FACTORS AFFECTING WOMEN'S MATERNAL HEALTH IN MPOWNDE IHUBIRIHA SUB-COUNTY, KASESE DISTRICT

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A RESEARCH REPORT SUBMITTED TO THE COLLEGE OF HUMANTIEIS AND SOCIAL SCIENCES INPARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A BACHELORS DEGREE IN DEVELOPMENT STUDIES OF KAMPALA INTERNATIONAL UNIVERSITY

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DECLARATION

I, KYAKIMWA ANGELLA RAHAB hereby declare that this research report has never been presented to any university or higher institution of learning for the award of degree or its equivalent. All the work is original except where the sources are referenced in the reference list.

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KYAKIMWA ANGELLA RAHAB

Date...08/05/2019.....

APPROVAL

This research report has been submitted with my approval as the students' University supervisor.

Signature: ..... Asheila .....

Madam Sheila Abaasa

Date..... 08/05/2019 .....

DEDICATION

I dedicate this piece of work to GOD for the gift of life and wisdom He has given me. I also dedicate it to my guardians Mr. and Mrs. Muwonge Richard and to my dear brothers and sisters.

ACKNOWLEGEMENT

I wish to express my gratitude to all people whose support has enabled me to complete my studies.

First I wish to acknowledge my beloved guardians Mr. and Mrs. Muwonge Richard, thank you for sponsoring my education and raising me into a responsible citizen. Without their support I wouldn't have accomplished my studies.

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I cannot forget to acknowledge my beloved mother Ithungu Magrate, sisters Asiimwe Lilian, Ithungu Gloria and brothers Mbambu Mariam Delilah, Samson Bwambale, and other relatives. Thank you for your generous contributions towards my education. Thank you for your love, care and financial support.

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May God bless you all.

TABLE OF CONTENTS

ABSTRACT

This study sought to examine the factors affecting utilization of maternal health in Mpondwe Ihubiriha sub county, Kasese District. The study was guided by three specific objectives which included; to find out the factors affecting the utilisation of maternal health care services in Mpownde Ihubiriha Sub county to examine the causes of increased maternal deaths in Mpownde Ihubiriha Sub county and to come up with possible ways of improving maternal health in Mpownde Ihubiriha sub county. The study used descriptive design which was explanatory in nature and it was based on quantitative and qualitative approaches. A sample of 40 respondents was used for data collection. The data instruments used were the questionnaires, observation and interviews.

The findings revealed that income levels, availability and accessibility of health facilities is a very important factor affecting utilization of maternal health care services. Others factors included having a supportive spouse and the position of a woman at work place. On causes of increased maternal deaths, the study revealed that teenage pregnancy, poor nutrition, chronic illnesses like HIV/AIDs, Cancer, etc, are the major causes of increased maternal deaths in Mpownde Ihubiriha sub-county. The results suggested that if education and literacy levels of women is improved, maternal mortality can as well be reduced. Reducing workload for pregnant mothers, provision of free antenantal and prenatal care as well as embracing the problems of poverty were suggested as mitigation measures to maternal deaths.

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This chapter presents the background to the study in terms of different perspectives. It also includes the statement of the problem, purpose of the study, objectives, research questions, scope and significance.

1.1 Background to the study

According to Marnach et. al., (2013) medically, maternal and prenatal health is of particular concern among women who are pregnant or parenting. The worldwide incidence of premature birth, low birth weight and infant mortality is higher among adolescent mothers especially Teenage mothers between 15-19 years old were more likely to have anemia, preterm delivery and low birth than mothers between 20-24 years old physiologically for the child as well as the mother. In addition, the association between the number of antenatal visits and the outcome of pregnancy is not a simple causal relation (Hall et al., 2004).

An important bias is caused by the fact that pregnancies ending preterm often have an unfavourable outcome; because most antenatal visits take place in the third trimester the number of visits in such pregnancies is usually small. In Finland in an extensive study a U-shaped relation was found between the number of antenatal visits and an unfavourable outcome of pregnancy. The best outcomes were found in the group of women with an average number of visits (Gissler & Hemminki, 19943).

Worldwide, maternal and child healthcare services are very important for the health outcomes of the mother and that of the child by ensuring that both maternal and child deaths are prevented from any harm (Deepak, 2018) Mothers risk so many health complication in the process of bring a new born in the world in addition to the risk of dying during pregnancy and childbirth, many more women suffer from short and long-term maternal disabilities and illness. According to WHO (2001) for every maternal death, an estimated 30 to 50 women suffer pregnancy related health problems such as vesicovaginal fistulae, infertility, and depression that can be permanently debilitating.

The Human Rights Committee has consistently expressed concern over high rates of maternal mortality, which it considers a violation of women's right to life. The Committee has linked high maternal mortality rates to the inadequate availability of family planning services, early childbirth, and harmful practices, including child and forced marriage and female genital mutilation (FGM) (Ssekitoleko, 2015). Maternal mortality can happen while a woman is pregnant, during labor and delivery, or in the 42 days after childbirth or the termination of pregnancy. If a woman passes away from an accident or a health issue that doesn't have anything to do with the pregnancy, then it is not considered a pregnancy-related death.

In practical terms, maternal mortality has been increasing due to factors such as lack of access to medical facilities, HIV/AIDS. However, various efforts have been made to avert the causes these included family planning, maternal nutrition, and free antenatal care services in some hospitals. However, there is a gap for access for rural women and lack of focus on critical periods in the health of women and their infants and adopting a series of interventions that target specific risks (Agarwal, 2007).

In Africa, the problems of maternal health and nutrition are so common though there are modifiable risk factors that must be addressed as part of infant mortality efforts. While maternal health is not the only factor in infant mortality reduction, it is part of a complex whole of interventions necessary to make a sustained difference (UNFPA, 2010). A focus on maternal health is not a new approach to reducing infant mortality. However, it is often inadequately addressed and must be integrated into all reduction and prevention activities. Maternal health has been found to have negative and social long lasting effects on the life of the mothers themselves and their children (Omrana et. al, 2013).

Utilization of maternal care service in many African states is relatively poor as reported by Sabyasachi (2018). The variations in utilizing maternal health care services and factors affecting its utilization varied by geographic area and socioeconomic and cultural settings in the country which calls for investigation of area and culture specific determinants of maternal health care utilization. For example the high rate of maternal mortality reported in The Gambia is influenced by many factors, such as difficulties in

accessing quality healthcare and facilities. In addition, socio-cultural practices in rural areas may limit the resources available to pregnant women, resulting in adverse health consequences. The risk of maternal mortality is higher for adolescent girls, especially those under age, 15 compared to older women.

Uganda since 1986 has embarked on major reforms both in the health sector and wider public health nutrition arena. In the health sector, the immediate emphasis was on rehabilitation of the existing facilities to restore functional capacity, and a shift of emphasis to Primary Health Care with a defined Minimum Package of cost-effective services (MoH, 2010). As in other developing countries, bilateral and multilateral development partners increased funding to the nutrition health sector and encouraged alternative mechanisms of financing nutrition services.

In the early 2000's the Ugandan government embraced Decentralization as part of crosscutting Public health nutrition Sector Reform whereby the central government through its Ministry of Health mandate remained nutrition policy formulation, standard setting guidelines and resource mobilization, where the nutrition practices of infant & young child feeding, maternal and child health nutrition mandate was to implement the policies and mobilize additional resources at the hospital level.

Public nutrition institutions such as Mwana Mugimu in Muago hospital were restructured and strengthened as part of wider Structural Nutrition Adjustment Programmed (MoH, 2010). During this period, the nutrition health, economy and other social indicators were all on the rise -improved access to safe drinking water food security, diet diversity, improved farming methods, better farming tools and improved seed variety, improved pit-latrine coverage and better nutrition at the household level all contributed to improvement of nutrition health status.(Matsiko and Kiwanuka, 2003).

Uganda has been implementing reforms in the health sector since 2011to reduce mortality and morbidity. The burden of disease among maternal, newborn and children is high in Uganda and this is constraining economic development because of the severe impact on the family and society in general (Kusters and Onama, 2004). Investment in child health

is not only a priority for saving lives but is also critical to advancing other goals related to human welfare in terms of growth and development, equity and poverty reduction. Almost 90% of all deaths among children under 5 years are attributable to poor feeding practices such as optimal breastfeeding with also infant and young child feeding (IYCF) and the six conditions (acute neonatal conditions, mainly from pre-birth, birth asphyxia and infections, lower respiratory infections mostly pneumonia, diarrhea, measles, malaria and HIV / AIDS). Most of these diseases are preventable through existing interventions that are simple, affordable and effective. These include oral rehydration therapy, antibiotics, anti-malarial drugs and insect treated nets, vitamin A and other micronutrients, promotion of breast-feeding, immunization and skilled care during pregnancy and childbirth (GAVI 2004).

1.2 Statement of the Problem

Child bearing is one of the hazardous experiences that women engage in while bringing new life to this world. It is often associated with complications that may cause morbidities, disabilities, and mortalities (Sabyasachi, 2018). The Ugandan Ministry of Health has embarked on improving maternal health in the 21st century, however concerns over the limited availability of programs and services and the lack of adequate data in the area of maternal, including data on early marriage and pregnancy have been raised. Cases related to complications resulting from illegal abortions and high infant and maternal mortality have been reported by the Uganda Demographic Health survey (2011). 18 per cent of teenage mothers and 12 per cent of young women have suffered from maternal related complications (MoH, 2013) in Kasese district alone. Mpowndehubiriha Sub-County is one of the sub counties that experience the high maternal mortality ratios in Kasese District. Women suffer long-term disabilities due to complications during pregnancy, delivery, or postpartum periods. Factors contributing to such pregnancy and child birth associated health complications have not been investigated in Mpownde Ihubiriha sub county hence a need for this study.

1.3 Purpose of the study

This study intends to investigate the factors affecting maternal health in Mpownde Ihubiriha sub county, Kasese District.

1.4 Objectives of the study

i. To find out the factors affecting the utilisation of maternal health care services in Mpownde Ihubiriha Sub county.
ii. To examine the causes of increased maternal deaths in Mpownde Ihubiriha Sub county
iii. To come up with possible ways of improving maternal health in Mpownde Ihubiriha sub county

1.5 Research questions

i. What are the factors affecting the utilisation of maternal health care services in Mpownde Ihubiriha Sub county.
ii. What are the causes of increased maternal deaths in Mpownde Ihubiriha Sub county
iii. What are the possible ways to improve maternal health in Mpownde Ihubiriha sub-county.

1.6 Scope of the study

1.6.1 Geographical scope:

The research was conducted in Mpownde Ihubiriha sub-county, Kasese District. Kasese district is located in western Uganda about 370 kilometers from the capital city, Kampala. The area is chosen because of the reported increasing maternal mortality in the recent years.

1.6.2 Content scope:

The study concentrated on the factors affecting maternal health, utilization of maternal health care services and lastly explored the possible ways of improving maternal health in Kasese district as a whole.

1.6.3 Time scope:

The research was conducted within a period of three months starting from March 2019 up to May 2019 based on time framework of the approval of the research proposal.

1.7 Significance of the study.

The study will help policy makers and medical personnel to recognize the critical causes of maternal mortality and implement the mitigation measures suggested in this research.

This study will provide reliable, complete and timely information for public health decision-making and action, including policy making, planning, programming, monitoring and reaching the health related issues of rural women.

The study was aimed to contribute to the understanding of the dynamics and complexities on the increasing rates of both maternal and infant mortality in rural areas. In essence, an appreciation of this relationship will go a long way into informing future strategies for controlling this development challenge.

Once proper recommendations are observed and implemented from this research that has been completed, the level will be mitigated and will help the situation as the findings will stimulate a desire for further research into the dynamics that explain the institutional challenges into curbing down the rate of mortality rates in Kasese district and uganda as a whole.

The study will complement other studies and fill in certain gaps which are uncovered. It is anticipated to be of use to a wide range of stakeholders who include Government, youths, policymakers, local authorities, local communities, human rights activists mostly, nongovernmental organizations, and researchers.

CHAPTER TWO

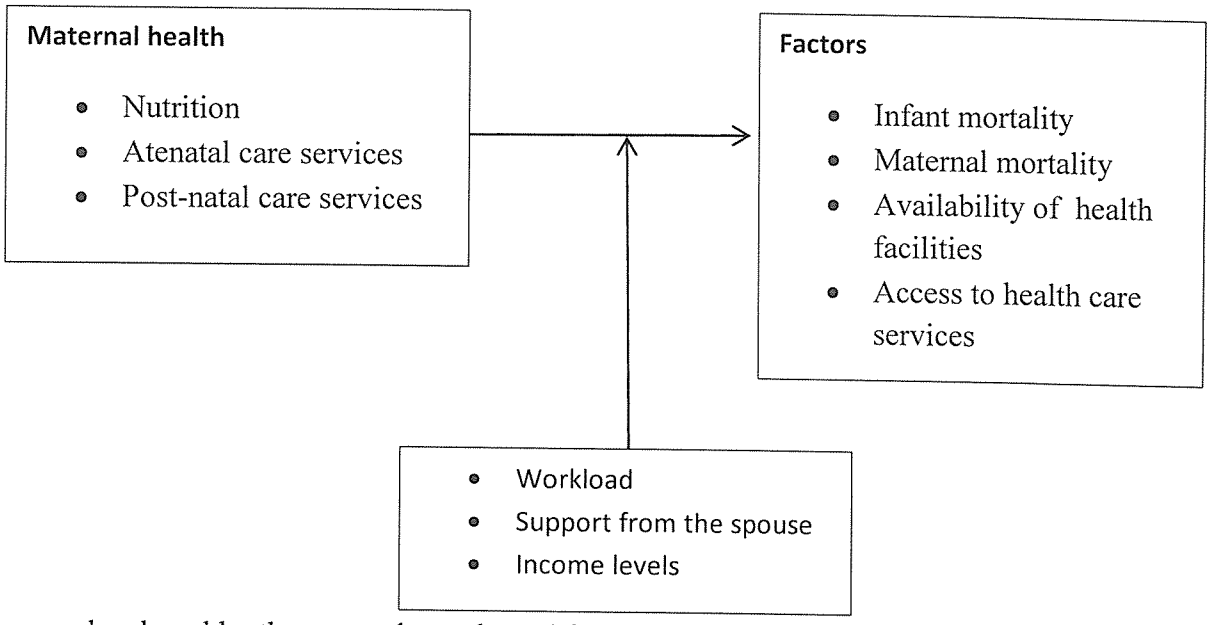
LITERATURE REVIEW

2.0 Introduction

This chapter presents the review of related studies in relation to the factors affecting maternal health and it is presented according to the themes of this study themes

2.1 Conceptual framework

Figure 1: The conceptual framework showing the factors affecting maternal health



Source: developed by the researcher, adopted from UNFPA, 2010.

The figure 1 above indicates that maternal health largely depends on the health status of a woman determined by antenatal (during pregnancy) care services received and post-natal (after child birth) services and this is also determined by factors such as availability of health services, nutrition while support from the spouse and income level of a mother are relevant factors to measure success and efficiency.

2.2 Factors affecting maternal health

Maternal health improvement has attracted global attention at the 1987 Safe Motherhood Conference held in Nairobi, Kenya. Since then, improving women's health issues pertaining to pregnancy and delivery has become the centerpiece of national development efforts in developing countries. However, despite this significant stride, there is little evidence to prove that maternal mortality has declined significantly in African countries, including Uganda (Agarwal, 2010).

A study of Cameroonian women reported that although women were generally worried about their health, the cultural background of gender roles blinded them from recognizing their right to maintaining good health (Weinger, 2007). These women considered the right to good health as contingent on fulfilling their purpose of taking care of and meeting the needs of "others" (such as husbands) at the expense of their own physical health and well-being. There is a religious and socio-cultural dimension for this consideration.

In a study among the Hausa of Northern Nigeria, Afonja (1998) found that the most important factors contributing to maternal deaths include an Islamic culture that undervalues women; a perceived social needs for women's reproductive health capacities to be under strict male control and the practice of purdah (wife seclusion), which restrict women's medical care; almost universal female illiteracy; marriage at an early age and pregnancy often occurring before maternal pelvic is complete and harmful traditional medical practices among others.

According to Dixon et al. (2014) intra-household dynamics impact male/female enrolment in national health insurance in Ghana. In this case mothering often prevented women from enrolling. Similarly, another study in Mali found women's own perceptions of their self-efficacy and the value of women in society as determinants for their preventive and health seeking behavior. A study in Benin Republic also reported that factors like husbands' approval and money for treatment had negative effects on maternal health seeking behavior . This finding shows the lack of decision-making autonomy and economic independence of women.

According to the 1992 survey, AIDS ranked fourth, responsible for ten per cent of deaths after diarrhoea (11.7%) and measles (18.8%); it was third by 1995 data, accounting for 11.9 per cent of deaths. However from the vital registration data AIDS accounted for only 4.8 per cent of the deaths and it was the fourth leading cause of death. Unreported causes of death were responsible for 7.6 per cent in the 1992 survey and 13.7 per cent in 1995.

The burden of malaria in Uganda is high with estimated 70-100,000 deaths per year among children under 5 years of age and between 10 and 12 million clinical cases treated in the public health system alone. The National Malaria Control Strategy has lead to progress towards effective malaria control through ITNs and internal residual spraying (IRS) in low lying and epidemic prone areas.

In 2010, the Global Strategy for Women's and Children's Health was launched by the office of the United Nations Secretary-General. The Initiative calls for a bold, coordinated effort around MDGs 4 and 5, building on what has been achieved so far - locally, nationally, regionally and globally. It calls for all partners to unite and take action – through enhanced financing, strengthened policy and improved service delivery.

Women's decision-making autonomy may be explained in relation to their lack of education and limited influence over material resources. Women's land rights in particular have been a major focus of empowerment efforts, yet only in a few countries do women constitute even one-quarter of the landowners . This gender disparity in land ownership impacts the economic status of women and further perpetuates a high level of dependency on their husbands, leading to male dominance (Azuh, 2015). Adding another voice to this discussion, Hansford et al. (2014) observed that although women may have access to land or retain control over their own income, many have no influence on the use of their husband's income. This may mean that women are particularly unlikely to make independent decisions about how money should be spent on high-expenditure items, including healthcare services.

The dynamics of the relationship between a woman and her husband can also determine a woman's access to healthcare and can lead to varying levels of partner-controlling behaviors, such as gender-based violence (Namasivayam, 2012), which studies have shown is associated with poor maternal health. A survey among antenatal care clinic attendees in The Gambia in 2011 revealed (61.8%) prevalence of intimate partner violence among study subjects, with 12% requiring medical care and 3% prevented from seeking healthcare as a result of such violence (Idoko , et. al, 2015). Another study in Matlab, Bangladesh, found that homicides and suicides that were motivated by stigma over unwanted pregnancy, beatings or dowries accounted for 6% of all maternal deaths in 1986 (Heise, 1993). Taken together, these issues highlight the consequences of women's living conditions in relation to their disadvantaged experiences, which are also connected to the gendered effects of socio-cultural practices affecting maternal health. This underscores the significance of this study, whose objective was to examine the factors affecting maternal health pertaining to pregnancy and delivery.

2.3 Causes of increased maternal deaths in Mponde Ihubiriha Sub county

In countries with a good economy, modern technology, and access to healthcare, the chances of dying during pregnancy, in childbirth, or in the days and weeks after delivery are very low. In places such as the United States, the United Kingdom, and Canada, most women have healthy pregnancies and births. Of course, there is still a small risk of maternal death, even in developed countries. However, maternal deaths are common in developing countries and believed to be caused by the following:-

Severe cases of malaria

In large regions of the world malaria is endemic. There is good evidence that parasitaemia is more common and heavier in children under five and their mothers, and that during pregnancy placental infection occurs. This leads to consequences for both mother and fetus (Lalloo, 2000). Frequently malaria is not controlled or treated well in adolescent pregnancy, because antenatal care in adolescents is often deficient (Okonofua et al., 1992; Brabin et al., 1998). In endemic areas malaria is an important cause of anaemia, especially during pregnancy, together with nutritional deficiencies. In

Mozambique, malaria is one of the most important causes of maternal and infant mortality (Granja et al., 2001).

Teenage pregnancy

Pregnancy that happened at teenage age is predominantly, due to lack of sex education therefore, parents responsibility to deliver an adequate sex education to their teenage daughters. Reproductive health situations are also important to be imparted to the young child so that they become aware of the various aspects related to sex and pregnancy.

According to the report by the UNICEF (2001), worldwide every 5th child is born to teenage mother is in most cases likely to be born with low weight, malnourish and difficult to make it to five years. Worldwide 13 million births each year occur to girls younger than 19 years. The incidence of teenage pregnancies varies dramatically between the different countries. Approximately 90% of the teenage births occur in developing countries. Nevertheless, there is also a significant variation in teenage pregnancy and birth rates between developed countries, although the teenage pregnancy and birth rate of developed countries are significantly lower than that of developing countries.

In many countries large numbers of adolescent pregnancies and births are reported. If, as is usual in health statistics, it is births which are counted (as opposed to pregnancies) then this figure will depend to a large extent on the number of spontaneous and induced abortions. Although the number of spontaneous abortions probably does not differ substantially (even in various populations) the rates of induced abortions are widely divergent in different countries and among different social or ethnic groups. In some countries the registration of legally induced abortions is reliable, but in other countries (and in relation to illegal and unsafe abortion) figures are often based on rough estimates or even speculation.

Limited capacity of health facilities to manage pregnancy complications and early childhood development, despite it being a major contribution to maternal illnesses, it equally leads to infant mortality. According to Mbonye (2011), of the 100 rural women,

20% have access to health facilities given their socio-economic status and support from their husbands. This is coupled with high levels of HIV/AIDs prevalence in rural areas and poor service availability for post natal care. This leads to mothers transmitting the infection to their babies.

Poverty

In developing countries, comparable relations between poverty and adolescent childbearing are observed. According to Angodia (2009), a multidisciplinary study was conducted aimed at understanding the complex social, economic, cultural and psychological contexts of unwanted and adolescent pregnancy. The information originated from in-depth interviews with adolescent girls. One of the main conclusions was that in Nicaragua unwanted pregnancy is to a large extent just another characteristic of poverty. Almost all of the women approached (for whom an unplanned pregnancy was both a frequent condition and a serious problem) came from and still lived under circumstances that could be described as destitution. Typically these women grew up in broken families with no or very poor contact with their fathers. Poor economic conditions, low self-esteem and lack of moral support from home implied early dropout from school.

Material dependency, the craving for emotional affection, lack of alternative opportunities and culturally sanctioned female subordination to machismo values leave very few options for a poor woman other than the physical and material protection of a man as a last resort (Berglund et al., 1997).

As a general rule, poverty leads to increased childbearing among adolescents too, because the greater the disadvantage within a population, the less difference adolescent childbearing makes in determining long-term success. Poor people have few opportunities and reasons to avoid or delay childbearing, and simply see no reason not to get pregnant (Furstenberg, 1998; Mawer, 1999).

Socio-economic factors: Childhood environment, lower educational and income levels have also been associated with high rates of child mortality because of negligence towards birth control methods and rigidity to access medical care. Similarly, Access for unmarried adolescents to contraceptive services is difficult in many countries. In the USA adolescents who wish to use contraceptives that require a prescription or insertion by a clinician often delay seeing a clinician for a contraceptive prescription until they have been sexually active for one year or more (American Academy of Pediatrics, 1999). The immature and irresponsible behavior arising due to complex teenage psychology is another important cause of teenage pregnancies. Teenagers often go through a number of emotions because of their own transition from childhood and peer pressure. In addition, weak family relationships fail to provide the emotional support that teenagers require. This lack of attention and affection from family resulting in depression forces them to seek love and support from other people, especially members of the opposite sex.

Anaemia

The increase in plasma volume and the subsequent decrease in haemoglobin concentration and haematocrit in normal pregnancy complicate the assessment of anaemia. WHO (2009) defines the minimum haemoglobin concentration in normal pregnant women as 11.0 g/dl the minimum haematocrit level is 0.31 g/dl (Letzky, 1991). In fact there are good reasons to set the minimum haemoglobin value somewhat lower than 11.0 g/dl because haemodilution in normal pregnancies may decrease this level to 10.4 g/dl (Van den Broek, 1998). Severe anaemia is haemoglobin <7.0 g/dl. A number of studies have reported on the prevalence of anaemia among children born to adolescent mothers compared to older pregnant women consequently resulting to both maternal and infant mortality. In their review of hospital-based studies up to 1993, Scholl et al. (1994) reported no statistically significant differences in the prevalence of anaemia in adolescents compared to adults in six studies from the USA. However in one hospital-based study in the United Kingdom, Osbourne et al. (1981) reported a two-fold statistically significant increase in the relative risk of anaemia (<10 g/dl) in adolescent pregnant women compared to adults in Glasgow.

The worldwide pandemic of HIV casts its shadow on childbirth, especially in developing countries. In some countries in Southern, East and Central Africa 20–30% of all pregnant women are infected. The infection is also spreading rapidly in South-East Asia and Eastern and Central Europe. In many countries however prevalence remains relatively low. The main concern with respect to childbirth is the vertical transmission of HIV from mother to infant during pregnancy, labour and postnatally through breastfeeding (WHO, 1998b). In developed countries, transmission rates in untreated non-breastfeeding populations have ranged from 14–25% compared with 13–42% among breastfeeding populations in resource-poor settings (Working Group on Mother-to-Child Transmission of HIV, 1995). With the advent of antiretroviral (ARV) therapy during pregnancy in developed countries, much lower transmission rates are now described (WHO, 1998c; De Cock et al., 2000). In the USA in 1990, the transmission rate was 22.7% in the absence of ARV therapy, but in 1999 studies involving the use of ARV combination therapies starting early in pregnancy have reported a fall in the transmission rate to 3.3% (Farley et al., 2002)

Each year, about 3,000 pregnancies are affected with neural tube defects. Studies have shown that up to 70 percent of these could be prevented if women consumed sufficient folic acid before pregnancy and during early pregnancy. A systematic review summarized results of studies that evaluated whether prenatal folic acidfortified multivitamins were protective against congenital anomalies. Use of multivitamin supplements was consistently protective against neural tube defects, cardiovascular defects, and limb defects (Goh et al. 2006). Only 18 percent of women of childbearing age know that folic acid prevents birth defects, and only 12 percent know it should be taken before pregnancy. Of the women who are aware of folic acid, 54 percent learned about it from the media, but only 33 percent from their physician or other health care provider.

Alcohol and Substance Abuse

Heavy alcohol consumption during pregnancy can lead to a combination of physical and mental birth defects called fetal alcohol syndrome (FAS), which affects both then mother

and the unborn. Roughly one in 1,000 newborns annually is affected due to drug abuse (Angodia, 2009). Alcohol abuse is the leading known preventable cause of mental retardation.

2.4 Ways of improving maternal health.

The Uganda parliament has been very engaged in promoting budget and policy support for women's and children's health at the national and global levels. Benefiting from many caucuses that are interested in achieving Vision 2040, Ugandan parliamentarians have passed a legislation to protect women during and after pregnancy through provisions in the national employment Act and Labour Act, Members of parliament in Uganda have also mandated the creation of clear budget lines for MNCH19.

One of the Millenium Development Goals (MDGs) is to reduce *under-five* mortality by two thirds between 1990 and 2015. This paper uses infant rather than under-five mortality because it allows for significantly larger and more relevant samples. To avoid censoring children who are not yet five, an analysis of under-five mortality would need to discard data for the children born within five years before the survey date, rather than one year in the case of infant mortality.

Among other problems, this would preclude an analysis of the impact of vaccinations on mortality because the latter are available only for children born with five years of the survey date. To make our analysis relevant to the MDG, then, we apply the same goal of a two-thirds reduction in infant mortality between 1990 and 2015, a goal that policy makers in Uganda have already accepted (Ministry of Finance, Planning, and Economic Development, 2002). In Uganda's case, this goal implies a reduction from about 90 per thousand in 1990 to about 30 per thousand in 2015. However, given that there is little evidence of improvement between 1990 and 2000, it is actually necessary to achieve the entire reduction of 60 deaths per thousand in the short period of 2000-2015. Is this possible?

Spending on women's and children's health is an investment, not just a cost, contributing to the well-being of families and communities, and to a nation's socio-economic development (Moh, 2010). Estimating costs and raising the required funds, and ensuring efficient and effective use of these resources, are key responsibilities - enabling "more money for health" and "more health for the money.

Another source of evidence of the relationship of income and maternal death comes from studies at the cross-country aggregate level. For example, Bulatao and Ross (2003) found that per capita income is negatively related to maternal mortality ratios. Conversely, Shiffman (2000), using a logistic regression, found that when maternal mortality rate is controlled by other factors like health services and education, per capita income is not significant. Rosamans et al. (2006) pointed out that cross-country differences in maternal mortality cannot be explained exclusively by income or different levels of development. For example, they said that countries like Sri Lanka and Vietnam have lower levels of maternal mortality, but have similar per capita income like Côte d'Ivoire and Yemen; they attributed the differences in maternal death to different maternal health services.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter shows how the research was conducted and the elements in it included; the research design, area and population of study, sample size and selection, area and population of study as well as the limitations of the study.

3.1 Research design

This study employed the descriptive survey design. Descriptive studies are non-experimental researches that describe the characteristics of a particular individual, or of a group. Both qualitative and quantitative approaches will also be used. No other method of observation provided this general capability. Many questions were asked about the research topic giving considerable flexibility to the analysis.

3.2 Area and population of study

3.2.1 Study Population

The population of this study included medical officers, midwives, community leaders and the local people considered as parents and guardians. The study also involve both expectant and breastfeeding mothers as subjects to maternal health. Key informants in this study will be medical officers, midwives and mothers.

3.3. Sample Size& Sample Design

The sample size used comprised a total of 40 respondents: 20 young mothers, 10 parents/guardians, 2 medical officers, 3 midwives and 5 community leaders of the people of Mpownde Ihubiriha Sub county.

The sampling method used for the informants was purposive. These were divided into three categories i.e. Medical personnel (doctors and midwives), expectant and breast feeding mothers/parents and guardians and then local leaders. The assumption is that each of the sampled informants in this category was in position to provide maximum information since they have in one way experienced or attended to issues of maternal health.

3.4 Data Collection Methods

a) Interviewing

This is one of the most recommended methods of data collection especially for social research. The method involved an interaction between the interviewer and the interviewee. The interaction was both through face to face and over the phone. For this research in particular, this method was used on almost all planned respondents including key respondents in the sample size.

b) Observation

This method involves the researcher studying the proposal subjects by critically examining them with his naked eye. The method was mainly applicable where the research subject(s) were overt. Observation as a method was very important to this research as it enabled the evidencing of the factors influencing maternal health service delivery on the people of Mponde Ihubiriha, Kasese district.

c) Questionnaire Administration

This method involved the writer to use pre-set list of questions to draw responses or opinions from the respondents. Questionnaires were used as a tool for this method and these were normally categorized as self-administered and mailed questionnaires. They were open ended especially where opinions were targeted, or closed ended where a particular emphasis was required. This method is important for this research since some of the targeted respondents were comfortable with it. Otherwise, this method was only limited to people who could read and write.

c) Document Reviewing

This is referred to as a secondary data collection method. It involved the researcher revisiting earlier records on the study subject(s) in a way of comparing notes with what had been written and recorded about the study subject or in relation to it. Such write-ups were in form of journals, newspapers, magazines, textbooks, diaries, reports, brochures, among other records. This method was more commendable on issues that were studied over time which involved trends. These were be also used in this study.

3.5 Data Validity and Reliability

Validity and reliability were secured by measuring the research instruments before setting out to the field to ascertain whether they actually provide answers to the research variables and questions.

Secondly, the researcher had to do double checking both in the field and out of the field in order to do away with omissions and errors. Reliability was also achieved by using a representative sample size for final findings drawing.

3.6 Data Analysis and Presentation

a) Qualitative data analysis

To ensure coherence, comprehensiveness, legibility and completeness, editing was used in qualitative data analysis to eliminate any error and omissions, coding was done to create data categories for classifying the data to be analyzed. i.e. code categories, themes and classifications. All this involved in the qualitative analysis of data. Data analysis was done by explaining and comparing of the extensive variations, quotation of data sources and discussion of research data so that it can be easily comprehended by the third party.

b) Quantitative data analysis

Editing was done to ensure coherence, comprehensiveness, legibility and completeness, editing was used in qualitative data analysis to eliminate any error and omissions. Coding was done to create data categories for classifying the data to be analyzed. i.e. code categories, themes and classifications. All this involved in the quantitative analysis of data. Data analysis was done by manual tabulation of data, generating rates, quantities, percentages, frequencies, and the use of Pyramid graphs (histograms). Pyramid graphs, line graph etc. This involved depicting and analyzing quantitative data presented.

3.7 Ethical Considerations

The researcher was always presentable and professional while conducting this research. This enabled her get the most relevant data from the most prominent respondents easily.

The researcher kept her word on the confidentiality of the respondents and none of their details and opinions will be shared with a third party.

The researcher did not base on stereotypical and racial demographics while soliciting for opinions from respondents.

3.8 Study Limitations

In conducting the research, a number of methodological and practical impediments were experienced as highlighted below;

Securing appointment say interviews was rather hard; the researcher thus, will be looking for alternative respondents and also became more aggressive in this regard.

Respondents may not be willing to avail the researcher with the required information due to negative attitudes, suspiciousness and speculations. In this case the researcher will highlight the importance of the study and also create awareness with the help of top level management staff.

The time allocated for conducting the research is very limited for the esearcher to cover the area of study since she has other academic obligations. The researcher therefore, will prioritize her schedule according to deadlines in order to utilize the given time effectively and efficiently.

The researcher will also be encountered with financial constraints since the study involved such costs as typing, printing, travel and telephone costs. To address this problem, the researcher will have to save some money for the study and also have to raise some more from parents and relatives just in time prior to conducting the research.

CHAPTER FOUR

PRESENTATION OF FINDINGS, INTERPRETATION AND DISCUSSION

4.0 Introduction

This chapter presents the findings of the study. For clarity, it is arranged according to the research objectives which included; to find out the factors affecting the utilisation of maternal health care services in Mpownde Ihubiriha Sub county; to examine the causes of increased maternal deaths and; to come up with possible ways of improving maternal health.

4.2. Background information of respondents

Frequency tables and percentages were used to summarize background information. They included the following, age, religion, education level, and marital status of the respondents. The results are summarized in tables below;

Table 1: Age of respondents

Variable		**Frequency**	**Valid percentage**
Age bracket	18-25	07	18
	26-30	18	45
	31-35	10	25
	36-40	03	8
	Above 40	02	5
Total		**40**	**100**

Source: Primary data

Table 1 shows that majority of the respondents were aged 26-30yrs with 45%, followed by those between 31-35 years with 25%, those between 18-25 comprised of while ages between 36-40 and above 40 years comprised of 8% and 5% respectively. This means that all respondents were mature enough to give viable information about the study.

Table 2: Religion of respondents

Religion	Frequency	Valid Percentage
Christian	18	45
Muslim	10	25
Born again	6	15
Catholic	6	15
Total	**40**	**100**

Source: Primary data, 2019

Table 2 shows that majority of respondents were Christians who comprised of 45, followed by Muslims with 255 while born again and Catholics were 15% each. The distribution of religion among the respondents was average and mostly Christians and Muslims dominated the study.

Table 3: Education level

Religion	Frequency	Percent
Primary	13	33
Secondary	19	48
Diploma	5	13
Degree	3	8
Total	**40**	**100**

Source: Primary data, 2019

Results in table 3 indicate that 33% of the respondents had acquired primary school education, 48% had studied up to secondary level while 13% had diplomas and only 8% had degrees implying that higher education levels are still low in Mponderubiriha sub county in Kasese. However, majority the respondents had acquired basic education to help them respond to the questionnaire and a cross section of different qualifications was

due to involvement of medical personnel and midwives to provide more reliable information about maternal health.

Table 4: Marital status

Religion	Frequency	Percent
Married	22	55
Single	18	45
Total	**40**	**100**

Source: Primary data, 2019

Results in table 4 shows that majority of the respondents were married (55%), while equally a significant number 45% were singles implying that that most respondents were married and atleast have had children, a subject matter that is related to this study.

4.2. Factors affecting utilization of maternal health care services in Mponderubiriha sub-county , Kasese district.

Objective one of this study was to find out the factors affecting utilization of maternal health care service in Mponderubiriha sub-county. Results are presented below;

Table 5: Factors affecting utilization of maternal health care services

Response	Frequency	Valid Percentage
Age	9	23
Availability of health facilities	18	45
Level of income	8	20
Support from the spouse	2	5
Position of women at workplace	3	8
Total	**40**	**100**

Source: primary data, 2019

4.2.1 Availability of health facilities

According to the findings in table 5, majority of the respondents 18 (45%) said that availability of health facilities is a very important factor affecting utilization of maternal health care services. This implies that Mpownde Ihubiriha sub-county being a village area, there are few health centres and sometimes accessibility is a problem because of long distances women must move hence a major factor that influencing the material health. In addition, a respondent during interviews said that;

"*Here in this village, we only go to the hospital at the onset of labor and we normally don't travel to other places in preparation for delivery because we are usually constrained the distance yet we also do a lot of work at home including caring for other family members.*

4.2.2 Age

Results also indicated that age of a mother also affects the way she utilizes or acquire maternal healthcare services, this was according to 23% of the respondents. They said that many young girls are getting pregnancy in the villages yet they have little knowledge on the importance visiting health centres for both pre-natal and post-natal services. This implies that young mothers are less likely to utilize maternal health care services than adults. During the interviews, a midwife said that:

"Teenage pregnancy is common in our community but for most girls you will only notice they are pregnant when they come for labour and brought by either a relative or a good Samaritan because some of them leave in isolation with the spouse or parents"

4.2.3 Level of income

Results further indicated that income levels are a significant factor affecting utilization of maternal health care services in Mpownde Ihubiriha Sub Coun ty. They said that a few women can afford to pay for medical and other related expenses, like transport fare, when they have to access maternal health care services implying that those without money rarely access maternal health care services.

4.2.4 Support from the spouse

According to 5% of the respondents, having a supportive spouse highly determines how frequent a pregnant woman will access and utilize maternal health care services implying that women with supporting spouses are most likely to utilize material health care services than those who husbands/spouses are not supportive. As explained by a mother, She said that: "*Whenever I want to go to the antenatal care, if I ask my husband for money for transport, his complaint is that he has no money, and if I insisted, it resulted in problems, so usually I keep quiet and stay home – I just wait for the day of delivery.*

4.2.5 Position of a woman at work place

Lastly, results indicated that the position of a woman at work place also affects her level of utilization of maternal health care services. This was submitted by 8% of the respondents - they said that particularly working class women who are employed may not have the liberty to stop their daily activities without asking for permission first and in case permission is not granted, it may be difficult for them to access medical facilities.

4.3 Causes of increased maternal deaths in Mpownde Ihubiriha sub-county

Cause	Frequency	Percentage
Maternal age	15	37.5
Poor nutrition	15	37.5
Chronic illnesses	2	5
HIV/AIDS infection	8	20
Total	**40**	**100**

Source: Primary data, 2019

Maternal age

According to the findings, 37% of the respondents submitted that maternal age and poor nutrition are the major causes of increased maternal deaths in Mpownde Ihubiriha sub-county. They attributed this to the fact that young women are subject to maternal complications as their bodies are not primarily ready for pregnancy. Respondents explained that there is an increase in the number of teenage mothers giving birth to twins

and multiple births are more often delivered at earlier gestational ages than single births, resulting in a greater risk of mortality.

In the same way 37.5 % said that poor nutrition is another cause for increased number of infant mortality in Mpownde Ihubiriha Sub County. This is because both under- and over-nutrition may place pregnant women at increased risk of an antagonistic pregnancy outcome and in most causes women in the area are not aware of the benefits of having a balanced diet. A medical personnel at the sub-county health centre explained that "Low folate levels in the preconceptional period and very early pregnancy are now recognized as a risk factor for neural tube defect among infants. The levels of obesity in the mothers especially from the rural areas are rising dramatically and place mothers at additional risk".

Chronic illnesses

It was established by 5% of the respondents that chronic illnesses like cancer, high blood pressure and tuberculosis leads to maternal mortality in the sub county. This was as well attributed to low income levels among mothers which in most cases accompanied by stress of poverty. This affects expecting mothers and the end result could be death of both the child and the mother.

HIV/AIDS infection

20% of the respondents said that HIV/AIDs is still prevalent in Mpownde Ihubiriha despite the strategic mitigation campaigns. This affects expecting mothers and their children through cervical and uterine infections. Besides other infections like asymptomatic bacterial vaginosis are now all recognized as increasing the risk of premature delivery and may be important factors in explaining higher maternal mortality rates.

According to Doctor Muwaire, he explained that if a mother is not well catered for during pregnancy in terms of nutrition and antenatal care, her health (maternal health) is most likely to be vulnerable to other complications that consequently leads to death.

Table 3: Solutions to improve maternal health and reduce infant mortality

Solution	Agree	Percentage
Education	12	30
Extension of free antenatal care services to rural women	13	33
Reduce poverty	5	13
Reduce on workload	10	25
Total	40	100

Source: Primary data

Education

According to the findings, 30% of the responses showed that women should be educated and be informed about maternal health related issues. This is because low education level is related to higher levels of maternal mortality through different ways like hygiene, lack of knowledge about the benefits of nutrition among others. The results imply that women with higher education may have some awareness about the effects of illness and treatment; and they may have a higher demand for prenatal care.

Extension of free prenatal and antenatal care services

33% of the responses showed that the government through its local governments and public health centres should extend free prenatal and antenatal care services to rural women, because due to poor economic status in the community it's difficult to for most preganany mothers to access specialists in times of needs. Hence free services for pregnant women and at a quality level in addition to equipping the available public health services with enough equipment and facilities to help mothers have safe delivery of their babies.

Poverty reduction

In the findings, 13% revealed that in order to improve utilisation of maternal health services, poverty must be reduced among households in Mpownde Ihubiriha. Respondents said that most women do not have access to health professionals even when a complication has been earlier discovered and preventable if seen a health professional.

Reduce on workload

25% of the respondents submitted that pregnant women in Mpownde Ihubiriha need to reduce on workload as a strategy to improve maternal health. It was reported that heavy workload can increase health risks of pregnant women and their fetus because contractions and reduction of blood flow to the placenta. reducing workload and allowing enough time to rest can help to reduce any complication that might occur during or after delivery.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summary of findings according to the themes of this research which included (i) finding out the factors affecting utilization of maternal health care services in Mpownde Ihubiriha sub-county, examining the causes of increased maternal deaths and establishing the possible ways to improve maternal health. Conclusion and recommendations have also been presented in this chapter.

5.2. Summary

The findings revealed that that availability of health facilities is a very important factor affecting utilization of maternal health care services of which accessibility to health facilities was a problem due to long distances. Results also indicated that age of a mother also affects the way she utilizes or acquire maternal healthcare services, because many young girls are getting pregnant in the villages yet they have little knowledge on the importance visiting health centres for both pre-natal and post-natal services. In addition income levels was identified as a significant factor affecting utilization of maternal health care services . according to the study a few women can afford to pay for medical and other related expenses, like transport fare, when they have to access maternal health care services implying that those without money rarely access maternal health care services. Others factors included having a supportive spouse and the position of a woman at work place.

According to the findings on objective two of this study, it was established that maternal age and poor nutrition are the major causes of increased maternal deaths in Mpownde Ihubiriha sub-county. There is an increase in the number of teenage mothers who literally have enough capacity to acquire basic health care services. poor nutrition is another cause because both under- and over-nutrition may place pregnant women at increased risk of an antagonistic pregnancy outcome and in most causes women in the rural areas are not aware of the benefits of having a balanced diet. Furthermore chronic illnesses like

cancer, high blood pressure and tuberculosis are becoming common in the villages of the study area leading to increased maternal mortality. This was as well attributed to low income levels. Another factor raised was the prevalence of HIV/AIDS which affects expecting mothers and their unborn babies if safety precautions are not followed.

The results suggested that if education and literacy levels of women is improved, maternal mortality can as well be reduced because expecting mothers would have acquired the basic knowledge about issues related to maternal health. Reducing workload for pregnant mothers, provision of free antnantal and prenatal care as well as embracing the problems of poverty were suggested as mitigation measures to maternal deaths.

5.3. Conclusion

In summary, factors affecting women's maternal health are many but more specifically poverty, age of a mother and accessibility and availability of health facilities were key factors. A few women can afford to pay for medical and other related expenses like transport fare, check-ups, among others. Nutrition cannot be exclusively underlooked because its equally important to any expectant mother. However extension of quality antenatal and prenatal services in rural areas particularly Mpondwe Ihubiriha is urgently needed plus sensitization of women on the importance of accessing the same services during and after pregnancy. The study further established that women and their spouses have to be supportive so that expectant mothers are not burdened with heavy workload be it domestic or at work places. This all will improve maternal health in rural communities especially in Mpondwe Ihubiriha.

5.4. Recommendations

The researcher came up with the following recommendations and they are based on the findings of this study;

Every expectant mother and infant must have quality medical care available and accessible which includes the entirety of pregnancy and beyond. Government need to make available antenatal care services reachable by every women even those from remote areas.

Pregnant women and their loved ones need to have information made readily available to them about the hazards of poor feeding and nutrition as well as safer, more natural alternatives in childbirth to avoid complications during child birth.

All stakeholders and the government need to work together in the efforts to reduce maternal mortality by making sure that every pregnant mother receives a maternity kit with all the equipment to be used during and after pregnancy.

Women should also be sensitised on how to properly use faming planning to avoid getting unwanted pregnancies. This will help them reduce on the risk of pregnancy related complications.

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APPENDIX 1

Questionnaire

Dear respondent,

I am **KYAKIMWA ANGELLA RAHAB,** a student from Kampala International University carrying out a research on factors affecting maternal health in Mpondweruiriha sub county, Kasese district,. You have been identified as a key person who has got very useful information for this study. Please be assured that this study is for academic purpose only and that all the information you are going to provide will be treated confidentially. Answer the questionnaire as sincerely as possible. You do not have to write your name anywhere that can identify you.

Thank you

Part One: Back Ground Information. (Fill in the gaps)

1. Age.....

2. Marital status.....

3. Occupation .....

Section B: Prevalence of Infant mortality

5. What is the rate of women dying during pregnancy or after giving birth?

Very high ☐
High ☐
Moderate ☐
Low ☐

What do you think are the causes of such deaths (Tick Yes or No in each case)

	Question	Response	
1.	Teenage pregnancy	Yes	
		No	
2.	Poor nutrition	Yes	
		No	
3.	HIV/AIDs	Yes	
		No	
4.	Chronic diseases	Yes	
		No	
5.	Poverty	Yes	
		No	
6.	Lack of access to medical access	Yes	
		No	

Effect of maternal health on infant mortality

How does maternal health affect the health status of the mother and the child? Please explain in details

.....

.....

.....

.....

.....

.....

What are some of the factors affecting maternal health in your area

.....

.....

.....

What are some of the effects that can happen to a woman if she does not get enough health care during pregnancy and after giving birth

.....

.....

.....

Please suggest ways in which maternal health can be improved in your area

.....

.....

.....

APPENIX 2: INTERVIEW GUIDE FOR KEY INFORMANTS.

Dear respondent,

I am **KYAKIMWA ANGELLA RAHAB,** a student from Kampala International University carrying out a research on factors affecting maternal health in Mpondweruiriha sub county, Kasese district.. You have been identified as a key person who has got very useful information for this study. Please be assured that this study is for academic purpose only and that all the information you are going to provide will be treated confidentially. Answer the questionnaire as sincerely as possible. You do not have to write your name anywhere that can identify you.

1. What is Maternal health ?
2. Do you have access to antenatal care services
3. Are health centres accessible by women in your village
4. Are the health centres well equipment?
5. After child birth, do women consider going back for post-natal care services
6. How does it relate with maternal health
7. What are the causes of maternal mortality
8. As a health personnel, what are the implications of maternal health to child mortality?
9. What is the level of prevalence of maternal mortality in this area?
10. What measures can be implemented to reduce on Maternal mortality