

**KNOWLEDGE AND SOCIO-DEMOGRAPHIC FACTORS HINDERING BIRTH
PREPAREDNESS AMONG MOTHERS WHO COME TO DELIVER AT KAMPALA
INTERNATIONAL UNIVERSITY TEACHING HOSPITAL**

BY

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**A RESEARCH REPORT SUBMITTED TO THE SCHOOL OF ALLIED HEALTH
SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
AWARD OF A DIPLOMA IN CLINICAL MEDICIENE AND COMMUNITY HEALTH
OF KAMPALA INTERNATIONAL UNIVERSITY**

JULY 2017

Declaration

This is to declare that this research report is my own work and has never been presented anywhere to any academic institution for any award other than the one for which it is now being submitted for.

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REG NO.DCM/0089/143/DU

SignDate.....

Approval

This is to approve this study which has been designed under my direct support and supervision and is now ready to be submitted to the School of Allied Health Sciences of Kampala International University in partial fulfillment of requirement of the award of a diploma in Clinical Medicine and Community Health of Kampala International University.

Supervisor

Mr.Mburugu Martin.

Sign.....Date.....

ACKNOWLEDGMENT

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LIST OF ACRONYMS

ANC	Antenatal care.
BP	Birth Preparedness
BPCR	Birth-Preparedness and Complication Readiness
KIU-TH	Kampala international university teaching hospital
WHO	World Health Organization
UNICEF	United Nation international children's emergency fund
UN	United Nations

ABSTRACT

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A descriptive cross sectional study conducted at Kampala international university teaching hospital-maternity ward to assess the socio-demographic factors hindering birth preparedness among mothers who come to deliver at KIU-TH. It was done by administering interviewers schedule to 70 respondents who were mothers.

RESULTS

The majority of the respondents were married catholic with average level of education and major occupation being self-employment hence low income earners

Regarding knowledge, most of the mothers had knowledge about birth preparedness .The main source of information were from health workers and radio.

ANC clinical services were being utilized by the majority of the mothers in the area. They were being counseled, health educated, and tested for conditions such as malaria, HIV/AIDS. Few mothers did not know about ANC services

Majority of mothers decided by themselves to start ANC visit and most of them had at least three ANC visit.

However, those mothers who could not make decision on their own to start ANC visit had to take made by their husbands. While some had to decide with someone else to start ANC visit

CONCLUSION

The majority of the respondents were married catholic with average level of education and major occupation being self-employment hence low income earners. Most of the mothers had knowledge about birth preparedness and their main source of information were from health workers and radio.

CHAPTER ONE

INTRODUCTION

1.0 General Introduction

In this chapter; background of the study, problem statement, justification of the study, broad objective, specific objective, research questions, significance of the study, scope of the study will be presented.

1.1 Study Background

Maternal mortality is a global burden, with more than 500,000 women dying each year due to pregnancy and childbirth-related complications while maternal mortality and morbidity remains a formidable challenge in many developing countries like Uganda, Birth preparedness and complication readiness by mothers are critical in reducing morbidities and mortalities due to these complications (Urassa, et al., 2012).

Birth preparedness is the process of planning for normal birth and anticipating the actions needed in case of an emergency. It is also a strategy to promote the timely use of skilled maternal care, especially during childbirth, based on the theory that preparing for childbirth reduces delays in obtaining this care (Markos & Bogale, 2014).

It is a comprehensive strategy to improve the use of skilled providers at birth, the key intervention to decrease maternal mortality. Birth-preparedness includes many elements, including, **knowledge of danger signs; plan for where to give birth; plan for a birth attendant; plan for transportation; and plan for saving money.**

The World Health Organization (WHO) estimates that about 800 women die daily from pregnancy and childbirth-related complications each year, mainly in developing countries. (WHO,2014)

In Sub-Saharan Africa, this situation is most dire and one out of every 16 women dies of pregnancy-related causes during her lifetime. (WHO,2014)

For every woman who dies, 30-50 more women suffer childbirth-related injuries, infections, or diseases.(Population Reference Bureau,2014) Beyond the emotional loss caused by her death, her children are also negatively impacted, with increased risk of dying before the teenage years, reduced nutritional status, mental health outcome, and lower educational attainment. (Ronsman et al.,2014)

Every pregnant woman faces risk of life-threatening obstetric complications. A birth-preparedness package promotes active preparation and assists in decision-making for healthcare seeking in case of such complications (Kakaire, et al., 2011).It is a safe motherhood strategy which addresses delays that could increase the risk of dying in pregnancy, child birth and the immediate postpartum period (Kuteyi et al., 2013).

In Uganda, the maternal mortality ratio is 432 per 100,000 live births, (WHO, 2012).These deaths arise from pregnancy, childbirth or postpartum complications. A key strategy that can reduce the number of women dying from such complications is making a birth plan that constitutes birth-preparedness and complication-readiness measures for pregnant women, their spouses and their families, :(Economic Commission for Africa, African Union, African Development Bank Group, UNDP. 2012).

Birth preparedness helps ensure that women can access professional delivery care when labor begins and reduces the delay that occurs when women experience obstetric complications (Envuladu & Zoakah, 2014).

Improved knowledge of obstetric danger signs, birth preparedness practices, and readiness for emergency complications are among the strategies aimed at both enhancing utilization of maternal health services and increasing access to skilled care during childbirth, particularly for women with obstetric complications (Mbalinda et al., 2014).

Improving knowledge of obstetric danger signs and promoting birth preparedness practices are strategies aimed at enhancing utilization of skilled care in low-income countries (Kabakyenga, et al., 2011).

1.2 Problem statement

In developing countries, most women have at least four antenatal care visits, and are attended to by a skilled health worker during childbirth, and receive postpartum care. In contrast, only 47% of Ugandan women receive antenatal care coverage and only 42% of births are attended by skilled health personnel (UNICEF, 2012). Among the poorest 20% of the population, the share of births attended by skill health personnel was 29% in 2005/2006 as compared to 77% among the wealthiest 20% of the population (UN, 2012). The case of Jennifer Anguko of a popular elected official who bled slowly to death in the maternity ward in a major hospital, aptly exemplifies the poor state of maternal health care that is provided to women, even in major urban healthcare facilities (Dugger& Celia, 2011)

Despite the national policy of promoting maternal health through promoting informed choice, service accessibility and improved quality of care through the national Safe Motherhood Programme (SMP), it remains a challenge to the Ugandan government as to how it would achieve its 2015 Millennium Development Goals of reducing maternal mortality rates and 100% births attended to by skilled health personnel. In order to achieve future economic growth, it is vital that the population remains healthy.

According to the study done in 2007 in 54 districts and 553 health facilities in Uganda to determine availability of emergency obstetric care and its related maternal deaths. The study found that few of these units had running water; electricity or a functional operating theater .However, having these items was shown to have a protective effect on maternal deaths (A.K.Mbonye et al, 2012).

The availability of midwives had the highest protective effect, reducing the case fatality rate by 80%. This study found that while 97.2% of health facilities were expected to have emergency obstetric care services, few had provided these services. This is the most likely explanation for the high health facility-based maternal death rate of 671 per 100,000 live births in Uganda in 2007. The study concluded that addressing health system issues, particularly among human resources, and increasing access to emergency obstetric care could reduce maternal mortality

1.3 Objectives

1.3.1 Broad Objectives

To assess factors hindering birth preparedness among mothers who come to deliver at KIU-TH, Bushenyi District.

1.3.2 Specific Objectives

1. To assess how the socio-demographic characteristics affects birth preparedness among mothers who come to deliver at KIU-TH.
2. To assess the knowledge of mothers about birth preparedness

1.4 Research question

1. What are the social-demographic characteristics that affect birth preparedness among mothers who come to deliver at KIU-TH?
2. What are the knowledge of mothers about birth preparedness?

1.5 Significance.

The study findings will add onto existing literature that may be used by other researchers as well as recommendations providing a basis for research.

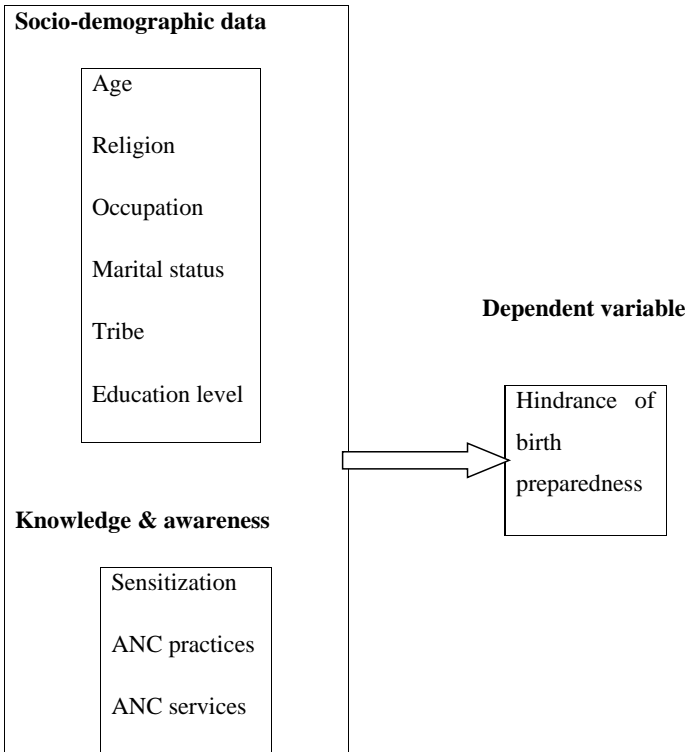
This research will be important to policy makers, program designers and implementers who help in laying strategies for intervention, monitoring and evaluation of maternal and child health,

The study will find out the social-demographic characteristics of mothers and highlight the knowledge and practices of birth preparedness among mothers who come to deliver at KIU-TH.

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1.6 conceptual frame work

Independent variable



CHAPTER TWO

LITERATURE

2.0 General Introduction

This chapter includes information from related studies on the knowledge, attitude and practices of birth preparedness among pregnant women attending antenatal care.

2.1 Social-demographic affecting the awareness of obstetric danger signs and birth preparedness

In Nigeria, it was found that higher socioeconomic status was associated with knowledge of danger signs, but not with knowledge of life-threatening, critical danger signs. Antenatal care visits did not increase knowledge of critical danger signs, but they were associated with skilled birth attendance. Knowledge of critical pregnancy danger signs also was associated with skilled birth attendance. Improving the quality and coverage of ANC will ensure greater awareness of the critical danger signs (Doctor, et al., 2013).

Deblew and friends documented in their study that the status of birth preparedness and complication readiness was 23.3%. Being in urban residence and having health center within two hours distance were among the higher level factors increasing birth preparedness and complication readiness. Educational status of primary or above, husband's occupation of employed or merchant, third or above wealth quintiles, knowledge of key danger signs during labor, attitude and frequency of antenatal care visits were among the lower level factors found to increase the likelihood of preparation for birth and its complications (Debelew, et al., 2014).

Furthermore, the relationship between knowledge of at least one key danger sign during pregnancy or during postpartum and birth preparedness showed statistical significance which persisted after adjusting for probable confounders (OR 1.8, 95% CI: 1.2-2.6) and (OR 1.9, 95% CI: 1.2-3.0) respectively. Young age and high levels of education had synergistic effect on the relationship between knowledge and birth preparedness. The associations between knowledge of at least one key danger sign during childbirth or knowledge that prolonged labour was a key danger sign and birth preparedness were not statistically significant (Kabakyenga, et al., 2011).

When considering the age groups, the mean age of those involved in a study was 26.8 ± 6.6 years, while mean age of the spouse was 32.8 ± 8.3 years. However, over 100 (73.8%) women and 75 (55.2%) of their spouses had no formal education or only primary level of education respectively. On multivariable analysis, Primigravidae compared to multigravida, education level of spouse of secondary or higher versus primary level or none, formal occupation versus informal occupation of spouse, presence of pregnancy complications and the anticipated mode of delivery of caesarean section versus vaginal delivery, were associated with having a birth plan (Kakaire, et al., 2011).

Among the invited men, 95.9% agreed to participate in the community survey. Fifty-three percent could mention at least one danger sign during pregnancy, 43.9% during delivery and 34.6% during the postpartum period. Regarding birth preparedness and complication readiness, 54.3% had bought birth kit, 47.2% saved money, 10.2% identified transport, 0.8% identified skilled attendant. In general, only 12% of men were prepared (August, et al., 2015).

After controlling for confounding and clustering effect, significant determinants of birth preparedness and complication readiness were found to be maternal education, spouse employment, booking at ANC, Four or more antenatal visits, and knowledge of key danger signs. Prepared for birth was found to be associated with institutional delivery (Bintabara, et al., 2015).

In the bivariate analysis, age of the woman, education, marital status, number of ANC visits and knowing ≥ 3 obstetric danger signs were associated with birth preparedness and complication readiness. In multivariate logistic regression analysis, women with primary education and above were twice more likely to be prepared and ready for birth and complications. Women who knew ≥ 3 obstetric danger signs were 3 times more likely to be prepared for birth and complications (Urassa, et al., 2012).

Controlling for education, parity, average distance to health facility, and the number of antenatal care visits, planning to save money was associated with giving birth with the assistance of a skilled provider ($p=0.05$). Qualitative interviews with women who had given birth within 12 months of the survey ($n=30$) support these findings. Most women saved money for delivery, but had less concrete plans for transportation (Moran et al., 2006).

2.2 Awareness and practices regarding BP among mothers who come to deliver at KIU-TH.

Maternal mortality in northern Nigeria is among the highest in the world. To understand better the pathways through which the socio-demographic environment affects awareness of obstetric danger signs (i.e., potential problems associated with pregnancy), preparations for delivery, and skilled birth attendance, we conducted a survey of 5,083 women with recent pregnancies in three northern Nigerian states. Only 25% attended antenatal care (ANC), and 91% of all births took place at home. Less than one-third knew three or more danger signs of pregnancy or labor and delivery (Doctor, et al., 2013).

Knowledge of at least one key danger sign was significantly associated with being birth prepared (adjusted OR 1.7, 95% CI 1.2-2.3). Birth preparedness consisted of saving money, identifying transportation, identifying a skilled birth attendant and buying a delivery kit or materials. Overall, respondents had a poor knowledge of key newborn danger signs: 58.2% could identify one and 14.8% could identify two. We found no association between women attending the recommended number of antenatal care visits and their knowledge of danger signs (adjusted OR 1.0, 95% CI 0.8-1.4), or between women using a skilled birth attendant at delivery and their knowledge of danger signs (adjusted OR 1.2, 95% CI 0.9-1.7) (Sandberg, et al., 2014).

Only about 1 in 3 women were able to mention at least three of the five basic components of BPCR, and could be regarded as 'knowledgeable on BPCR'. One in every 4 women could not mention any of the five components. Women with history of obstetric problems during the previous pregnancy were more likely to be knowledgeable on danger signs when compared to those who had no complications in prior pregnancy. Women who were knowledgeable on danger signs were four times more likely to be knowledgeable on BPCR as compared to those who were not knowledgeable (Mbalinda et al., 2014).

(Kabakyenga, et al., 2011) documented that Fifty two percent of women knew at least one key danger sign during pregnancy, 72% during delivery and 72% during postpartum. Only 19% had knowledge of 3 or more key danger signs during the three periods. Of the four birth preparedness practices; 91% had saved money, 71% had bought birth materials, 61% identified a health professional and 61% identified means of transport. Overall 35% of the respondents were birth prepared.

Among them 587 (97.8%) attended antenatal clinic (ANC) at least once during their last pregnancy. Two thirds of the women were 20-34years old and had at least primary education level. Three hundred and forty six (57.7%) had parity between two and four. Only 14.8% of the women knew three or more obstetric danger signs. The obstetric danger signs most commonly known included vaginal bleeding during pregnancy (19%), foul smelling vaginal discharge (15%) and baby stops moving (14.3%). The majority (86.2%) of the women had decisions made on place of delivery, a person to make final decision, a person to assist during delivery, someone to take care of the family and a person to escort her to health facility. Majority (68.1%) of the women planned to be delivered by skilled attendant. One third of the women planned to deliver at home in the absence of a skilled birth attendant (Urassa, et al., 2012).

Over 60% of the respondents were counselled by health workers on various elements of birth preparedness. Eighty seven point three per cent of the respondents were aware of their expected date of delivery, 84.3% had set aside funds for transport to hospital during labor while 62.9% had funds for emergencies. Sixty seven per cent of the respondents knew at least one danger sign in pregnancy while only 6.9% knew of three or more danger signs. One hundred and nine per cent of the respondents did not have a clear plan of what to do in case of an obstetric emergency. Level of education positively influenced birth preparedness (Mutiso, et al., 2008).

Only 29.9% of the respondents were prepared for birth and its complications. And, only 82 (14.6%) study participants were knowledgeable about birth preparedness and complication readiness. Variables having statistically significant association with birth preparedness and complication readiness of women were attending up to primary education, attending up to secondary and higher level of education, the presence of antenatal care follow up, knowledge about key danger signs during pregnancy, and knowledge about key danger signs during the postpartum period (Markos & Bogale, 2014).

Around 50% of the respondents planned for first antenatal check-up (ANC) within 12 weeks, four or more ANCs and institutional delivery. Proportion of women aware of at least one key danger sign each of pregnancy, labor, postpartum, and newborn ranged from 12.1% to 37.2%, whereas 58.3% knew at least one key component of essential newborn care. Around two-thirds and one-third of women, respectively, especially those from backward and below poverty line (BPL) families knew about cash incentive and referral transport schemes. Proportions of women

with first ANC within 12 weeks, four or more ANCs, institutional delivery, saving money, identifying transport, and blood donor were 50.4%, 33.6%, 46.2%, 40.8%, 27.3%, and 9.6%, respectively (Mukhopadhyay et al., 2015).

About one in three women was not informed of any danger sign. For most danger signs, fewer than half of the women were counselled. Vaginal bleeding and severe abdominal pain were the signs most counselled on (between 52% and 66%). At study facilities in Burkina Faso, 58% of the pregnant women were not able to mention a danger sign, in Ghana this was 22% and in Tanzania 30%. Fever, vaginal bleeding and severe abdominal pain were the danger signs most frequently mentioned. The type of health worker (depending on the training they received) was significantly associated with counselling practices. Depending on the study site, characteristics significantly associated with awareness of signs were women's age, gestational age, gravidity and educational level (Duysburgh et al., 2013).

Elsewhere, there results showed that 161(64.4%) identified a place of delivery, 210(84%) said they wanted to deliver in the hospital, while 40(16%) choose home as their preferred place. 135 (54%) made arrangement for transportation, while 115(46%) did not. Only 58(23.2%) of the pregnant women made arrangements for blood donation, while majority (83.6%) of the women saved money for the purchase of delivery items. The findings of this study suggests therefore, that a large proportion of the pregnant women did not prepare for childbirth and emergencies especially the prior arrangement for transportation and blood donation. Key words: Birth, emergency, preparedness, danger signs, pregnant women(Envuladu& Zoakah, 2014)

CHAPTER THREE

METHODOLOGY

3.0 General introduction

This chapter discusses the blue print of this study; that is the methods that were used in the study. This included the study design, study site, study population, sample size, sampling methods, pretesting, Data collection, Data analysis, quality control, study limitation, ethical considerations and dissemination of results.

3.1 Study Area

The study was conducted at Obstetrics and Gynaecology) ward of KIU-TH, Bushenyi District. Bushenyi District is bordered by Rubirizi District to the northwest, Buhweju District to the northeast, Sheema District to the east, Mitooma District to the south and Rukungiri District to the west.[1] The largest town in the district, Ishaka, is located 75 kilometers (47 mi), by road, northwest of Mbarara, the largest city in the sub-region. The coordinates of the district are:00 32S, 30 11E.KIU-TH is a private not for profit located in Bushenyi district, western Uganda.

KIU-TH is one of the health facilities providing ANC services to pregnant women in KIU, neighboring villages and sub counties in Bushenyi district.

Obstetrics and Gynecology cases, pediatrics and child health and HIV/AIDS care are among specialized services offered by KIU-TH in relation to ANC and maternal health.

3.2 Study Design

The study was a descriptive cross-sectional study.

3.3 Target Population

Mothers who came to deliver and the mothers who delivered within the two weeks attending health care services at KIU-TH.

3.4 Study Population

Mothers who came to deliver at KIU-TH (from April to June 2017).

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3.5 Accessible Population

Mothers who came to deliver at KIU-TH on study days and staff offering the services

3.6 Selection Criteria

3.7 Inclusion Criteria

Mothers who came to deliver at KIU-TH.

3.8 Exclusion Criteria

Mentally ill mothers and those that denied to be interviewed.

3.9. Sample size determination

The sample size was determined using Krejcie & Morgan Sample Size Formula for Finite Population:

$$s = \frac{X^2 NP (1 - P)}{d^2 (N - 1) + X^2 P (1 - P)}$$

Where:

s = required sample size.

X = the value on the table value for 1 degree of freedom at the desired confidence level (1.96 for a 95% confidence level).

N = the population size (70-85 patients in a month).

P = the population proportion (assumed to be 50% since this would provide the maximum sample size).

d = the error margin (.05).

On substituting the values in the above formula, the sample(S) can be got as bellow;

$$S = \frac{(1.96)^2 (85) (0.5) (1-0.5)}{(0.05)^2 (85-1) + (1.96)^2 (0.5) (1-0.5)}$$

$$(0.05)^2 (85-1) + (1.96)^2 (0.5) (1-0.5)$$

Therefore, 70 participants were considered for the study according to the above formula.

3.10 Method of Data Collection

Semi-structured questionnaires for survey respondents was used to capture information from respondents about the factors hindering birth preparedness among mothers who came to deliver at KIU-TH.

3.11 Quality control

Quality assurance started with the recruitment of qualified research assistant, appropriate training and orientation of the interviewers before the survey for example when reading the questions:

Questions are to be read exactly as they were written

Questions are to be read at normal speed (not too fast or too slow)

Only questions relevant to the respondents would be asked (skip rules are to be followed)

Exact answers of the respondents are to be coded; interviewers are not allowed to interpret responses

Where the respondents have difficulty understanding the questions: the question or part of it is repeated, probing is used according to the general instructions that are given.

Appearance and behavior of the interviewers are to be professional none is to show any reactions to the respondents' answers.

Pre-testing of the tools shall be done and data management is to be executed professionally.

Respondent bias and researcher bias will be checked by random selection of eligible patients.

Data collection process was monitored by researchers to ensure that questionnaires were correctly filled.

3.12 Data Analysis

The findings was analyzed statistically using micro soft excel 2007 and was presented in the form of percentages, frequency tables, graphs, and pie-charts.

The analysis was made using variables such as age of the respondents, religion, and sex, level of education, access to health facility, and carder of the staff.

3.13 Ethical Considerations

The ethical clearance to carry out the study was obtained from the dean school of Allied health sciences, Kampala international University which was taken to the executive director KIU-TH so as to get permission to have access to the obstetric and gynecological ward (maternity)

A verbal consent was obtained from the mothers who had come to deliver so as to access information through questionnaires.

Assurance was given to respondents that all information would be treated with at most confidentiality, and that they were free to quit the study any time they want.

CHAPTER FOUR

STUDY FINDINGS

Presented are the findings from a sample of 70 mothers, data was analyzed in terms of percentages and frequencies and presented in frequency distribution tables, short statements, pie charts and bar graphs.

4.1 SOCIO-DEMOGRAPHIC OF MOTHERS WHO CAME TO DELIVER AT KIU-TH.

Most of respondent by age of the mothers 25(35.7%) were aged between 31-36years, while minority 10(14.3%) were aged between 43-45years.

Majority of respondents 30 (42.9%) were Banyankole .However 20(28.6) of the respondents were Bakiga, 10(14.3%) Batoro, 07(10%) Baganda and only 03(4.3%) of them belonged to other tribes

The majority of respondents 30(42.9%) were Catholics. However 15(21.4%) were Protestants, 20(28.6%) Muslims and others 05(7.1%) were from various religions like Seventh day Adventist and born again churches.

Most mothers 26(37.1%) were peasants, 19(27.1%) were self-employed, 15(21.4%) were civil servants, and finally others were 10(14.3%)

Majority of the mothers 23(32.9%) were never married, 20(28.6%) were married, 14(20%) were widowed and 13(18.6%) were separated.

According to the study, the majority of the respondents 24(34.3%) completed upper primary. However, 17(24.3%) of the respondents completed O level, 15(21.3) A level, 10(14.3%) tertiary institutions and only 4(5.7%) attained lower primary education.

The detail of the demographic data is summarized in the table below

Age of respondents	Frequency	Percentage
18-25	05	7.1
26-30	15	24.4
31-36	25	35.7
37-42	15	21.4
43-45	10	14.3
	70	100
Tribe of respondents		
Banyankole	30	42.9
Bakiga	20	28.6
Batoro	10	14.3
Baganda	07	10
Others	03	4.3
	70	100
Religions of respondents		
Catholics	30	38.5
Protestants	15	26.9
Muslims	20	19.2
Others	05	15.4
	70	100
Occupations of respondents		
Civil servants	15	21.4
Self employed	19	27.1
Peasants farmer	26	37.1
Others	10	14.3
	70	100
Marital status of the respondents		
Married	20	28.6

Never married	23	32.9
Widowed	14	20
Separated	13	18.6
	70	100
Educational level of respondents		
Upper primary	04	5.7
Lower primary	24	34.3
S.1-S.4	17	24.3
S.5-S.6	15	21.3
Tertiary institution	10	14.3
Total	70	100

4.1 TABLE 1. KNOWLEDGE OF MOTHERS ABOUT BIRTH PREPAREDNESS.

Mothers who had	Frequency	Percentage (%)
Knowledge	64	92
No knowledge	06	08

Most of the mothers 64(92%) had knowledge about birth preparedness and very few, 6 (08%) had no knowledge about birth preparedness.

4.1.1 TABLE 2: INFORMATION ABOUT BIRTH PREPAREDNESS TO MOTHERS

Source of information	Frequency	Percentages
Health worker	30	42.9
Radio	25	35.7
News paper	10	14.3
Friend	05	7.1
Total	70	100

The majority of the respondents 30(42.9%) heard the information about birth preparedness from health workers. Whereas 25(37.5%) heard it from the Radio,10(14.3%) New papers and only 5(7.1%) of the respondents heard it through friends.

4.1.2 TABLE 3: MOTHERS WHO HAD HEARD ABOUT BIRTH PREPAREDNESS BEFORE.

Birth preparedness	Frequency	Percentage number of mothers
Had idea (Yes)	64	92
Had no idea (No)	06	08
Total	70	100

The majority of the respondents 64(92%) had heard knowledge about birth preparedness while only 06(8%) had no idea about birth preparedness.

4.1.3 FIGURE 2: KNOWLEDGE OF MOTHERS ABOUT ANC SERVICES.

Mothers had	Frequency	Percentage (%)
Knowledge		
No knowledge		

The majority of the respondents 62(89%) had knowledge about ANC while on a few of them 8(11%) did not have any knowledge about ANC.

4.1.4 TABLE 4: KNOWLEDGE OF SERVICES OFFERED AT ANC VISIT.

Knowledge about ANC services	Frequency	Percentage of respondents
Counseling of mothers	35	50
Health Education of mothers	21	30
Testing of mothers	11	16
I don't know	03	04
Total	70	100

The majority of the respondents 35(50%) said counseling of mothers are done at ANC. However 21(30%) said health education of mothers is done at ANC visit, 11(16%) said mothers are tested for conditions like malaria, and 3(4%) of the respondents did not know services offered at ANC.

CHAPTER FIVE

5.0 INTRODUCTION, CONCLUSION AND RECOMENDATIONS

This chapter entails the discussion, recommendations and conclusions of the study findings collected at Kampala University International Teaching Hospital in chapter four.

5.1 DISCUSSION

A total number of 70 mothers were interviewed at KIU-TH from 21ST/APRIL/2017 to 4TH/JUNE/2017.

5.1 SOCIODEMOGRAPHIC DATA OF MOTHERS

5.1.1 AGE DISTRIBUTION

According to the study findings the majority of the respondent 25(35.7%) were aged 18-25 years. However, 19(27.1%) of the respondents were aged 26-30, 11(5.7%) aged 31-36), 10(14.3%) aged 37-42) and only 5(7.1%) were aged 43-45. This revealed that, mothers of younger age were not much knowledgeable about birth preparedness (saving money, identifying transportation, identifying a skilled birth attendance and buying delivery items or materials). While older mothers had much experienced on birth preparedness and complication readiness, recognize dangers signs such as foul smelling vaginal discharges, vaginal bleeding, and abdominal bleeding. This is be closed to a study done in Nigeria which showed that Women with history of obstetric problems during the previous pregnancy were more likely to be knowledgeable on danger signs when compared to those who had no complications in prior pregnancy. Women who were knowledgeable on danger signs were four times more likely to be knowledgeable on BPCR as compared to those who were not knowledgeable (Mbalinda et al., 2014).

5.1.2 TRIBE OF RESPONDENTS

Pertaining tribe of the respondendents, the study area is inhabited by majorly the Banyankole, 30(42.9%).However 20(28.6) of the respondents were Bakiga, 10(14.3%) Batoro, 07(10%)

Baganda and only 03(4.3%) of them belonged to other tribes. the respondents that belonged to other tribes came to do business as a family, work, while some came to study.

5.1.3 RELIGION OF RESPONDENTS

The majority of respondents 30(42.9%) were Catholics. However 15(21.4%) were Protestants, 20(28.6%) Muslims and others 05(7.1%) were from various religions like Seventh day Adventist and born again churches.

5.1.4 OCUPATION OF THE RESPONDENTS

Most mothers 26(37.1%) were peasants, 19(27.1%) were self-employed, 15(21.4%) were civil servants, and finally others 10(14.3%) worked as casual labours .This gives a clear indications that the majority of the respondents are low income earners. this is the major factor causing inadequate and timely birth preparedness and complication readiness.

5.1.5 MARITAL STATUS OF THE RESPONDENTS

Majority of the mothers 23(32.9%) were never married, 20(28.6%) were married, 14(20%) were widowed and 13(18.6%) were separated.

5.1.6 EDUCATION LEVEL

According to the study, the majority of the respondents 24(34.3%) completed upper primary. However, 17(24.3%) of the respondents completed O level, 15(21.3) A level, 10(14.3%) tertiary institutions and only 4(5.7%) attained lower primary education. this clearly indicates that the level of education above primary was significant to the mothers knowledge of birth preparedness and complication readiness. This study is close to that done by Deblew and friends in which they documented in their study that the status of birth preparedness and complication readiness was 23.3%. Being in urban residence and having health center within two hours distance were among the higher level factors increasing birth preparedness and complication readiness. Educational status of primary or above, husband's occupation of employed or merchant, third or above wealth quintiles, knowledge of key danger signs during labor, attitude and frequency of antenatal care

visits were among the lower level factors found to increase the likelihood of preparation for birth and its complications (Debelew, et al., 2014)

5.1.7 KNOWLEDGE OF MOTHERS ABOUT BIRTH PREPAREDNESS

Most of the mothers 64(92%) had knowledge about birth preparedness and very few, 6 (08%) had no knowledge about birth preparedness.

5.1.8 MEDIA THROUGH WHICH MOTHERS HEARD ABOUT BIRTH PREPAREDNESS

When asked the media through which they heard the information, the majority 30 (42.9%) said they heard the information about birth preparedness from health workers. Whereas 25 (37.5%) heard it from the Radio, 10(14.3%) New papers and only 5(7.1%) of the respondents heard it through friends. This implies that with more health education particularly on maternal programs should be emphasized on all forms of media because this would increase mothers access to information and better utilization of the available medical services

5.1.9 KNOWLEDGE OF SERVICES OFFERED AT ANC

According to the study obtained, the majority of the respondents 35(50%) said counseling of mothers are amongst the services offered at ANC. However 21(30%) said health education of mothers is done at ANC visit, 11(16%) said mothers are tested for conditions like malaria, HIV/AIDS, and others. While only 3(4%) of the respondents did not know services offered at ANC.

5.1.11 ANTENATAL VISIT SCHEDULED

Most of the mothers 49(70%) had three ANC visit, followed by 8(12%) of the mothers who visited ANC two times and few mothers 6(08%) who only had one ANC visit.

5.2 CONCLUSION

Demographically the majority of the respondents were married catholic with average level of education and major occupation being self-employment hence low income earners

Regarding knowledge, most of the mothers had knowledge about birth preparedness ().The main source of information were from health workers and radio.

ANC clinical services were being utilized by the majority of the mothers in the area. They were being counseled, health educated, and tested for conditions such as malaria, HIV/AIDS. Few mothers did not know about ANC services

5.3 RECOMMENDATIONS

As indicated by the findings of the study, the following recommendations were made.

The government should empower women through women's group, open SACCOS for them and provide provide startup capital for them. This will improve their standard of living and their standard of living

Maternal health programs should be emphasized on all forms of media to increase mother's access to information

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Appendix III: CONSENT FORM

Good morning / afternoon madam. By names I am **Ocedo Andrew** a student offering a diploma in Clinical Medicine and Community Health. I am carrying out a research of the topic “factors hindering birth preparedness among women who come to deliver at KIU-TH, Bushenyi District”.

This research is a prerequisite for the award of a **Diploma in Clinical Medicine and community Health** by the School of Allied health Examination Board of Kampala International University.

Therefore I would like you to offer for me a little of your time 30 – 45 minutes to interact with you and help me fill the questionnaire provided

The information collected is for academic purposes and shall be kept confidential

Signature..... date.....

Name.....

Data collection tool

Appendix IV: QUESTIONNAIRE

PART A: Demographic Data

1. Age..... (Completed in years)
2. Marital status
 - a) Married/cohabiting [] b) Never married [] c)Widowed []
 - d) Divorced [] e) Separated []
3. Tribe.....
4. Education level
 - a) Never [] b) P.1 – P.4(lower primary) [] c) P.5 – P.7(upper primary)[]
 - d) S.1 – S.4 [] e) S.5 – S.6 [] f) Tertiary []
 - g) Others (specify.....)
5. Religion
 - a) Catholic [] b)Protestant [] c)Muslim []
 - d) Others (specify.....)
6. Occupation
 - a) Civil servant [] b) Peasant farmer [] c) Self-employed []
 - d) Others (specify.....)
7. Main occupation of the head of house hold.
 - a) Peasant [] b) Formally employed [] c) Businessman []
 - d) Unemployed []

SECTION B: Knowledge of mothers about birth preparedness.

8. Have you ever heard of birth preparedness?

a) Yes [] b) No []

9. If yes, what is birth preparedness?

- a) Attending to all ANC services [] b) plan for where to give birth []
- b) Plan for saving money [] d) Plan for a birth attendance [] d) All of them (a, b,c and d)[]

10. How did you know about birth preparedness?

- a) Through friends [] b) Through radios []
- c) Through a health worker [] d) through newspapers []
- e) Others specify.....

11. Have you ever heard of antenatal care (ANC) services in the nearest facility?

a) Yes [] b) No []

12. How did you know about antenatal care?

- a) Through friends [] b) Through radios [] c) Through a health worker []
- d) Through newspapers []

13. What kind of services do they normally offer at the antenatal clinic?

- a) Counseling of mothers [] b) health educating of the mothers []
- c) Testing of mothers [] d) I don't know []

16. How many times did you attend antenatal care?

- a) Once [] b) twice [] c) three times [] d) more than three times []

17. Do you know your expected date of delivery?

a) Yes [] b) No []

A MAP OF UGANDA SHOWING BUSHENYI DISTRICT.



KEY



BUSHENYI DISTRICT

A MAP OF BUSHENYI DISTRICT SHOWING KAMPALA INTERNATIONAL UNIVERSITY TEACHING HOSPITAL



KEY

 KIU-TH

