every step I took, but after removing the pregnancy-related items from inside me, I felt relieved from the pain. It was like something heavy had been removed from inside me. I could at least walk without holding myself, and that meant a lot because I had been suffering since the previous night." (IDI_6, 28 years)

The majority of the participants reported that the speed of response also shaped their experiences. In emergencies, visible urgency from healthcare providers conveyed both seriousness and competence, reinforcing women's confidence that care was effective. This indicated that rapid response mattered not only clinically but also experientially, as women interpreted prompt attention as a sign that their condition was recognised as serious and that their lives mattered.

"When I reached there, they all rushed, wanting to know what had happened to me. One doctor was already asking questions before I had even sat down, and another was already preparing to examine me. That reaction made me feel that my situation was being taken seriously and that I was in the right place." (IDI_14, 42 years)

However, these positive accounts were not uncomplicated. Women who described care as good still frequently narrated pain, fear, or emotional trauma within the same account. This shows that favourable descriptions of care in emergency settings should not be read as evidence that all dimensions of care were satisfactory. Rather, they often reflect the fact that women entered care in a state of acute danger, in which survival became the minimum acceptable outcome. In this context, physical rescue may temporarily overshadow shortcomings in communication, privacy, or emotional support.

"I thought I was going to die! The bleeding was so heavy, and I was feeling very weak by the time I got to the hospital. Even when they told me they were going to work on me, the fear did not go away immediately because I did not understand what was happening inside my body." (IDI_16, 23 years)

4.4 Pain, fear, and emotional distress during treatment

Despite the central importance of survival, some women also described EPAC as intensely painful and emotionally distressing. Their experiences during treatment were frequently characterised by bodily suffering, fear of death, shock, and profound inner emotional turmoil. These experiences show that EPAC was not merely a medical response to a complication, but also a deeply difficult and memorable ordeal.

Procedural pain emerged strongly in the narratives, particularly during uterine evacuation and related interventions. Women described that the pain was severe, frightening, and difficult to forget.

"The moment when the machine was pulling the placenta out was so painful. It reached the point that when I heard metals being banged, I got scared and started shaking. I kept asking them to stop, but they told me to be patient because they were almost done" (IDI_3, 32 years)

In some cases, the memory of pain appeared to persist beyond the procedure itself, raising concerns about potential psychological sequelae.

"The pain was too much when the doctor put in the hand, it was like my whole inside was being pulled out. I cried and asked him to stop, but he said he had to finish what he was doing. I sometimes dream of what he did to me, and I wake up feeling that same pain all over again." (IDI_4, 21 years)

Fear of death was another recurring feature. Some of the participants reported often bleeding heavily on arrival in the hospital. They often reported experiencing severe pain or being uncertain about what was happening within their bodies. This uncertainty intensified fear and made treatment emotionally overwhelming. Even where clinical outcomes were positive, and providers offered some reassurance, the emotional weight of nearly dying remained central in how women narrated the event, underscoring that the fear of death shaped the entire care episode regardless of its outcome.

"I thought I was going to die because of how much blood I had lost before reaching the hospital. But there was a female doctor who told me that people had come in

worse conditions than mine and had survived. That calmed me a little, even though the fear was still there." (IDI_16, 23 years)

In addition to pain and fear, some women described emotional conflict linked to the pregnancy event itself. Feelings of guilt, regret, or self-blame emerged across several transcripts. This revealed that emotional distress was not solely a reaction to physical suffering. It was also shaped by personal interpretation, social norms, and internal moral struggle, extending EPAC's meaning beyond the procedure to include the woman's own reckoning with what had happened.

"I didn't like what I had done, and lying there in that bed made me think about it even more. I was feeling guilty and in pain at the same time, and there was nobody I could really talk to about it ..." (IDI_16, 23 years)

Women also expressed anxiety about future fertility and the possible long-term effects of the complication or procedure. Such uncertainty broadened the experience of distress beyond the immediate emergency.

"My question was, if I want to conceive, what is the right period for me to get pregnant? They gave me a range, saying six months, eight months, but I wanted the exact answer because I do not want to make any mistakes. Not knowing the right time kept disturbing my mind even after I had left the hospital and was feeling physically better." (IDI_15, 38 years)

4.5 Reassurance and support as buffers against vulnerability

Women's experiences of EPAC were strongly shaped by the support they received from healthcare providers, family members, and social networks. Support did not eliminate pain or danger, but it changed how women were able to endure them. Reassurance from providers and practical assistance from relatives often softened vulnerability, whereas the absence of support made treatment feel harder, lonelier, and more frightening.

Provider reassurance emerged as a particularly important form of emotional support. Participants valued providers who spoke calmly, explained what was happening, and reassured them that they would recover. For women in pain and fear, these forms of reassurance reduced anxiety and helped

them cope with what was happening. Emotional support from providers, therefore, contributed directly to the quality of the care experience, functioning as a therapeutic intervention in its own right.

"The doctor took time and counselled me and comforted me, making me feel calm. He told me I would be fine, since people in worse conditions had survived and gone back to live their normal lives... I had arrived at the hospital believing I was going to die, and after he spoke to me, I started to think that maybe I would make it"
(IDI_2, 45 years)

Family and social support also played a major role. Women described husbands, relatives, and other close contacts who provided money, transport, food, and emotional support, which helped both emotionally and practically. It helped women access treatment, meet unexpected costs, and cope physically and psychologically during recovery.

"My husband helped me throughout the whole time I was in the hospital. Whenever I needed a blood transfusion, he would provide the money, and if he didn't have it, he would borrow from relatives or friends without complaining. Knowing he was there and willing to do whatever was needed gave me the strength to go through everything that was happening to me." (IDI_2, 45 years)

However, not all women had such support. Some described being alone at a time when they were weak and unable to help themselves. Where support was absent, women's vulnerability was intensified as they became more dependent on staff, more emotionally exposed, and less able to navigate care demands.

"I had come alone because I did not want anyone to know why I was going to the hospital. But when I got there, and things became serious, I realised how much I needed someone. I couldn't do anything on my own, and I had to depend completely on the nurses and doctors for everything. I was helpless..." (IDI_1, 20 years)

4.6 Dignity under pressure: communication and privacy in EPAC

Women's experiences of care were also significantly influenced by whether they felt treated with dignity during emergency management. Dignity was expressed primarily through the quality of

communication and the protection of physical privacy. Women noticed whether providers explained procedures, listened respectfully, and protected their bodily privacy during care. These issues mattered greatly because EPAC occurred at a time when women were already physically weak and emotionally exposed.

Some participants described respectful communication positively. They appreciated being welcomed, asked what was wrong, and given explanations. Such interactions provided reassurance and helped women feel recognised as persons rather than merely as emergency cases. However, even where providers communicated respectfully, women in acute pain or fear reported limited capacity to absorb information in the moment fully.

*"... He didn't talk badly to me at all; he asked me what was wrong and even took me away from the crowded reception because I was in pain and began examining me immediately. When I asked him about what he thinks about my condition, he explained until I understood, which I did not expect from a government hospital."
(IDI_11, 28 years)*

At the same time, other women experienced communication as dismissive, judgmental, or harsh. These interactions were experienced as insensitive and, in the setting of abortion-related complications, as implicitly judgmental. Such communication deepened women's emotional discomfort and added a moral dimension to an already distressing clinical encounter.

"The doctor kept asking why I was alone and why we got pregnant at such a young age, and the way he was asking made me feel like I had done something very wrong. I wanted to explain myself, but he did not seem willing to listen; he kept repeating the same questions. That made me feel ashamed on top of everything else I was already going through." (IDI_1, 20 years)

Privacy was another major component of dignity. Some women described efforts to protect privacy through curtains and restricted visibility.

"They put a curtain and closed it before they started working on me, so the other patients and visitors could not see what was happening. Only the doctors and nurses who needed to be there could see me, and that made me feel safer. I had

been worried about that before they started, but when I saw them do that, some of the embarrassment went away." (IDI_13, 34 years)

Others, however, reported feeling exposed and embarrassed during procedures. Some participants noted that their dignity in EPAC was conditional rather than consistently safeguarded. Emergency conditions, overcrowding, and system pressure may have limited the ability to ensure privacy, but women still noticed whether efforts were made.

"They worked on me in the open when everyone was seeing, there was no curtain and no screen between the other people in the room and me. I just felt embarrassed and kept looking away, hoping the people nearby were not watching, but I had come to be worked on; there was nothing to do. I had to endure it because I needed the treatment..." (IDI_1, 20 years)

4.7 Structural barriers across the pathway of care

Women's experiences of EPAC were also strongly shaped by structural conditions within the health system. These included delays in receiving care, overcrowding, shortages of critical resources, financial burdens, and repeated movement across facilities before reaching definitive treatment. Such factors affected not only access to care but also the emotional and practical meaning of the care experience.

Delays in receiving attention were frequently described. Some women narrated long waiting times despite severe bleeding or pain.

"I waited for over 4 hours, and no doctor had checked on me, yet I was bleeding so much that I had to keep changing my clothes. Doctors were passing me by and not really listening when I tried to tell them how bad things were; they would nod and walk on. We just sat there, I and two other women who had also been waiting a long time, all of us suffering in silence and hoping someone would come." (IDI_10, 26 years)

The experiences of delay were not merely a logistical issue; it became part of the emotional experience of illness, increasing fear, desperation, frustration, and the feeling of being neglected.

"If you don't fight for your life, you can wait till evening without anyone bothering to check on you. I had to stand up twice and go and ask about my situation before they finally attended to me. It should not be that way, especially for such people in our condition, you bleeding, and you in pain. By the way, not everyone has the strength to keep asking to be helped." (IDI_12, 25 years)

Overcrowding and limited resources were also visible in the narratives. Some participants recognised the strain on the system and had adapted their expectations to the realities of a busy public hospital. However, normalising constraints did not remove their impact on their care experience.

"We waited for a long time, but that waiting time was fine. Many people come to that hospital every day. I could see the doctors and nurses moving quickly and trying to help everyone, so I understood they could not attend to all of us at once. I waited for about two hours, and I could see they were doing their best." (IDI_7, 19 years)

Financial burden was another major structural issue. Women reported paying for scans, medicines, and other care-related needs, despite attending a public health facility where they thought everything they needed for their health care was free of charge and available.

"The doctor asked for money for the scan, it was sh.20000, but I had only sh.15000, and I didn't know what to do. I was sick and worried and now I had to think about money on top of everything else..." (IDI_6, 28 years)

These costs added stress and uncertainty to emergency care, particularly for women who were already financially dependent on others.

"I was told to go to the pharmacy to get medicine after the procedure, and I felt relieved that I would be going home with something to help me recover. But when I reached the pharmacy, the drugs were not there. Instead, I went outside, and they told me it was sh.40000. My heart sank because I had nothing close to that amount. I couldn't get the complete treatment, so I left with only part of the medicine and hoped it would be enough." (IDI_3, 32 years)

Importantly, women's experiences often began before arrival at KNRH. Some described moving between facilities due to a lack of blood, equipment, or service capacity at other facilities. Their experiences of EPAC were shaped across the broader referral pathway, not only within the walls of the referral hospital itself.

"They did not have blood to put on me at the first hospital, and yet I was losing so much that the doctor said I needed to get blood urgently. They told my husband to take me somewhere else, and that is how we ended up being sent to another hospital that later transferred me to Kawempe... By the time I finally got the blood I needed, I had been moving from place to place for hours while getting weaker." (IDI_2, 45 years)

Not all structural experiences were negative. Some women still described the system as responsive, noting the dedication of individual staff despite these conditions.

"With every patient they brought in, you would see the doctors hurry to them, three can run to the patient and ask how they are, and in the end, a doctor is working on them. You cannot see any patient without a doctor caring for them. They gave me three bags of blood, and I did not pay for any of it, so I tell people who say Kawempe makes you pay that they are lying, because the care was truly there." (IDI_13, 34 years)

4.8 Experiences beyond discharge: Incomplete recovery and uncertainty

Women's experiences of EPAC did not end at discharge. Many participants described a continuation of the care experience through recovery, where persistent physical symptoms, limited follow-up, unanswered questions, and variable social support shaped how they understood what had happened and how fully they had recovered. This indicated that women experienced EPAC as a continuum rather than a single hospital event. Some participants continued to experience pain, bleeding, weakness, or possible signs of infection after leaving the hospital.

"Right now, I am feeling some pain, a little pain in my lower abdomen that has not gone away since I left the hospital. I also think I keep producing pus because there is something that comes out which does not look normal to me. I don't know if this

is supposed to happen, but I think something is wrong, and if I recall well, nobody told me what to expect after going home." (IDI_6, 28 years)

For some women, the physical burden of EPAC remained unresolved, showing that discharge did not always coincide with full recovery or resolution of the issues they had.

"I continued bleeding even after going home, and it was not light bleeding; it was enough to need pads every few hours. No one wants to be bleeding all the time because, apart from the discomfort, it is mentally tiring. After all, you keep wondering when it will stop. The pads also irritate after a while, and the whole thing made it very difficult for me to rest and recover properly." (IDI_7, 19 years)

Follow-up care was largely absent. Women reported no contact, no review, and little guidance after discharge. This lack of continuity contributed to uncertainty about what was normal, when to seek help, and whether recovery was progressing appropriately.

"No one has called me since I was discharged, not to check if I am okay or if the symptoms have changed. I thought maybe they would follow up in a day or two, but nothing came of it. After you're discharged, that's it. If something goes wrong at home, you find your way back because no one is coming to look for you, no one knows you..." (IDI_6, 28 years)

Women also expressed unresolved concerns about future fertility. Questions about conception timing and bodily recovery remained unanswered for a number of participants, extending the emotional weight of the experience well beyond hospital treatment. The experience of EPAC continued beyond the emergency intervention itself as women left the hospital alive, but not always reassured, fully informed, or fully recovered.

"... When I got home, I went somewhere else to do a scan to confirm everything was fine. I still had the pain, and I thought my body was not fully back to normal. I was also worried about whether I can still have children properly..." (IDI_9, 34 years)

Social context also mattered after discharge. Some women received continued support from family, while others limited disclosure of their experience due to stigma or fear of judgment. This meant that recovery was not only medical but also social and emotional.

"My mum called me, and I told her I was fine, because I did not want her to worry about the details of what had happened. She asked me about the doctor who worked on me, and I just said the doctors there are good. I did not tell her everything. I know she wanted to know much more and ask and ask and ask many questions. But I was not ready for that, and neither was I ready for what she would think of me..."
(IDI_13, 34 years)

CHAPTER FIVE: DISCUSSION

Women judged EPAC quality primarily by whether they survived and whether bodily stability was restored. When bleeding stopped, pain resolved, and the emergency was controlled, women described EPAC as good, even where communication, pain management, or privacy had been inadequate. This pattern reflected what may be termed a survival threshold in emergency reproductive care. Women's evaluative criteria under such life-threatening conditions were compressed such that physical rescue temporarily overshadowed all other quality dimensions. This finding was consistent with Baum *et al.* (2021) and Ouedraogo *et al.* (2023), who documented that technical competence is necessary but insufficient for a positive care experience. The present study extended those findings by demonstrating that in emergency settings, the primacy of survival was not merely a preference but a fear-driven reordering of perception. This finding also challenged the sole use of patient satisfaction surveys as quality measures in EPAC, since women who had survived life-threatening complications frequently rated care positively regardless of whether communication, pain management, or privacy were adequately addressed (Kruk and Leslie, 2017; WHO, 2017).

Once the immediate danger had subsided, the embodied suffering that had accompanied treatment came into sharper perspective. Pain in EPAC was not only a clinical symptom; it was an interpretive experience carrying social, moral, and psychological weight. The convergence of physical and emotional suffering has been documented by Coast *et al.* (2025) and Ganatra *et al.* (2025). This study extended those findings in an emergency context, which revealed that inadequate pain management and emotional absence during procedures amplified distress rather than containing it.

What mediated between suffering and the capacity to endure it was the presence or absence of reassurance. Reassurance from providers served as a therapeutic intervention rather than supplementary comfort. When providers spoke calmly, explained what was happening, or remained emotionally present during painful procedures, women reported being better able to manage fear and tolerate discomfort. Conversely, dismissive or abrupt provider behaviour deepened distress and intensified the sense of abandonment. This was consistent with Baum *et al.*

(2021), Whitehouse *et al.* (2021), and Chekol *et al.* (2024). In emergency settings, this therapeutic function was amplified. Women who were having severe vaginal bleeding and were terrified were far more dependent on reassurance than those undergoing a planned procedure. Absence of family support intensified vulnerability and dependence on provider behaviour (Baynes *et al.*, 2019; Lythgoe *et al.*, 2021).

In Uganda's context of legal restriction and stigma, judgmental communication carried moral weight well beyond poor service. It signalled condemnation to an already vulnerable woman. Cleeve (2019) and Ouedraogo *et al.* (2023) documented this similar pattern in their studies. This study extended both findings: in emergency settings, where women cannot leave to seek care elsewhere, such communication was coercive. Privacy violations carried a related social exposure risk, since being seen seeking abortion-related care had real community consequences.

Structural conditions constrained provider capacity for dignified care. Delays, shortages, and out-of-pocket costs at a public facility shaped the conditions under which relational care was possible which was consistent with previous studies (Izugbara *et al.*, 2020; Atuhairwe *et al.*, 2021; Muga *et al.*, 2024). Fragmented referral documented by Ouma *et al.* (2023), meant that for many women, EPAC had begun hours earlier under deteriorating conditions before reaching KNRH.

Discharge marked not the end of EPAC but a transition to largely unstructured recovery. Most prior Ugandan studies examined access and utilisation, not the post-discharge period (Izugbara *et al.*, 2020; Jackline *et al.*, 2024; Anena and Auma, 2025). Lythgoe *et al.* (2021) showed that post-discharge experiences in SSA directly shaped women's future engagement with health services. The present study confirmed these findings specifically for EPAC and added the observation that fertility-related uncertainty, which persisted when discharge counselling failed to address conception timing and long-term recovery, led to ongoing psychological distress, constituting an extension of the care experience itself.

Together, these findings showed that women's EPAC experiences arose from the interaction of bodily vulnerability, provider behaviour, structural conditions, and social meaning operating simultaneously from crisis to post-discharge recovery.

Factors influencing women's experiences of EPAC guided by the SEM

The Socio-Ecological Model was applied as an interpretive lens following thematic analysis, rather than as a deductive coding framework. No single level fully accounted for women's experiences; the findings at each level were necessary but not sufficient on their own.

At the individual level, bodily vulnerability, including the severity of haemorrhage, pain intensity, fear of death, and reproductive anxiety, shaped how women entered the care encounter and what they were able to perceive and evaluate. Women who arrived in extreme situations were least able to assert their preferences or notice deficiencies in communication and privacy, and were most dependent on providers and least able to advocate for themselves. This explained why the same clinical procedure produced qualitatively different experiences depending on provider behaviour: an empathetic provider amplified resilience; a dismissive one amplified distress.

At the interpersonal level, provider communication, family support, and provider attitudes were decisive mediating factors. These were not independent as they were shaped by facility-level conditions such as overcrowding and staff pressures, and by community-level factors such as stigma. Cleeve (2019) showed that provider stigma in Kampala shaped staff interactions with women seeking post-abortion care. This study extended that finding, showing how stigma translated into specific communication practices, including judgmental questioning and dismissive referrals that deepened women's distress.

At the facility level, KNRH's structural conditions, including high patient volumes, blood product shortages, inadequate privacy, and the absence of follow-up systems, shaped the relational possibilities of care, not only its technical delivery. These structural conditions are documented across comparable settings in SSA (Izugbara *et al.*, 2020; Muga *et al.*, 2024). This study showed how they were experienced from the inside by a woman trying simultaneously to survive and navigate a system failing to protect her dignity.

At the community level, abortion stigma in Uganda shaped the entire care trajectory. Women delayed seeking care for fear of judgment, arrived at the hospital carrying shame and guilt, interpreted provider behaviour through a moral lens, and, after discharge, limited disclosure of

their experience to protect themselves from community condemnation. Ouma *et al.* (2023) and Ndayisenga *et al.* (2024) both documented how stigma shapes abortion care pathways in East Africa. This study found that stigma operated within the facility, shaping how provider communications were interpreted, and continued after discharge, shaping recovery. Interventions must therefore extend beyond clinical training to encompass the social environment.

The SEM explained an apparent paradox: how women could simultaneously describe care as life-saving and inadequate. Survival was secured at the individual and facility levels through clinical intervention. But dignity was undermined at the interpersonal level by poor communication and at the facility level by compromised privacy and delays. Community-level stigma made these indignities more painful than they would otherwise have been. The SEM, by mapping these interactions, showed that EPAC quality was not a single outcome but a product of multiple, interacting, and sometimes contradictory forces operating simultaneously.

Strengths and limitations

This study has several important strengths. It is among the few qualitative studies to focus specifically on women's experiences of EPAC at the national referral hospital level in Uganda, providing evidence directly relevant to policy and practice in a high-volume, high-acuity setting. By using in-depth interview data and thematic analysis, the study captured the depth, complexity, and contextual meaning of women's experiences in ways that quantitative satisfaction surveys cannot. The use of the SEM as an interpretive framework enabled a multi-level analysis that goes beyond describing what women experienced to explaining the factors and interactions that produced those experiences. The inclusion of sixteen participants with diverse socio-demographic characteristics, including variation in age, parity, marital status, education, and occupation, strengthened the analytical breadth of the findings and reduced the risk of a single-perspective account.

A further strength is that the findings were deliberately examined for both positive and negative experiences, including internal contradictions within individual accounts. This approach, consistent with the rigour criteria outlined by Lincoln and Guba (1985), ensures that the analysis

reflects the full complexity of women's experiences rather than selectively presenting either a flattering or a damning picture of EPAC at KNRH (Morse, 2015).

The main limitation of this study is that it was based on secondary analysis of interview transcripts. Although the transcripts were rich and detailed, secondary analysis constrains interpretation to the information available in the existing data: it was not possible to probe emerging themes directly with participants, clarify ambiguous responses, or pursue new analytical directions that the primary interviewers did not anticipate. This means that some dimensions of experience that might have emerged through iterative follow-up questioning may not be fully represented in the data.

The single-site design is a further limitation. All participants received care at KNRH, a high-volume national referral hospital with distinct institutional characteristics. The findings may not transfer directly to lower-level facilities, private-sector settings, or rural hospitals, where resource constraints, patient volumes, and provider cultures may differ. Oluka (2014) noted similar limitations in a single-facility satisfaction study at Mulago Hospital, observing that single-site studies in Uganda provide depth but not breadth across the health system.

There is also potential for social desirability bias in interviews about care quality conducted by researchers affiliated with the healthcare system. Some participants may have moderated their accounts, particularly those with negative content, to avoid affecting their relationship with the facility or its staff. While the study cannot fully rule this out, the presence of multiple negative accounts across the dataset suggests that participants felt sufficiently safe to share critical experiences, reducing, though not eliminating, this concern.

The 14-day post-discharge recruitment window also imposed a methodological constraint. While this timeframe was designed to allow sufficient initial recovery while minimising recall bias, it may have been too short for participants to fully reflect on and articulate certain dimensions of their experience, particularly the psychological consequences of fertility uncertainty, the emotional processing of guilt or grief, and the practical challenges of recovery, which tend to become more salient over a longer period. Furthermore, because all participants were recruited within a short window at a single facility, the dataset may reflect conditions prevailing at KNRH during that period, including levels of medication availability, staffing, and patient flow, rather than a more

representative cross-section of conditions over time. Periods of stock-out, high occupancy, or staff shortage may have been over- or under-represented, which should be considered when interpreting the findings on structural barriers. Longitudinal follow-up of women after EPAC discharge would provide a more complete picture of recovery trajectories, fertility outcomes, and the lasting dimensions of the care experience.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study explored women's experiences of EPAC at KNRH, Uganda. Care was experienced not as a single clinical event but as a multi-dimensional encounter shaped by bodily vulnerability, provider behaviour, structural conditions, and the social context of abortion. Survival was necessary but not sufficient as a measure of quality. Communication, pain management, and privacy were core quality dimensions, not supplementary comforts. Structural barriers such as delays, shortages, out-of-pocket costs, and fragmented referrals constrained dignified care. The experience of EPAC extended beyond discharge as recovery was largely unstructured, and fertility uncertainty persisted without follow-up. EPAC services at KNRH were effective in saving lives despite the numerous challenges. Improving quality requires a patient-centred approach addressing clinical care, communication, system efficiency, and continuity of care.

6.2 Recommendations

6.2.1 Recommendations for clinical practice

Healthcare providers delivering EPAC should communicate clearly, calmly, respectfully, and without judgment at all points of care, even under conditions of urgency. Brief explanations of procedures and expected recovery should be routine. To support this, a standardised provider explanation checklist should be developed and adopted at KNRH, prompting providers to cover key information points (diagnosis, planned procedure, expected pain, duration, and recovery) at every EPAC encounter. This checklist, informed directly by the communication gaps documented in this study, would serve as a practical, low-cost tool to promote consistent and dignified communication without requiring lengthy clinical encounters.

Pain management should be prioritised as an essential component of EPAC, given that intense procedural pain was identified as one of the most prevalent and memorable dimensions of women's EPAC experiences. Pain management should not be a secondary consideration. Clinical protocols for uterine evacuation should include consistent analgesia and emotional reassurance during procedures, in line with the WHO Abortion Care Guideline (WHO, 2022). A standardised

EPAC pain management checklist, confirming pre-procedural analgesia assessment, intra-procedural pain relief administration, and post-procedural pain review should be introduced and used routinely.

6.2.2 Recommendations for health facility management, health system and policy

KNRH should strengthen triage and patient workflow to reduce avoidable delays for critically ill women presenting with EPAC. Study findings documented delays as a significant source of distress, particularly for women who bled or waited in pain without reassurance. Triage prioritisation for women with haemorrhage, severe pain, or clinical instability should be clearly defined and consistently applied. Privacy during examinations and procedures should be protected through better use of curtains, spatial reorganisation, and control of unnecessary observers. Reliable availability of essential medicines and blood products must be ensured to prevent women from incurring distressing out-of-pocket costs during emergencies.

A standardised EPAC patient pathway checklist should be developed and integrated into routine care at KNRH. This checklist, covering triage prioritisation, privacy protection during examination and procedures, consent documentation, post-procedural review, and discharge readiness criteria, would operationalise the quality dimensions identified in this study and provide a consistent quality benchmark for EPAC encounters at the facility.

Structured discharge counselling and follow-up mechanisms should be formally integrated into EPAC pathways. Women should leave with a standardised discharge information checklist covering expected symptoms, danger signs, fertility recovery timelines, and when to return for care. As noted from the study, women experienced significant post-discharge uncertainty, particularly around fertility and ongoing symptoms, due to inadequate information at discharge. A feasible phone-based or community health worker follow-up protocol should also be implemented, particularly for women residing far from the facility.

Non-judgmental communication and dignity-preserving conduct during EPAC encounters should be institutionally promoted at KNRH through regular supervision and peer review of EPAC care interactions. This is grounded in study findings documenting dismissive and judgmental

communication as a direct contributor to women's distress. Facility-level measures, such as patient feedback mechanisms and clear codes of conduct for EPAC providers, can reinforce respectful care standards without requiring population-level stigma reduction campaigns that fall outside the scope of this study's findings.

6.2.3 Recommendations for future research

Future studies should explore women's experiences before reaching KNRH—including their care-seeking pathway, interactions at lower-level facilities, and the experiences that shaped their condition and expectations on arrival. This study was unable to explore pre-hospital experiences systematically, as participants were recruited at the review visit following EPAC at KNRH. Yet women's narratives frequently referenced prior referrals and delays, suggesting that the full EPAC experience begins before hospital admission. Research focusing on this pre-hospital trajectory would provide a more complete picture of women's emergency reproductive care experiences and identify earlier intervention points across the referral pathway.

Additional research should examine long-term physical, psychological, and reproductive outcomes after EPAC, since this study's findings indicate that discharge does not mark the end of the EPAC experience for many women.

Studies that include the perspectives of healthcare providers delivering these services would provide additional insight into the challenges and facilitators of quality EPAC and could inform more balanced, multi-stakeholder interventions that address both patient and provider needs.

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APPENDIXES

APPENDIX I: Budget

ITEM	QUANTITY	UNIT COST	TOTAL UGX
Research Assistants	2	@ 20,000/= day for 14 days	560,000
Disposable face mask	2 boxes	36, 865/=	73,730
Hand sanitiser ½ gallon jug	4	73,915/=	295,660
Voice recorders	2	50,000/= per recorder	100,000
Printing proposal	40 pages x 3 copies	100/=/page	12,000
Printing interview guides	5 pages x 30 copies	100/=/page	15,000
Compensation to participants	30 participants	10,000/= per participant	300,000
Secure storage for documents	2 boxes	12,000/= per box	24,000
Printing report	120 pages x 3 copies	100/=/page	36,000
Printing the final thesis	120 pages x 3 copies	100/=/page	36,000
Internet	9 GB per month	50,000/= for 6 months	300,000
Box file	5	@ 12000/=	60,000
Pens	1 box	12,000/=	12,000
Notebooks	6	5,000/=	30,000
Transport	30 days		500,000
Feeding/refreshment		200,000	200,000
Miscellaneous		500,000/=	500,000
TOTAL			3,054,390

APPENDIX II: Informed consent form for women who have received emergency post-abortion care - English version

Participant's Identification Number:

TITLE OF THE PROPOSED STUDY:

Women's experiences of Emergency Post-Abortion Care at Kawempe National Referral Hospital, Uganda.

Investigator

Principal Investigator: Kawungu Saad Sessimba

Email: aklatsad@gmail.com Phone: +256-704483212 / +256-785752526

Affiliation: Department of Obstetrics and Gynaecology, Makerere University College of Health Sciences

Registration number: 2023/HDO7/2816U

Background and Rationale for the Study

Many women in Uganda seek treatment for abortion related complications, and Kawempe National Referral Hospital receives a large number of such cases. While clinical treatment is available, women's personal experiences and feelings about the care they receive are not well-understood. This study seeks to learn from women who were treated for abortion related complications at Kawempe Hospital, so we can better understand how care is experienced and identify ways to improve post-abortion services. Your participation will help us generate knowledge that may improve the quality of care for future patients. All information will be confidential and used only for research purposes.

Research Sponsors and Affiliation

This research is self-sponsored by **Kawungu Saad Sessimba**, a third-year Master's in Obstetrics and Gynaecology at Makerere University College of Health Sciences. The study partially fulfils the requirements for the Master's degree in Obstetrics and Gynaecology.

Purpose of the Study

This study seeks to understand how women experience emergency post-abortion care after treatment for abortion related complications at Kawempe Hospital. This research does not involve any medical treatment or experimentation. It only consists of talking with you about your experience.

Estimated Duration of Participation

The entire study will run for approximately one year. Your involvement will take about 45–60 minutes for a one-time interview. No follow-up visits will be required.

Study Procedures

If you agree to participate, you will take part in a private, face-to-face interview. You will be asked to describe your experience at the hospital after receiving care for abortion-related complications. The interview will take place after your routine return visit for review. With your permission, the interview will be audio-recorded to ensure your words are accurately captured. You may decline to answer any question or stop at any time.

Who Will Participate

The study will include approximately 24 women who were treated for abortion related complications at Kawempe Hospital and returned for their scheduled review.

Risks/Discomforts

There are minimal risks. Talking about your experience may cause emotional discomfort. If you feel upset, we will pause the interview and offer support. If needed, you may be referred to a counsellor or medical team member at the hospital at no cost to you.

Benefits

While participants may not receive direct personal benefits, their insights will contribute valuable information to improve EPAC services, potentially benefiting future patients by informing targeted interventions and policies to reduce maternal complications and mortality.

Confidentiality

Your name will not appear anywhere. A study number will be used instead. Only the research team, the Makerere University School of Medicine Research and Ethics Committee, and the Uganda National Council for Science and Technology may review the data for oversight purposes. Your information will be securely stored and used only for research purposes.

Alternatives

Participation is voluntary. Your decision will not affect the care you receive at this hospital. You may withdraw at any time without penalty.

Cost

There is no cost for participating in the study.

Compensation / Reimbursement

You will receive UGX 10,000 in transport reimbursement and compensation for your time spent, as the interview is conducted after your routine return appointment. This refund is not a payment, but support for transport as approved by ethics.

Questions about the Study

If you have any questions or concerns, you may contact **Kawungu Saad Sessimba** on +256704483212 / +256785752526.

Questions about Your Rights

Your rights in this study will be observed and respected. Participation in this study is voluntary. Suppose you have questions now or later about your rights as a research participant. In that case, you can address your concerns to the chairperson of the School of Medicine Research Ethics Committee, Prof. Ponsiano Ocama, at **+256-772421190**.

Statement of Voluntariness

Participation in this study is entirely voluntary. You may choose not to participate or withdraw without penalty or loss of benefits.

Dissemination of Results

The study results will be shared with Kawempe National Referral Hospital and may be published in research journals. However, no personal information will be included in any reports or publications.

Ethical Approval

This study has been reviewed and approved by the *Makerere University School of Medicine Research and Ethics Committee*.

STATEMENT OF CONSENT

I have read and understood the purpose and procedures of the study “*Women’s experiences of Emergency post-abortion care at Kawempe National Referral Hospital, Uganda...*” I understand that my participation is voluntary, and I may withdraw at any time. I also understand that my responses will remain confidential.

By signing below, I voluntarily agree to participate in this study.

Name of Participant.....

Signature/thumb print of participant Date

Name of Witness (For illiterate participants).....

Signature of witness.....Date.....

Name of interviewer/Person obtaining informed consent.....

Signature of interviewer/Person obtaining informed consent Date

APPENDIX III: Informed consent form for women who have received care for abortion related complications: translated to Luganda

Foomu Y’okukkiriza Okwetaba mu Kunoonyereza

Ennamba y'Omwetabi: _____

OMUTWE GW’OKUNOONYEREZA:

Ebyo Abakyala bye Bayitamu n’Endowooza yaabwe ku Buweereza bwa Wiili y’Obujjanjabi Oluvannyuma lw’Okufuna Obujjanjabi Obw’Amangu mu Bikwatagana ku Kugyaawo Olubuto mu Ddwaliro lya Kawempe National Referral Hospital, Uganda.

Omunoonyereza

Kawungu Saad Sessimba

Email: aklatsad@gmail.com

Essimu: +256-704483212 / +256-785752526

Ekitongole: Department of Obstetrics and Gynaecology, Makerere University College of Health Sciences

Ennamba yesomero: 2023/HDO7/2816U

Ensonga lwaki tukola okunoonyereza kuno

Abakyala bangi mu Uganda bajja mu ddwaliro nga balina obuzibu oluvannyuma lw'okuggyamu embuto. Kawempe National Referral Hospital efuna abakyala bangi abetaaga obujanjabi bw'amangu ng'obuno. Wabula, tetumanyi bulungi ebyo abakyala bye bayitamu mu kiseera kye bajjanjabibwa – nga bakwatibwa batya, nga bawulira batya, era nga balowooza batya ku ndabirira gye bafuna.

Okunoonyereza kuno kugenderera okuwulira okuva eri abakyala abajjanjabiddwa mu ddwaaliro lino, tusobole okutegeera engeri gye bayitamu era tusobole okuwa amagezi agandiyamba okukola obujanjabi obulungi mu biseera eby'omu maaso.

Abawagira okunoonyereza kuno

Okunoonyereza kuno kwasasulwa Kawungu Saad Sessimba kennyini. Tewali kitongole kyonna kituwadde ssente. Kino nkikola okutuukiriza ebinsubulwa mu diguli yange mu by'obujanjabi abakyala.

Ekigendererwa ky'Enoonyereza

Ekigendererwa kwe kumanya bulungi ebyo abakyala bye bayitamu n'engeri gye bawulira nga bawereddwa obujanjabi ku nsonga yokuvamu olubuto olutto mu ddwaliro lya Kawempe. Kunno kunonyeliza, sikuwa ddagala oba kujanjabwa.

Obudde obwetaagisa

Enoonyereza lijja kubeera mu kiseera kya **mwaaka ogumu**.
Ggwe ojja kwetaba omulundi gumu, olutwala **edakiika 45–60**.
Tewajja kaba nsisinkano ndala oluvanyuma olwo.

Eby'ojja okukola

Bw'okkiriza, tugenda okwogera naawe mu kifo ekya kyama ekisanidde. Ekilala Ojja kutubuulira ku byoyitamu mu ddwaliro. Ekilala tulikwongerera okukola kino **oluva ku lusooka lw'okuddayo (review)**. Ekilala tuyinza okukozesa eddoboozi (audio-recording) bw'oba okikkiriza. Oyinza okujjako ekibuuzo kyonna oba okukomya mu kiseera kyonna.

Abagenda okwetaba

Tujja kufuuzza **abakyala 24** abajjanga ku review nga bawereddwa obujanjabi ku abortion related complications mu Kawempe.

Obuzibu / Okweraliikirira

Tewali buzibu bwa mubiri ku kunoonyereza kuno.
Kyokka w'oyinza okujjukira obuzibu oba ne wetaaga akaseera okulowooza oba okwewummuza.

Tubadde tukulaba ng’oli wansi w’enkakakkalira, tugenda okutuusa gy’oli muguma era nga kyetaagisa okutuma gy’omu kusunsulibwa (counselling) mu ddwaliro nga tewali kisasu.

Ebiyinza okukuyamba

Esisinkano enno siya kukwa byanfuna oba togenda ganyulwa katikati. Naye ebyo byoyogera byetujja okusinzira ko okuteleza ndabilira yabakyala mu dwairo.

Okukuuma Ekyama

Erinnya lyo terijja kugenda kulabibwa. Tunaakozesa nnamba yokka.

Fayiro z’ojja kubeeranga mu kifo ekisibwa nga temanyibwa muntu atali ku team y’enoonyereza. Makerere SOMREC ne UNCST basobola okuzuula fayiro nga kikakasibwa nti ebintu biri mu nteekateeka ennungi ya ethics, naye tebajja kumanya erinnya lyo.

Okwekuuma mu Kunoonyereza

Tewali nsonga y’okukugobako obujanjabo oba nsonga yonna bw’otawetaba oba bw’osazaamu.

Eby’ensimbi

Tewali kisasu ky’owulira ku kunoonyereza kuno.

Ojja kufuna 10,000/= shillings nga ensimbi y’okuddayo (transport refund) kubanga oyitiddwa ku lunaku lwo lwa review.

Ensimbi zino si musaala, wabula okuyamba ku mugendo.

Ebibuuzo ku kunoonyereza : Bw’oba n’ebibuuzo, oyinza okukubira: **Kawungu Saad Sessimba +256-704483212 / +256-785752526**

Ebibuuzo ku ddembe lyo

Okwetaba kwa kyewaliridde ddala. Bw’oba n’obuzibu oba ekibuuzo ku ddembe lyo, oyinza okuyita: **Omuyobozi wa SOMREC Prof. Ponsiano Ocama. Simu: +256-772421190**

Okukkiriza kwa kyewala

Okwetaba kwa kyewaggale ddala. Osobola okusazaamu mu kiseera kyonna.

Okumanyisa ebivudde mu kunoonyereza

Ebivudde mu kunoonyereza bijja kusembezebwa ku Kawempe National Referral Hospital ne Makerere University, era bisobola okuwandikibwa mu bitabo by'eennoonyereza naye nga **tewali kumanya muntu yenna**.

Okukkirizibwa kwa Ethics

Eenoonyereza liweereddwa olukusa okuva ku Makerere University School of Medicine Research and Ethics Committee (SOMREC).

OKUKKIRIZA OKWETABA

Ntegedde ebyo byonna ebikwata ku kunoonyereza kuno kwa Abakyala byebayiseemu n'endowooza zaabwe ku ndabirira ey'amangu oluvannyuma lw'okuggyamu embuto mu ddwaaliro lya Kawempe National Referral Hospital, Uganda.

Ntegedde nti nnooneka nga nsazeewo okujjako, era nti obubaka bwange bujja kubeera mu kyama.

Erinnya

Iy'omwetabi.....

Omukono

gw'omwebabi.....**Olunaku**.....

Omujulizi (bwaba tamanyi soma).....

Omukono

gw'omujulizi.....**Olunaku**.....

Erinnya ly'oyo abuuza.....

Omukono gwe.....**Olunaku**.....

APPENDIX IV: Work plan 2025-2026

N o	Activity	Jan-25	Feb-25	Nov-25	Feb-26	March-26	April-26
1	Concept development						
2	Proposal writing and revisions						
3	Proposal Submission and Approvals						
4	Tool piloting and training						
4	Data collection						
5	Data analysis						
6	Report writing and submission						

APPENDIX V: Interview guide: for women who have received health care for management of abortion related complications at KNRH-English version

STUDY TITLE: Women's Experiences of Emergency Post-Abortion Care at Kawempe National Referral Hospital, Uganda.

Interviewee Characteristics:

Initials: _____ Marital status: _____ Occupations: _____
Age: _____ Education-level: _____ Parity _____

1. Opening Question: Tell me about the emergency post-abortion care you received at Kawempe National Referral Hospital. How would you describe your experience, from the moment you realised something was wrong until you left the hospital?

Probes:

- What happened, step by step?
- What stands out most to you about that time, and why
- Did you feel you had privacy? Beyond physical privacy, did you feel confident that your personal information and the reason for your visit would be kept confidential? Did you feel safe from judgment or harm while you were at the hospital? How did that affect your experience?
- What did staff say or do that made you feel respected or not respected? Can you describe a specific moment and how that affected your experience?

2. Prior Knowledge and Expectations: Before this experience, what did you know or expect about care for complications like yours?

Probes:

- What had you heard from others - friends, family, or community members about this kind of care?
- Had you heard any stories—positive or negative—about Kawempe hospital specifically?
- Describe how that knowledge or lack of it impacted your experience of care, including your feelings about coming to the hospital.

3. Interactions with Health Workers: Tell me about your interactions with the health workers – the nurses, doctors, and others who cared for you.

Probes:

- Can you explain things in a way you could understand? How did that- or lack of it impact your experience?
- Did you feel involved in decisions about your care? Describe how that involvement—or lack of it—made you feel, and whether it relates to your everyday life or sense of dignity. Can you

describe a specific moment?

4. **Communication and Information:** Describe how you came to understand what was happening to you and what treatment you needed.

Probes:

- Was there anything you wanted to ask and didn't ask? Describe what happened in that moment—what stopped you, and how did that impact your experience?
- Did you feel you could ask questions if you wanted to? Why or why not?

5. **Support from Family and Others:** Who was with you – or who did you wish was with you – during this time?

Probes:

- Did you receive emotional support from a partner, health workers or others? How did that support – or lack of it – affect you during and after your time in the hospital?
- Did you tell anyone you were coming to the hospital? Why or why not, and how did that decision affect your experience?

6. **Community Attitudes and Stigma:** In your community, how are women viewed when they seek care like this – and did those views affect you personally? If so, how? If not, why do you think that is?

Probes:

- Did you feel shame, judgment, or guilt at any point during this experience? Where did those feelings come from—inside yourself, from others, or from the environment around you?
- How did those feelings affect your decisions, your interactions with staff, or your overall experience?

7. **Health System and Policy Context:** Based on your experience, what do you think should change about how emergency care is provided to women with pregnancy complications in Uganda?

Probes:

- If you were asked to advise the Ministry of Health or Kawempe Hospital, what would you want them to know or change?

8. **Final Reflection:** Is there anything else about your experience that you feel is important for me to understand – anything we haven't touched on that you want to share?

Probe

- If you could change just one thing about the experience you had, what would it be and why? What would that new experience look like for the next woman who comes here?
- Was there anything that went well—anything you think they should definitely keep doing? Why was that important to you?

APPENDIX VI: Interview guide: for women who have received health care for management of abortion related complications at KNRH - translated to Luganda

OMUTWE GW'OKUNONYEREZA:

Abakyalala bye bayiseemu n'endowooza zaabwe ku ndabirira ey'amangu oluvannyuma lw'okuggyamu embuto mu ddwaaliro lya Kawempe National Referral Hospital, Uganda.

Ebikwata ku muntu abuuziddwa:

Erinnya: _____ Embera zobufumbo: _____ Omulimu: _____

Emyaka: _____ Obuyigilize bwe: _____ Parity: _____

1. Ekibuuzo ekiggulawo: Mbuulira ku ndabirira ey'amangu oluvannyuma lw'okuggyamu embuto gye wafuna mu ddwaaliro e Kawempe National Referral Hospital, wandinnyonnyodde otya by'oyitamu, okuva lwe wategeera nti waliwo ekikyamu okutuusa lwe wava mu ddwaaliro?

Nonyeleza kwebino nabyo:

- Kiki ekyaliiwo, omutendera ku mutendera?
- Kiki ekisinga okukukwatako ku kiseera ekyo era lwaki
- Wawulira nti olin eby'ekyama? Ekyo kyakwata kitya ku by'oyitamu?
- Kiki abakozi abakola ekyakuleetera okuwulira ng'ossaamu ekitiibwa? Osobola okunnyonnyola akaseera ako n'engeri gye kaakuleetera okuwulira?

2. Okumanya n'ebisuubirwa nga tebinnabaawo: Nga kino tekinnatuuka, kiki kye wali omanyi oba kye wali osuubira ku kulabirira ebizibu nga byo?

Nonyeleza kwebino nabyo:

- Kiki kye wali owulidde okuva mu balala ku kulabirirwa okw'engeri eno? Nnyonnyola engeri okumanya okwo oba obutabaawo gye kwakwata ku bumanyirivu bwo mu kulabirirwa.

3. Enkolagana n'abakozi b'ebyobulamu: Mbuulira ku nkolagana yo n'abakozi b'ebyobulamu – ba nurse, abasawo, n'abalala abakulabirira.

Nonyeleza kwebino nabyo:

- Bannyonnyola ebintu mu ngeri gy'osobola okutegeera era ani gye byakwata ku by'oyitamu?
- Wawulira nga weenyigira mu kusalawo ku kulabirira kwo? Nnyonnyola engeri gye kyakwataganamu n'obulamu bwo obwa bulijjo

4. **Empuliziganya n’Amawulire:** Nnyonnyola otegeera otya ebyali bikutuukako n’obujjanjabi bwe weetaaga?

Nonyeleza kwebino nabyo:

- Waaliwo kye wali oyagala okubuuza n’okola oba n’otosaba? Nnyonnyola ekyaliwo, engeri gye kyakwata ku by’oyitamu.

5. **Obuwagizi okuva mu Famire n’Abalala:** Ani eyali naawe – oba ani gwe wali oyagala abeere naawe – mu kiseera kino?

Nonyeleza kwebino nabyo:

- Wafuna obuyambi mu nneewulira okuva mu munno, abakozi b’eby’obulamu oba abalala? Obuwagizi obwo – oba obutabaawo – bwakukwatako butya?

- Waliwo gwe wagamba nti ojja mu ddwaaliro? Lwaki oba lwaki nedda?

6. **Endowooza z’ekitundu n’okuvumwavumwa:** Mu kitundu kyo, abakyala batunuulirwa batya nga banoonya okulabirira bwe bati – era endowooza ezo zaakukwatako ggwe kennyini? Bwe kiba bwe kityo otya? Bwe kiba nga si bwe kiri, Lwaki?

Nonyeleza kwebino nabyo:

- Wawulira ensongi, ng’osaliddwa omusango oba ng’olina omusango? Enneewulira ezo zaava wa era zaakukwatako zitya?

7. **Enkola y’ebyobulamu n’enkola embeera:** Okusinzira ku bumanyirivu bwo, olowooza kiki ekirina okukyuka ku ngeri obujjanjabi obw’amangu gye buweebwa abakyala abalina ebizibu by’embuto mu Uganda?

Nonyeleza kwebino nabyo:

- Singa osabibwa okuwabula Minisitule y’ebyobulamu oba eddwaliro ly’e Kawempe, kiki kye wandyagadde bamanye oba bakyuse?

8. **Okufumiitiriza okusembayo:** Waliwo ekirala kyonna ku by’oyitamu ky’owulira nti kikulu gyendi okutegeera – ekintu kyonna kye tutakwatako ky’oyagala okugabana?

Nonyeleza kwebino nabyo:

- Singa osobola okukyusa ekintu kimu kyokka ku by’oyitamu, kyandibadde ki era lwaki? Obumanyirivu obwo obupya bwandibadde butya eri omukyala addako okujja wano?

- Waaliwo ekintu kyonna ekyatambula obulungi —ekintu kyonna ky’olowooza nti ddala balina okusigala nga bakola? Lwaki ekyo kyali kikulu gy’oli?

APPENDIX VII: Certificate of good clinical practice



Hereby Certifies that
KAWUNGU SAAD SESSIMBA
has completed the e-learning course
**ICH GOOD CLINICAL
PRACTICE E6 (R2)**
with a score of
100%
on
20/11/2024

This e-learning course has been formally recognised for its quality and content by the following organisations and institutions

*This ICH E6 GCP Investigator Site Training meets the Minimum Criteria for ICH GCP Investigator Site Personnel Training identified by **TransCelerate BioPharma** as necessary to enable mutual recognition of GCP training among trial sponsors.*



Global Health Training Centre
globalhealthtrainingcentre.org/elearning
Certificate Number 8c0f468e-f4ab-4927-bda7-38f5818dcd31 Version number 0

APPENDIX VIII: SOMREC- approval letter

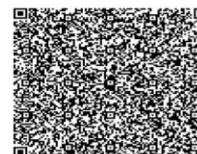


18/02/2026

To: KAWUNGU SESSIMBA

+256704483212

Review Type: Initial Review



Re: Mak-SOMREC-2025-913: WOMEN'S EXPERIENCES OF EMERGENCY POST-ABORTION CARE AT KAWEMPE NATIONAL REFERRAL HOSPITAL, UGANDA

I am pleased to inform you that at the **211** convened meeting on **03/02/2026**, the MAK School of Medicine REC (Mak-SOMREC) meeting voted to approve the above referenced application. Approval of the research is for the period of **18/02/2026** to **18/02/2027**.

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

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **18/02/2027** in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by MAK School of Medicine REC (Mak-SOMREC):

No.	Document Title	Language	Version Number	Version Date
1	Work plan	English	VERSION 4	2026-02-16
2	Protocol	English	VERSION 4	2026-02-16
3	Indepth Interview Guide translated to Luganda	Luganda	VERSION 4	2026-02-16
4	In-Depth Interviews (IDIs)	English	VERSION 4	2026-02-16
5	Protocol	English	Version 3	2025-11-19
6	Translated consent	Luganda	Version 3	2025-11-19
7	Informed consent form for the recruitment of research participants	English	Version 3	2025-11-19
8	COVID-19 & EBOLA risk management plan	English	Version 3	2025-11-19
9	Community Engagement plan	English	Version 3	2025-11-19

Yours sincerely,

Prof. Ponsiano Ocama
For: MAK School of Medicine REC (Mak-SOMREC)

APPENDIX IX: Kawempe National Referral Hospital Approval

Tele : 0414 672552
Email : kawemperefnosp18@gmail.com

FOR ANY CORRESPONDENCE ON THIS
SUBJECT PLEASE QUOTE NO: KNRH/REC:033



Office of the Executive Director
Kawempe National Referral Hospital
Plot 1035/3883 Kawempe, Bombo Road
P. o. Box 3253 Kampala, Uganda

THE REPUBLIC OF UGANDA

KAWEMPE NATIONAL REFERRAL HOSPITAL RESEARCH ETHICS COMMITTEE

25th February 2026

The In-Charge
Gynae Clinic and Gynae Emergency
Kawempe NRH

RE: Administrative Clearance to Conduct Research at Kawempe National Referral Hospital

This is to confirm that Dr Kawungu Saad Sessimbwa **has** been granted **administrative clearance** to conduct his research project titled:

"Women's experiences of emergency post-abortion care at Kawempe National Referral Hospital, Uganda"

Kawempe National Referral Hospital acknowledges receipt and review of the following documents:

- The research protocol and study documents submitted by Dr. Kawungu
- Ethical approval letters issued by Makerere University school of Medicine research and ethics committee

Having reviewed and found the study in line with institutional policies and ethical standards, the Hospital hereby grants administrative clearance to proceed with the research within our facility.


Dr. Byaruhanga Kayogoza Emmanuel
Executive Director

