ASSESSMENT OF FACTORS ASSOCIATED WITH LATE ANTENATAL CARE ATTENDANCE AMONG PREGNANT WOMEN AT KAMPALA INTERNATIONAL UNIVERSITY TEACHING HOSPITAL ISHAKA BUSHENYI

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A RESEARCH REPORT SUBMITTED TO THE DEPARTMENT OF CLINICAL MEDICINE AND COMMUNITY HEALTH IN PARTIAL FULFILMENT FOR THE REQUIREMENT OF AWARD OF A DIPLOMA IN CLINICAL MEDICINE AND COMMUNITY HEALTH OF KAMPALA INTERNATIONAL UNIVERSITY

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DECLARATION

I, Ipulet Benah DCM/0040/du do hereby declare that this proposal is my original work and has never been submitted to any institution of higher learning for an academic award.

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Date………………………………………………………………………..

APPROVAL

This is to certify that this report was carried out under my supervision as an internal University supervisor and is now ready for submission for examination.

Name: …………………………………………………………………

Signed…………………………………………………………………

DEDICATION

I dedicate this piece of work to my parents Mr. Okiria Robert and Mrs. Asisi Mary; for they have been a source of inspiration, engine of courage and secret of my achievements since my childhood. I also dedicate it to my sisters and brothers for all the support.

ACKNOWLEDGEMENT

To God be the glory for the great things He has done. He gave me the opportunity and favor to join this course and conduct this study.

I extend my heartfelt gratitude to my supervisor Mr. Isaac Echoru for his guidance, constant encouragement and constructive suggestions towards writing this proposal without which I would not have reached this far.

I am grateful to my forever interested, encouraging and always enthusiastic parents, Mr. Okiria Robert and Mrs. Asisi Mary who were always keen to know what I was doing and how I was proceeding, I miss your screams of joy. Without you my future would be doom, may almighty bless you and live to see the fruits of your investment.

My sincere gratitude also goes to my siblings Ajala Charles, and Otaget Gerald who have provided me through moral and emotional support in life, I treasure you. Special appreciation goes to my husband and friend Mr: James Peter Otim and Akasairi Ocwa respectively for the support, motivation, enthusiasm, immense encouragement, and relentless, constructive and wise advice offered me which kept me moving on despite the hard moments.

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May the Almighty Lord reward all of you abundantly!

ABSTRACT

BACKGROUND.

Early initiation of antenatal care visits is an essential component of services to improving maternal and new born health. The Uganda Demographic and Health Survey (UBOS, 2007, UDHS, 2006) conducted in 2006 and Uganda Bureau of Statistics conducted in 2007 indicated that 94% of women in rural areas being twice less likely to attend ANC than the urban women, only 8% of rural women in Uganda received ANC from a doctor. However, detailed study to identify factors associated with late initiation of care has not been conducted in KIU-teaching hospital. The aim of this study is to assess the factors associated with late ANC care attendance and to determine the proportion of women who attend late to ANC in KIU-teaching hospital.

Methods:

The study design will be cross-sectional, the study Participants will be pregnant women, nurses, administrators doctors; it will be conducted at Kampala international teaching hospital for a period of one month. Data was collected using pre-tested questionnaire and interview method. Logistic regression analysis was done to identify factors associated with late first ANC with the level of significance set at 0.056.

Results:

A total of 156 women participated in the study; 100 (64.1%) of them came for their first ANC visit late, after 12 weeks of gestation. Most common reasons for coming late for first ANC were financial constraints (38.5%, 60) and long distance to the hospital (34.5%, 45). Factors associated with late start of first ANC, Traditional beliefs (25, 22.9%), Myths and misconceptions (05, 14.3%), Ignorance (02, 11.4%), Age (04, (17.1%),

Conclusion:

About half of pregnant women do not start ANC early in the first trimester largely due to large family size, low monthly income and long distance to the hospital, age, alternatives, poor quality of services, harassments from health workers.

Keywords:

Antenatal care, Late ANC, focused groups, attendees.

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
DHMT	District Health Management Team
FANC	Focused Antenatal Care
GOU	Government of Uganda
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
IPT	Intermittent Presumptive Therapy
MCH	Maternal and Child Health
PMTCT	Prevention of Mother to Child Transmission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background

Despite the global efforts initiated to improve maternal health, more than half a million women worldwide die each year as a result of complications arising from pregnancy and child birth (Ronsmans et al. 2006). Almost all of these deaths occur in developing countries with sub-Saharan Africa accounting for almost 47% of the toll (WHO, 2004).

Globally 529,000 maternal deaths occur every year, with 99% of this in developing countries (2008, Alarm International). Uganda having a high maternal mortality and neonatal morbidity ratios, of 29 deaths per 1000 live births and 435:100,000 live births respectively, typical of many countries in sub-Saharan Africa these still remain a challenge for Uganda (UBOS, 2007, UDHS, 2006).

However according to (UBOS, 2007).the overall one time antenatal attendance in Uganda was found at 94% with women in rural areas being twice less likely to attend ANC than the urban women. According to the report only 8% of rural women in Uganda received ANC from a doctor. Regionally South-western Women were more likely to receive skilled care (20%), than Eastern women (3%), while only 2% of the women in Karamoja were reported to seek the same. It was reported that women in Uganda tend to seek antenatal care very late 37% attending for the first time at 6 months or more (UBOS and Macro International Inc. 2007, UDHS, 2006).

Developing countries such as Uganda still face a challenge of poorly implemented ANC programs with irregular clinical visits and long waiting times plus poor feedback to the women (Villar, *et al*, 2002).

A study done in Hadiya zone, Ethiopia found that majority of the mothers who attended ANC did not receive adequate number of visits and initiated the visits later than recommended by the World Health Organization (Zeine, *et al*, 2010).

A similar study done in Nigerian teaching hospital found that Nigerian women tended to obtain care late in pregnancy, and about one third the care was inadequate with almost half (47 %) of women attending the ANC clinic in the third trimester (Karl, *et al*, 2005).

A study done in rural Uganda revealed ANC attendance being irregular with few women appreciating the fact that ANC attendance was to monitor both the growth of the baby and the

health status of the woman. This study also identified that perceived high cost of ANC services, conducting a delivery, treatment, and perceived inadequacy of services provided by the formal health system had a significant influence in ANC attendance, notwithstanding the level of education, religion and marital status did affect most Ugandan women ANC seeking behavior (Ndyomugyenyi, *et al*, 1998).

The greatest risk of maternal deaths, which is now compounded by the HIV/AIDS pandemic, is faced by women in Sub-Saharan Africa (O'Callaghan, 1999). Yet most of the maternal and neonatal deaths are avoidable according to (Stevens-Simon 2002). A number of studies have demonstrated the association between antenatal care attendance and reduction of premature birth, low birth weight, congenital malformations, congenital infections, neonatal tetanus, pre-eclampsia and anaemia (Orvos et al. 2001).

World Health Organization (WHO) (2002) issued guidance on a new model of antenatal care (ANC) called goal-oriented or focused antenatal care (FANC), for implementation in developing countries (Villar et al., 2001). In this new strategy of focused antenatal care, WHO recommends four antenatal care visits in low risk pregnancies and prescribes the evidence-based content for each visit (Villar et al., 2002).

This also helps in screening for health and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO, 2009).

Therefore many Intervention have proved to be of great benefit to the mother and the child such as iron and folate supplementation in areas with high prevalence of anemia, serological screening for and treatment of syphilis, routine obstetric examination, intermittent presumptive therapy (IPT) for malaria, and tetanus immunization (van Eijk , 2006).

Furthermore prevention of mother to child transmission (PMTCT) of HIV has recently been incorporated in the antenatal care service program. These would fully benefit women if they started attending antenatal early in pregnancy.

Globally, progress has been made in terms of increasing access and use of one antenatal visit, although the proportion of women who are obtaining the recommended minimum of four visits is too low (Carroli, 2001; Van Eijk et al 2006), observed that there was a tendency towards late

attendance for the first ANC visit in Kenya, making the whole of Sub-Saharan Africa to lag, behind other developing regions (WHO, 2006).

Various studies have reported factors associated with late entry to ANC, these include place of residence, ethnicity, age, education, employment status, intention to get pregnant, use of contraceptive methods, economic status, health insurance, and travel time (Trinh, 2006; Adekanle, 2008).

It's vital to report that men play a role in determining the health needs of a woman. In developing countries, men are decision makers and in control of all the resources, they decide when and where woman should seek health care. It has been demonstrated that lack of male involvement in pregnancy and antenatal care and in prevention of mother-to child transmission (PMTCT) of HIV programmes have been identified as major bottlenecks to effective programme implementation (Horizons Programme Report, 2002).

1.2 Problem statement

Globally, developing countries still face a challenge of poorly implemented ANC programs with irregular clinical visits and long waiting times plus poor feedback to the women (Villar, et al, 2002).

There is a great concern that the progress towards the fifth Millennium Development Goal, "Improve Maternal Health," has been disappointingly slow. This has brought up a pressing need to address the factors that contribute to maternal mortality, one of which is failure to attend to antenatal care services. This health demand is particularly urgent in countries in sub-Saharan Africa, most especially Uganda where maternal mortality is disproportionately high with maternal mortality ratio of 435:100,00 live births and neonatal mortality of 29:1000 live births death UBOS, 2007, UDHS, 2006) compared with developed countries. It's even more crucial for women who have either fled or been evicted from their countries at or around the time of their pregnancy.

1.3 Purpose of the study

To assess factors associated with late antenatal care attendance among pregnant women in Kampala international teaching hospital.

1.4 Specific objectives

1. To determine the factors influencing late antenatal care attendance among pregnant women
2. To establish the proportion of pregnant women with late antenatal care visit.

1.5 Research questions

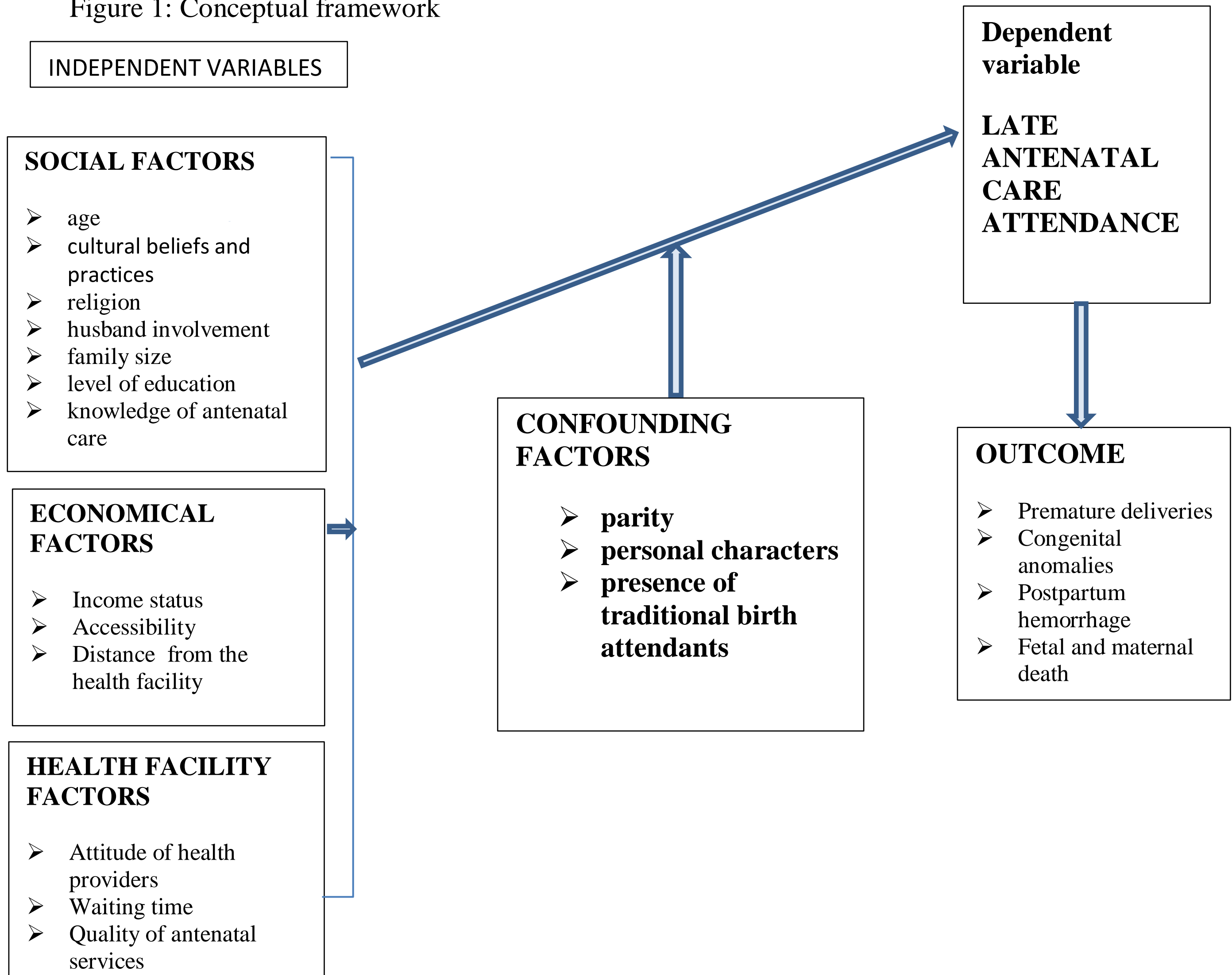
1. What are the factors influencing late antenatal care attendance among pregnant women?
2. What is the proportion of pregnant women with late antenatal care visit?

1.6 Significance of the study

It is hoped that information obtained from this study will add to the existing body of knowledge in the area of maternal and child health. It may also be useful to policy makers and stakeholders as regards to reproductive health. It improves on the level of antenatal care attendance by pregnant women hence improving on both maternal and child health.

1.7 Conceptual framework

Figure 1: Conceptual framework



1.8 Scope of the study

According to the conceptual framework above, the following independent variables like education levels, age, attitude of the health workers, cultural believes, family influence, low income status, distance and waiting time, knowledge about antenatal care, accessibility and marital status will be studied in this research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The following factors will be discussed in this section; i.e. A study done by (Simkhada B., et al, 2008), also included maternal education, husband's involvement, marital status, availability, cost, household income, women's employment, ethnicity, age, parity, intention to get pregnant, Family size, use of contraceptive methods, economic status, health insurance, and travel time, media exposure and having a history of obstetric complications. But not leaving out Cultural beliefs, and ideas about pregnancy.

2.2 Maternal Education

The study done by World Bank (1994), Mothers' level of education influenced the use of ANC for which Mothers with primary educational level were more likely to attend ANC than women who are unable to read and write. This study further revealed that availability of women's time is important as women spend more time on their multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, and trade than on their own health.

2.3 Family size

This determines on the family expenditure, therefore the bigger the family the more likely one to ignore incurring extra expenses such may include antenatal costs. A study done in Hadiya; Ethiopia, Family size was a strong determinant of ANC service utilization with greater household size limiting the use of ANC service (Zeine, et al, 2010).

2.4 Religion

A study done in Ibadan, Nigeria revealed that Women who were Muslims or other religions were more than 2 times likely to attend ANC clinic than women who were Christians. The same study showed that Women who were 25 years and older as Christians utilized ANC more than women who were below 25 years of age which agrees with study made in Bangladesh (Dairo, *et al*, 2010), (Nguyen, et al, (2012).

2.5 Socio-economic conditions

Income at household level has a bearing on antenatal attendance. This was established in Studies from Jamaica that found that, an increased probability of early antenatal care attendance was associated with increased household expenditure (Gertler *et al*. 1993).

2.**6 Attitude of health workers**

In a study done by (Dennis et al. 1995), some women stated that the reasons affecting their delay in antenatal care attendance due to the way they are treated by antenatal service providers. Lack of skilled staff at primary level, the absence of the obstetrician gynecologist for at least three days, complaints of abuse, neglect, lack of respect and sympathy, and poor treatment from midwives in the hospital had all led to mistrust and cynicism about attending these facilities.

2.7 Cultural beliefs

A study done in Ogun State, Nigeria, identified that women preferred TBAs for various reasons which included: cheap and easily accessible culturally acceptable services and more compassionate care than professional health workers, and for some it was the only maternity they knew, however some respondents acknowledged that complications could arise from TBA care, (Ebuehi, *et al*, 2012), (Bang, et al, 1994).

2.8 Accessibility of antenatal care services

Physical accessibility of health services has been an important determinant of utilization of health services in developing countries.

A study done in Kalabo district of Zambia on maternity services indicated that, distance is a significant factor affecting delay to decide to seek care from health facilities. It also influences the delay caused by the travel time from home to the clinic. The geographical features, absence of any roads or transport systems were also hindrance factors to maternity service utilization (Stekelenburg *et al*. 2004).

2.9 Inadequate knowledge

Most pregnant women especially adolescents, may not be aware of the problems that results from not attending ANC (Dennill *et, al* 1999). Lack of knowledge about dangers of not seeking health

care in pregnancy and delivery, including inability to make independent decisions were major barriers to seeking health care among pregnant women in Uganda (Matua, 2004),(Kisuule, *et al*, 2013)

The lack of knowledge about pregnancy, reproduction and related health care on the part of the women and their communities, as one health worker pointed out, was mostly due to lack of education generally. Rural communities fully recognize the life-threatening risks associated with pregnancy and childbirth, but by emphasizing endurance and tolerance of physical pain and other life-threatening symptoms, they have unwittingly taught women to suppress concerns about conditions which require urgent attention, so that they may not communicate with anyone until it is too late.

2.1.0 Social and Cultural support

In many countries, TBAs are an important source of social and cultural support to women during childbirth and due to economic constraints, and the difficulty in posting trained professionals to rural areas; many women continue to deliver with TBAs (Allotey, 1999), (Akpala, 1994).

2.1.2 Age

The ANC Service utilization in Ethiopia was significantly influenced by maternal age, where mothers aged between 25 - 29 years were less likely to utilize ANC service than women who were 35 years and older. Positive husband attitude towards ANC was also significantly related to ANC service utilization (Zeine, *et al*, 2010), (Mesganaw, *et al*, 1990).

2.1.3 Intention to get pregnant

The use of antenatal care services can also be delayed by woman's attitude towards her pregnancy. Teenagers with unplanned pregnancies may have a negative attitude towards their pregnancy and, for this reason they may seek ANC much later than would older married women (Kogan *et al*. 1998).

2.1.4 Husbands level of education

It's vital to note that men play a role in determining the health needs of a woman. In developing countries, men are decision makers and in control of all the resources, they decide when and where woman should seek health care. It has been demonstrated that lack of male involvement in pregnancy and antenatal care and in prevention of mother-to child transmission (PMTCT) of HIV

programmes have been identified as major bottlenecks to effective programme implementation (Horizons Programme Report, 2002).

CHAPTER THREE

METHODOLOGY

3.1 Study design

The study design will be cross-sectional, the study Participants will be pregnant women, nurses, administrators doctors; it will be conducted at Kampala international teaching hospital

3.2 Study population

The study population consisted of pregnant women attending antenatal care, at Kampala international teaching hospital after twenty weeks of gestation

3.3 Study site

The study will be carried out at Kampala international teaching hospital, located southwest of Mbarara town about 30km off Mbarara, Bushenyi Kasese Road, western Uganda, it's a private hospital with both in-patients and out-patient departments, operating 24 hours, it has the following sections: maternity, pediatric, surgical, accident and emergency, eye, ear and throat, psychiatric, antenatal clinic, family planning section with bed capacity of about 100 in each ward.

3.4 Sample size determination

The sample size (n) was calculated using the Kish and Leachier formula

Where n= sample size

d=margin of error setting a significance level of 0.056,

p = estimated population size of 0.15 or 15% ("factors associated with late antenatal care attendance by pregnant mothers.)

z=level of significance 1.96

$$n = \frac{z^2 p(1-p)}{d^2}$$

$$n = \frac{1.96^2 \times 0.15\,(1-0.15)}{(0.056)^2}$$

n= 156

3.5 Inclusion and exclusion criteria.

3.6 Inclusion criteria

a) All pregnant women attending antenatal clinic at Kampala international teaching hospital,

b) Willingness to participate in the study.

c) All pregnant women who have come for antenatal care for the first time at 20 weeks of gestation and above

3.7 Exclusion criteria

a) Non- pregnant women

b) All pregnant women who have come for the first time but below 8 weeks of gestation.

c) Not willing to participate

3.8 Data collection tools

A semi-structured questionnaire will be administered to pregnant women.

3.9 collection method

The data was collected using the pretested questionnaire and interview method.

3.10 Data presentation and analysis

Data collected from the study will be analyzed by use SPSS and it will then be presented Using charts, bar graph and tables.

3.12 Study limitations

1. Inadequate time available for collecting data
2. Language barrier where by most women knew only local language
3. Inadequate finances to run the study appropriately, i.e printing out enough questionaires.
4. Lack of co-operation by some mothers in giving accurate information.

3.13 Ethical consideration

Confidentiality will be throughout the research process and the interviews will be conducted in a reasonable privacy. Participants who feel uncomfortable will be allowed to withdraw at any moment in the data collection process without any penalty

CHAPTER FOUR

4.0 findings

In this chapter the study looks at data presented analysis which is guided by tables of data, graphs and recommendation and conclusion thereafter

4.1 Social demographic characteristics of the respondents

This section focuses on both ANC providers and ANC attendees as the study set out to establish in terms of age, gender, and economic status, level of education, marital status, occupation and religion.

Table .1: Socio-Demographic Characteristics of ANC respondents
Age in years.

Factor	No.	Percentage (%)
Age category		
15-19	10	6.4
20-24	68	43.6
25-29	22	14.1
30-34	40	25.6
35+	16	10.3
Marital Status		
Married	130	83.3
Widowed	04	2.6
Occupation		
House wife /farmer	100	64.1
Business	51	32.7
Civil Servant	05	3.2
Education		
Primary	78	50
Secondary	14	09
None	64	41
Religion		
Christians	122	78.2
Muslims	34	21.8
Income		
Low	142	91
Fairly average	14	09

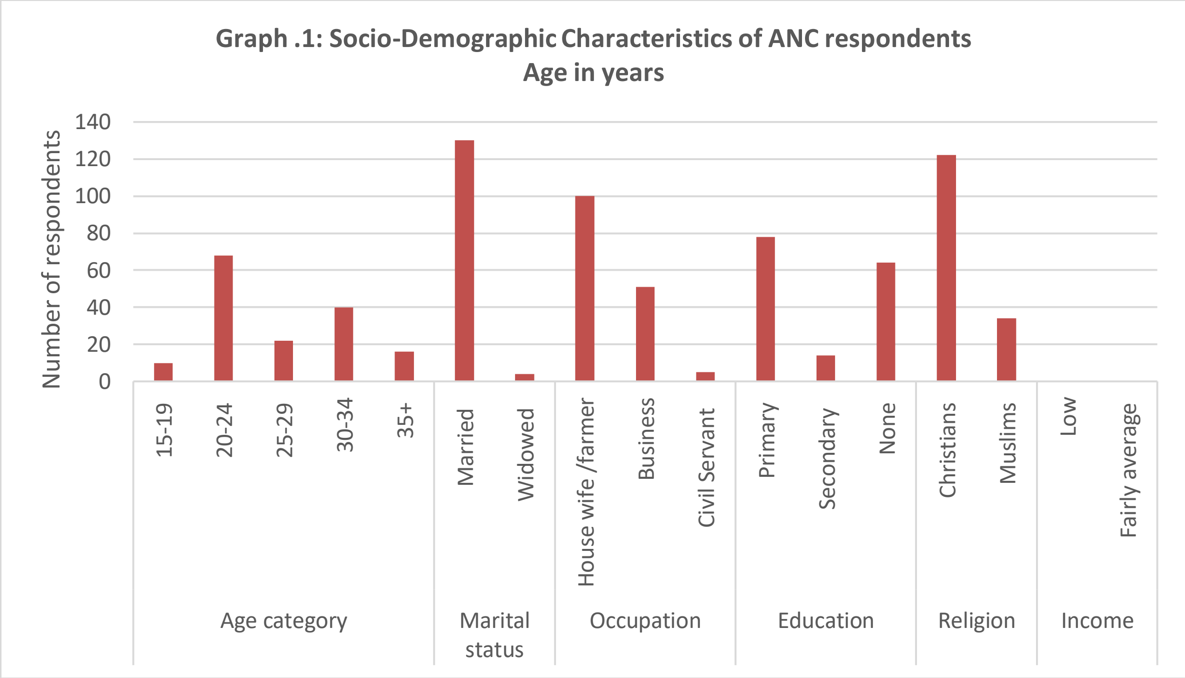


Table and graph 1 above demonstrates the socio-economic characteristics of ANC respondents in KIU-teaching hospital. In terms of age, the majority of ANC clients were in the age bracket of 20-24 years (43.6%).

The field results showed that majority of the women 64.1% were housewives/farmers, and their level of income was low. Level of income at a household was defined on the basis of one member having permanent job, engaged in small scale business and subsistence farming.

Households with a reasonable source of income were categorized as having fairly high income. Low –income level households were those that depended on subsistence farming for their living.

The overall level of income of the ANC attendees was low (91.0%).This means that there are high poverty levels among women in the area of study which in one way or the other affects their ability to access and utilize ANC facilities that are in most cases far away from their area of residence.

As for religious beliefs, majority of the respondents were Christians comprising of 78.2% In comparison of Christian and Islam religions on the utilization of ANC services revealed no significant difference. Religious affiliation does not influence the timing of the ANC services, in the area of study.

On levels of education, majority (50%) of respondents indicated that they had attended primary school while 41% of them had never attended school. There was significant difference in

proportion of the ANC attendees in the timing for antenatal care and use of other ANC alternatives in relation to literacy levels.

The study findings revealed that, the low levels of education had significantly influenced the timing and utilization of ANC at health facilities.

The findings in table 1 further portrays that, majority of the respondents (83.3%) were married, the study revealed that marital status plays a significant role in determining women‘s utilization of ANC service. It was discovered that most married women go for antenatal care early than single, widowed and divorced mothers. A critical analysis of the field results in table 1 indicates that, most of the mothers were young, and had not attended school. All these contribute to limited ability to utilize ANC and therefore poor antenatal care seeking behavior. Education of the mother and that of members of the household were found to be significantly associated with the levels of utilization of ANC services.

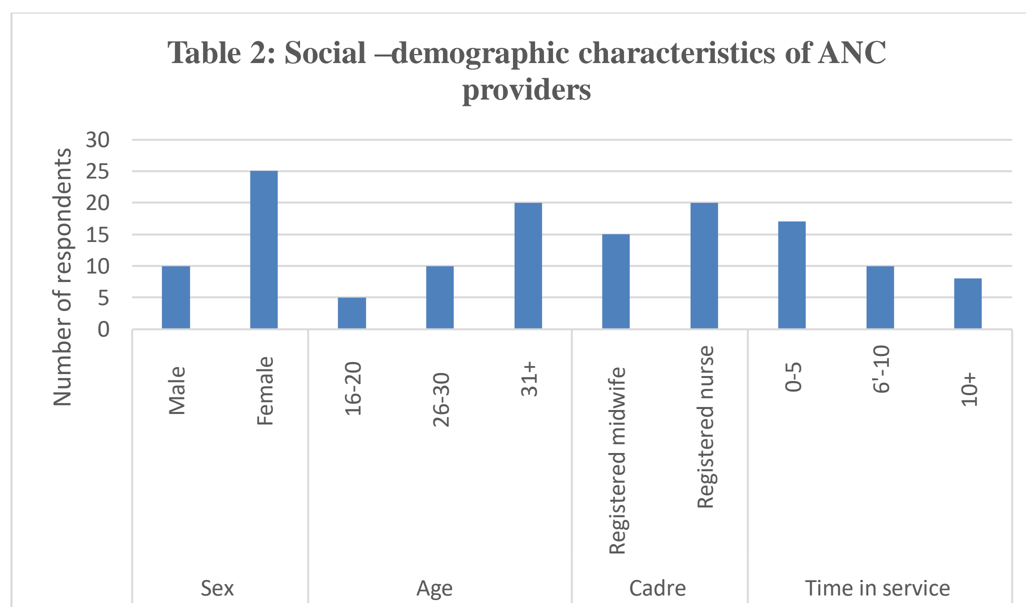
Respondents reported having first attended an antenatal clinic during the second trimester of pregnancy, and had attended at least once before the third trimester. Some respondents whose first ANC visit was later than the second trimester, the reasons given for late attendance were: having had no problems during pregnancy and therefore no need to visit the clinic; a long distance to travel from home to the clinic, avoiding making many trips to the health facilities, thinking they were earlier on in gestation than actually was, much time is wasted waiting to be attended by health care provider, and sometimes harassments deter them from seeking antenatal care services.

4.2. Characteristics of ANC providers

Thirty five of the ANC providers were contacted of these included the nurses and midwives offering ANC services from KIU-teaching hospital as shown in the table 2

Table 2: Social –demographic characteristics of ANC providers

Variable	Frequency	Percentage %
Sex		
Male	10	28.6
Female	25	71.4
Age		
16-20	05	14.3
26-30	10	28.6
31+	20	57.1
Cadre		
Registered midwife	15	42.9
Registered nurse	20	57.1
Time in service		
0-5	17	48.57
6-10	10	28.57
10+	8	22.86



According to the study findings, in table 2 above majority of the ANC providers were females (71.4%) in the age group of 30+ years. Majority was enrolled nurses comprising 57.1% and had been in service for the period of 0-5years (48.57%). ANC providers had a positive perception

towards antenatal care and were helping ANC seekers obtain the necessary services. However, ANC providers identified challenges of shortage of facilities and equipment's necessary for ANC services.

4.3. Factors influencing late Antenatal care attendance

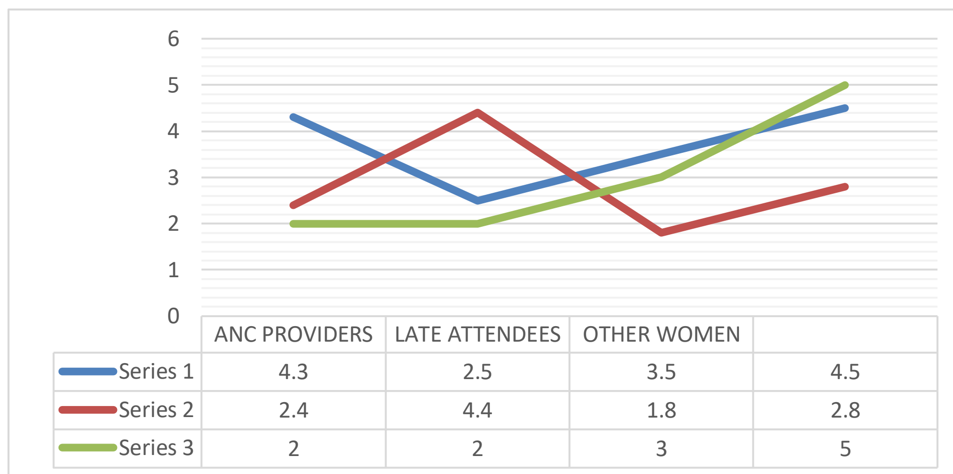
One of the objectives of the study was to determine reasons for ANC late attendance by pregnant women in KIU-teaching hospital. To investigate the timeliness of ANC attendance, a categorization of 'early first attendance' was defined as a first visit to ANC at or before 4 months gestation, compared to the national average of 19.6 weeks and prior to the scheduled delivery of the first IPTp dose of 20–24 weeks while those who made their visit after four months were categorized as late starters/beginners.

Through exit interviews with ANC attendees, participants (early and late starters) were asked to mention one or more dangers /disadvantages a woman might come across when ANC is sought late during pregnancy. Responses from respondents were summarized in tables 3 (a) and (b)

Table 3 (a) responses from early starters

Disadvantages of starting ANC late in pregnancy	No.	frequency
The woman does not access the services that go together with ANC such as iron supplement and TT injection	45	64.3
If one comes late for ANC, will be abused by nurses and might not be well received by the ANC providers.	20	28.6
If there is any complication it cannot be detected early thus can lead to death	25	35.7
The uterus may rapture	10	14.3
There might be spontaneous miscarriages	25	35.7
The woman may have ill health and pass it to the baby	22	31.4
The woman cannot know how the pregnancy is progressing	09	12.9

Fig 2. Line graph showing the responses



1. Red graph shows response from the ANC providers
2. Blue line graph shows responses from other mothers
3. Green line graph shows responses from ANC attendees

Table 3(b) responses from the late starters

Disadvantages of starting ANC late in pregnancy	**No.**	**Frequency**
The woman does not receive medical assistance early	40	46.5
if there are any medical conditions that need attention	05	5.8
The woman might be ignored by ANC providers	25	29.1
The woman misses a lot of information pertaining to various aspects of pregnancy	30	34.9
There might be spontaneous miscarriage	10	11.6
The woman may not deliver at a health facility	02	2.3
The pregnancy does not progress well The woman may have ill health	10	11.6
The woman can die from pregnancy complications	34	39.5

The responses from both groups of ANC clients indicated that the two groups of respondents had knowledge about the dangers /disadvantages of starting ANC late in pregnancy.

Responses from tables above fell within the premises of the dangers a woman might come across when ANC is initialed late in pregnancy. Therefore their knowledge levels on the dangers of starting ANC late were similar.

The study intended to establish why women sought ANC late. ANC providers and attendees gave the following views as the reasons why mothers seek ANC late:

Table 4: Reasons for late attendance

Reasons mentioned by ANC providers and Attendees for late attendance	**No.**	**No.**	**%**	**%**
	A	**B**	**A**	**B**
Poor Quality	00	55	00	35.3
Myths and misconceptions	05	05	14.3	3.2
Traditional beliefs	08	25	22.9	16
Financial difficulties	05	60	14.3	38.5
Alternatives to ANC	09	05	25.7	3.2
Ignorance	04	02	11.4	1.3
Age	06	04	17.1	2.6

Where **A**-represents responses from ANC providers

B-represents responses from ANC attendees

4.3.1 Poor Quality of Care

Poor quality care at the health facility was mentioned by the respondents. The type and quality of antenatal care services that the women reported receiving were inconsistent and inadequate, and differed greatly from Ministry of Health.

Fewer than half received any type of immunization services, and no hemoglobin tests, urine analysis, syphilis screening, or voluntary counseling and testing for HIV. Moreover, no counseling on risk factors and warning signs and symptoms during pregnancy were reported, and no adequate information related to delivery was given to women.

In this regard one woman mentioned that, the reputation of nurses and midwives regarding care for delivering women was not good and as a result many women were scared of their bad behavior. A second woman echoed nurses are particularly strict on clothing, gloves, cotton wool, and panties for mothers and their babies, and because most men cannot buy these things, women prefer to postpone their visits to health facilities for ANC services and even sometimes deliver at home."
Another significant finding from the study in relation to poor quality care was mistreatment by ANC providers.

With respect to delivery care, services nearly most women were not satisfied with the care they received at their final place of delivery, because they reported health providers were rude and not treated well or were not treated in a timely manner.

Mothers who were satisfied reported that the facility had saved their life and/or their baby's life. In addition, nearly all of the women believed that the causes of maternal deaths at health facilities were providers 'mistakes or hospital procedures.

The above findings contravene the fact that; every woman has the right to access high quality maternal health services that in turn must be accessible, affordable, effective, appropriate and acceptable to them in order to avoid preventable morbidity and mortality. Many complications of pregnancy and child birth that lead to mortality can be prevented by providing quality care that involves early detection of problems and appropriate timely interventions.

This again represents a significant discrepancy from UMOH guidelines as providers are expected to develop delivery plans with the women during their first visit, and to review these plans in the third and fourth visits.

The reasons offered by providers for these assessments included ; some women sought ANC services in the last days of their pregnancy which could not allow health workers draw delivery plans for them and even this made the risks higher.

4.3.2 Myths and misconceptions

The knowledge, perceptions and attitudes of ANC attendees were assessed. The study established that pregnant women had myths and misconceptions about seeking ANC early. The main reasons cited for failure to attend ANC early were based on the woman's own beliefs that the facility would not provide quality care, or on the advice given by family members.

Beliefs and attitude of mothers were yet another factor advanced by the respondents regarding ANC late attendance. As observed through the interviews, focused group discussions, attitudes influence decisions on where and when to attend ANC.

On the reasons why some mothers did not attend antenatal care services in health units, reasons such as smooth experience with previous pregnancies were given. This means that if nothing is changed, a perceived negative attitude of health workers and poor quality of care would remain barriers to attending ANC early.

All of the ANC attendees and other women around pointed out that the private facility health care providers are not polite in handling patients. They do not explain when doing procedures; misplace records and reject referrals sent by TBAs, they charge high fees for their services This sometimes demoralizes some women. However, as reported by some women and ANC providers, such are misconceptions for there was no way a trained health provider would do such a thing.

However, this calls for supportive supervision to monitor service delivery standards and to ensure that abusive health workers are held accountable for mistreatment of clients. The study is not able to confirm independently the reports of negligence leading to abuse of patients at any point in the service delivery cycle. However, the negative experiences of women regarding the care they received and the belief among many participants that late attendance was caused by providers and this requires a thorough investigation into the quality of maternity services at KIU-teaching hospital.

4.3.3 Traditional Beliefs and Practices

The study demonstrates that many women in KIU-teaching hospital are still engulfed in the traditional past. The respondent’s views revealed that many women seek ANC services late. ANC attendees and women around reported that community norms were significant constraints in planning for early ANC and Facility-based delivery. They commented that:

Our culture discourages us from planning for a baby who is not yet born. Prior planning is believed to bring bad lack. Some women are discouraged by relatives not to mention their pregnancy early as it would bring bad luck. Another woman elaborated on this point, The fact that many women go to traditional healers and deliver from home also had influence on other women‘s decisions to seek ANC early.

She elaborated that the influence of culture is deeply rooted in society, which makes utilization of health services generally low among women. Others even have the false belief that medical

officials harass them.‖ In addition, late attendance was attributed to fear of walking long distances yet pregnant women were told not to walk long distances because they may get a miscarriage.

The established fact is that the status of women in the area of study was still low and they cannot make independent decisions about their health even when they have money and are aware of the advantages of attending ANC early.

One respondent added that, heavy work load makes it impossible for pregnant women to start ANC before 5 months. It is a common practice that women go to the health facility if they have a problem that requires medical attention.

It was also observed that, some primitive men also refuse their wives to go for ANC because to them pregnancy is not sickness, that instead a pregnant woman who over complains is a sign of laziness/cowardice. The cultural resistance to ANC early attendance and health facility deliveries also needs to be addressed through a variety of channels, some of which need to include men who give permission and the money to their wives for these visits.

It was also reported that, some pregnant women feel shy and do not want anybody else to look at their private parts. They will deliver outside a health facility since they have heard or experienced the fact that health workers look at and touch their private parts when they go to deliver. In the focus group discussions it was found out that there are very few times when women‘s genitals are looked at either by herself or by other people during her life time as such even those that would wish to use health services take their time thinking about that.

4.3.4 Financial Difficulties

As established by the study, the level of income of the respondents based on their economic activities was so low. As a result their utilization of ANC facilities/services was reported to be minimal. It was established that, perceived expense of the ANC hinders early attendance, the respondents stressed that transport costs, physical inability to travel long distances make many women utilize the available ANC alternatives and visit health units late.

The fact that predisposing characteristics and enabling resources accounted more for the variation in pregnancy duration at entry to ANC than needs implied that inequality existed between women. Younger women, especially teenagers, are more likely to have unplanned pregnancies and lack information and the resources to access ANC services.

Early entry to antenatal care (ANC) is important for early detection and treatment of adverse pregnancy related outcomes. The World Health Organization (WHO) recommends that pregnant

women in developing countries should seek ANC within the first 4 months of pregnancy. However, due to financial constraints women in KIU-teaching hospital tend to seek ANC in the seventh or even the ninth month of pregnancy.

In this study, majority of women complained of poverty and sometimes their finances being in the hands of their husbands while the widowed lacked control of property left to them. This reflects the real situation in the area of study.

4.3.5. Alternatives to ANC

The ANC providers indicated that some mothers undertake other alternatives in early phases of pregnancy. Some mothers use Traditional birth attendants and come for ANC in the seventh month. As a result substantial proportions of women do not receive services offered by the ANCs such as breastfeeding and newborn counseling, malaria prevention and counseling on complications. Yet the ANC through the health care system remains the primary source of information about pregnancy and newborn care.

This survey provides missed opportunities on pregnancy programming and planning. It is clear that maternal mortality from within and without the health care system is not well addressed. The low ANC rate found in this research is inconsistent even though many strategies have been laid by the government as well as District authorities. The research indicates the need to target outreach about the importance of ANC to those most at risk for not being aware of or able to access appropriate care.

There is also need to focus on women with no formal education and particularly those who have already had lost a newborn or young infant. Late ANC attendance does not provide women with a chance of benefiting fully from preventive strategies, such as iron and folic acid supplementation, and intermittent preventive malaria treatment in pregnancy among others. To encourage earlier ANC attendance, service delivery must be improved and messages that aim at removing barriers to ANC utilization should be increased.

4.3.6. Ignorance

The study established that, the majority of the respondents had less education levels which were also a reflection of the entire community. In this regard some ANC providers revealed that most of the women access antenatal late because of ignorance. Many mothers do not want to make many visits to the hospital. Thus they start ANC late to make fewer visits.

Because of the high illiteracy levels among women interviewed in the survey and generally among ANC attendees, there is need for outreach efforts by employing community engagement strategies, and counseling and educational materials used during ANC also need to be audio-visual, interactive and pictorial. This will enable the health providers to reach the uneducated women most at risk for not attending ANC or learning the details about assessing their own risk if they do not attend ANC early.

4.3.7 Age

The results of the study indicate that ANC late attendance was associated with age. In Ishaka many girls tend to marry at a young age of 15 and 16 yet the recommended age at marriage is 18 years and above according to GOU. The frequency distribution of ANC attendees illustrated that the majority of the respondents were young mothers 43.6% .10 mothers of the age group 15-19 years were in 1-2 gravidity a likelihood of early marriages.

Young mothers tend to go for antenatal care late for fear of being identified as young mothers by ANC providers and even in the community which puts their life at a risk. As reported, many hospital deaths among pregnant mothers were due to age and mostly common in young mothers. However, a midwife at the hospital revealed that, women with more previous pregnancies may be more confident because of their experience. However, they may also find it harder to attend ANC because of difficulties with child care.

4.4. Knowledge of mothers about benefits of attending ANC early

The results of the study show that there is a high level of literacy among ANC attendees, this was established when attendees were prompted with a series of questions; of why mothers go for ANC, a problem a mother may encounter when does not seek ANC early, services offered when seeking ANC.

Their responses indicated that the respondents had knowledge about dangers a mother might come across if she attended ANC late in pregnancy.

4.5. Traditional Birth Attendants

The study established that TBAs are widely used by pregnant women and mothers in the study area. The study revealed that TBAs are appreciated in the community as they adhere to the norm of deliveries, always being an emergency in the community and that they act quickly and are always available.

The respondents mentioned visiting TBAs because they are nearer/closer to the mothers than ANC facility. The commonly cited reason for use of TBA‘s was the difficulty in transport that left mothers with no alternative but to use TBAs. The respondents added that TBA‘s were more accessible, and flexible enough to carry out a delivery in one‘s home than health units. However, some respondents raised concern that TBA‘s were incompetent and not well trained.

In spite of the continued occurrences of home deliveries, some mothers do acknowledge the dangers associated with seeking primitive ANC alternatives. They seemed not to be aware of labor complications could not be adequately managed at home and the mother would be at risk of getting tetanus and over bleeding.

4.6. Distances to ANC health facilities.

Seeking and utilization of ANC services by pregnant women and mothers is determined by a number of factors of which distance and mode of transport is one of them. To establish what influences women to seek ANC alternatives and attend late. The study findings on the availability and distances of antenatal care clinics revealed that women cover long distances of more than 0-5km to the health facility where antenatal care services are provided. This was expressed by respondents during questionnaire interviews, in depth interviews and focus group discussions.

It was noted that the majority of women live at a distance of 1km from the nearest health Centre where antenatal care services are available. On the overall, less than 50% of the ANC attendees indicated that they live between 0-5km from the health facility where they could get antenatal care. The other half of the women lives beyond a distance of 5km.

On comparison between the two groups of ANC attendees, it was revealed that 17.6% of the early starters lived between 0-5km from ANC health facility. More than a half of the first trimesters /early starters live beyond a distance of 5km from the ANC clinic. On the other hand ,15.7% of the late trimesters/starters indicated that they lived between 0-5km from the health facility while 73.6 % of them lived beyond a distance of 5km. the figure below illustrates distance from Health facility.

4.7. The mode and means of transport used by ANC attendees

The majority of respondents indicated that they walk to antenatal care health facility when they want antenatal care services. It was observed that many ANC attendees who came to the antenatal care health facility did so on foot”. Some commented that I had to walk from my village to get

here to the hospital'. One of the respondents mentioned that most of the women you see here have come on foot" .There is no alternative transport means or they cannot afford to hire a bicycle" Most of them do not own bicycles or cannot afford to hire one which is usually 1,000 Ug shs from home to the health facility. (FGD woman in Chahi)

Exit interviews with ANC attendees revealed that a bigger proportion of respondents had to walk to antenatal care facility. In depth interviews with ANC attendees, many mothers reaffirmed that they walk from their homes to hospital for ANC services. One woman pointed out that;

On the overall, 51.4% of the respondents indicated that they walked to the health facility, followed by 32.4% who had used bicycles. Only 10.8 % of them had used motorcycles while 5.4% of the attendees used motor vehicle to get to the health facility.

Similar pattern was shown when the two groups of ANC attendees were compared. The majority from both groups gets to the health facility on foot; 58.8% for the early and 49% for late starter's respectively.29.4% of the early starters had come by bicycles as compared to 33.3 % for the late starters. There were 5.8% among the early starters who had used a motor vehicle while 5.3% of the late starters had come by a motor vehicle.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 DISCUSSION

5.1.1 Alternatives to ANC at KIU- teaching hospital

The research findings show that; majority of the ANC attendees had other alternatives to ANC they were undertaking in their early phases of pregnancy. These included use of traditional birth attendants and traditional healers. This implies that, cultural beliefs are still a determining factor to women‘s decision in seeking ANC services.

The study established ill treatment of ANC attendees by ANC providers. Some ANC providers are rude; abuse mothers and sometimes beat them especially at that critical time when a mother is having labor pains. . This demonstrated less ethical values among health providers. In addition research findings obtained, there was an observation some mothers seek ANC alternatives because the husbands were refusing to accompany or even block them from attending antenatal care. This was because some husbands are afraid of testing for HIV/AIDS and yet it is a requirement in all ANC facilities in Uganda.

5.1.2 Antenatal Care late attendance

The study findings also illustrate that almost all of the respondents accessed ANC late in their fifth and sixth month contrary to the recommended 0-16 weeks by the government of Uganda.

There is evidence to suggest that mothers seek ANC late because of poverty. The study findings show that many of the respondents‘ income is low, so mothers fail to raise money for transport, lunch while on ANC visit and lack what to put on like maternity dresses and knickers. Thus some mothers seek ANC late because the husbands cannot raise money for the wife to use going to Hospital.

The study reveals that distances from health facility contribute greatly to mothers seeking ANC late. Many of the ANC health facilities are within a distance of over 5km to 10km.

The biggest percentage of ANC attendees traveled longer distances to the hospital/health facility. Moreover Ishaka is very hilly, with very bad Roads when it is rainy season some are impassable. This suggests lack of adequate means of transport in some parts of the area of study was a hindrance to accessing ANC services.

The findings indicated that women in the area of study are engaged in both in- home and tedious out-door farming activities for which they allocate little time for seeking medical care in general. Related to this; a study in Ethiopia, established that heavy workload, lack of access to health services, poverty, traditional practices, poor social status and decision-making power, and lack of access to education are among the highly prevalent socio-cultural factors that potentially affect the health of women (Marina and Mugoni:2005).

A number of respondents attended ANC at least once before the third trimester of pregnancy and approximately half made their first visit early-during or before the fourth month of gestation, which is consistent with other reports of ANC attendance. However, no evidence was found of an association between early ANC attendance and uptake of intermittent preventive treatment (IPTp), a key malaria preventive strategy. This suggests that efforts to encourage timely ANC attendance alone are unlikely to improve the uptake of this intervention.

According to the National Policy Guidelines and Service Standards for Sexual Reproductive Health and Rights issued by the Uganda Ministry of Health (UMOH: 2006:49), women should have at least four ANC visits during pregnancy. However, the type and quality of ANC services that the women reported receiving were inconsistent and inadequate. Fewer than half received any type of immunization services, and a minority of women reported that the health worker listened for the fetal heartbeat. A few women had their blood pressure checked, were advised to eat a balanced diet, or were weighed. No hemoglobin tests, urine analysis, syphilis screening, voluntary counseling and testing for HIV, or counseling on risk factors and warning signs and symptoms during pregnancy were reported.

The findings also suggest that other factors, aside from service availability, may drive service utilization differentials between and among rural women. These factors include disparities in economic and cognitive access, perceived quality of ANC services, and differences in individual knowledge and attitudes towards ANC services. The study established that, late attendance was attributed to women seeking alternatives to ANC. This is a clear marker of how health and social systems threaten the capacity of women to deliver safely. While not attending ANC services as presented by the respondents, its true causes are grounded in women‘s acute socio-economic vulnerability which denies them access to timely and appropriate care. The severe shortage of health workers, unavailability of transport to facilitate emergency referrals, severing poverty that denies people to afford health care; lack of education regarding basic reproductive health and the

complications of childbirth. More tragically, however, lack of adequate ANC services has contributed to the continuing and unabated acceptance that women naturally die in childbirth, or are left with devastating disabilities.

Age was identified as a factor in ANC late attendance, slightly more than half of the women in the study whose age was reported were less than 30, and the majority of respondents were on their third pregnancy. The findings indicate the potentially serious health effects of early pregnancy. It also highlights the need for girls and young women to possess the fundamental rights to determine freely when they will marry and when they will begin having children. While it remains vital to recognize the severe impact of ANC late attendance on young girls, the findings expand on the widely held assumption that ignorance on seeking proper and adequate ANC services predominantly affects very young women on their first pregnancy.

The findings of the study highlighted that those women who are slightly educated have maximally availed delivery care services when compared to less educated and illiterate women. Significant differences have been observed according to women‘s education in consulting a health professional. Women with only primary and middle school education are less likely to see a professional in connection with their pregnancy and delivery. Attainment of education has a major influence on utilization of maternal health care services.

In terms of delivery assistance, antenatal checkup and place of delivery, there appears to be a big gap according to the women‘s standards of living. Women from poorer sections of the population are less likely to avail of maternal health care services than rich women. The reason might be that the cost of delivery care at private or public medical facilities is high. Poor families do not find themselves in a position to be able to bear the cost of delivery care service. Even if they wish to avail the public sector medical facilities, they have to bear the cost of medicines and are expected to give gift in kind or cash to the attending doctors and other paramedical staff.

A quick review of research findings shows that some pregnant women received antenatal care from health units. Paradoxically, when it comes to delivery time, a glaring smaller proportion of these women give birth in these unit, instead they deliver elsewhere. During the study it was also established that some women attend antenatal care in health units and fail to deliver in these same health units, this calls for detailed study on what encourages mothers to go for antenatal care and not deliver from hospitals.

5.1.3 Respondents recommendations on how to improve ANC utilization at KIU-teaching hospital.

The study identified that it was significant to provide women with education and counseling on pregnancy, labor, and delivery. In particular, the danger signs of pregnancy and labor and the need for skilled delivery assistance should be emphasized. This means that Women in Bushenyi Ishaka District in general should be encouraged strongly to deliver in a health facility so they can receive emergency care promptly when needed.

Public education and programs to prevent women from seeking dangerous ANC alternatives must therefore, target all women of reproductive age. In particular, maternal health services should provide accurate and timely counseling to women as well as key decision makers, such as husbands, mothers-in-law and parents on the importance of utilizing ANC in early days of pregnancy and delivery, and encourage women and their families to have a birth plan in place as well as provisions for handling emergencies.

Training for health workers on clinical skills, as well as on client-provider interaction, was suggested as critical to ensure high quality, professional ANC and delivery services. Supplies and equipment must be available to health workers, and supportive supervision instituted to monitor service delivery standards. Health workers, in turn, need to be supported through training and supervision to provide essential, adequate, services to ANC attendees.

The Government should pursue its efforts to improve the availability of ANC services at existing and/or new health facilities, particularly those that are offering ANC services. Any interventions that aim to increase maternal health service utilization should include efforts to target women of lower health status and educational achievements, as well as areas where women in general do not have high educational achievements.

TBAs also need to be informed about how pregnancy complications occurs and how it can be prevented and treated, since there were many misconceptions about them by hospital and clinic workers. Additionally, TBAs need to be informed about when and where to refer women in case of prolonged obstructed labor and other emergencies.

Broad-based educational and advocacy programs are needed to dispel negative myths about seeking ANC at health units as well as to encourage social support for girls and women living with HIV to always visit health facilities. Consistent and reliable information on where and when services are available also needs to be disseminated to assist women to access treatment quickly.

Radio programmes and outreach through faith-based institutions may represent effective communication channels to reach women in rural Ishaka.

To successfully manage and promote safe motherhood there is need for comprehensive strategies not just for antenatal care, but also intrapartum and post-partum care by skilled health professionals, midwives, nurse-midwives or doctors backed up by hospital care and expand access to these services to all child-bearing women. This is because effective and efficient strategies are known to dramatically reduce maternal mortality and morbidity. By safeguarding maternal health and well-being the health, economic and societal benefits will be enormous, far outweighing any investments made. However, this requires strong political will and commitment.

From the findings, it is clear that ANC programmes in KIU-teaching hospital must address the reduction of maternal mortality from within and without the health care system. The low ANC rate found in the survey is an indication that, there is need for community outreaches about the importance of ANC to those most at risk for not being aware of or able to access appropriate care. In KIU-teaching hospital efforts need to be intensified. There is also need to focus on women with no formal education and particularly those who have already had lost a newborn or young infant. Although the perceived expense of the ANC may hinder attendance, it is uncertain that free ANC would increase coverage substantially because transport costs, physical inability to travel long distances, and a perceived negative attitude of health workers and poor quality of care would remain barriers.

5.2 Conclusions

The health and survival of newborns in Uganda has gone unnoticed for too long. However both immediate and long term opportunities exist to improve the situation at all levels. Uganda has many policies in place but the utilization of ANC services illustrates a critical policy gap, especially in regard to the early starting antenatal care visits.

Existing policies and guidelines have not been fully disseminated, integrated or implemented by service providers, leading to poor and inconsistent utilization of ANC services especially in rural areas like Bushenyi Ishaka. Existing policy implementation is poor partly due to limited funding of the overall health sector and services delivery at the district level. There is an opportunity for policy makers to take a leading role to improve utilization of ANC from the highest level in both public and private facilities .This can be achieved through making and disseminating appropriate

policies, improving staffing and supervision in facilities and creating an enabling environment for community level care.

5.3 Recommendations

The study findings unveiled a number of gaps in the provision of ANC services and midwifery educational programs; gaps in information dissemination systems to pregnant women and structural and organizational barriers relating to accessibility of ANC services. Thus in order to change the habit of women seeking alternatives and attending ANC late, the study recommended;

1. Health workers should be encouraged to take opportunity of the numbers of mothers that attend ANC services and educate them on the unpredictability of complications of pregnancy and delivery. This opportunity should also be used to impress upon the mothers, their spouses and community the importance of having a planned pregnancy and hospital/clinic deliveries.

2. Having realized the weaknesses in the health service in KIU-teaching hospital, in Ishaka Bushenyi District there is need for training of health providers in the concept of focused ANC, with specific emphasis on scheduling of visits, continuity of provider for each client, incorporating PMTCT and developing an Individual Birth Plan (IBP) to respond to existing knowledge gaps.

3. To improve women access and utilization of ANC services in rural areas, there is need to establish or strengthen national policies and locally adapted guidelines to protect the rights of all women, regardless of their socioeconomic status or place of residence. There is a need for evidence-based guidelines at the national level detailing the essential minimum components of ANC, in line with the country epidemiological profile and country priorities and based on WHO guidelines and recommendations.

4. The study also recommends the need to strengthen the quality of ANC services by promoting evidence based guidelines and standards for focused ANC. This is because quality improvement approaches and tools help identify and overcome local constraints to providing client-orientated, effective ANC and ensure that women return after their first ANC visit.

5. Considering the study findings that are not unique to KIU-teaching hospital but also a true reflection of other parts of rural Uganda, the study suggests that strategies should be developed for empowering communities to overcome obstacles to reach ANC. These may include using community channels to identify pregnant women, targeting those more likely to be nonusers, such as adolescents and women who are poor and single, and making the services more responsive to the needs of women.

6. Quality and performance improvement to mitigate factors affecting performance of ANC providers were identified as a way of ensuring quality of ANC. This interdisciplinary approach should include key stakeholders, including district and regional health management teams, to identify service gaps. Based on the gaps identified, priority interventions should be implemented focusing on a range of performance factors such as supervision, knowledge and skills; development, and availability of key resources, supplies and equipment to ensure sustainability and long-term results.

7. The study established that many of the medical personnel handle their clients in an inhuman manner a sign of poor client handling. Training for health workers on clinical skills, as well as on client-provider interaction, is critical to ensure high quality, professional ANC and delivery services.

8. Continuous community based health education and facility-based education, peer group discussions in the community and group education among pregnant women and mothers and at the same time raise the issue and discuss ANC and its advantages will help to create a sense of belongingness, build their consciousness to seeking health services.

9. The study recommends an improvement in health care systems at all levels and improving maternal survival and well-being, through improving physical infrastructure, essential drugs supplies, equipment to improve the extremely difficult working conditions for staff and enable providers to offer quality care.

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APPENDICES

APPENDIX 1: Consent form

(To be translated and explained to respondents)

Study tittle: Factors associated with late antenatal attendance by pregnant women in Kampala International University Teaching Hospital in Bushenyi District in Western Uganda.

I am IPULET BENAH an investigator of Kampala international university teaching hospital.

I am researching this information in partial fulfilment of a ward of a diploma in clinical medicine and community health.

This study will be helpful to the ministry of health for improving antenatal care attendance by pregnant women, improving men's involvements during pregnancy and ensure that good antenatal services are provided for the benefit of both mother, unborn child and community at large.

Therefore the participants of this study will be pregnant women who have come for antenatal care for the first time at 20 weeks of gestation.

Your voluntary participation is highly requested in this study whereby you will be provided with questionnaires that you are to answer some few questions.

Your cooperation will be highly appreciated if you accept to participate in this study, please sign below

………………………………. ………………………… ……………………………

(Name of participant) (Signature) (Date)

Study time:

Start…………………………………………… Stop…………………………………………….

APENDIX II: Questionnaire

SECTION A

SOCIO-DEMOGRAPHIC DATA

Age ……………………………………………..

MARITAL STATUS

a) Married □ Single □

b) Divorced □ Widowed □

OCCUPATION

a) Government employed □ c Self employed □

b) Private employed □ Non employed □

ATTITUDE OF HEALTH PROVIDERS

Do you like the way you are treated health providers?

YES □ NO □

If no does it affect the way you come for antenatal visits?

YES □ NO □

KNOWLEDGE ABOUT ANTENATAL CARE

What do you understand by antenatal care?

....

What services are offered during antenatal care visit? ....

How many time is pregnant woman supposed to come for antenatal care?

Three times □ Four times □

One time □ Do not know □

Do you think it's good for pregnant mother to come for antenatal care early?

YES □ NO □

Give reasons for the answer…………………………………………………………………………………………

……………………………………………………………………………………………………

…………………………………………………………………………………………………

At how many month of pregnancy is pregnant mother supposed to report for the first visit?

Three to four months □ five months □.

Nine months □ do not know. □

SECTION B. ECONOMIC FACTORS.

Do you pay money for your antenatal services?

YES □ NO □.

If yes do you think it affects you coming for the services?

YES □ NO. □

ACCESSIBILITY.

What is the distance from your home to the health Centre?

Five miles □ ten miles. □

Fifteen miles □ twenty miles. □

If none of the above specify………………………………

How long do you take at the health Centre waiting for the services.

Thirty minutes. □ Forty five minutes. □

One hour. □ Two hours. □

If none of the above specify……………………………………………

CULTURAL BELIEVES

Does your culture support you to come for antenatal care?

YES. □ NO. □

If no do think it is problem to you?

YES □ NO □

HUSBAND INVOLMENT.

How many wives does your husband have………………………………....

Does your husband encourage you to come for antenatal care?

YES □ NO. □

Does your husband support you during pregnancy?

YES □ NO. □

If yes how……………………………………………………………

Do think it is good for men to accompany their wives for antenatal care?

YES □ NO. □

How do you feel when your husband denies you from antenatal care?

Bad □ good. □

Do not care. □

SECTION C,

Give ways on how late antenatal care attendance by pregnant mothers can be improved?..
....
....
....
....
....
....

List antenatal care services. given to pregnant mother…………………………………………………………………………………………
……………………………………………………………………………………………………
…………………………………………………………………………………………

Give benefits of early antenatal care attendance by women…………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………

What are the effects of late antenatal care attendance?...
....
....
....

Thanks may God bless you.

Ipulet benah

ACTIVITIES	JAN	FEB	MAR	APRI	MAY	JUN	JUL	SEP	OCT	NOV	DEC
Selecting the research topic and approval											
Writing chapter one											
Writing chapter two and three											
Data collection and analysis											
Handing in the proposal											
Defense											

APPENDIX III: Map of Uganda showing Bushenyi