FACTORS INFLUENCING BIRTH PREPAREDNESS AMONG ANTENATAL CARE WOMEN AT KASANGATI HEALTH CENTER IV

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DECLARATION

I do declare that this research report is my own original work and has not been submitted for any award of degree by any other person or university. There is a complete reference to all the sources of information used in the report.

NAMPEWO SARAH SSENKUNGU

Signature…….

Date ……

APPROVAL

This is to declare that this research report has been conducted under my supervision and assistance and is submitted to the University with my approval.

MS. WANYENZE EVA

Signature…….…….

Date…..…….

DEDICATION

I whole heartedly dedicate this work to my family who worked hand in hand with me to lay my education foundation from my first day in school up to what I am today. Thank you for guiding me through all walks of my life.

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I would like to thank my supervisor Wanyenze Eva for her guidance throughout the whole process of this research dissertation. She has always been there to guide me every time I need her despite her busy schedule, God bless you abundantly.

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OPERATIONAL DEFINITIONS

Birth preparedness- it is a plan that a pregnant woman makes by identifying a place of birth, means of transport, saving money for delivery expenses, identifying a birth attendant, decision maker for delivery, companion and home care taker while in hospital.

Determinant of birth preparedness- it is a variable that influenced birth preparedness, either positively or negatively on logistic regression at statistically significant level ($p<0.05$).

Maternal death – death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes.

Maternal mortality ratio -The number of maternal deaths per 100,000 live births in a specified period.

Skilled birth attendant- accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, child birth and immediate post natal period and in the identification, management and referral of complications in women and newborns.

Women of reproductive age- These are women aged 15-49 years

LIST OF ABBREVIATIONS

AIDS	:	Acquired Immuno-Deficiency Syndrome
ANC	:	Ante-natal Care
BP	:	Birth Preparedness
HIV	:	Human Immuno-Deficiency Virus
MDG	:	Millennium Development Goal
MNH	:	Maternal and Neonatal Health
MOH	:	Ministry Of Health
UNICEF	:	United Nations Children's Fund
WHO	:	World Health Organization

ABSTRACT

Background: Birth preparedness and complication readiness is the process of planning for normal birth and anticipating the action needed in the case of emergency. It is also a strategy to promote utilization of skilled maternal and neonatal care timely, based on the assumption that preparing for child birth and being ready for complications reduces delay in obtaining this care

Objective: The aim of the study was to assess the factors influencing birth preparedness among antenatal women at Kasangati Health center IV

Method: A descriptive cross sectional study was employed to assess the factors influencing birth preparedness among antenatal women at Kasangati Health center IV. A total of 368 women attending ANC clinic in Kasangati Health Centre were included in this study using non probability, convenient sampling technique. A structured questionnaire was used to collect data. Data were entered and analyzed using SPSS version 20.

Result: From the assessment done the level of birth preparedness was low at 19.6%. Occupation (OR=0.000), time taken to reach the nearest facility (OR=0.002), distance (OR=0.002), health education at ANC (OR=0.000), number of ANC visit (OR=0.040), giving birth to still birth (OR=0.000) and having babies who developed complication (OR=0.003) were independently associated with birth preparedness

Conclusion: The findings highlight the level of birth preparedness is low. The research recommends to ministry of health to sensitize women of reproductive age on birth preparedness. Birth preparedness should also be improved through quality ANC. The government through relevant agencies should encourage the education of the girl child and put in place strategies to increase the average income of women.

CHAPTER ONE: INTRODUCTION

1.0 Background of the study

Birth preparedness and complication readiness is the process of planning for normal birth and anticipating the action needed in the case of emergency. It is also a strategy to promote utilization of skilled maternal and neonatal care timely, based on the assumption that preparing for child birth and being ready for complications reduces delay in obtaining this care (MoH, 2004). Birth preparedness includes selecting birth location, identifying skilled provider and making the necessary plan to receive skilled care for normal birth and preparing for rapid action in the event of an obstetric emergency. An emergency plan should include identifying the nearest functional 24 hours emergency obstetric care facility, means of transportation in emergency, suitable blood donors, source of emergency funds, designation of person to make decision on the women's behalf and a person to care for her family while she is away (Donagh, 2006).

Inadequacy or lack of birth and emergency preparedness is one of several factors contributing to maternal deaths. Birth and emergency preparedness is an integral component of focused antenatal care which involves planning with the key stakeholders; the health provider, pregnant women and relatives and the community (Moran et al., 2006).

Adequate birth preparedness and emergency/complication readiness (BP/CR) planning could determine the survival of a pregnant woman and her unborn child (Onayade et al., 2010). BP/CR planning is a key component of globally accepted safe motherhood programs. It helps women to reach professional delivery care when labour begins and reduces delays that occur when mothers in labour experience obstetric complications (Hailu, Gebremariam, Alemseged & Deribe, 2011).

Birth preparedness programmes generally address 'three delays' to care-seeking for obstetric emergencies; delay in recognition of problem, delay in seeking care, and delay in receiving care at health facility. These delays represent barriers that often result in preventable maternal deaths (JHPIEGO, 2004).

Pregnant women who do not have adequate and appropriate information about pregnancy and childbirth would be ill-equipped to make choices that will contribute to their own wellbeing. Antenatal care should place emphasis on birth preparedness and complication readiness to

improve access to skilled and emergency obstetric care which has been shown to be critical in reducing maternal and/or perinatal mortality and morbidity (Mutiso et al, 2008)

BP/CR plan reduces delays in deciding to seek care in two ways. First, motivating pregnant women to plan to have a skilled provider at every birth. If women and families make the decision to seek care before the onset of labour, and they successfully follow through with this plan, the woman will reach care before developing any potential complications during childbirth, thus avoiding the first two delays completely. Second, complication readiness plan raises awareness of danger signs among women, families, and communities, thereby improving problem recognition and reducing the delay in deciding to seek care (Hailu et al., 2011).

Birth preparedness is one of the elements of focused ante-natal care (WHO, 2006). Birth preparedness and complication readiness is an approach that aims at raising awareness at the community level and creating a stronger demand for quality health services. Since pregnancy is perceived as an ordinary event, most families do not plan for a birth nor do they expect an emergency. Thus it is imperative that all women and their families are equipped with adequate information about the danger signs of a pregnancy complication and what actions should be taken. In addition, building or strengthening networks in the community is essential in order to ensure timely referrals and establish reliable transportation options (Paula, 2005)

A birth preparedness plan includes identification by the pregnant woman of the following elements; the desired place of birth, the preferred birth attendant, the location of the closest appropriate care facility, funds for birth related and emergency expenses, a decision maker during birth process, a birth companion, support in looking after the home and children while the woman is away, transport to a health facility for the birth, transport in the case of an obstetric emergency and identification of compatible blood donors in case of emergency (WHO, 2006).

WHO recommends that pregnant women should have a written plan for birth and for dealing with unexpected adverse events, such as complications or emergencies, that may occur during pregnancy, childbirth or the immediate postnatal period, and should discuss and review this plan with a skilled attendant at each ante-natal assessment and at least one month prior to the expected date of birth (WHO, 2006).

To have birth preparedness and complication readiness at the provider level, nurses, midwives, and doctors must have the knowledge and skills necessary to treat or stabilize and

refer women with complications, and they must employ sound normal birth practices that reduce the likelihood of preventable complications.

Birth and emergency planning is important because of the unpredictability of obstetric complications. It has been acknowledged that receiving care from a skilled provider is the single most important intervention in safe motherhood but often women are confronted with delays in seeking care (Udofia, 2013).

Adabre (2012) stated that there is some lack of women empowerment in theWakio district, central Uganda as a result decision about health care choices are often left in the hands of male partners who consult a soothsayer and make pronouncement on the outcome of an expected delivery before a woman in labour is sent to a clinic to deliver. That may delay efforts in seeking professional care and mortality may occur.

Despite the great potential of Birth Preparedness and Complication Readiness in reducing the maternal and new born deaths, the successes of this strategy is not well known in most of Uganda including Kasangati.

1.1 Statement of the problem

In Kasangati Health Center IV, an average of 200 mothers delivers every months both C-section and spontaneous vagina delivery. Almost half of these mothers, 80 (40%) come to the facility during labor/delivery with completely nothing, not even a piece of cloth to receive the baby and with not attendants to provide support and something to eat for these mothers during and after labour. And those who come in with obstetric complication faced a lot of hardship with referral as they as well don't have any one to attend to them outside the health workers sight. This is so because the mothers think they are entitled to the mama kits provided by the government, which the facility get about 250 kits every two months and the fact that they think the facility should provide everything, poverty and ignorance about birth preparedness.

Failure to plan in advance for a normal birth and inadequate preparation for urgent action in event of obstetric complications are factors contributing to delays in receiving skilled obstetric care and consequently contribute to maternal and neonatal mortality at Kasangati Health Center IV.

Failures by many pregnant women to prepare for their birth has made it hard to recognize the danger signs of obstetric complication. When complications occur, such unprepared women,

her spouse and / family waste time in recognizing the problem, making the decision to seek emergency obstetric care getting organized, getting money, finding transport and reaching the appropriate referral facility, and unprepared woman also faces problems after normal delivery such as keeping the baby warm, feeding herself and stigmatization from fellow women at the ward (Kasangati Health Center IV quarterly report, April 2016).

Despite efforts by government to provide mama kits to pregnant women, the mama kits only contains small cotton wool, child health card, ligatures, 2 pair of surgical gloves, baby soap and a mackintosh, which does solve the whole problem of birth preparedness as perceived by some pregnant women, and the health workers efforts to prepare these mothers during ANC by health educating them, most of the mothers still come to the facility during labor either not prepared at all or partially prepared making it delivery to become a big health problem.
The study therefore aim at exploring the factors influencing birth preparedness among antenatal women at Kasangati Health center IV

1.2 Justification

Every pregnant woman faces risk of life threatening obstetric complications (Othman et al., 2011). The UN Millennium Development Goal (MDG) on maternal health aims to reduce the number of women who die in pregnancy and childbirth by three-quarters between 1990 and 2015. To achieve this goal, it is estimated that an annual decline in maternal mortality of 5.5% is needed; however between 1990 and 2005 the annual decline was only 0.5% in the sub-Saharan region, compared to 4.2% for the middle income countries of Asia (WHO, 2006). With a maternal mortality ratio estimated to range from 215 to 558/100,000 live births and with only 42% of women assisted by skilled attendants during birth, Uganda is one of the countries still facing the burden of unsafe motherhood. The country target derived from the Millennium Development Goal five (MDG 5) to reduce maternal mortality ratio to 131/100,000 live births may not be achieved unless well-designed and focused interventions are instituted. The government of Uganda has embarked on a road map to accelerate the reduction of maternal/neonatal mortality and morbidity so as to achieve the MDG 5. One of the strategies laid down in this roadmap is to empower communities to ensure a continuum of care between the household and the health care facility (ministry of health, 2009).

1.3 Significance of the study

This study will generate information that can be used by decision makers to improve birth preparedness and consequently increase skilled birth attendance. The implementation of the findings of this study will lead to change in decisions at individual, family, county and national level. It can be used at policy and operational levels

The study will also contribute to the existing literature in Uganda concerning birth preparedness among pregnant women. This will help to identify the knowledge gaps that will be covered by future researchers for better outcomes.

This study will lead to award of Bachelor of Nursing Sciences of International Health Sciences University for the researcher once the study is completed.

1.4 Study objectives

1.4.1 Main objective

To determine the factors influencing birth preparedness among antenatal women at Kasangati Health center IV

1.4.2 Specific objectives

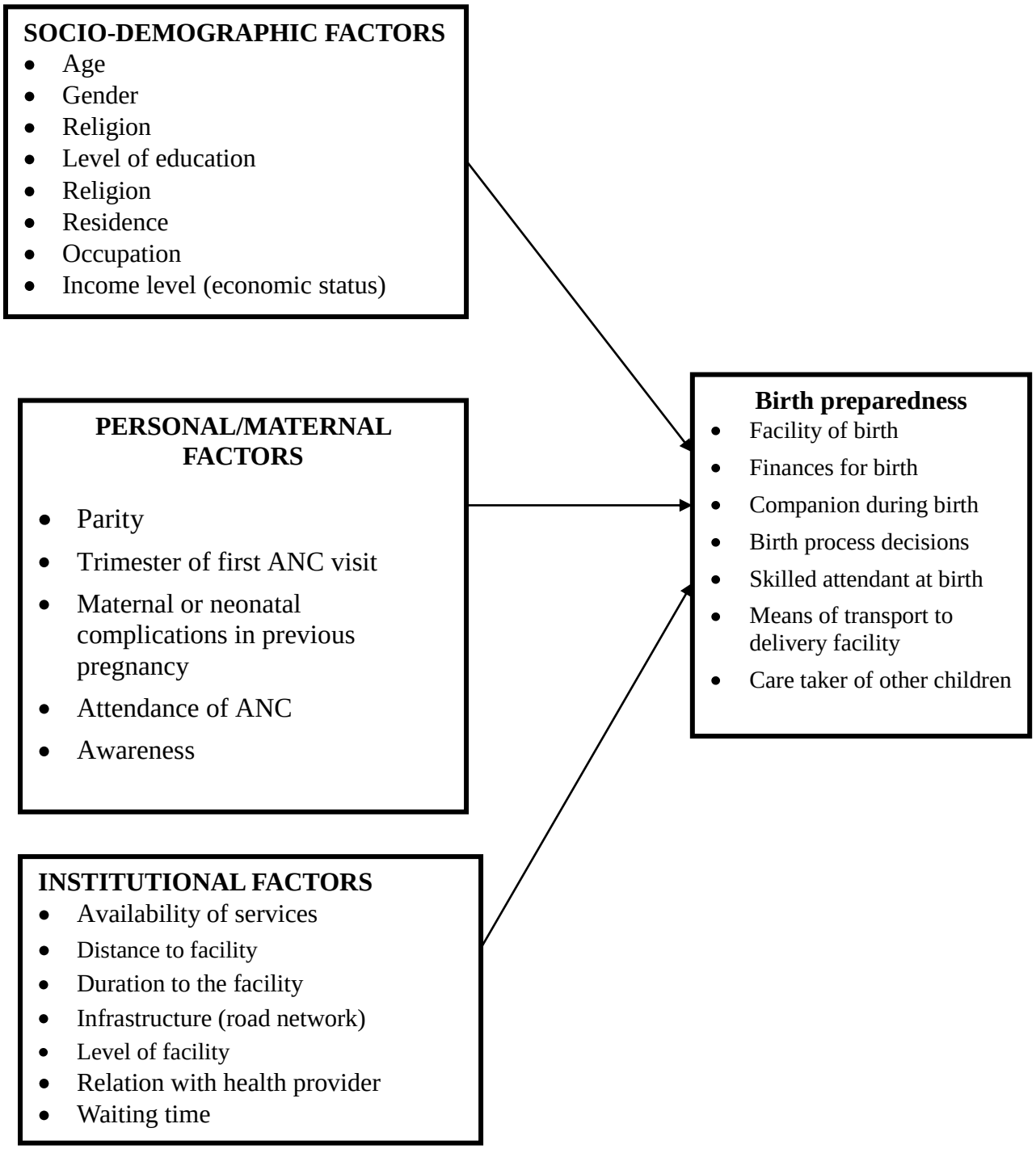
- To assess the socio-demographic related factors influencing birth preparedness among antenatal mothers at Kasangati Health center IV
- To determine the institutional related factors influencing birth preparedness among antenatal mothers at Kasangati Health center IV
- To determine the personal/maternal factors influencing birth preparedness among antenatal women at Kasangati Health center IV

1.5 Research question

- What are the socio-demographic related factors influencing birth preparedness among antenatal women at Kasangati Health center IV?
- What are the institutional related factors influencing birth preparedness among antenatal women at Kasangati Health center IV?
- What are the personal/maternal factors influencing birth preparedness among antenatal women at Kasangati Health center IV?

1.6 Conceptual framework

Figure 1: conceptual framework



The institutional and community factors are essential in achieving birth preparedness. The concept of birth preparedness is part of ante-natal care where mothers are taught on how to prepare for birth by health care workers. The approach and attitude expressed during the teaching determines to some extent the level of uptake of birth preparedness. The availability of services also determines whether one will prepare to seek services in that particular facility.

The community factors include factors found within the community that can be social or infrastructural. Infrastructure like road network is essential in having skilled attendance and reducing the delay of accessing the health facility. In a context like Kasangati where there is poor road network mothers need to prepare in advance. The means of transport like a vehicle to take one to hospital during labour is a major determinant of skilled attendance. A cultural belief like one has to deliver at home to prove that one is a 'real African woman affects need to deliver in a health facility'.

The socio-demographic factors includes age, residence, occupation, religion and level of education. An individual or a combination of factors may influence having birth preparedness. The level of education may affect decision making while religious affiliation may influence the acceptability of facility services.

Maternal factors include parity, gestation, outcome of previous pregnancies and place of birth of the last child may influence birth preparedness. Women with many births may occasionally not make plans because of their 'experience in labour' or prepare out of good practices learnt while the ones with the first pregnancy may prepare out of anxiety or fail to do so because of ignorance

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

In this chapter the goal is to review the literature in relation to the topic. Specific findings in relation to the literature and debates are identified in an attempt to widen the frontiers of factors associated with birth preparedness

2.1 Overview of level of birth preparedness among antenatal care women

A cross sectional study in Adrigat town (Ethiopia) identified poor comprehensive knowledge and practices of preparation for birth (Mihret et al., 2006). Among 538 randomly selected respondents taking into account identification of place of delivery, means of transport and saving money indicated that only 22% were prepared (Mihretet al., 2006).

In a related cross sectional study in Southern Ethiopia among 743 pregnant women, only a 20.5% of them identified a skilled provider and 8.1% identified a health facility for delivery care. Identification of means of transport to the delivery facility was also low (7.7%) and only 34.5% had saved money for delivery costs. Majority of the respondents delivered at home (87.9%), with only 8% planning to deliver in hospital (Hailuet al, 2011). In another descriptive study in northern Nigeria on birth preparedness and fathers' participation, 736 randomly selected respondents, only 6.2% had saved money for delivery costs and 19.5% had made arrangements for transport in the hospital (Zubairu, et al., 2010).

Siddaharth, et al., (2010)and his colleagues in their cross sectional study on birth preparedness among slum women in Indore city (India) indicated in that 47.8% of the 1,584 volunteer women prepared for birth in respect to identification of skilled attendance, place of delivery, means of transport and saving money for delivery costs. They deemed those who had at least three aspects to have prepared.

Deoki (2009) in a descriptive cross sectional study in Indore, India found that 18.6% of the 828 randomly selected women had transportation means and 44.2% had saved money for delivery. The overall birth preparedness index was 47.5%. Another descriptive Research in Homa Bay, Kenya among 234 respondents, showed that women and families prepared for the arrival of a new baby by setting aside some money but many do little else to prepare for the upcoming birth (Paula, 2005).

In a descriptive cross- sectional study among 994 women attending antenatal care at Kenyatta National hospital were interviewed using a pre-tested questionnaire between May 2006 and August 2006. Clients who were above 32 weeks gestation and had attended the clinic more than twice were recruited. Systematic sampling was used to select the study participants with every third client being interviewed, the study byMutiso (2008), over 60% of the respondents were counselled by health workers on various elements of birth preparedness. The study also established that most of the respondents (84.3%) had set aside funds for transport to hospital during labour while 62.9% had funds for emergencies and found that 65.2% had identified a birth companion.

A cross-sectional study was conducted among randomly selected 3612 pregnant women from June-September 2012. The data were collected by interviewer-administered structured questionnaire, the status of birth preparedness was 23.3% (Debelew et al, 2014)
A descriptive study using data from interviewer administered questionnaires and in-depth interviews to assess birth preparedness, complication readiness and male participation in maternity care in Ungogo, a northern Nigerian community. Majority of pregnancies were unplanned (96%). Only 32.1% of men ever accompanied their spouses for maternity care. There was very little preparation for skilled assistance during delivery (6.2%), savings for emergencies (19.5%) or transportation during labour (24.2%). Young paternal age, formal education and non-Hausa Fulani ethnicity were independent predictors of male participation in maternity care.

A descriptive cross-sectional study among pregnant women attending antenatal clinics in Ife Central Local Government Area, Ile-Ife, Osun State, Nigeria. The study population was stratified by type of facility (primary, secondary and tertiary health facilities) and respondents were selected proportional to client caseload per level of facility. Four hundred and one antenatal women were recruited. One hundred and fifty eight (39.3%) respondents knew no danger sign in pregnancy, childbirth and postpartum period. Only 24 (6.0%) had adequate knowledge of obstetric danger signs without prompting. Three hundred and forty (84.8%) and 312 (78.3%) women respectively had identified a birth place and begun saving money for delivery. As many as 304 (79.4%) made no arrangement for a blood donor. Majority of pregnant women (60-82%) took five other steps towards emergency readiness. By the study criteria, 140 (34.9%) and 265 (66.1%) were birth and complication prepared respectively.

A community based cross sectional study was conducted in Gobaworeda, Oromia region, Ethiopia.Multistage sampling was employed to assess birth preparedness and complication readiness among women of child bearing age group, 580 participants were recruited, the study found that only 29.9% of the respondents were prepared for birth. And, only 82 (14.6%) study participants were knowledgeable about birth preparedness and complication readiness (Desalegn et al, 2014)

Community-based cross-sectional study supplemented by qualitative design was conducted in January, 2012.A total of 575 women from 5 kebeles were selected after proportionally allocated to population size and interviewed using structured and semi-structured, pre-tested questionnaires to find out knowledge and practices towards birth preparedness and complication readiness and associated factors among women of reproductive age group (15-49) in Robe Woreda, Arsi Zone, Oromia Region, Ethiopia. Taking into account place of delivery identification, means of transportation, skilled attendant identification and saving money, about 16.5% of the respondents were prepared for birth and its complications (Kaso et al, 2014).

A cross-sectional survey was conducted where 756 recent fathers were invited through a two-stage cluster sampling procedure. A structured questionnaire was used to collect socio-demographic characteristics to assess the level of knowledge of obstetric complications among men in a rural community in Tanzania, and to determine their involvement in birth preparedness and complication readiness. Among the invited men, 95.9% agreed to participate in the community survey. Fifty-three percent could mention at least one danger sign during pregnancy, 43.9% during delivery and 34.6% during the postpartum period. Regarding birth preparedness and complication readiness, 54.3%had bought birth kit, 47.2%saved money, 10.2%identified transport, 0.8% identified skilled attendant. In general, only 12% of men were prepared (Furaha et al, 2015)

In 2004, a cross-sectional survey with a random sample of respondents was conducted to measure the impact of birth-preparedness and complication readiness on the use of skilled providers at birth. Of the 180 women who had given birth within 12 months of the survey, 46.1% had a plan for transportation, and 83.3% had a plan to save money. Women with these plans were more likely to give birth with the assistance of a skilled provider. The majority of women reported planning for birth; 43.4% planned for a birth provider, 46.1% planned for

transportation, and 83.3% planned to save money in the case of an emergency. Birth-planning was also high among pregnant women. Seventy-one percent planned for a birth provider, 51.1% planned for transportation, and 61.1% planned to save money in the event of an emergency (Moran AC et al 2006)

A community based cross-sectional study was conducted in 2013 to assess birth preparedness and complication readiness and its associated factors among pregnant woman in DugunaFango District in Wolayta Zone, South Ethiopia., on a sample of 578 randomly selected pregnant women. Data were collected using pre-tested and structured questionnaire, among 578 pregnant women only one tenth (10.7%) of pregnant women identified skilled provider. Only 103 (18.1%) arranged transportation to health facility. Two hundred forty eight (43.6%) identified health facility for delivery and/or for obstetric emergencies. More than half (54.1%) of families saved money for incurred costs of delivery and emergency if needed. only few 17(3%) identified potential blood donor in case of emergency hundred sixty four (46.4%) of the respondents reported that they intended to deliver at home, and more than half (53.6) planned to deliver at health facilities. Overall less than one fifth 18.3%of pregnant women were well prepared (Gebre et al, 2015)

A cross sectional study conducted to assess knowledge and practices with respect to birth preparedness and complication readiness among women in Mpwapwa district in Tanzania.Through a multistage cluster random sampling a total of 600 women from the whole district were selected to be included in the study. Among them 587 (97.8%) attended antenatal clinic (ANC) at least once during their last pregnancy. Two thirds of those who attended ANC made four or more visits. The median gestation age at booking for antenatal care was 16 weeks. However, 73.9% the women booked after 16 weeks of gestation. Two thirds of the women were 20-34years old and had at least primary education level. Three hundred and forty six (57.7%) had parity between two and four. Only 14.8% of the women knew three or more obstetric danger signs. The obstetric danger signs most commonly known included vaginal bleeding during pregnancy (19%), foul smelling vaginal discharge (15%) and baby stops moving (14.3%). The majority (86.2%) of the women had decisions made on place of delivery, a person to make final decision, a person to assist during delivery, someone to take care of the family and a person to escort her to health facility. Majority (68.1%) of the women planned to be delivered by skilled attendant. One third of the women planned to deliver at home in the absence of a skilled birth attendant (Urassa et al, 2012)

2.2 Socio-demographic factors influencing birth preparedness among antenatal care women

A descriptive study among 472 pregnant women in Adrigat, Ethiopia indicated that maternal education was a strong predictor in preparation for birth and complication. Literate mothers were about two times more likely to be prepared for birth and complication than illiterate women. Marital status was another factor that was strongly associated with birth preparedness and complications readiness. Married women were more likely to be prepared for birth/complication than non-married. There was a statistically significant association between parity and preparation for birth and its complication. Women with parity range of 2 to 4 were more likely to prepare for birth and its complication than grand multiparas (more than 4 deliveries) and primiparous women (first time delivery). Women who had history of still birth were also more likely to prepare for birth and its complication than those who did not have still birth. Advice given on preparation for birth and its complication during ANC follow up was also significantly associated with preparation for birth/complication. Women who were advised about where to give birth and arrangements for money and transportation during their ANC follow up were more likely to be prepared for birth and its complication than those that were not given such advice (Mihretet al., 2006).

A cross sectional study on birth preparedness among slum women in Indore city (India) found that literacy, availability of ante-natal services, literate husband, better knowledge about maternal/newborn danger signs suggestive for seeking referral were associated with well preparedness (Siddaharth, et al., (2010).

A cross sectional study conducted to assess knowledge and practices with respect to birth preparedness and complication readiness among women in Mpwapwa district in Tanzania. Through a multistage cluster random sampling a total of 600 women from the whole district were selected to be included in the study, age of the woman, education, marital status, number of ANC visits and knowing ≥3 obstetric danger signs were associated with birth preparedness and complication readiness (Urassa et al, 2012).

In A descriptive cross- sectional study among 994 women attending antenatal care at Kenyatta National hospital were interviewed using a pre-tested questionnaire between May 2006 and August 2006. Clients who were above 32 weeks gestation and had attended the clinic more than twice were recruited. Systematic sampling was used to select the study participants with every third client being interviewed, the study found that the level of

education positively influenced birth preparedness (Mutiso, 2008). In a study in Uganda, parity, age of spouse, education level, occupation of spouse, presence of pregnancy complications and the anticipated mode of delivery were associated with having a birth plan. Educated women have better pregnancy outcome compared with uneducated women, possibly since they are better informed, are likely to make better choices, are more likely to develop and implement a birth plan, and are more socially or financially empowered to make the necessary decisions in case of obstetric emergencies. Information, education and counselling plays a vital role in prevention of maternal death. This it does by making the pregnant women (and their partners) aware of the sequence of events from late recognition of danger signs, through delays in seeking care to delays in receiving prompt care (Kakaireet al., 2011)

A community based cross sectional study was conducted in Gobaworeda, Oromia region, Ethiopia. Multistage sampling was employed to assess birth preparedness and complication readiness among women of child bearing age group, 580 participants were recruited, place of residence, occupation, educational level, family size, as well as gravida and parity were found to have statistically significant association with birth preparedness and complication readiness. The odds of birth preparedness and complication readiness were two times greater among urban resident when compared to rural resident, educational level of mother was also found as a predictor of birth preparedness and complication readiness. The odds of birth preparedness and complication readiness of woman who attended to the primary, and secondary and higher level of education were three and nearly three times higher than that those who did not attend formal education respectively (Desalegn et al, 2014).

A cross-sectional study was conducted among randomly selected 3612 pregnant women from June-September 2012. The data were collected by interviewer-administered structured questionnaire, among the socio-demographic and economic characteristics considered as level-1, educational status, husband's occupation and wealth quintiles were found to have statistically significant association with BP practice. Women who attended primary, secondary or tertiary were more likely to be prepared as compared to women who didn't attend any formal education. Women having employed or merchant husbands were more likely to be prepared as compared to women having farmer husband. Women in the third, fourth or fifth wealth quintiles were more likely to be prepared as compared to women in the lowest quintiles (Debelew et al, 2014)

A descriptive study using data from interviewer administered questionnaires and in-depth interviews to assess birth preparedness, complication readiness and male participation in maternity care in Ungogo, a northern Nigerian community forty three of the 97 respondents under the age of 30 years (44.3%) ever accompanied their wives to the hospital for maternity care compared to 82 (28.1%) of 292 men 30 years or older. This difference was statistically significant. Men who had formal education n=103, 37.9%) were more likely to participate in maternity care compared to those with non-formal education (n=22, 18.8%). Furthermore, a higher proportion (n=18, 51.4%) of non-Muslim men participated in maternity care compared to their Muslim counterparts (n=107, 30.2%). Table 6 shows that after adjustment for the effect of confounding using logistic regression (Iliyasu et al, 2010)

A descriptive cross-sectional study among pregnant women attending antenatal clinics in Ife Central Local Government Area, Ile-Ife, Osun State, Nigeria. The study population was stratified by type of facility (primary, secondary and tertiary health facilities) and respondents were selected proportional to client caseload per level of facility. Bivariate analysis showed that both socio-demographic and clinical factors are significantly associated with the respondents' preparation for delivery. Respondents from the tertiary health facility, those with tertiary education, those who were married and of the high upper socioeconomic class, those who had four or more antenatal visits, those booked in the third trimester or who were in the third trimester at the time of study and those who lived within 30 minutes of travel from their chosen birth places were more likely to have made adequate preparation for the birth of the in their baby (AbioyeKuteyi et al, 2011)

A total of 575 women from 5 kebeles were selected after proportionally allocated to population size and interviewed using structured and semi-structured, pre-tested questionnaires to find out knowledge and practices towards birth preparedness and complication readiness and associated factors among women of reproductive age group (15-49) in Robe Woreda, Arsi Zone, Oromia Region, Ethiopia. Preparation for birth was higher among educated mothers. Monthly income of >716 Ethiopian birr, ANC visit, knowledge of obstetric complications and those who had given birth at health facility before their last delivery were also significantly associated with birth preparedness. By Applying multiple logistic regression on socio demographic variables; women's education and monthly income and obstetric factors; gravida, parity, ANC visit, knowledge of the danger signs of obstetric

complications, presence of history of still birth, history of delivery at health facility before last delivery, and birth order were adjusted. Only their educational status and their monthly income were significantly associated with birth preparedness and complication readiness among sociodemographic variables. If women have secondary education and above six times and monthly income above 716 Ethiopian birr two times were more likely to prepare for birth and its complication respectively (Kaso et al, 2014)

A Qualitative phenomenological type of study was conducted; and analyzed using thematic analysis. Respondents consisting of 87 pregnant women were selected purposely. Focus group consisted of 5-10 women during each session of 45 minutes interview, Socio demographic, economic, knowledge of key danger signs, attitude toward antenatal care use were identified as associated factors hindering birth preparedness in this community (Arunibebi et al, 2015)

2.3 Institutional factors affecting birth preparedness among antenatal care women

For effective implementation of birth preparedness, policy makers are expected to create an environment that supports the survival of women and newborns. This is by formulating the appropriate policies, using evidence based decision making and providing adequate resources. The facilities should be well adequately staffed and managed to provide skilled care for the pregnant women and newborn. The health care providers should be well skilled to manage normal and complicated pregnancies (JHPIEGO, 2001).

Institutional based cross-Sectional study was conducted on 224 sampled pregnant women from September 14, 2014- October, 24 2014 who were attending Ante Natal Care in Federal Referral Police Hospital, Addis Ababa. About 126(56.3 %) of the women were considered as prepared for birth, maternal age was significantly associated with birth preparedness and complication readiness. Mothers whose age less than 20 years were about 3times more likely to prepare for birth and it's complication than mothers with age 20 years and above other socio demographic factor did not show significant association with birth preparedness (Tiku et al, 2015).

A cross-sectional study was conducted among randomly selected 3612 pregnant women from June-September 2012. The data were collected by interviewer-administered structured

questionnaire, Being in urban residence and having health center within two hours distance were among the higher level factors increasing birth preparedness (Debelew et al, 2014)
A total of 575 women from 5 kebeles were selected after proportionally allocated to population size and interviewed using structured and semi-structured, pre-tested questionnaires to find out knowledge and practices towards birth preparedness and complication readiness and associated factors among women of reproductive age group (15-49) in Robe Woreda, Arsi Zone, Oromia Region, Ethiopia. Preparation for birth was higher among those who had given birth at health facility before their last delivery. Knowledge of danger sign of obstetric complications was also significantly associated with birth preparedness. Mothers who know the presence of obstetric complications were three times more likely to prepare for birth and its complications than mothers who didn't know the presence of complications (Addisse et al, 2014)

A Qualitative phenomenological type of study was conducted; and analyzed using thematic analysis. Respondents consisting of 87 pregnant women were used for the study. Focus group consisted of 5-10 women during each session of 45 minutes interview. Results shows that majority of the participants do not visit any health care facility until their third trimester, whereas the TBAs places are mostly visit. Also majority of the participants do not engage in any form of preparation until after delivery. Participants noted that they will invite their mothers to assist them with domestic chores and care of the new baby. However they seem not to have any formal preparation for other siblings. The status of birth preparedness and complication readiness was low in Okpatu community (Arunibebi et al, 2015).
A Community survey methods was used to identify 759 recently delivered women from 120 villages in rural Mbarara district to assess the influence of birth preparedness practices and decision-making and assistance by SBAs among women in south-western Uganda. Interviewer-administered questionnaires were used to collect data. Education, household assets and birth preparedness showed clear synergistic effect on the relationship between decision-maker on location of birth and assistance by SBAs. Other factors which showed statistical significant relationships with assistance by SBAs were ANC attendance, parity and residence (Kabakyenga et al, 2012).

2.4 Personal factors influencing birth preparedness among antenatal care women

A cross-sectional community-based study conducted in September and October 2006 to assess knowledge and practices with respect to birth preparedness and complication readiness and factors associated with their practices among women who gave birth in the last 12 months preceding the survey in Adigrat Town, Tigray Regional State, Ethiopia. A total of 538 women who gave birth in the last 12 months preceding the survey were randomly selected for interview, the majority (94.4%) of the respondents have attended antenatal care (ANC) at least once in their lifetime. Of the total, about 63% respondents started their follow up while the pregnancy was between 4 and 6 months and 21.2% respondents had first ANC visit by a skilled care provider in the first three months of pregnancy. About 73% of the total respondents had 4 or more visits. Three hundred forty seven (65.0%) women gave birth in health institutions whereas 35.0% delivered at home. Three hundred ninety eight (74.5%) women gave birth at a place where they planned ahead (Mihretet al., 2006).

A cross-sectional study was conducted among randomly selected 3612 pregnant women from June-September 2012. The data were collected by interviewer-administered structured questionnaire, among the obstetric related factors considered at individual attitude and frequency of ANC visits had significant association with BP and CR practice. Women, having favorable attitude towards BP was found to increase the likelihood of preparation significantly. ANC visit was also among the strong predictors of BP and CR. Having 1-3 visits and greater or equal to 4 visits were found to increase the likelihood of preparation as compared to those who didn't attend ANC visit at all (Debelew et al, 2014)

In A descriptive cross- sectional study among 994 women attending antenatal care at Kenyatta National hospital were interviewed using a pre-tested questionnaire between May 2006 and August 2006. Clients who were above 32 weeks gestation and had attended the clinic more than twice were recruited. Systematic sampling was used to select the study participants with every third client being interviewed, the study, only 21.8% of the respondents had commenced antenatal care during the first trimester, and 29.3% of the respondents were not given information on signs of labour. In the study 14.7% of the respondents were not informed about the importance of hospital delivery (Mutiso, 2008).

A community based cross sectional study was conducted in Gobaworeda, Oromia region, Ethiopia. Multistage sampling was employed to assess birth preparedness and complication readiness among women of child bearing age group, 580 participants were recruited,

Regarding some of the factors affecting birth preparedness and complication readiness, the study found educational status of the women, and ANC follow up has significant statistical association with birth preparedness, the odds of birth preparedness was eight times greater among women who have ANC follow up when compared with women who did not have ANC follow up (Desalegn et al, 2014).

A total of 575 women from 5 kebeles were selected after proportionally allocated to population size and interviewed using structured and semi-structured, pre-tested questionnaires to find out knowledge and practices towards birth preparedness and complication readiness and associated factors among women of reproductive age group (15-49) in Robe Woreda, Arsi Zone, Oromia Region, Ethiopia. Preparation for birth was higher among ANC visit, and knowledge of obstetric complications. The majority (86.4%) of the respondents have attended antenatal care (ANC) at least once in their last pregnancy period. Out of the total mothers who have attended ANC, 49% of the respondents started their follow up while the pregnancy was between 4 and 6 months and 31% of the respondents had their first ANC visit in the first three months of pregnancy. One hundred thirty nine (28%) of the respondents had 4 or more visits. obstetric factors; Gravida, parity, ANC visit, knowledge of the danger signs of obstetric complications, presence of history of still birth, history of delivery at health facility before last delivery and birth order with socio demographic variables; women's education and monthly income were adjusted, only ANC visit and history of delivery at health facility before last delivery have significantly associated with birth preparedness. Women who had ANC visits were six times more likely to prepare for birth when compared to those who did not have ANC visit. Women who had history of delivery at health facility before last delivery were four times more likely to prepare for birth when compared to those who did not have history of delivery at health facility before last delivery (Kaso et al, 2014)

Another cross sectional study revealed that birth order of four or more and being grand multipara found to be significantly associated with birth preparedness and complication readiness. As birth order increases birth preparedness and complication readiness decreases. As gravidity and parity increases more than five pregnancy/child birth, birth preparedness and complication readiness decreases respectively. Obviously, prenatal visit was found to be factors associated with birth preparedness and complication readiness. Women who had hi story of antenatal visit were more likely to prepare for birth and its complication. Frequency

of antenatal care follow-up also found to be strong predictor of birth preparedness and complication readiness. Mothers who had given birth at health facility before their last delivery were more likely to prepare for birth and its complication. Moreover, mothers who had past history of still birth were more likely to prepare for birth and its complication. By Applying multiple logistic regression on socio demographic variables; women's education and monthly income and obstetric factors; gravida, parity, ANC visit, knowledge of the danger signs of obstetric complications, presence of history of still birth, history of delivery at health facility before last delivery, and birth order were adjusted, mothers who know the presence of obstetric complications were three times more likely to prepare for birth and its complications than mothers didn't know the presence of complications (Addisse et al, 2014)
A cross-sectional survey was conducted where 756 recent fathers were invited through a two-stage cluster sampling procedure. A structured questionnaire was used to collect socio-demographic characteristics to assess the level of knowledge of obstetric complications among men in a rural community in Tanzania, and to determine their involvement in birth preparedness and complication readiness. Birth preparedness was associated with knowledge of danger signs during pregnancy. It was less likely for men living in the rural area to be prepared (Furaha et al, 2015)

A qualitative study design using Focused Group Discussions was conducted. Twelve focus group discussions were held with four separate groups: young men and women and older men and women in a rural community in Tanzania. The community members expressed a perceived need to prepare for childbirth. They were aware of the importance to attend the antenatal clinics, relied on family support for practical and financial preparations such as saving money for costs related to delivery, moving closer to the nearest hospital, and also to use traditional herbs, in favour of a positive outcome. Community recognized that pregnancy and childbirth complications are preferably treated at hospital. Facility delivery was preferred; however, certain factors including stigma on unmarried women and transportation were identified as hindering birth preparedness and hence utilization of skilled care. Challenges were related to the consequences of poverty, though the maternal health care should be free, they perceived difficulties due to informal user fees (Furaha et al, 2015)
A cross-sectional survey with a random sample of 180 respondents conducted to measure the impact of birth-preparedness. Controlling for education, parity, average distance to health facility, and the number of antenatal care visits, planning to save money was associated with giving birth with the assistance of a skilled provider. Women with knowledge of at least five

danger signs were no more likely to give birth with the assistance of a skilled provider than women with less knowledge of danger signs (odds ratio [OR]=1.08; 95% confidence interval. Similarly, women with a plan for transport were no more likely to give birth with the assistance of a skilled provider than those women who did not plan for transport. It was also included education of women and parity as the literature demonstrates that these variables are strongly associated with use of skilled care at delivery (Moran AC et al, 2015)

A community based cross sectional study conducted in 2007, on a sample of 812 pregnant women to assess practice and factors associated with BPACR among pregnant women in AletaWondo district in Sidama Zone, South Ethiopia. Data were collected using pre-tested and structured questionnaire, 743 pregnant women only a quarter (20.5%) of pregnant women identified skilled provider. Only 8.1% identified health facility for delivery and/or for obstetric emergencies. Preparedness for transportation was found to be very low (7.7%). Considerable (34.5%) number of families saved money for incurred costs of delivery and emergency if needed. Only few (2.3%) identified potential blood donor in case of emergency. Majority (87.9%) of the respondents reported that they intended to deliver at home, and only 60(8%) planned to deliver at health facilities. Overall only 17% of pregnant women were well prepared. The adjusted multivariate model showed that significant predictors for being well-prepared were maternal availing of antenatal services and being pregnant for the first time (Hailu et al, 2011)

A community based cross-sectional study was conducted in 2013 to assess birth preparedness and complication readiness and its associated factors among pregnant woman in DugunaFango District in Wolayta Zone, South Ethiopia., on a sample of 578 randomly selected pregnant women. Data were collected using pre-tested and structured questionnaire, being well-prepared were significantly associated with maternal availing of antenatal services, being pregnant for the first time, having knowledge of at least two danger signs during pregnancy and history of past obstetric complication (Gebre et al, 2015)

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter describes the methodology that was used in the study, factors influencing birth preparedness among antenatal mothers at Kasangati Health Centre IV. It presents the study setting, population, inclusion and exclusion criteria, sample size estimation, variables, data collection, data management and analysis, quality control and ethical considerations are described in this chapter.

3.1 Study design

This was a cross sectional study that relied on both quantitative methods of data collection. This design has been chosen because data on preparedness among antenatal mothers was collected at one point in time due to the time constraint. This study design was reported to be the most suitable for describing associations between variables and therefore informs decisions for further research.

3.2 Study site/area

This study was carried out at Kasangati Health Centre IV located in Kasangati, Wakiso district, Central Uganda. Kasangati is 16.5 kilometres north of Kampala on the Kampala-Gayaza Road. This town is immediately south of the slightly smaller area of Gayaza along the Kampala-Gayaza Road. The facility is located approximately 1 hours' drive north from Kampala central business centre. The facility have a medical and surgical wards, an outpatient department and maternity services. The facility delivery an average of 200 mothers every month.

3.3 Sources of data

3.3.1 Primary data

The primary source of data for this study was the information collected from antenatal mothers at Kasangati Health Centre IV.

3.4 Population

3.4.1 Target population

This study targets all antenatal mothers in Wakiso district

3.4.2 Accessible population

The accessible population included all antenatal mothers attending ANC services at Kasangati Health Centre IV, Wakiso district

3.4.3 Study population

This study included antenatal mothers attending ANC clinic at Kasangati Health Centre IV who met the eligibility criteria in the inclusion criteria and consented to take part in the study.

3.5 Sample size calculation

Sample size was estimated using the Kish and Leisley formula of 1965 for descriptive studies sample size calculation.

$N= (Z^2pq) /d^2)$

Where;

N represents number of respondents required for the study

Z is the value corresponding to 95% confidence interval or risk level (1.96)

P = 40% of mothers who come to the facility unprepared for the birth (Kasangati Health Centre IV quarterly report, April 2016).

d=the study will accommodate an error of 5%

N= (1.96 x1.96 x 0.4 x (1-0.4)/ (0.05 x 0.05)

N= 368 study participants.

3.6 Selection criteria

3.6.1Inclusion criteria

The following were included in the study;

All antenatal mothers, age 18 years and above attending ANC clinic in Kasangati Health Centre IV who consented to participant in the study.

3.6.1 Exclusion criteria

The following were excluded from the study

Antenatal mothers attending ANC clinic in Kasangati Health Centre IV who were very sick and below the age of 18 years.

Antenatal mothers attending ANC clinic in Kasangati Health Centre IV who were mentally unfit were not enrolled in the study.

3.7 Sampling procedure

This study employed a non-probability sampling method, convenient sampling methods. Every antenatal mothers who fitted in the inclusion criteria and consented to participate were included until the required sample size is attained.

3.8 Study variables

3.8. 1 Dependent variables

Dependent variable in this study was prevalence of birth preparedness among antenatal mothers at Kasangati Health Centre IV.

3.8.2 Independent variables

Demographic factors

- Age
- Gender
- Religion
- Level of education
- Religion
- Residence
- Occupation
- Income level (economic status)

Maternal factors

- Parity
- Trimester of first ANC visit
- Maternal or neonatal complications in previous pregnancy
- Attendance of ANC
- Awareness

Health facility factors

- Availability of services
- Distance to facility
- Duration to the facility
- Infrastructure (road network)

- Level of facility
- Relation with health provider
- Waiting time

3.9 Data collection techniques

Data was gathered through an administered in depth interview with antenatal mothers at Kasangati Health centre IV using a pretested questionnaires. The questionnaires were translated to Luganda orally while being administered and it was collected information on factors influencing birth preparedness. Research assistants were trained to help in administration of the questions. The qualitative data was collected by the use of Focus Group discussion from the group of at least 8 antenatal mothers and Key informant interview guide was used to collect data from purposely selected health workers

3.10 Data collection tools

The research instrument was the questionnaires which was used and could be applied on many respondents, Focus group discussion and Key informant interview guide. The questions were both closed and open ended in English language. The questionnaires were pre-tested in Naguru hospital to improve the quality and minimize information bias and each questionnaire was measured both the dependent ad independent variables. Questions generated information on factors influencing birth preparedness among antenatal mothers. The questionnaires constituted of four parts, the first part contained questions that assessed the demographic characteristic of the respondents, the second parts contained questions regarding the institutional factors , the third parts had questions assessing the maternal factors on birth preparedness and the finally the fourth part assessed the birth preparedness

3.11 Data management

The questionnaires were checked after being filled by research assistant to ensure that there is no question left unanswered and then kept under lock and key. Data was coded to increase accuracy, data was entered and analysed using SPSS. Descriptive summary statistic such as percentage was computed. Uni-variate analysis was used for the frequency, Bi-variate analysis was used to find out the association between the dependent and independent variables and multi-variate analysis was explained the detailed association between variables.

3.12 Plan for data analysis

After the interview, questionnaires were checked for completeness, questionnaires were kept in a secure place where only the researcher and the supervisor were accessed to them. When all the data were collected, the responses processed into a meaningful study finding using SPSS statistical computer package. Frequency counts, tables and graphs were used to summarize the data in a manner that yielded answers to research questions

3.13 Quality control

Quantitative data using structured questionnaires were translated orally into Luganda to facilitate communication. The questionnaires were piloted in Naguru hospital to improve clarity of the questions. Research assistant were well trained. Data quality was ensured by giving identification number and code to help in data entry and checking.

3.14 Ethical consideration

International health Sciences University first approved the research proposal. Permission to carry out the research was obtained from the authority of Kasangati health centre IV and the respondents was provided with a written consent form before the interview is conducted. Voluntary participation was emphasized, the participants was given the opportunity to ask questions and confidentiality was assured to them. Informed consent was secured from the study participants and confidentiality was maintained throughout the study, no name appeared on the questionnaires to maintain anonymity, only codes were used.

Participants had the right to withdraw from the study or withdraw any statement before analysis. No physical harm was expected since no clinical samples was required. All the information that was obtained from the study was strictly be for academic purposes and not for any other reasons against the respondents. The respondents were informed that they were free to withdraw from the study at any time if they wish

3.15 Limitation of the study

The researcher anticipates the following problems;

Many people declined to take part claiming to be busy or because of fear of stigmatization

The study findings depended on the respondents answer whether they are wrong or right

3.16 Plan for dissemination

The findings of this study was presented to International Health Sciences University, as a partial fulfillment for the award of the degree in nursing science. The report was disseminated to Kasangati Health centre IV. The findings may also be published in the ministry of health bulletin

CHAPTER FOUR: RESULTS

4.0 Introduction

A total of 368 women age 15-45 were interviewed during the period of data collection. The results of the study are presented according to the study objectives. Results from Uni-variate, bi-variate and multi-variateare presented in text and tables and figures. For most findings tables have been used in the presentation of the gathered information.

4.1 Demographic factors influencing birth preparedness among antenatal care women

Table 1: showing the respondents' demographic characteristic

Variables	**Frequency, n**	**Percentage, %**
Age of the respondent		
15-19	93	25.3
20-24	117	31.8
25-29	83	22.6
>30	75	20.4
Highest level of education of the respondent		
No formal education	56	15.2
Lower primary education	52	14.1
Upper primary education	70	19.0
Incomplete secondary education	56	15.2
Complete secondary education	68	18.5
Tertiary college	66	17.9
Marital status during pregnancy and delivery		
Never married	28	7.6
Married	308	83.7
Separated	17	4.6
Divorced	9	2.4
Windowed	6	1.6
Religion of the respondent		
Protestant	137	37.2
Catholic	139	37.8
Muslim	92	25.0
others		
Occupation of the respondent		
House wife	95	25.8
Subsistence farmer	86	23.4
Salaried employment	71	19.3
Unemployed	89	24.2
Business lady	27	7.3
Occupation of the spouse/partner		
Subsistence farmer	68	18.5
Unemployed	99	26.9
salaried employment	89	24.2
Business	112	30.4
What is your estimate average income per month		
less than 50k	178	48.4
50-150	114	31.0
more than 150	76	20.7
Residence		
Rural	196	53.3
Urban	172	46.7

Majority of the respondents 31.8% were in the age group 20-24. Regarding education level, 19% of the respondents had attained upper primary education while 18.5% had completed secondary education. Most of the respondents 83.7%were married. Catholics at 37.8% was the most dominant religion. Most of the respondents 25.8% were housewife. Regarding the occupation of the spouse, 30.4% were businessmen. Most of the respondents 48.4% had monthly income of less than 50,000ugx and finally, 53.3% reside in the rural area.

Table 2: The demographic characteristics and birth preparedness

Variables	**Birth preparedness**		**X^2**	**p-value**
	prepared	**Unpreparedness**		
Age of the respondent			1.667	0.644
15-19	20(27.8%)	73(24.7%)		
20-24	19(26.4%)	98(33.1%)		
25-29	19(26.4%)	64(21.6%)		
>30	14(19.4%)	61(20.6%)		
Highest level of education of the respondent			46.141	O.001*
No formal education	13(18.1%)	43(14.5%)		
Lower primary education	10(13.9%)	42914.2%)		
Upper primary education	15(20.8%)	55(18.6%)		
Incomplete secondary education	9(12.5%)	47(15.9%)		
Complete secondary education	14(19.4%)	54(18.2%)		
Tertiary college	11(15.3%)	55(18.6%)		
Marital status during pregnancy and delivery			8.514	.050
Never married	17(23.6%)	81(27.4%)		
Married	10(13.9%)	65(22.0%)		
Separated	17(23.6%)	60(20.3%)		
Divorced	7(9.7%)	42(14.2%)		
Windowed	21(29.2%)	48(16.2%)		
Religion of the respondent			3.084	0.214
Protestant	29(40.3%)	108(36.5%)		
Catholic	21(29.2%)	118(39.9%)		
Muslim	22(30.6%)	70(23.6%)		
Occupation of the respondent			6.334	0.013*
House wife	17(23.6%)	78(26.4%)		
Subsistence farmer	21(29.2%)	65(22.0%)		
Salaried employment	18(25.0%)	53(17.9%)		
Unemployed	14(19.4%)	75(25.3%)		
Business lady	2(2.8%)	25(8.4%)		
Occupation of the spouse/partner			5.405	0.034*
Subsistence farmer	8911.1%)	60(20.3%)		
Unemployed	24(33.3%)	75(25.3%)		
salaried employment	21(29.2%)	68(23.0%)		
Business	19(26.4%)	93(31.4%)		
What is your estimate average income per month			1.110	0.574
less tha 50k	32(44.4%)	146(49.3%)		
50-150	26(36.1%)	88(29.7%)		
more than 150	14(19.4%)	62(20.9%)		
Residence			.777	0.378
Rural	35(48.6%)	161(54.4%)		
Urban	37(51.4%)	135(45.6%)		

The socio demographic factors of educational level X^2=46.141, P=0.001), occupation of the respondents X^2=6.334, P=0.013), and occupation of the spouse (X^2=5.405, P=0.034) were significantly associated with birth preparedness

4.2 Institutional factors influencing birth preparedness among antenatal care women

Table 3: The institutional factors of the respondents

Variables	**Frequency, n**	**Percentage, %**
How long does it take to reach your nearest delivery health facility using your common means of transport?		
less than one hour	69	18.8
1-2 hours	74	20.1
3-5 hours	118	32.1
more than 5 hours	107	29.1
What is your common mode of transport to the health facility?		
public transport		
private vehicle	140	38.0
motorbike	70	19.0
on foot	94	25.5
others	64	17.4
How far is your home from the health facility that provides non operative delivery services?		
Less than 2Km	63	17.1
2-5Km	84	22.8
5-10km	74	20.1
More than 10km	147	39.9
How long does it take to reach the health facility that provides non operative delivery services?		
less than 1 hour	107	29.1
1-5 hours	140	38.0
more than 5 hours	121	32.9
How far is your home from a facility that can offer operative delivery services?		
Less than 5km	73	19.8
5-10km ``	65	17.7
10-20km	52	14.1
20-30km	82	22.3
More than 30km	96	26.1
Were you health educated during ANC about birth preparedness?		
Yes	155	42.1
No	213	57.9
Were you given any items during ANC?		
Yes	197	53.5
No	171	46.5

Most of the respondents 32.1% reported that they take 3-5 hours to reach the nearest delivery health facility using common means of transport. Most of the respondents 38% use public transport as the common mode of transport to the health facility. 39.9% of the respondents said their home is more than 10 km from the health facility that provides operative delivery services. Majority of the respondents 38% they take more than one to five hours to reach the nearest facility that provide non operative delivery services. Most of the respondents 26.1% reported that the nearest health facility that offer operative delivery services was at least 30km. Most of the respondents 57.9% said they were health educated during the ANC about birth preparedness and finally, 53.5% of the respondents reported they were given items (mama kits) during ANC

Table 4: The institutional factors and birth preparedness

Variables	**Birth preparedness**		**X^2**	**p-value**
	prepared	**unpreparedness**		
How long does it take to reach your nearest delivery health facility using your common means of transport?			12.425	0.048*
less than one hour	12(16.7%)	57(19.3%)		
1-2 hours	18(25.0%)	56(18.9%)		
3-5 hours	19(26.4%)	99(33.4%)		
more than 5 hours	23(31.9%)	84(28.4%)		
What is your common mode of transport to the health facility?			2.255	0.521
public transport	27(37.5%)	113(38.2%)		
private vehicle	17(23.6%)	53(17.9%)		
motorbike	19(26.4%)	75(25.3%)		
on foot	9(12.5%)	55(18.6%)		
How far is your home from the health facility that provides non operative delivery services?			15.049	0.008*
Less than 2Km	12(16.7%)	51(17.2%)		
2-5Km	14(19.4%)	70(23.6%)		
5-10km	18(25.0%)	56(18.9%)		
More than 10km	28(38.9%)	119(40.2%)		
How long does it take to reach the health facility that provides non operative delivery services?			2.315	0.314
less than 1 hour	18(25.0%)	89(30.1%)		
1-5 hours	21(29.2%)	100(33.8%)		
more than 5 hours	33(45.8%)	107(36.1%)		
How far is your home from a facility that can offer operative delivery services?			6.194	0.185
Less than 5km	12(16.7%)	61(20.6%)		
5-10km ``	7(9.7%)	58(19.6%)		
10-20km	14(19.4%)	38(12.8%)		
20-30km	17(23.6%)	65(22.0%)		
More than 30km	22(30.6%)	74(25.0%)		
Were your health educated during ANC about birth preparedness?			12.005	0.030*
Yes	29(40.3%)	126(42.6%)		
No	43(59.7%)	170(57.4%)		
Were you given any items during ANC?			.872	0.351
Yes	35(48.6%)	162(54.7%)		
No	37(51.4%)	134(45.3%)		

The institutional factors of time taken to reached the nearest delivery health facility using the common health facility (x^2=12.425, P=0.048), distance from the nearest non-operative health facility (x^2=15.049, P=0.008) and health education on birth preparedness (x^2=12.005, P=0.030) were significant associated with birth preparedness

4.3 Personal factors influencing birth preparedness among antenatal care women

Table 5: Personal factors of the respondents

Variables	**Frequency, n**	**Percentage, %**
Have you heard of birth preparedness?		
Yes	181	49.2
No	187	50.8
How many completed months have passed since you started ANC		
<1	110	29.9
2-3	127	34.5
>3	131	35.6
How many times have you been pregnant		
one	99	26.9
2-4	86	23.4
>4	183	49.7
How many times have you given birth		
1	99	26.9
2-3	86	23.4
>4	183	49.7
Have ever given birth to a still birth?		
Yes	52	14.1
No	316	85.9
Have ever developed any complication from any of your deliveries if applies?		
Yes	9	2.4
No	359	97.6
if yes in (a) above, specify		
tears	1	11.2
infections	4	44.4
bleeding	4	44.4
Have any of your babies ever developed any complications after delivery if applies?		
Yes	151	41.0
No	217	59.0
if yes in (a) above specify		
inborn disease	17	11.4
breathing problems	65	43.6
infections	69	45.0
How many times did you attend ante-natal clinics in the last pregnancy		
less than 4	249	67.7
>4	119	32.3
At what month of pregnancy did you start attending ante natal clinic		
1-3months	111	30.2
4-6	105	28.5
7-9	152	41.3
You made most of most your ante-natal care visits in which facility		
HC II	83	22.6
HC III	100	27.2
HC IV	88	23.9
hospital	97	26.4

Most of the respondents 50.8% had not heard about birth preparedness. Most of the respondents had more than 3 pregnancies. Majority of the respondents 49.7% had given birth to more than 4 times. 14.1% of the respondent have given birth to still birth, most of the respondents 97.6% had not developed complication from any of their deliveries. 44.4% of the 9 people either experience infections or bleeding. Most of the respondents 59% said their babies had no complication after deliveries and among those who developed complication, 54% had serious infections (diarrhea). Most of the respondents 67.7% had attendance ANC less than 4 times. 41.3% were in the 7-9 months of gestation age and 27.2% made most of the ANC visits at health center III

Table 6: The personal factors with birth preparedness

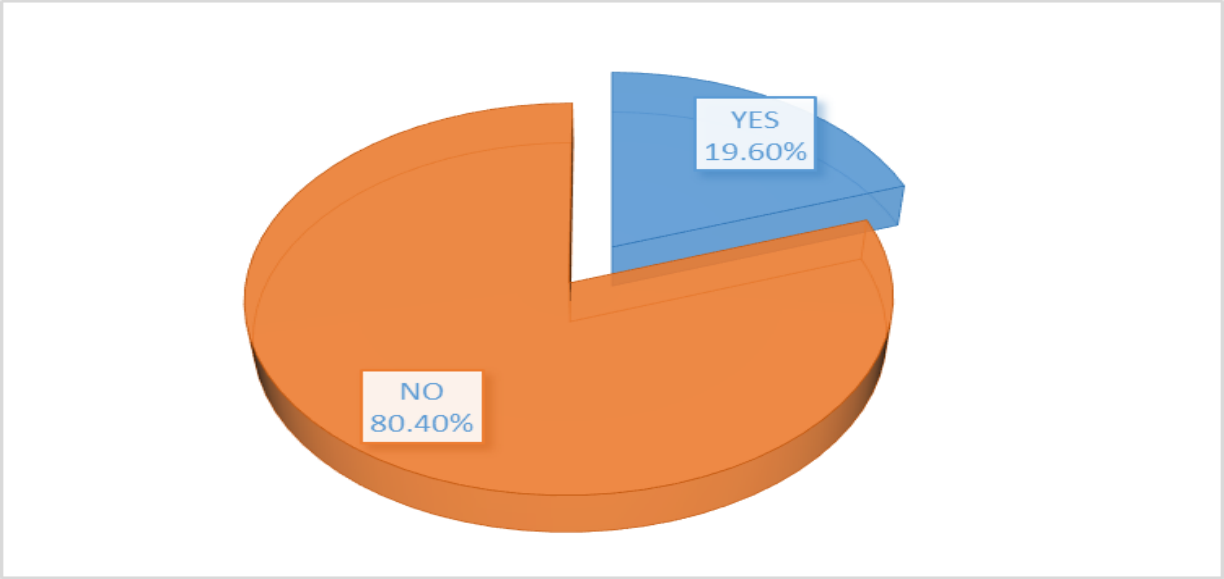
Variables	**Birth preparedness**		**X^2**	**p-value**
	Prepared	**unprepared**		
Have you heard of birth preparedness?			.138	0.710
Yes	34(47.2%)	147(49.7%)		
No	38(52.8%)	149(50.3%)		
How many completed months have passed since you started ANC			16.63	0.035*
<1	23(31.9%)	87(29.4%)		
2-3	28(38.9%)	99(33.4%)		
>3	21(29.2%)	110(37.2%)		
How many times have you been pregnant			.608	0.738
one	22(30.6%)	77(26.0%)		
2-4	16(22.2%)	70(23.6%)		
>4	34(47.2%)	149(50.3%)		
How many times have you given birth			.608	0.738
1	22(30.6%)	77(26.0%)		
2-3	16(22.2%)	70(23.6%)		
>4	34(47.2%)	149(50.3%)		
Have ever given birth to a still birth?			8.16	0.006*
Yes	41(56.9%)	151(51.0%)		
No	31(43.1%)	145(49.0%)		
Have ever developed any complication from any of your deliveries if applies?			1.270	0.756
Yes	27(37.5%)	152(51.4%)		
No	45(62.5%)	144(48.6%)		
if yes in (a) above, specify				
	12(44.4%)	49(32.2%)		
	9(33.3%)	45(29.6%)		
	6(22.2%)	58(38.2%)		
Have any of your babies ever developed any complications after delivery if applies?			4.448	0.005*
Yes	24(33.3%)	127(42.9%)		
No	48(66.7%)	169(57.1%)		

if yes in (a) above specify 	 4(17.4%) 10(43.5%) 9(39.1%)	 13(10.3%) 55(43.7%) 58(46.0%)	2.737	0.255
How many times did you attend ante-natal clinics in the last pregnancy less than 4 >4	 55(76.4%) 17(23.6%)	 194(65.5%) 102(34.5%)	2.193	0.139
At what month of pregnancy did you start attending ante natal clinic 1-3months 4-6 7-9	 28(38.9%) 15(20.8%) 29(40.3%)	 83(28.0%) 90(30.4%) 123(41.6%)	1.059	0.589
You made most of most your ante-natal care visits in which facility HC II HC III HC IV hospital	 11(15.3%) 27(37.5%) 12(16.7%) 22(30.6%)	 72(24.3%) 73(24.7%) 76(25.7%) 75(25.3%)	3.115	0.078

Number of months since starting ANC visit (X^2=16.63, P=0.035), still birth (X^2=8.160, P=0.006) and babies compactions (X^2=4.448, P=0.005) were significantly associated with birth preparedness.

4.4 Birth preparedness influencing birth preparedness among antenatal care women

Figure 2: The birth preparedness



The figure show that only 19.6% were prepared for the birth, this was got by considering those had identified the facility of the delivery, skilled birth attendants and save some money.

Table 7: The preparedness of the respondents

Variables	**Frequency, n**	**Percentage, %**
Which Is your identified place of birth for the baby?		
health facility	90	24.5
home	162	44.0
not identified	116	31.5
Which is your identified/planned source of money for delivery expenses?		
Own savings	104	28.3
Spouse	69	18.8
Insurance	80	21.7
another relative	115	31.2
What is your identified mode of transport to the health facility?	133	36.1
On foot	115	31.2
Public service vehicles	67	18.2
privately booked vehicle	53	14.4
motorbike		
Who have you identify as a birth attendant?		
skilled birth attendant	158	42.9
traditional birth attendant	105	28.5
not identified	105	28.5
Who is your identified birth companion?		
spouse/partner	131	35.6
relative (not spouse/partner)	237	64.4
Who is the identified home caretaker during the time of delivery?		
spouse/partner	151	41.0
relative (not spouse/partner)	217	59.0
Is your birth plan written?		
Yes	112	30.4
No	256	69.6

Most of the respondents 31.5% had not identified their place of birth. Majority of the respondents 28.3% had save their own money for delivery. Most identified mode of transport to the health facility was foot at 36.1%. At 42.9% most respondents at identified skilled birth attendants. Most of the respondents 64.4% reported they have identified relative as a birth companion. Majority of the respondents 59% had identified their relatives as caretakers during the time of delivery and 69.6% had a written birth plan

Table 8: Factors independently associated with birth preparedness

Variable	**Crude Odd ratio**	**(95% CI)**	***P*-value**
Occupation of the respondent			0.000*
House wife	1.93	0.38-4.39	
Subsistence farmer	1.62	0.71-9.33	
Salaried employment	4.46	2.31-10.02	
Unemployed	2.72	1.10-4.63	
Business lady	1.0	Reference	
How long does it take to reach your nearest delivery health facility using your common means of transport?			0.002*
less than one hour	1.46	0.17-7.12	
1-2 hours	4.33	2.62-6.19	
3-5 hours	3.81	1.83-5.41	
more than 5 hours	1.0	Reference	
How far is your home from the health facility that provides non operative delivery services?			0.000*
Less than 2Km	3.22	1.79-5.22	
2-5Km	2.88	2.01-4.64	
5-10km	2.33	1.32-6.91	
More than 10km	1.0	Reference	
Were your health educated during ANC about birth preparedness?			0.000*
Yes	20.96	12.33-57.39	
No	1.0	Reference	
How many completed months have passed since you started ANC			0.040*
<1	0.14	0.09-7.82	
2-3	0.37	0.23-5.41	
>3	1.0	Reference	
Have ever given birth to a still birth?			0.000*
Yes	4.96	3.13-8.23	
No	1.0	Reference	
Have any of your babies ever developed any complications after delivery if applies?			0.003*
Yes	2.61	1.95-7.03	
No	1.0	Reference	

The final model was constructed using forward stepwise logistic regression. Variables with a significant association in the analysis ($p<0.05$) and those related to the objectives of the study such as occupation, time taken to reach the nearest health facility, distance from the nearest health facility with non-operative delivery services, health education at ANC visit, history of

still birth and development of complication by the baby were included in the final logistic regression.

The analysis of occupation of the respondents was significant associated with birth preparedness; housewife were almost 2 times more likely to be prepared for birth (OR=1.9), salaried employed women are 4 times more likely to prepared for birth (OR=4.4) and unemployed women were 2.7 times more likely to prepared for birth compared to the business ladies. Time spend to reach the nearest delivery hospital using the common mode of transport was significant associated with birth preparedness; those who spend 1-2 hours were 2 times more likely to prepared for birth (OR=4.33), and those who spend 3-5 hours were 3 times more likely to prepare for birth (OR=3.81) compared to those who spend more than 5 hours. Distance from the nearest health facility that provide non-operative delivery services was significant associated with birth preparedness; those who live less than 2 km were 3 times more likely to prepare for birth (3.22), those who live 2-5km were two times more likely to prepare for birth (OR=2.88) and those who live 5-10 km were two times more likely to prepare for birth (OR=2.33) compared to those who live more than 10 km. Health education on birth preparedness during ANC was significantly associated with birth preparedness; those who said they received health education of birth preparedness were 20 times more likely to prepare for birth (OR=20.96). Still birth was significantly associated with birth preparedness; having given birth to a dead baby was 4 times more likely to prepare for birth (OR=4.96) compared to those who never had still birth experience. And finally, complication in babies was significantly associated with birth preparedness; women who had their babies developed complication after delivery were 2 times more likely to prepare for birth (OR=2.61) compared to the counterpart whose baby never developed complication.

CHAPTER FIVE: DISCUSSION OF RESULTS

5.0 Introduction

This chapter discusses the research findings in relation to the problem statement, literature review of studies conducted elsewhere with and in line with the specific study objectives. It also explains the obtained results from the study.

5.1 Birth preparedness

The study found that only 19.6% of the women attending ANC were prepared for their birth. This implies low level of birth preparedness among the women. This is in line with Debelew et al, (2014) which reported that the status of birth preparedness was 23.3%. Similarly, Desalegn et al, (2014) also found that only 29.9% of the respondents were prepared for birth. Another study also agrees with this findings that about 16.5% of the respondents were prepared for birth and its complications (Kaso et al, 2014). However. Gebre et al, (2015) found that more than half of the respondent had prepared for birth. This difference in the study finding could probably be because of the difference in study design, Gebre et al, (2015) was a community study whereas our study is s facility based study. This implies that the ministry of health should increase the sensitization of the community members on the important of birth preparedness and encourage and improve the socio-economic status of the women so that the can solve some of their minor issues regarding birth and maternal health without barely depending on the government.

The study found that 24.5% of the women had identified health facility of delivery, 28.3% had saving for the delivery, 18.2% had privately booked vehicles and 42.9% had identifies skilled birth attendants. This could probably because most of the women are not so much aware of birth prepared and delivery caught them by surprise. This is in line with Hailuet al, (2011) which stated that only a 20.5% of them identified a skilled provider and 8.1% identified a health facility for delivery care. Identification of means of transport to the delivery facility was also low (7.7%) and only 34.5% had saved money for delivery costs. Majority of the respondents delivered at home (87.9%), with only 8% planning to deliver in hospital. Similarly, Siddaharth, et al., (2010) agrees with this findings when he says that that 47.8% of the 1,584 volunteer women prepared for birth in respect to identification of skilled attendance, place of delivery, means of transport and saving money for delivery costs. Deoki (2009) also agrees with this findings when he indicated that that 18.6% of the 828 randomly

selected women had transportation means and 44.2% had saved money for delivery. The study revealed that 35.6% of the respondents had the spouse as the companion at delivery. This is in line with Desalegn et al, (2014) who found that 32.1% of men ever accompanied their spouses for maternity care. There is need to provide health education and proper information about pregnancy and birth so that the women get more knowledge hence favoring maternal health including birth preparedness.

5.2 Socio-demographic factors of the respondents

The study also found that occupation of the respondents was significant associated with birth preparedness; housewife were almost 2 times more likely to be prepared for birth (OR=1.9), salaried employed women are 4 times more likely to prepared for birth (OR=4.4) and unemployed women were 2.7 times more likely to prepared for birth compared to the business ladies. This is in line with study by AbioyeKuteyi et al, (2011) which stated that there is a significant association between socio-demographic including the occupation of the women. Similarly, Debelew et al, (2014) which stated that Women having employed or merchant husbands were more likely to be prepared as compared to women having farmer husband. This implies that women need to be empowered economically allowing easy access to better maternal health services

The study found no significant association between education level of the mothers and birth preparedness. This is inconsistent with by Debelew et al, (2014) which stated that level-1, educational status were found to have statistically significant association with BP practice. Women who attended primary, secondary or tertiary were more likely to be prepared as compared to women who didn't attend any formal education. This difference in the studies could be of the difference in the study settings. Conversely, found that the level of education positively influenced birth preparedness (Mutiso, 2008)

The study found that found no association between marital status and birth preparedness. This is not in line with status by Mihretet al., (2006) which stated that marital status was another factor that was strongly associated with birth preparedness and complications readiness. Married women were more likely to be prepared for birth/complication than non-married. This could be because married women received social support from the husband. Conversely, Urassa et al, (2012) which stated that age of the woman, education, marital status, number of

ANC visits and knowing ≥3 obstetric danger signs were associated with birth preparedness and complication readiness

The study found no association between occupation of the spouse and birth preparedness. This is in consistent with Mutiso, (2008) who stated that occupation of spouse was statistically associated with birth preparedness.

The study also found that parity was not significantly associated with birth preparedness. This is not in line with Desalegn et al, (2014) which stated that gravida and parity were found to have statistically significant association with birth preparedness and complication readiness. This difference could be probably due to difference in the study designs and the sampling technique where one study use randomly sampling and one used convenient sampling technique.

5.3 Institutional factors

The study found that Health education on birth preparedness during ANC was significantly associated with birth preparedness; those who said they received health education of birth preparedness were 20 times more likely to prepare for birth (OR=20.96). This could be because after health education the women gain knowledge that make them able to prepare for birth. This is line with Mihretet al., (2006) which stated that Advice given on preparation for birth and its complication during ANC follow up was also significantly associated with preparation for birth/complication. Women who were advised about where to give birth and arrangements for money and transportation during their ANC follow up were more likely to be prepared for birth and its complication than those that were not given such advice. This implies that government should encourage girl child education and empowering these women with basic knowledge on their reproductive health so that they are always ready for pregnancy as well as birth.

The study found that Time spend to reach the nearest delivery hospital using the common mode of transport was significant associated with birth preparedness; those who spend 1-2 hours were 2 times more likely to prepared for birth (OR=4.33), and those who spend 3-5 hours were 3 times more likely to prepare for birth (OR=3.81) compared to those who spend more than 5 hours. This is in line with Debelew et al, (2014) which stated that Being in urban residence and having health center within two hours distance were among the higher level factors increasing birth preparedness. This implies that more health workers needs recruited

to reduce the patients: health workers relationship thereby reducing the waiting time and more one-on-one time with the health workers which improve quality of the maternal health services and proper preparation of the woman during pregnancy and child birth.

The study found no association between the having experience complication and birth preparedness. This could be because very limited number of the mothers had experienced complications. This is inconsistent with Addisse et al, (2014) which stated that Knowledge of danger sign of obstetric complications was also significantly associated with birth preparedness. Mothers who know the presence of obstetric complications were three times more likely to prepare for birth and its complications than mothers who didn't know the presence of complications

5.4 Personal factors

The study found that Still birth was significantly associated with birth preparedness; having given birth to a dead baby was 4 times more likely to prepare for birth (OR=4.96) compared to those who never had still birth experience. This could be because most of the women think still birth was because of lack of preparedness. This is line with study by Mihretet al., (2006) which stated that Women who had history of still birth were also more likely to prepare for birth and its complication than those who did not have still birth. This implies that women learnt through the experience not by knowledge therefore, women need proper sensitization in the principla of birth preparedness.

The study found that 67.75% of the respondents attended ANC less than 4 times. This is in line with (Mihretet al., (2006) which stated that, the majority (94.4%) of the respondents have attended antenatal care (ANC) at least once in their lifetime. Of the total, about 63% respondents started their follow up while the pregnancy was between 4 and 6 months and 21.2% respondents had first ANC visit by a skilled care provider in the first three months of pregnancy. About 73% of the total respondents had 4 or more visits. This implies that more emphasis should be put on increasing the number of ANC attendance through information provision, empowering VHTs to spread the issues of ANC attendant among the women and community in their respective village.

This study also found that 41.2% most of the respondents started ANC visits at 7-9 months. This is in line with Mutiso, (2008) which stated only 21.8% of the respondents had commenced antenatal care during the first trimester, and 29.3% of the respondents were not

given information on signs of labour. Similarly, Kaso et al, (2014) which stated that 49% of the respondents started their follow up while the pregnancy was between 4 and 6 months and 31% of the respondents had their first ANC visit in the first three months of pregnancy ANC follow up has significant statistical association with birth preparedness, the odds of birth preparedness was eight times greater among women who have ANC follow up when compared with women who did not have ANC follow up (Desalegn et al, 2014). This implies that the women need to be encouraged to start ANC visits as soon as they realized that are pregnant other waiting when they are almost delivery, this will allow them to taught how get ready for birth process.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter deals with the brief summary of the steps taken in the study, conclusions, study findings and implications to District management and recommendations.

6.1 Conclusion

Generally, the level of birth preparedness was low at 19.6%

Only 24.5% of the respondents had identified health facility has the place of delivery and only 42.9% had identified skilled birth attendant

6.1.1 Socio-demographic factors

Occupation of the respondents was significant associated with birth preparedness; housewife were almost 2 times more likely to be prepared for birth (OR=1.9), salaried employed women are 4 times more likely to prepared for birth (OR=4.4) and unemployed women were 2.7 times more likely to prepared for birth compared to the business ladies.

6.1.2 Personal factors

Time spend to reach the nearest delivery hospital using the common mode of transport was significant associated with birth preparedness; those who spend 1-2 hours were 2 times more likely to prepared for birth (OR=4.33), and those who spend 3-5 hours were 3 times more likely to prepare for birth (OR=3.81) compared to those who spend more than 5 hours.

Distance from the nearest health facility that provide non-operative delivery services was significant associated with birth preparedness; those who live less than 2 km were 3 times more likely to prepare for birth (3.22), those who live 2-5km were two times more likely to prepare for birth (OR=2.88) and those who live 5-10 km were two times more likely to prepare for birth (OR=2.33) compared to those who live more than 10 km.

Health education on birth preparedness during ANC was significantly associated with birth preparedness; those who said they received health education of birth preparedness were 20 times more likely to prepare for birth (OR=20.96).

6.1.3 Institutional determinants of birth preparedness

Still birth was significantly associated with birth preparedness; having given birth to a dead baby was 4 times more likely to prepare for birth (OR=4.96) compared to those who never had still birth experience.

complication in babies was significantly associated with birth preparedness; women who had their babies developed complication after delivery were 2 times more likely to prepare for birth (OR=2.61) compared to the counterpart whose baby never developed complication

6.2 Recommendations

From the findings of the study, we therefore recommend the following Based on the results of this study the following recommendations have been made;

The ministry of health should do a sensitization on birth preparedness among women of reproductive age.

The ministry of health should improve the level of birth preparedness through quality ante natal care.

The government through all relevant ministries should put in place strategies to increase the average income of the women and households.

The ministry of health should upscale the attendance of ante natal care to a minimum of four visits per pregnancy.

6.3 Suggested areas for further research

The following areas have been suggested for further research.

Determinants of utilization of birth preparedness strategy among health care providers in Uganda.

The outcomes of utilization of birth preparedness by women in rural Uganda.

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APPENDIX I: CONSENT FORM

Factors influencing birth preparedness among antenatal mothers at Kasangati Health Centre IV

You are invited to participate in a research study investigatingfactors influencing birth preparedness among antenatal mothers at Kasangati Health centre IV. The purpose of the study is to determine the factors influencing birth preparedness among antenatal mothers at Kasangati Health centre IV.

This study is being conducted by **Nampewo Sarah Ssenkungu**who is student of International Health Sciences University. You have been selected because you are an antenatal mother at Kasangati Health centre IV.

Procedure:

You are requested to answer the question attached to this consent form by ticking the box corresponding to the appropriate answer. This will take approximately 20 minutes to complete.

Risks and Benefits of the study

There are no known risks involved in participating in this study.

Confidentiality

Any information in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. In any written report or publication, no one will be identified or identifiable and only aggregate data will be presented.

Voluntary nature of study

Your decision whether or not to participate will not affect your attending ANC services at the facility. If you decide to participate, you are free to withdraw at any time before your data is de-identified.

Contact and questions:

The researcher in this study is **Nampewo Sarah Ssenkungu**. You may ask questions you have at this time. If you have questions later, you may contact **0772880040 orsarah.nampewo@yahoo.com**

I……..…….give my consent to/ for then researcher to use the data collected for presentation of the research. (Please write yes or no and initials). You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time before the information is de-identified without prejudice after signing this form should you choose to discontinue participation in this study.

APPENDIX II: QUESTIONNAIRE

Section a: Socio-demographic factor

Q1. Age of the respondent (in years) _____

Q2. Highest level of education of the respondent

1 No formal education

2 Lower primary education

2 Upper primary education

3 Incomplete secondary education

4 Complete secondary education

5 Tertiary college

Q3. Marital status during pregnancy and delivery

1 Never married

2 Married

3 Separated

4 Divorced

5 Windowed

Q4. Religion of the respondent

1 Protestant

2 Catholic

3 Muslim

4 others (specify)……

Q5. Occupation of the respondent	Q6. Occupation of the spouse/partner (if applicable)
1 House wife	1 Subsistence farmer
2 Subsistence farmer	2 Unemployed
3 Salaried employment	3 Salaried employment
4 Unemployed	4 Business
5 Business lady	5 others (specify)
6 others (specify)……	6 Not applicable

Q7. What is your estimate average income per month? _____

Q8. Residence

1= Rural 2= Urban

SECTION B: INSTITUTIONAL FACTORS

Q9. How long does it take to reach your nearest delivery health facility using your common means of transport?

1 =less than one hour

2 =1-2 hours

3 =3-5 hours

4 =more than 5 hours

Q10. What is your common mode of transport to the health facility?

1 public transport

2 private vehicle

3 motorbike

4 on foot

5 others (specify) _____

Q11.How far is your home from the health facility that provides non operative delivery services?

1= Less than 2Km

2= 2-5Km

3= 5-10km

4= More than 10km

Q12.How long does it take to reach the health facility that provides non operative delivery services?

1= less than 1 hour

2= 1-5 hours

3= more than 5 hours

Q13. How far is your home from a facility that can offer operative delivery services?

1 = Less than 5km

2 = 5-10km ``

3 = 10-20km

4 = 20-30km

5 = More than 30km

Q14. Were you health educated during ANC about birth preparedness?

1 =Yes

2 =No

Q15. Were you given any items during ANC?

1 =Yes

2 =No

SECTION C: PERSONAL FACTORS

Q16. Do you have any knowledge on birth preparedness?

1= Yes

2= No

Q16. How many completed months have passed since you started ANC? _____

Q17. How many times have you been pregnant? _____

Q18. How many times have you given birth? _____

Q19. Have ever given birth to a still birth?

1 =Yes

2 =No

Q19 (a) Have ever developed any complication from any of your deliveries if applies?

1 = Yes

2 =No

Q20 (b) if yes in (a) above, specify……

Q21 (a) have any of your babies ever developed any complications after delivery if applies?

1 = Yes

2 = No

Q22 (b) if yes in (a) above specify……

Q23. How many times did you attend ante-natal clinics in the last pregnancy……

Q24. At what month of pregnancy did you start attending ante natal clinic……..

Q25.You made most of most your ante-natal care visits in which facility

SECTION D: BIRTH PREPAREDNESS

Q24 Which Is your identified place of birth for the last baby? 1= health facility 2= home 3= not identified
Q25 Which is your identified/planned source of money for delivery expenses? 1= Own savings 2= Spouse 3= Insurance 4= another relative 5= other (specify) 6= not identified
Q26 What is your identified mode of transport to the health facility? 1= On foot 2= Public service vehicles 3=privately booked vehicle 4= motorbike 5=others (specify)…….. 6=not identified
Q27 who have you identify as a birth attendant? 1 =skilled birth attendant 2 =traditional birth attendant 3 =not identified
Q28 Who is your identified birth companion? 1= spouse/partner 2= relative (not spouse/partner) 3= others (specify)……. 4= not identified
Q29 Who is the identified home caretaker during the time of delivery? 1= spouse/partner 2= relative (not spouse/partner) 3= others (specify)…… 4= not identified

Q30. Is your birth plan written?

1 =Yes

2 =No

Q31. Perception of birth preparedness by the mothers

1. Very strongly, 2. Strongly agree, 3. Agree, 4. Disagree, 5. Strongly disagree and 6. Very strongly disagree

Aspect/Scale	**1**	**2**	**3**	**4**	**5**	**6**
Birth preparedness is not useful						
Birth preparedness can reduce pregnancy related complications						
Birth preparedness is not practical						

APPENDIX III: INTRODUCTORY LETTER

IHSU INTERNATIONAL HEALTH SCIENCES UNIVERSITY
sanitas per scientiam

making a difference in health care

Office of the Dean, School of Nursing

Kampala, 19th August 2016

TO IN-CHARGE
KASANGATI HEALTH CENTRE IV
WAKISO DISTRICT LOCAL GOVERNMENT
P.O.BOX 7218
KAMPALA

Dear Sir/Madam,

RE: ASSISTANCE FOR RESEARCH

Greetings from International Health Sciences University.

This is to introduce to you **Nampewo Sarah Ssenkungu,** Reg. No. **2013-BNS-TU-022** who is a student of our University. As part of the requirements for the award of a Bachelors degree in Nursing of our University, the student is required to carry out research in partial fulfillment of her award.

Her topic of research is: **Factors influencing birth preparedness among antenatal mothers at Kasangati Health Center IV**

This therefore is to kindly request you to render the student assistance as may be necessary for her research.

I, and indeed the entire University are grateful in advance for all assistance that will be accorded to our student.

Sincerely Yours,

IHSU INTERNATIONAL HEALTH SCIENCES UNIVERSITY
10 SEP 2016
SCHOOL OF NURSING
P.O. Box 7782, Kampala - Uganda

Ms. Agwang Agnes
Dean

The International Health Sciences University
P.O. Box 7782 Kampala – Uganda
(+256) 0312 307400 email: aagwang@ihsu.ac.ug
web: www.ihsu.ac.ug

AAPPENDIX IV: CORRESPONDENCE LETTER

WAKISO DISTRICT LOCAL GOVERNMENT

Office of the District Health Officer
P.O.Box 7218, Kampala.

14th September 2016

The In-charge
Kasangati H/C IV

RE: PERMISSION TO MS.NAMPEEWO SARAH TO CARRY OUT REASEARCH AT KASANGATI H/C IV

The above named student from Registrar International Health Sciences University Kampala has been granted permission to collect a research data at Kasangati H/C IV in MCH department.

Any assistance rendered to her is highly appreciated

Thank you

Ssejjibwa Peter
FOR: DISTRICT HEALTH OFFICER

Received 16/09/2016

KASANGATI HEALTH CENTRE IV
KYADONDO EAST HSD
16 SEP 2016
P.O BOX 19013,
KASANGATI