THE KNOWLEDGE AND ATTITUDES OF MOTHERS TOWARDS THE UTILISATION OF ANTENATAL CARE SREVICES IN ISHAKA MUNICPAILTY, BUSHENYI DISTRICT, WESTERN UGANDA

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Declarations

I, **Ahmed Nur Mohammed**, hereby declare that this research report is the outcome of my independent work. It has not been awarded at any institutional level or produced by any other person or persons.

AHMED NUR MOHAMMED.

Signature………………………………Date:……………………………………………..

Supervisor's Approval

This is to approve that this research report has been prepared under my close supervision and advice and is therefore, now ready to be submitted to the faculty of clinical medicine and dentistry of Kampala International University, Western Campus

DR.MANINGA JOSEPHAT

Signature………………………………Date:………………………………………………..

Dedication

This research is dedicated to my mother, my allah rest her soul in heaven and be merciful to her as she was to me in my childhood.

Acknowledgement

Special thanks to my supervisor Dr maninga josephat for his advice and guidance in compiling this report. I also appreciate all the help I reveived from my family,friends and class mates.

Above all I thank the almighty allah for seeing me through this work.

List of abbreviations:

%	Percentage
ANC	Antenatal Care
ARV	Antiretroviral
EDHS	Ethiopian Demographic Health Survey
EMOC	Emergency Obstetric Care
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency syndrome
LC	Local Council
MCH	Maternal and Child Health
MDG	Millennium Developmental Goals
MOH	Ministry of Health
NGO	Nongovernmental Organization
PMTCT	Prevention of mother to child transmission
PIH	Pregnancy Induced Hypertension
Qty	Quantity
STI	Sexually Transmitted Infections
TBA’s	Traditional Birth Attendants
UNICEF	United Nation’s International Children’s Emergency Fund
VCT	Voluntary counseling and testing
WHO	World Health Organization

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Abstract

A cross sectional retrospective study was conducted in Ishaka, Bushenyi municipality, Bushenyi district from January 2014 to June 2014 to determine knowledge and attitudes of mothers towards the utilization of antenatal care services in Ishaka Bushenyi municipality, district, western Uganda.

The study found out that 38(60.3%) of the respondents have heard about comprehensive ANC services and 39.7% of the respondents have not heard about comprehensive ANC, that majority of the respondents are able to afford ANC services. Of those who agreed that comprehensive ANC is affordable and accessible, majority were female 37%, 31% were male and that majority of the respondents wanted to deliver from the Hospitals 23%, followed by those who will prefer to deliver from a private clinic 15% and the least preferred place to deliver is the homes, 11%.

This study concluded that there is a positive attitude and good knowledge about ANC services utilizations in Ishaka-Bushenyi Municipality.

Finally, the study recommended that: Educating women about ANC to improve their acceptability of ANC services which will improve their utilization of the services; Improvement in communication between the health system and the population so that ANC services are culturally sensitive, and integrating health communication especially about ANC to the other social services delivery mechanism so that there is a wider distribution of ANC knowledge

CHAPTER ONE: INTRODUCTION

Background:

Antenatal care is planned program of medical management of mothers from the time of conception till delivery directed towards a healthy outcome for the mother and the baby. ANC services are those services given to women of childbearing age that is 15-49 years during pregnancy, labour and puerperium .these services lead to the healthy pregnancy, delivery of normal baby, preparing the mother psychologically for her labour and also after her delivery given nutritional guide.

Antenatal is the key entry point for pregnant mothers to receive abroad range of health promotion and prevention services. Nearly 70% of pregnant women have at least one antenatal care visit, and the majority of women presenting for any antenatal have at least four visits. All age groups show the similar rates of four or more visits .Rural and uneducated women are least likely to receive antenatal care. Women reporting at least four visits are on average 3:3 times more likely than other women to give birth with a skilled provider (WHO/UNICEF 2003).

Aim of ANC is as follows: Making the mothers are of the benefits of antenatal care services at pregnancy and after delivery, Dealing with the illness that the mother has come with for example giving malaria treatment, anemia and vaccination against neonatal tetanus, Giving health education to mother of disease prevention, nutrition and maintaining personal hygiene, Prepare mother physically, psychologically, overcoming her fears and her bad believes, Identifying mothers who “at risk” and those who may have problems during labour and correcting the anomalies then referring the pregnant mother for further management

The following are the services offered at the ANC, Voluntary testing and counseling, Health education on HIV/AIDS and other STIs, Physical examination, Laboratory investigations, Developing a delivery and post partum care plan for every mother who visits antenatal clinic, Management of complains, referring high risk mothers and those with complications,

Immunization against tetanus, Screening and risk assessment, Height, Weight and blood pressure assessment

ANC is not meant to detect abnormalities only but also for emergency preparedness .every year more than 150 million women become pregnant and at least 20percent are likely to develop complications related to pregnancy which will require skilled care to prevent deaths and disabilities.

Million of the women in developing countries lack access to adequate care during pregnancy and 60 percent of the women in developing countries get ANC. The standard recommended number of ANC visit is four visits as a minimum but a number of times a client can be seen may vary depending on her condition. Women who may develop complication may be recommended for frequent visits. In a normal pregnancy there are four visits (WHO/UNICEF 2003)

ANC visits are segmented into; first visit at 10-16 weeks, Second visit at 20-24 weeks, Third visit at 28-32 weeks and Fourth visit at 36 weeks

1st visit at 10-16 weeks

Here compete history is taken and physical examination. The goals include baseline risk assessment, health education and lab investigation, immunization against tetanus, ruling out chronic illnesses, hereditary disease and making a plan of missed immunizations and that for delivery. Neonatal tetanus causes about 200,000 infant deaths every year accounting for 8% of neonatal deaths (UNICEF 2002).

2nd visit at 20-24 weeks

There is further assessment by taking action if abnormal lab results, exclude multiple pregnancy, assessed for signs of PIH, check fetal growth, exclude anemia and assessing the degree of patients risk (normal or high).

3rd visit at 28-32 weeks

The mothers health is assessed, adequacy of the pelvis, determine the presenting part and review of the delivery plan.

4th visit at 36 weeks

This the final visit that the mother comes if she has any complications, which can be handled in the hospital .Therefore ,the mothers with abnormal presentations especially breech must be referred to the hospital for delivery as it is an emergency.

Community health works &TBA's must there for be encouraged to send mothers to antenatal care clinics. They must be helped to understand that they cannot deal with some compilations. The health of the pregnant mothers would be improved if they could attend or utilize the available antenatal care services in their locality, because antenatal care is one of the corner stone to their health. Also use of mass media to address safe motherhood establishing a community mobilization system ensuring high quality services and skills (JHPIEGO/MNH programme 2006).

1.2 Problem Statement

Maternal morbidity remains one of major public health problem in developing countries like Uganda. Each year pregnancy and childbirth claim over 6,000 women and approximately 120,000 new born's in Uganda (state of population 2005). Hoestermann et-al 1996 urges that several studies have shown both ante-partum and post-partum hemorrhage to be the most important direct causes of maternal mortality in hospitals, health centers and villages in Africa. Many women in the world do not get modern prenatal, delivery or postnatal care. The study intends to find out the factors that affect the utilization of antenatal care services by mothers in ishaka Bushenyi district.

1.3.0 Study Objective

1.3.1 Broad Objectives

To assess the knowledge and attitudes of mothers towards the utilization of antenatal care services in Ishaka municipality, Bushenyi district, western Uganda

1.3.2 Specific Objectives

1. To establish the knowledge of mothers in Ishaka on antenatal care
2. To assess the accessibility of antenatal care services to mothers in Ishaka town
3. To determine the attitude of mothers towards antenatal care in Ishaka town

1.4 Justification

Uganda is one of the countries with a high fertility rate and poor family planning services utilization. Therefore a high maternal mortality rates hence a problem to mothers of the childbearing age (15-49). In rural areas in developing countries like Uganda where medical resources are limited giving birth at home is the rule of both economic and cultural reasons, only mothers who are at high risk of complicated labour are screened and referred to the hospital (Duja & Din Et-Al 1996).

At present there is no recent research done at sub county level as rural women are less likely to get ANC than women in urban areas, so this motivated the researcher to carry out the study and give more light in this problem.

This study helped the researcher to identify factors contributing to the reduced utilization of antenatal services in Ishaka town Bushenyi and came up with recommendations that will help in design of interventions and strategies to help the rural mothers to access this essential health services.

The researcher also hopes to have generated and contributed more current literature for health workers in this field. A copy of this research project will be availed to the ministry of health to ensure that there is adequate health and especially ANC services which are accessed to all pregnant women

1.5 Scope of Study

1.5.1 Time Scope

This study was conducted from January 2014 to June 2014.

1.5.2 Content Scope

The content study for this study was limited to the assement of mothers knowledge on the components of ANC and most especially, the timing and frequency of Antenatal care services. Another dimension involved in this study was the access to the service point. The study gauged residence within 5km from the service deleievry point as being assesible and finally, the attitudes determined by the willingness to utilize the ANC services by mothers within Ishaka

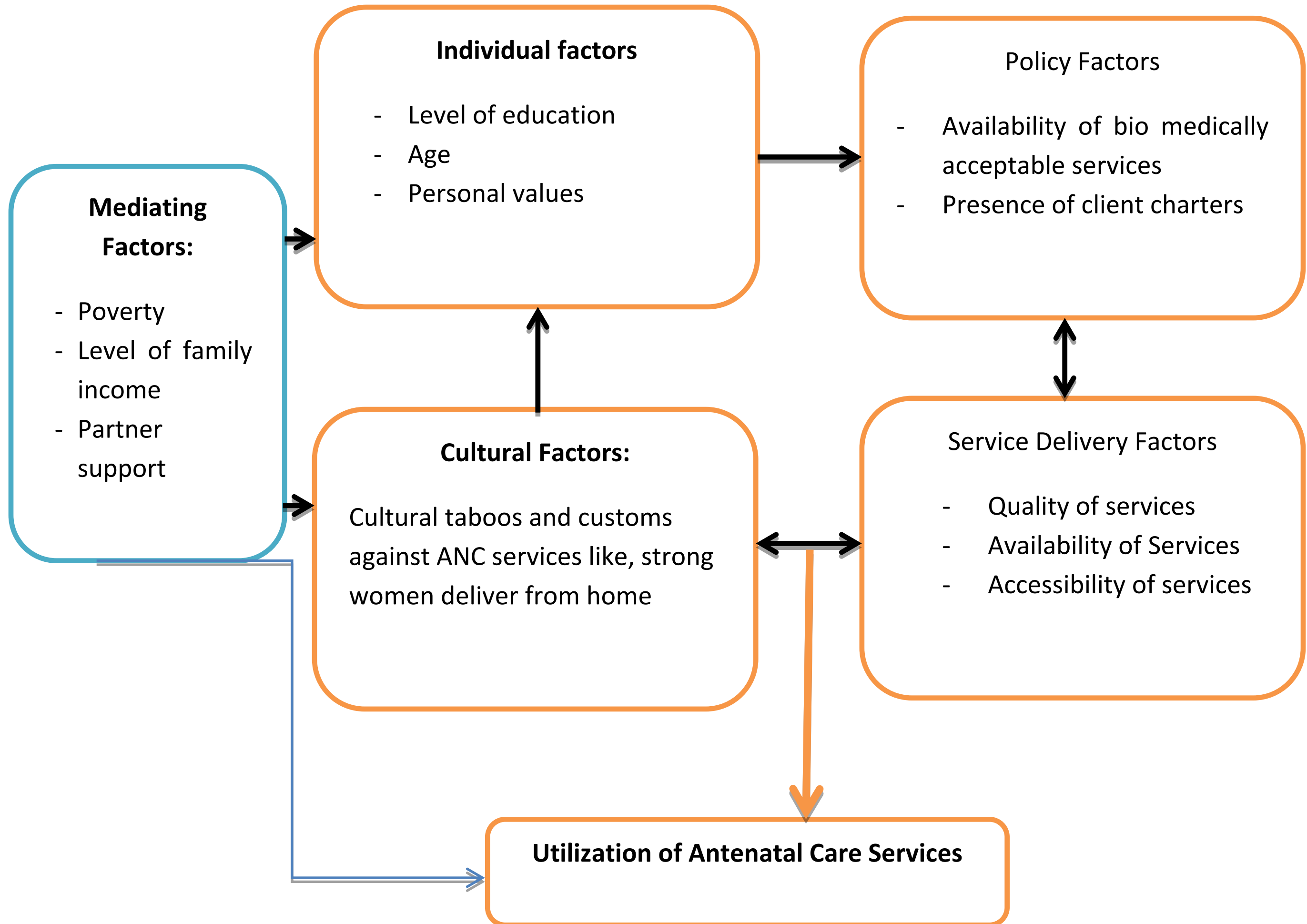
1.5.3 Geographical Scope

The study was conducted within Ishaka Municipality, Bushenyi district, western Uganda. Most of the mothers enrolled in this study were resident within the areas of Bushenyi municipality. Respondents from outside this area who were available at this time of the study within Ishaka were explicitly excluded from the study.

Bushenyi District is one of the oldest districts in Uganda created in 1974 when it was curved out of Mbarara District Administration then, In 2009, it was split into five districts (4 new districts of Buhweju, Mitooma, Sheema and Rubirizi districts) with one new Municipal Council of Bushenyi-Ishaka. This has drastically reduced the size of Bushenyi District from five counties to one of Igara that includes the municipality. The District is made of 1 County (Igara), 9 Sub-counties, 1 Municipal Council, 4 Town Boards, 3 Wards, 64 parishes and 565 villages.

1.6. Conceptual Framework

Figure 1: Conceptual Framework



1.6.1 Description of Conceptual Framework

The conceptual framework above describes the dependent and independent variables facilitating the uptake of ANC services in Uganda. The major independent variables in the conceptual framework are the ndividual factors like level of education, age, health status and personal values. These personal factors are mediated by factors like poverty, level of family income and family size. Cultre and social norms do determine these.

The other major dependent varioables are the policy and service deleivery frameworks.

CHAPTER TWO: LITERATURE REVEIW

2.0 General Introductions

In this chapter, the researcher has presented the review of different research works on antenatal care, got from books, newspapers and news (in radios or televisions) findings on the same topic.

2.1 Previous Literature

2.1.1 Global and Local Situations

Worldwide, male attendance of skilled ANC and delivery care remains a challenge to safe motherhood. About 210 million women become pregnant each year with 30 million (15%) developing complications, resulting into over half a million maternal deaths [Bernis,2003,]. Developing countries account for more than 99% of all maternal deaths; about a half occurring in sub-Saharan Africa, and a third in South Asia [WHO,2005,UNICEF,2007].

The World Health Organization (WHO) estimates that about 529,000 women die worldwide every year in connection with pregnancy and childbirth. Nearly all (99 %) maternal, newborn, and child deaths occur in low and middle income countries. Moreover, acute morbidity may affect over 50 million pregnancies/deliveries each year, and severe chronic and long-term disabilities like fistulas and prolapse affect an estimated 10 million women each year (WHO 2005).

Maternal mortality is the highest by far in sub-Saharan Africa, where the lifetime risk of death from pregnancy-related conditions is 1 in 16, compared with 1 in 2800 in rich countries (Oluwole 2004).

As early as 2001, the World Health Organization (WHO) established proven safe motherhood interventions that are required at household, community and facility levels to enable every pregnant woman to have a safe pregnancy and childbirth, and to provide couples with the best chance of having healthy infants [Potera, 2003]. The strategies

include; providing skilled attendants to prevent, detect and manage the major obstetric complications, together with providing equipment, drugs and other supplies [WHO,2005, MOH,2008].

Obstetric complications are the leading cause of death for women of reproductive age in developing countries today, and constitute one of the world's most urgent and intractable health problems (Singh 2004).

2.1.2 Knwoldge of Mothers on Antenatal Care

Male attendance of skilled ANC is a fairly new field to research in Uganda. The available estimates depict a low attendance averaging 3% in 2006 [MOH,2006] but are based on health facility information systems that monitor male attendance in the PMTCT programme. Gulu district is located in northern Uganda, a region recovering from a 20-year-old insurgency. The civil war forced majority of its population into Internally Displaced Peoples' (IDP) camps. According to Gulu development plan (2007), the district has a maternal mortality ratio (MMR) of 700/100,000; infant mortality rate of 172/1,000 and ANC HIV sero-prevalence of 8.8% [Gulu District Development Plan,2007].

The reasons for an increasing MTCT of HIV might include lack of knowledge of mothers on the risk of MTCT, lack of access to voluntary counseling and testing (VCT) and the benefits of preventive interventions, like antiretroviral (ARV) drugs and infant feeding options. ARV prophylaxis and avoiding breastfeeding are cornerstones of the strategy of PMTCT. In the absence of breastfeeding, most infections occur during labour, and delivery (Decock, 2000)

2.1.3 Attitudes of mothers

Since the introduction of routine antenatal counselling and testing for HIV in June 2006. However, no documented information was available about opinions of pregnant women in eastern Uganda about this HIV testing approach.(Byamugisha, 2010)

In Uganda, young people aged 10-24, constitute about 33% (MISR, 2000) while 47.3% of the total population is below 15. Due to the, HIV/Aids epidemic and the common belief that most adolescents are either too young or are expected to be in schools, antenatal care (ANC) uptake amongst this group, has been accorded less attention contributing to relatively high maternal mortality rates 33% (MOH,2004).

In most part of rural Uganda like western Uganda, where health facilities do not provide a full range of Primary Health Care services, undermining access to RH services, including basic EmOC and comprehensive EmOC services. Almost all level II health centers in Uganda do not provide maternity services. As a result,

Maternal mortality has remained high, (527/100,000 in 1989, and 505/100,000 in 1995-2001), that the PEAP target of 354 for 2005 was not achieved. This if it persists, negative impacts will be dealt on the MDG target of 31/100,000 by 2015. The study therefore, focuses on the socioeconomic and demographic factors responsible for the expected low antenatal uptake, despite the relatively high, antenatal care coverage (92%) provided freely in all Ugandan government hospitals

In Uganda, pregnancies occurring within 15 months of a previous birth and first pregnancy have the highest risk of pregnancy loss or early neonatal death (59 and 51 pregnancy losses, or early deaths per 1000 pregnancies) respectively. The safest pregnancy interval is between 27-28 months (UBOS, 2001; MOH, 2004)

Asiimwe, (2010), found out that in western Uganda, the ability of a woman to afford antenatal care (ANC) services has a significant association to the number of ANC visits she is likely to make. This resonates with studies elsewhere that women having to take transport to ANC facility, high fees for necessary but costly laboratory fees, drugs and consultation fees in case of private centers not serviced by government hospitals are deterrence to the utilization of maternal services as highlighted by Atuyambe et al., (2005).

Poor utilization of quality reproductive health care services continues to contribute to maternal morbidity and mortality in developing countries. Understanding the different forms of social representations from which individuals or group members of a society draw

meanings from the different social milieu and other external factors that may influence their preferences will help to identify policy gaps and develop strategies that will improve utilization of skilled obstetric services and thereby reduce unnecessary loss of lives (Abdool-Karim Lockwood et al., 1994)

CHAPTER THREE: STUDY METHODOLOGY

3.1 Study area

This study was carried out in Ishaka town of Bushenyi district, with a population of about 800,000 people (spread over an area of 5396 km^2) whose main source of income is subsistence agriculture. The population of Bushenyi is about 95% rural-based. About 60% of the population is within one hour's walk of a public health facility. Administratively, Bushenyi district is divided into 5 counties 27 sub-counties (third level local councils-LC3), 161 parishes (LC2s) and 2052 villages (LC1s).

The district is served by 3 hospitals (one public and two for non-governmental organizations (NGOs). 49 health centers, many private clinics. According to Uganda population and Housing Census Report 2002, 77% of the population engages in agriculture. However, there are other activities like trade addition to agriculture (peasantry, plantations, animal husbandry and fishing).

3.2. Study population

The study targeted people leaving in Ishaka town, 100 mothers were provided with questionnaires. Both open and closed ended questionnaires.

3.3 Study design

A cross sectional study was carried out between May and June 2014.

3.4 Data collection methods.

The data was collected using a semi structured questionnaire. Both open and close ended questions was be used.

3.4.1 Data Collection Tools

The researcher and his assistant used the following tools to collect data; open ended questionnaires, pens, pencils, eraser, ruler, calculators, notebooks and plain papers.

3.5 Pre-Testing

Pre-testing was done on ten people in Ishaka town. Self administration of questionnaires to randomly selected ten people was done by the researcher in a different area other than the study area. This assisted the researcher to correct mistakes in the questionnaires and avoid confusions during the research time.

3.6 Data Quality Control

The information was collected by asking individual (patient) directly and also using questionnaires; this method was easy to use and reduces bias.

3.7Sample size calculations

Sampling size was calculated by the use of Fichrer's et al 1990 formula

$$A = \frac{PQz^2}{d^2}$$

Where, N-desired sample size

Z-standard normal deviation taken as 1.96 at a confidential level of 95%

P-proportion of target population, estimated to have similar characteristics (where 50% is used if no measurable estimate or 0.5)

Q-is standardized =1.0 – P; where P is 0.5,

There for Q will be, 1.0-0.5=0.5 or 50%

D-degree of error =0.05 or 5%

Calculation:

Confidential level was, 79%

Degree of error was, 10%

On substitution; If 95% gives 1.96 (standard deviation)

79% gives (79×1.96) ÷95=1.63 thus my deviation

Degree of error 10/100=0.1

Thus N= $(1.63^2 \times 0.5 \times 0.5) \div 0.1^2$=66 people.

3.8 Sampling procedure

A random sampling method was used to select the respondents, regardless of sex, marital status, tribe, nationality, and educational back ground.

All 100 mothers were interviewed either at home, antenatal clinic or at their work place and questionnaires were used.

Anyone who was not interested was left out of the study

3.9 Data collection methods.

The data was collected using a semi structured questionnaire. Both open and close ended questions were used.

3.10 Data analysis

Data was sorted manually for missing questionnaires; the fully filled questionnaires were sorted out. Data was then entered into EPI info 7 and then migrated into SPSS for the generation of graphs, charts and tables that were used to present the report.

3.11 Ethical considerations

Approval was obtained from the Faculty of clinical medicine and dentistry of KIU-WC and from Bushenyi Municipality council district director of health services

The researcher and research assistants explained the purpose of the research to the respondents and formal consent were obtained.

Respondents were reassured of confidentiality that was to be maintained during data collection, processing, analysis, discussion and dissemination by ensuring that data collected is only used for research purpose.

The researcher explained to the participants that there were be no risk since it is non-invasive and involves answering questions only.

The benefits of the study to the participant were; improvement in patients' care improve working relationships between health workers, treatment supporters and patients and guide in policy formulation on ANC care.

CHAPTER FOUR: STUDY FINDINGS AND RESULTS.

4.0 Introductions

4.1 Socio-demographic data

4.1.1 Age

		Frequency	Percent	Cumulative Percent
Valid	Below 18	8	8.0	8.0
	18-27	28	28.0	36.0
	28-37	22	22.0	58.0
	38-47	18	18.0	76.0
	48-57	11	11.0	87.0
	58 and above	13	13.0	100.0
	Total	100	100.0	

Table 1: Distribution of Respondents by Age

The table above shows that the majority of the respondents involved in this study were 18-27 years old age groups followed by the 28-37 years age groups. The least frequent number if respondents were the ones below 18 years old, making 8 % and the 48-57 years age groups, 11%.

4.1.2 Gender

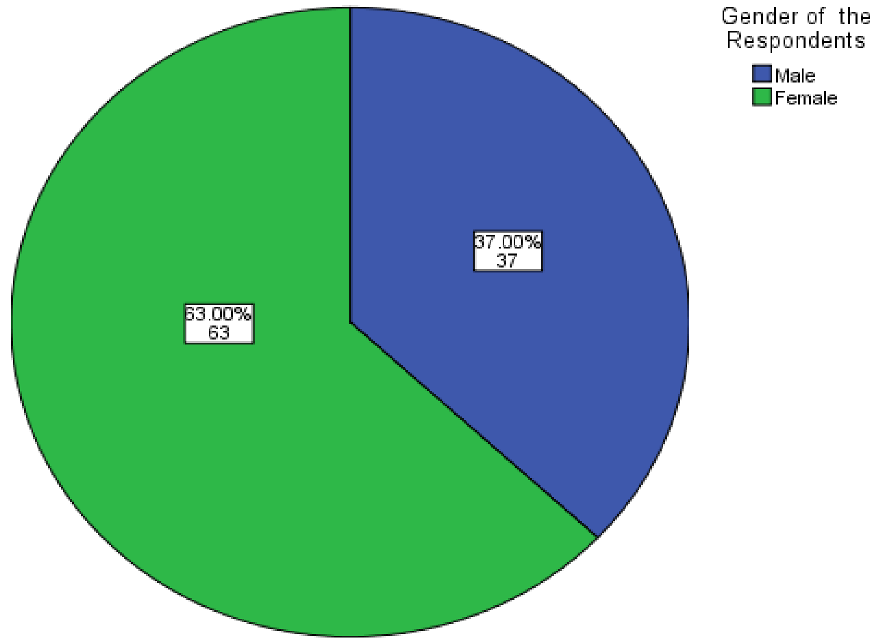


Figure 2: Distribution of Respondents by Gender

Figure 1 above shows that the majority of the respondents who took part in this study were female, 63.0% and the males made 37% of the respondents

4.1.3 Tribe

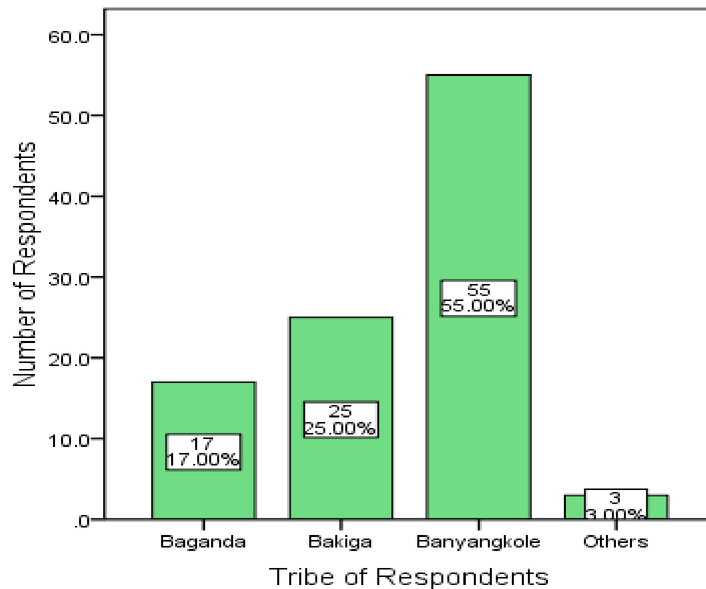


Figure 3: Tribe of Respondents

From figure 2 above, the Banyankole were the majority of the tribes in this study, 55%, followed by the Bakiga 25% and the Baganda 17%. Other tribes made up three,3,% of the respondents

4.1.4 Marital Status

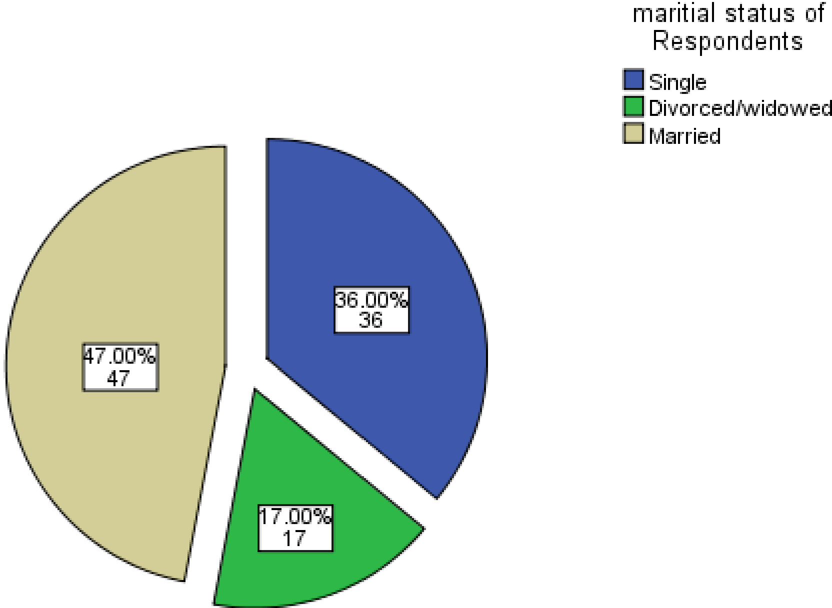


Figure 4: Marital Status of Respondents

According to figure 3 above, the majority of the respondents were married, 47%, followed by those who were single, 36% and the least were the divorced and/or widowed who made up 17% of the respondents

4.1.5 Occupation and education of respondents

level of education and Occupation of Respondents

		Occupation of Respondents				Total
		Peasant Farmer	Employed	Business	Students	
level of education	No formal education	4	0	0	0	4
	Primary	6	2	4	2	14
	Secondary	11	1	5	13	30
	University and Tertiary Institution	22	5	8	17	52
Total		43	8	17	32	100

Table 2: Distribution of Respondents by education levels and occupation

The table, above shows that majority of the respondents involved in the study were institutional levels 22 followed by the secondary school 11, and lowest number were those with no formal education, 4, and primary levels were 6.

In terms of employment opportunities and occupations, most of the respondents were peasants, 43, and students, 32. The lowest were 17 were business persons, and those involved in formal employment were 8.

4.2 Knowledge of ANC services

4.2.1 Heard about comprehensive ANC services

		Frequency	Percent	Cumulative Percent
Heard	Have heard about ANC services	30	81.1	81.1
	Have not heard about ANC services	7	18.9	100.0
	Total	37	100.0	

a. Gender of the patient = Male

Table 3: Distribution of Male Respondents by knowledge about ANC

The table above shows that 30 (81%) of the male respondents have heard about comprehensive ANC services and 18.9% of the respondents have not heard about comprehensive ANC.

		Frequency	Percent	Cumulative Percent
Heard	Have heard about ANC services	38	60.3	60.3
	Have not heard about ANC services	25	39.7	100.0
	Total	63	100.0	

a. Gender of the respondent = Female

The table above shows that 38(60.3%) of the female respondents have heard about comprehensive ANC services and 39.7% of the respondents have not heard about comprehensive ANC.

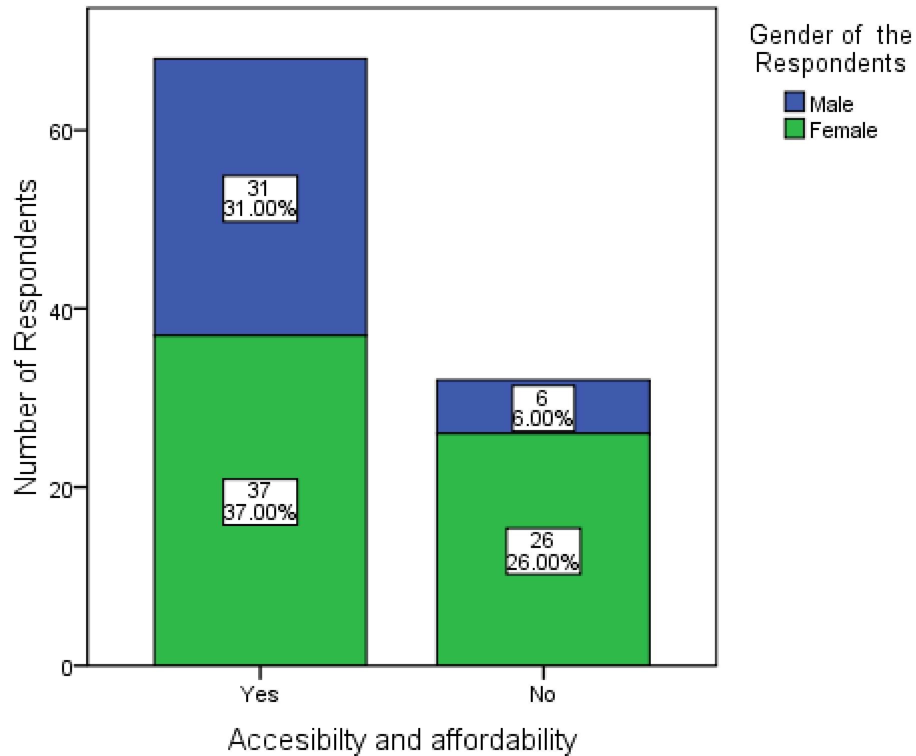


Figure 5: Distribution of respondents according to affordability and accessibility of ANC services

Figure above shows that majority of the respondents are able to afford ANC services. Of those who agreed that comprehensive ANC is affordable and accessible, majority were female 37%, 31% were male. And of those who said ANC are not affordable, 26% of the 32% were female and the remaining 6% were males.

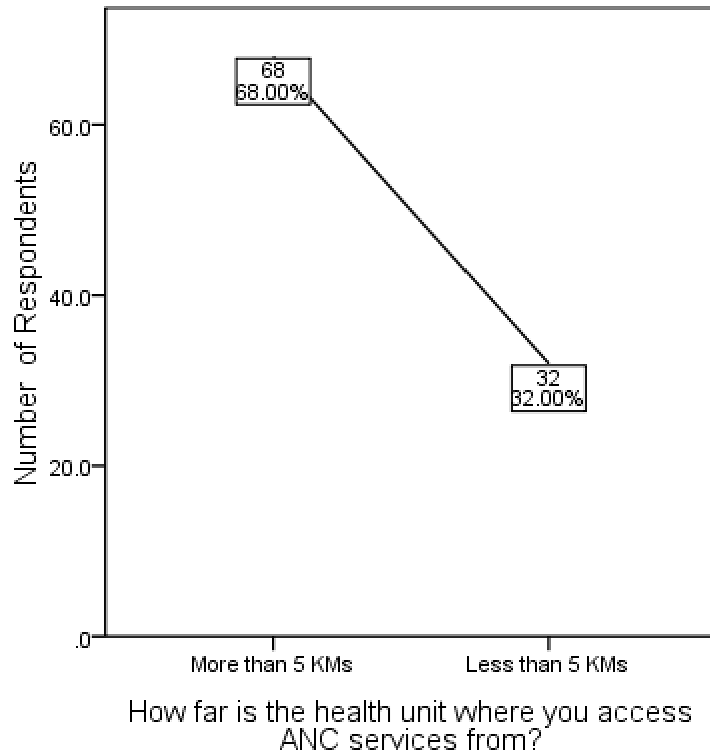


Figure 6: Distance to the Health units where ANC services is available

Figure 5 above shows that 68% of the respondents were staying more than 5 KMs away from the health unit where ANC services is available and 32% of the respondents were leaving within 5 kms from where ANC services is available

		Frequency	Percent	Cumulative Percent
Valid	Hospital	23	36.5	36.5
	Clinics	15	23.8	60.3
	TBA	14	22.2	82.5
	Home	11	17.5	100.0
	Total	63	100.0	

Table 4: Distribution of Respondents by where they want to deliver

The table above shows that majority of the respondents wanted to deliver from the Hospitals 23%, followed by those who will prefer to deliver from a private clinic 15% and the least preferred place to deliver is the homes, 11%.

CHAPTER FIVE: DISCCUSSIONS, CONCLUSION AND RECOMEDNATIONS

5.1 Discussions

5.1.1 Discussions of objective one

Bairkey et al discussed that informed decision making involves making reasoned choice based on relevant information about the advantages and disadvantages of all the possible courses of action (including taking no action). In his particular study on the Informed decision making: An annotated bibliography and systematic review, he revealed that maternal understanding on ANC is very critical.

This study showed that 38(60.3%) of the respondents have heard about comprehensive ANC services and 39.7% of the respondents have not heard about comprehensive ANC.

This study much as it shows a high knowledge, does not eventually turn into the number of mother accessing ANC services.
Other studies had reported mentioned that there is a high incidence of mother to child transmission of HIV within Bushenyi district. This could have been due to maternal knowledge gaps about ANC especially the PMTCT component.

This observation could be close to those explanations given by Decock in 2000. Decock mentioned that the reasons for an increasing MTCT of HIV might include lack of knowledge of mothers on the risk of MTCT, lack of access to voluntary counseling and testing (VCT) and the benefits of preventive interventions, like antiretroviral (ARV) drugs and infant feeding options. ARV prophylaxis and avoiding breastfeeding are cornerstones of the strategy of PMTCT.

5.1.2 Discussions of objective two

Access to good-quality maternity services is critical to improve maternal health. In this study, we appraised access to quality antennal care through quantitative analysis of data asking respondents to show whether ANC was accessible to them or not. The study has revealed that majority of the respondents are able to afford ANC services. Of those who agreed that comprehensive ANC is affordable and accessible, majority were female 37%, 31% were male.

One of the factors to measure accessibility of ANC is the distance covered to access a unit where there is quality ANC services point available. Though it did not feature as a main objective of this study, respondents (70%) agreed that ANC is accessible within 5km.

The study findings slightly differed from those of the Myriad studies in Uganda and elsewhere in sub-Saharan Africa (SSA) which identified physical or geographical access to health care as a major barrier affecting health care seeking behaviors of patients generally, and women's reproductive health care seeking specifically (Kasolo et al., 1999).

But agreed with those of Tawiah et al, who argued that distance to health services, lack of available transportation, high transportation costs, poor road conditions and uneven distribution of health care facilities and lack of independence by women to make decision on matters that directly affect their health (Tawiah, 2011; Magadi et al., 2003; Anarfi and Ahideke, 2006).
In their studies, Tawiah et al showed that were there are available health services within a short distance; access was high as it was observed in this study. In fact, respondents considered Bushenyi district to have high access to ANC since there are about 4 hospital with many lower level health units, covering the distance for ANC services. Ishaka municipality where the study is conducted has 3 hospitals within 5 kms and other health unit.

5.1.3 Discussion of objective three

The results of this study showed that majority of the respondents wanted to deliver from the Hospitals 23%, followed by those who will prefer to deliver from a private clinic 15% and the least preferred place to deliver is the homes, 11%.

These findings show that many mothers are not willing to deliver from the hospital, compared to other health services points, a previous study by Kenneth and others had also realized that mothers were not willing to deliver from the hospital.

According to him, there is misalignment between current antenatal care provision and the social and cultural context of some women. Antenatal care provision that is theoretically and contextually at odds with local contextual beliefs and experiences is likely to be underused, especially when attendance generates increased personal risks of lost family resources or physical danger during travel, when the promised care is not delivered because of resource constraints, and when women experience covert or overt abuse in care settings.

5.2 conclusions

There is a positive attitude and good knowledge about ANC services utilizations in Ishaka-Bushenyi Municipality. This attitude and knowledge is key in the successful implementation of the comprehensive antenatal care services in Uganda. ANC service quality depends on the proper planning of, and support to, the training of health staff and sustained sensitization of pregnant women at health facility and community levels about the ANC to the unborn babies and mothers.

5.4 Recommendations

- ✓ Educating women about ANC to improve their acceptability of ANC services which will improve their utilization of the services.

- ✓ Improvement in communication between the health system and the population so that ANC services are culturally sensitive
- ✓ Integrating health communication especially about ANC to the other social services delivery mechanism so that there is a wider distribution of ANC knowledge

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Appendices

Appendix I: Consent form

FACULTY OF CLINICAL MEDICINE AND DENTISTRY,
WESTERN CAMPUS.
P.O.BOX71, BUSHENYI, UGANDA.
Tel:+256485443629
Email: admin@kiu.ac.ug

Topic: knowledge and attitudes of mothers towards the utilisation of antenatal care services in ishaka municpailty, bushenyi district .

Investigator: AHMED NUR MOHAMMED.

Dear Participant;

I am **AHMED NUR MOHAMMED.** from Kampala International University Western Campus. I am currently conducting research on the topic stated above. The study will be conducted by the investigator and other trained experts. The recommendations drawn from the study will be used for preventing maternal deaths and improving ANC services in ishaka town.

Confidentiality: Your records will be private and will not be disclosed to anyone. The information obtained will only be used for research purposes. Names are not used in analysis.

Voluntary participation: You are free to join the study or not to. You may leave the study at any point for any reason and you will not lose any healthcare service you are entitled to at the hospital.

Benefits: You will not receive any financial benefits by participating in this study, however the information obtained from this study will help the ministry of health in designing policy and interventions in preventing maternal deaths and improving ANC services.

The study has been explained to me and I have chances to ask questions. I have been informed that it is my free choice to be in the study and I can opt out of the study at any time without any penalty.

Appendix II: Questionnaire

Interviewers schedule for asking the mothers on factors affecting the utilization of antenatal care services during pregnancy.

Introduction

I am by names **AHMED NUR MOHAMMED**, a student at Kampala international university who is carrying out a research that intends to find out factors affecting the utilization of antenatal care services in Ishaka Bushenyi district. So I am going to ask you some question that you will please help me to answer and the information you are giving me will be kept confidential and will help the ministry and hospitals in improving in the above services in the district.

1 Put a tick in the space provided for an appropriate answer

2 Name of the respondent is not required

Socio-demographic data

1. Age of the respondent

a. 15-20 ( )
b. 21-25 ( )
c. 26-30 ( )
d. 31-35 ( )
e. 36-40 ( )
f. 41-45 ( )
g. >45 ( )

2. Tribe

a) Muyankore ( )
b) Bakyiga ( )
c) Banyarwanda ( )
d) Bafumbira ( )

e) Others (specify)……………………………………………………………………….

3. Level of education

a) Primary ( )
b) Secondary ( )
c) College ( )
d) Others (specify)………………………………………………………………………….

4. Religion of the respondent

a) Protestant ( )
b) Seven's day Adventist ( )
c) Catholic ( )
d) Muslim ( )
e) Others (specify……………………………………………………………………………

5. Occupations

a) Cattle keeper
( )
b) Peasant
( )
c) Employed
( )
d) None
( )

6. Marital status

a) Married ( )
b) Single ( )
c) Divorced ( )
d) Widow ( )

e) Others
   (specify)…………………………………………………………………………………
   ……...

7. Awareness

Do you ANC services are offered at the hospital?

Yes ( )

No ( )

If yes which one?

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

Where did you get information about antenatal care?

a) Clinic ( )
b) Health center ( )
c) TBA's ( )
d) Mass media ( )
e) Others
   (specify)…………………………………………………………………………………
   ……..

At what gestation age do you normally have your first antenatal visit?

a) 1-2 months ( )
b) 3-4 months ( )
c) 5 months ( )
d) More than 5 months ( )
e) Don't know ( )

How many times do you attend ANC before delivery?

a) Once ( )
b) Twice ( )
c) Thrice ( )
d) Four times
( )
e) More than four time
( )

8. Accessibility

Where do you go for your ANC services?

a) Hospital
( )
b) Health center
( )
c) Clinic
( )
d) Others (specify)
…………………………………………………………………………………

How far is ANC from your home?

a) 0-2 km ( )
b) 3-4 km ( )
c) 4-5 km ( )
d) More than 5 km ( )

What means of transport do you use?

a) Bicycle ( )
b) Motor cycle ( )

c) Vehicle

( )

d) Foot

( )

e) Others

(specify)…………………………………………………………………………………

…

In case you are pregnant where do you intend to deliver from?

a) TBA's

( )

b) Home

( )

c) Health unit

( )

d) Hospital

( )

e) Others

(specify)…………………………………………………………………………………

…….

9. Quality

Which ANC services are offered at your hospital, clinic or health center?

a) Family planning

( )

b) Immunization

( )

c) Examination

( )

d) Health education

( )

e) Counseling

( )

f) Blood testing

( )

g) Urine testing

( )

h) Others

(specify)……………………………………………………………………………………

………..

What benefits do you get from ANC services?

a) Health education

( )

b) Counseling

( )

c) Immunization

( )

d) Treatment

( )

e) Others

(specify)……………………………………………………………………………………

……….

How long did you wait there before you are attended to?

a) One hour

( )

b) One and half

( )

c) Two

( )

d) More

( )

Does ANC operate daily?

a) Yes

( )

b) No

( )

What can you comment on/ about the services provided?

a) Good

( )

b) Fair

( )

c) Bad/rude

( )

10. Affordability

How much do you pay for the ANC services?

a) 500

( )

b) 1000

( )

c) 1500

( )

d) More………………………………………………………………………………………

……………….

e) Free of charge

( )

How can ANC improve according to your suggestion?

a)……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………

b)……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………….

11. Attitude

How do nurses treat you when you for ANC services?

....
....
....

12. Culture

What happens when you fall sick during pregnancy?

……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………….

Where do you go?

a) TBA's ( )
b) Traditional healers ( )
c) Health facility ( )
d) Others
(specify)………………………………………………………………………………
………..

What traditional medicine do you use while pregnant?

....
....

Is your husband cooperation when you what to come and attend ANC services?

a) Yes ( )

b) No ( )

Does he come with you?

a) Yes ( )

b) No ( )

If yes how often?

……………………………………………………………………………………………………
…………………………………….

Appendix III: Time plan

	ACTIVITY MONTHS YEAR:2014	January	February	March	April	May	June
1	Problem identification						
2	Proposal writing						
3	Proposal presentation						
4	Data collection& analysis						
5	Report writing and submission						

Appendix IV: Budget

	ITEMS	UNIT	QTY	UNIT PRICE (UGANDAN SHILLINGS)	TOTAL	COMMENT
STATIONARIES	Pens	PCS	30	1000	30000	
	Pencils	PCS	20	500	10000	
	Erasers	PCS	10	1500	15000	
	Sharpeners	PCS	10	1000	10000	
	Note books	PCS	10	5000	50000	
	Printing papers	RIM	5	15000	75000	
Typesetting, printing and photocopying services					100000	
Assistant allowances	Lunch allowances	5 PERSONS	14	25000	35000	5 STAFFS FOR 2 WEEKS
	transport				15000	
	TOTAL COST				**UGX 340,000**	

Appendix V: Map of Uganda

Appendix VI: Map of Bushenyi District