

**ASSESSMENT OF FACTORS AFFECTING UTILIZATION OF ANTENATAL AND
POSTNATAL CARE SERVICES IN KASESE DISTRICT OF WESTERN UGANDA**

**A POST GRADUATE DESSERTATION PRESENTED TO THE INSITUTE OF
HEALTH POLICY AND MANAGEMENT IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF A DEGREE OF MASTER OF SCIENCE
IN PUBLIC HEALTH OF THE INTERNATIONAL HEALTH SCIENCE
UNIVERSITY.**

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(REG NO: 2010-MPH-RL-009)**

NOVEMBER, 2013

DECLARATION

I declare to the best of my knowledge that this research study presented has never been submitted anywhere for any award and it is original. Where other individuals' information has been used, references have been provided and in some cases quotations made. I am fully accountable for all errors in this report.

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APPROVAL

I certify that this dissertation satisfies the partial fulfillment of the requirements for the ward of the degree of Masters of Science in Public Health of International Health Science University, Kampala, Uganda.

Supervisor's approval:

This dissertation has been submitted for examination with approval of the following supervisor;

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DEDICATION

I dedicate this to my late Grandmother Suzan, who made the earliest and most profound efforts in my education career. Her humble but meaningful endeavors, have made me who I am to day.

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ACROYNMES AND ABBREVIATIONS

ANC	Antenatal care
DHO	District Health Officer
DHT	District Health Team
DV	Dependent Variable
FGD	Focus Group Discussion
IV	Independent Variable
MNCH	Maternal Newborn and Child Health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
PMNCH	Partnership for Maternal Newborn and Child Health
PNC	Postnatal care
PNFP	Private Not for Profit
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

OPERATIONAL DEFINITION

Antenatal care: Antenatal care is a package of healthcare provided by qualified health workers to expecting mothers during the course of pregnancy.

Postnatal care: Postnatal care is a package of healthcare provided by qualified healthcare workers to mothers and their newborn infants after delivery

Maternal Mortality or **Maternal Death** is 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes' (WHO, 2011).

Maternal Morbidity is defined 'as chronic and persistent ill-health occurring as a consequence of complications of pregnancy and childbirth'.

Skilled Birth Attendant is 'an 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, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns' (WHO, 2004).

Categorical regression analysis this analysis was used in order to incorporate optimal scaling and also because the predictor(s) and outcome variables were a combination of numeric, ordinal, or nominal.

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ABSTRACT

Background:

Utilization of antenatal care (ANC) and postnatal care (PNC) services can greatly impacts on major causes of infant death and significantly affects trends of mortality in women and children. Antenatal care plays an indirect role in reducing maternal mortality by encouraging women to deliver with assistance of a skilled birth attendant or in a health facility. In most rural settings of Uganda, there are challenges in increasing utilization of both ANC and PNC mainly due to the fact that the decisions that lead women to use these services seem to occur within the context of their education level, income level, proximity of health facilities, ways how health workers handle mothers and of course level of community awareness on the importance of these services. It is against this background that this study attempted to investigate how issues relating to socio demographics, health facilities and communities dynamics influence utilization of these vital maternal health services.

Broader objective:

To assess factors influencing utilization of both ANC and PNC services in Kasese district.

Study site: The study was carried out in Kasese District in mid western Uganda a district covering eight sub-counties.

Methodology: This was a cross-sectional and analytical study that used both quantitative and qualitative approaches in eight sub-counties of Kasese district, Midwestern Uganda. The data were collected from a representative sample of 364 women drawn from the study population using simple random sampling techniques. Two dependent variables were used in the analysis: The ANC, measured by whether a woman got the service (at least once) from a health facility or not during her last pregnancy and PNC which was approximated by whether the woman and her last born child completed the required PNC visits or not and how many visits were made. Socio demographic, health facilities and community characteristics were used as descriptive variables for both ANC and PNC dependent variables.

Data analysis: Data analysis started with computing the percentages of mothers who got antenatal care services from the health facilities which formed the first dependent variable, and also computed the proportion of mothers and their newborn children less than 24 months attended to services like immunization, postnatal checkups as per WHO definition formed the second dependent variable (PNC). Multivariate analysis using categorical regression analysis

was used to examine the association between the dependant variables and the independent socio demographic, health facility and community characteristics. In the logistic regression analysis, the first response variable (ANC) had four outcomes; whether a woman attended zero, one, two, three or four or more ANC from health facilities during her last pregnancy. Similarly, the second dependent variable was framed to have four outcomes; whether the woman and her last born child completed the required PNC services (like immunization, postnatal checkup) or not and how many visits were made. Since the interest is in identifying the probability of facing the outcome variable, the dependent variables were coded as 1, 2, 3, and 4+ if the event happened and zero if the event didn't happen. The logistic regression coefficients were used to inform association between the independent variable whether it increased or decreased the chance of ANC/ PNC given a 5 percent level of significance. Independent variables with p-values were less than 0.05 were considered predictive within the study.

Results: The study revealed that the level of ANC and PNC service utilizations is 94.8 % and 38.2% respectively but only 16.8% completed the required four ANC visits. The predicted probabilities, using multinomial logistic regression, showed that women who were highly literate, with high income levels, and with low parity are more likely to use both ANC and PNC services.

Conclusion: Although antenatal care service utilization seemed generally good, more utilized than PNC services, even then very few women completed the required four visits during pregnancy. Postnatal utilization was very low compared to the sub-regional figures. Key determinants of utilization include mother's level of education, parity, age and opportunities for awareness on the need for ANC and PNC services within the communities

Recommendations: The study recommended that promoting women's education, improving unmet needs for family planning, increasing awareness on the importance of use of the services to women at grass root level, provision of the services at both home and health facilities, and improving the quality and capacity of the health providers to provide friendly services can go a long way in improving the gap that exists in the utilization of these services.

Keywords: Antenatal Care, postnatal care, service utilization

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This chapter presents the background of the study, the statement of the problem, purpose of the study, objectives of the study, research questions, and the significance of the study. Also provided in this chapter is the scope of the study and the conceptual framework adopted.

1.1 Background to the study

Pregnancy related mortality is almost always preventable yet more than half a million women die annually worldwide (about 1,600 women die every day) due to pregnancy related complications and about 90-95% of these come from developing countries (WHO-PMNCH, 2012a). Improving the status of maternal and newborn health requires improving the existing evidence-based interventions in antenatal care (ANC), Safe Birth Care (SBC) and postnatal care (PNC). Antenatal care (ANC) coverage is a success story in most developed countries where 98 percent of women make at least one antenatal visit; 99 percent deliver with a skilled attendant; and 90 percent make at least one postnatal visit (Abou Z, et al 2000). Even in sub Saharan Africa the situation has been promising over the years, since over two-thirds of pregnant women (69 percent) have at least one ANC contact compared to the Asian percentage of 54 (UNICEF, 2006a). However, to achieve the full life-saving potential that ANC promises for women and babies, four visits providing essential evidence based interventions – a package referred to as “focused antenatal care” – are required. Essential interventions in ANC include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs). ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing.

According to Demographic and Health Survey (DHS) data from 23 African countries, two-thirds of women in Sub-Saharan Africa give birth at home, but only 13 percent of all women receive a postnatal visit within two days. Although attendance at ANC is encouraging, worrying gaps exist

in provision, and coverage statistics are usually based on women who have only one ANC visit, whereas four visits are recommended, and ANC quality varies (PMNCH, 2012b).

Most maternal deaths occur during labor, delivery or the first 24 hours postpartum, and most intrapartum complications cannot be reliably predicted or prevented, though most can be successfully treated with prompt and appropriate diagnosis and care. The neonatal period is only 28 days but accounts for 38 percent of all deaths in children younger than 5 year. ANC and PNC have the potential to contribute to reducing maternal and child morbidity and mortality. The World Health Organization (WHO) has been strongly advocating improvements of maternal health services as part of its Safe Motherhood Initiatives (SMI). Regular antenatal care has long been viewed as important for identifying a small minority of women who are at increased risk of adverse pregnancy outcomes and for establishing good relations between the women and their health care providers (WHO report, 2008). The study conducted in India reported that women who had received a high level of antenatal care were about four times as likely to use skilled assistance at delivery compared to women who received low levels of antenatal care (Bloom SS, 1999).

However, poor quality of routine ANC has been documented in terms of its ability to prevent, diagnose or treat complications (Mc Donagh, 2000). Recent studies have challenged the potential of ANC to reduce maternal mortality (Ndyomugyeniyi R, 2005). Both quality and coverage are essential to maximize impact. Impediments to the effective delivery of ANC include geographical, financial and cultural barriers .An estimated seven out of every ten women who do not give birth in a facility are not currently receiving PNC (Koblinsky M, 2006). Policies and programs have largely overlooked this critical period, hindering efforts to meet the Millennium Development Goals (MDGs) for maternal and child survival.

Although pregnant women are advised to start attending ANC before the 16th week of gestation, and services are free, more than 80% of pregnant women initiate ANC later than 17 weeks of gestation and although 95% of mother receive ANC from skilled providers, only 48% of women make four or more ANC visits during pregnancy (UDHS, 2011) as recommended by the WHO guideline on ANC.

The postnatal period (or called postpartum, if in reference to the mother only) is defined by the WHO as the period beginning one hour after the delivery of the placenta and continuing until six weeks (42 days) after the birth of an infant. Care during this period is critical for the health and survival of both the mother and the newborn. The 2011 Demographic Health Survey (UDHS, 2011) data reports that only one third of women received postnatal care in the first two days after delivery and for birth in the last two years preceding the UDHS survey, only 2 percent received a postnatal checkup within one hour, while 13 percent received a postnatal checkup with six days. This indicates a far less access to healthcare services by women during pregnancy, delivery and after delivery in Uganda. Currently, there are no guidelines for postnatal care. ANC and PNC services are key health interventions for reducing maternal and newborn morbidity and mortality. Although the current rate of ANC uptake is encouraging, detailed information about the actual quality utilization and effectiveness of ANC in practice is limited. This is largely because the packages vary so much from place to place in terms of components, timing, frequency of visits, and provider. Similarly, little evidence is available for the packaging of interventions for routine PNC for mother and newborn. Improvement in ANC and PNC can potentially reduce maternal mortality ratio (currently 436 per 100,000 live births) for Uganda and newborn mortality rate, which is 43 per 1000 live births in the study area.

1.2 Background to the study area

Kasese district is located along the Equator; it is bordered by Kabarole, Ntoroko and Bundibugyo Districts to the north, Kamwenge to the East, Rubirizi District to the south and Democratic Republic of Congo (DRC) to the west. The district is located 359 Kilometers by road to the west of Kampala, Uganda's capital city. The coordinates of the district are 00 11N, 30 05E.

The district has a total land area of 2724 square kilometers of which 885 square kilometers is reserved for Queen Elizabeth National Park, and 652 square kilometers for Rwenzori Mountain National Park, leaving only 1187 square kilometers for human habitation and economic utilization.

The current 2012 population estimate of the district was at 747800 with a population density of 547.1 per square kilometer. 52 percent of the total population is female with 45 percent of these in the reproductive age group and 4 percent of the total population is under 1 year. Like at

national level, 46 percent of the population under the age of 15, are 330,769, an implication that over the years Kasese's population will remain a young one with 18.5 percent being under five (UBOS, 2012).

Kasese is a multi-ethnic district with many people of different ethnic backgrounds. The main languages are Rutooro and Rukonzo the languages of the Batooro and Bakonzo people respectively. However there are other ethnic groups in the district who include Basongora, Banyankole and Bakiga.

Kasese district has 3 Health Sub Districts (HSD) of Busongora North; Busongora South; Bugonzo West; and Bukonzo East. The district is served by a number of health facilities at different levels of the healthcare system. There are 3 hospitals of which 2 are Private Not for Profit (PNFP); 3 health center IV which are all PNFP; 31 health center IIIs of which 13 are PNFP; and 55 health center IIs (unpublished DHT status report, 2013).

1.3 Problem statement

According to the WHO guidelines, every pregnant woman must access and utilize ANC services during pregnancy and PNC services with her newborn(s) after delivery from a qualified health practitioner. A minimum of at least four ANC visits are recommended at the 10th, 20th, 30th and 36th week of pregnancy for non complicated pregnancies and PNC services at six hours, six days, and six weeks after delivery for both mother and newborn(s).

Utilization of the ANC and PNC services in Kasese district is low when compared with the recommended WHO guidelines. Although 95.7 percent of mothers attend at least one Antenatal Care (ANC) visit, only 40 percent are likely to attend the recommended minimum of four visits in Uganda (MoH, 2011). PNC service utilization is at 28.1% lower than the national average of 33% (UDHS, 2011)

The result of this underserved population in terms of ANC and PNC may be attributed to the high maternal mortality rate averaging at 435 deaths per every 100000 live births (UBOS, 2011). To address this maternal health challenge, the District Health Team (DHT) together with a number of other partners has in the recent years deployed resources to support the health system to solve the challenges. Notable amongst them is Stride for Family Health; which has trained VHTs health workers, equipped health facilities, etc; Save the Children International which is implementing comprehensive Maternal Newborn and Child Health program within the region;

Strides for Family Health which has built capacity of health centers in leadership and management which is a pioneer approach in the district used to strengthen service delivery within health facilities. And indeed many NGOs are working in the district to build systems and structures to eliminate the broader service utilization bottlenecks.

Regardless of all these concerted efforts from the different players, it is not so clear why utilization to the recommended number of times for ANC and PNC services is still way below the standard needed to offer meaningful care and support to both mothers and their infants. Therefore it is prudent to examine determinants of access and utilization of ANC and PNC services within the district at individual, community, and health facility levels. Scholars have done related studies in other parts of Uganda looking at individual, health facility and community factors however most studies are limited in approach to only a particular maternal health service i.e. studies single out either ANC or delivery at health facilities or PNC rather than examining relationship in utilization between the different services and how the utilization of ANC influences the uptake of PNC.

This study seeks to build from the previous studies but looking at the context in which client related, health facilities related and community factors influence access and utilization of ANC and PNC in Kasese district and assess whether there are variations or similar patterns between utilization in Kasese and other parts of Uganda and sub-Saharan Africa at large. This will assist to bridge the knowledge gap and provide a comprehensive understanding of the determinants of utilization of ANC and PNC services in the district of Kasese.

1.4 Objectives of the study

General Objective

To assess factors influencing utilization of ANC and PNC services in Kasese district.

Specific Objectives

1. To identify the proportion of women utilizing ANC and PNC services within the district of Kasese.
2. To identify client/individual related factors influencing utilization of ANC and PNC services in Kasese district.

3. To assess health facility based factors that influence utilization of ANC and PNC services in the district of Kasese.
4. To establish the community factors influencing utilization of ANC and PNC services in the district of Kasese

1.5 Research questions

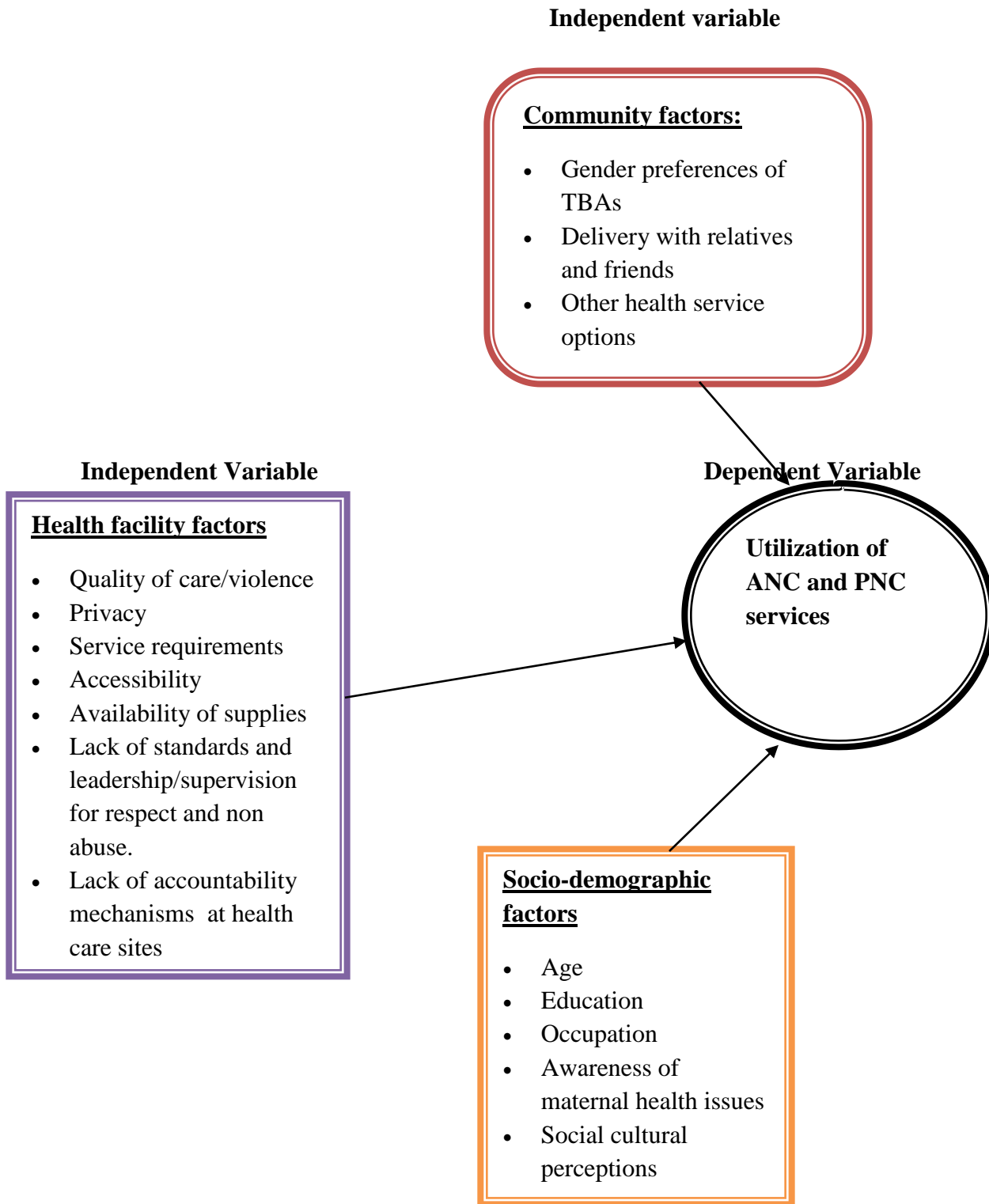
1. What is the proportion of women accessing ANC and PNC services in Kasese district?
2. What client/individual factors influence ANC and PNC service utilization in Kasese District?
3. What health facility based factors influence ANC and PNC services utilization in Kasese district?
4. What community factors influence utilization of ANC and PNC services in Kasese district?

1.6 Significance of the study

The only fundamental approach to reducing MMR in by ensuring all pregnant mothers access at least four ANC visits, delivery under the hands of a well facilitated and skilled healthcare worker and also attend after delivery at least three PNC services with their newborn(s) at six hours, six days and six weeks with a trained health worker. However for this to be achieved, it requires an understanding of all the factors that influence utilization of ANC and PNC services from individual determinants, community determinants and the health facility determinants.

This study therefore aimed to understand the factors that influence utilization of ANC and PNC services in the district of Kasese. The finding will increase the understanding of maternal healthcare challenges and also help to design effective strategies for safe motherhood in genera; within the district.

1.7 Conceptual framework



Description of the conceptual framework

The chart above shows how various factors are at interplay to influence access to maternal health services. These include;

Social demographic factors: individual factors such as age, sex, religion, income/occupation, marital status, education level and perceptions may affect a mother's ability to utilize both ANC and PNC services. Education of a mother may influence how much knowledge or access to information she has and uses for her health decision making especially like utilizing ANC and PNC services. Parity of the mothers may also determine how much experience mothers have in maternal related issues, their perceptions and understanding of the need to access care from health facilities or not. Economic status, income may influence utilization of maternal healthcare services. For instance existence of users' fees direct or indirectly hinder may hinder utilization of maternal services to mothers. Women may be forced to seek support outside health facilities either at home with relatives or with TBAs due to fear of embarrassment at facilities when they for instance lack the necessary birth or after birth requirements. Individually mothers' perceptions about the quality of healthcare provided by health facilities may determine whether she will come back for any further support and care. However, it is from individual perceptions that social/community perceptions are faced. How persons perceive healthcare received from facilities or TBAs, may contribute profoundly to the overall community's perceptions of healthcare as bad or good, leading to under or over utilization in some health facilities.

Health facility factors: factors like quality of healthcare, availability of care, health facility environment, accessibility in terms of distance to health facility, availability of health personnel, motivation levels of health personnel, health personnel's attitude and education may greatly undermine utilization of ANC and PNC services. Poor quality of care, limited accessibility, less motivated health workforce may form barriers to utilization of health facilities for maternal healthcare services. Attitudes of health workforce may negatively or positively affect the utilization of maternal healthcare services.

Community factors: community issues like gender dynamics in terms of control of resources and decision making, presence of TBAs, friends, socio-cultural practices, and general society perceptions may influence mother's choice on where to find service. For example, where gender

roles dictate less decision making powers to women, fewer women may not go to health facilities to seek healthcare simply because they are waiting for their husbands' consent. Preferences to TBAs and relatives to health facilities in terms of accessing healthcare services by pregnant women can determine where a woman would go for healthcare. The role of culture practices, traditions norms determine how pregnancies are treaded. In some Ugandan cultures for instance the sickness during pregnancy is considered as a manifestation of the evil spirits. Therefore it is not unlikely to find pregnant mothers using traditional concoctions or even visiting spiritualists for divine interventions for their health concerns.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

In this chapter, key variables of the selected areas of the research study are expounded on. The chapter highlights literature of other studies done and how their findings were in relations to social demographic characteristics, health facilities, community aspects and health sector policies and how they influenced access and utilization of both antenatal care and postnatal care services in other regions and countries. To better understand this literature, this section starts with an analysis of the maternal healthcare continuum access indicators.

2.1 Access to ANC and PNC

The literature shows that the lack of appropriate care at all levels (during pregnancy, birth and post delivery) i.e. antenatal care (ANC), skilled birth attendance (SBA), and postnatal care (PNC) is associated with poor maternal and newborn health outcomes. The role of perinatal health services factors such as the availability of Skilled Births Attendants (SBAs) and postnatal care (PNC) use has been shown to be key in its impact on neonatal mortality in Indonesia (Titaley et al., 2008). Research both recent (Buor and Bream 2004 for example) and historical (van Lerberghe and DeBrouwere 2001)-alludes to the important role of ANC and skilled birth attendance in its impact on maternal mortality. Given this scenario, there is now a call for a continuum of care for maternal and newborn health focusing on a) a continuity of care over time for every woman and baby) integrated service delivery in facilities (Kerber, de Graft-Johnson, Bhutta et al. 2007, de Graft-Johnson, Kerber, Tinker et al. 2006, PMNCH 2006, Tinker, Hooper - Bender, Azfar S et al. 2005 for example). The pathway for the continuum of care extends from pregnancy, to child birth and post delivery. A good referral system should connect the components of care with high quality services at all levels either in equipped facilities or community settings with trained staff.

While the implementation of the continuum of care in Uganda is still not well documented, the need for care along this continuum can never be under estimated. Mortality for both mother and baby are highest immediately post delivery particularly because many births take place at home without the care needed. Even if women do not die due to the non availability of care at these times, lasting maternal and newborn morbidities can have consequences for both as well as for

other household members. Equity in access to care is another concern. The poorest are most disadvantaged in access to all components in the continuum of care thus bearing a larger burden of mortality (Gwatkin, Buhuiya and Victora 2004, Tinker, Hoop-Bender, Azfar S et al. 2005).

2.1.1 Antenatal care

The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants. WHO recommends a minimum of four antenatal visits, ideally at 16 weeks, 24-28 weeks, 32 weeks and 36 weeks (USAID/Population Council, 2006). The Ministry of Health guidelines are specific on the content of antenatal care visits, which should avail care that is appropriate to the overall condition and stage of pregnancy and should include four main categories of care (with specific examples provided for each category): a) Identification of pre-existing health conditions (e.g., check for weight and nutrition status, anemia, hypertension, syphilis, HIV status); b) Early detection of complications arising during pregnancy (e.g., check for pre-eclampsia, gestational diabetes); c) Health promotion and disease prevention (e.g., tetanus vaccine, prevention and treatment of malaria, nutrition counseling, micronutrient supplements, family planning counseling); d) Birth preparedness and complication planning (e.g., birth and emergency plan, breastfeeding counseling, antiretroviral for HIV positive women and reducing mother-to-child transmission [MTCT] of HIV); e) Intermittent preventive treatment of malaria during pregnancy [IPTp] e.g., giving malaria preventive treatment doses at the 2nd and 3rd trimesters MoH (2010).

According to the UDHS 2011, 95 percent of mothers receive Antenatal care from skilled providers, a proportion similar to the 2006 UDHS. However only 48 percent of women make the four visits recommended during their pregnancy and this has remained almost the same since 2006.

Location of mother whether rural or urban has less significance in terms of access to ANC. There are only very minor differences in the use of antenatal care services between urban and rural women in Uganda. Ninety-seven percent of urban mothers received antenatal care from a skilled provider compared with 94 percent of rural mothers. Over 90 percent of the women in the western region received antenatal care from a skilled provider. The use of antenatal care services from a skilled provider increases with mother's education (UDHS, 2011).

Mothers' level of education affecting utilization of ANC services, with highly educated women most likely to utilize the services (Gwatkin, Buhuiya and Victora 2004). According to the recent UDHS report, 2011, 92 percent of women with no education received antenatal care from a skilled provider, compared with 95 percent of women with primary education and 97 percent of women with secondary and higher education. A study by Simkhada B, et al, (2008), in India identified maternal education, husband education, and marital status as key in influencing utilization of ANC and PNC services.

Similarly, women in the highest wealth quintile were more likely to receive care from a skilled provider (97 percent) compared with 94 percent of the women in the lowest wealth quintile. The proportion of women receiving antenatal care from a skilled provider has not changed in the past five years (UDHS, 2011). Ninety-four percent of women received antenatal care from a skilled provider in 2006. However, the proportion of women who received care from a doctor increased from 9 percent in 2006 to 12 percent in 2011. Finlayson et al 2013 noted misalignment between current ANC and PNC service provision that is not socially and culturally in context with some women in Low Income Countries a hindrance to utilization. Services that are theoretical and not contextualized with the belief systems of the women are likely to be underutilized.

The quality of ANC is seen to vary from health unit to health unit and from one class of people to another and also from the gestation period mothers attend their first ANC Tann et al (2007) while assessing quality of ANC in Entebbe Municipality observed that most mothers attended ANC mainly in the fourth and third trimester 56% and 37% respectively and often blood pressure monitoring and tetanus vaccination are the services frequently provided. Other services in the package of ANC like urine tests, weight-taking, sensitization on danger signs of pregnancy, and blood sample taking are often not emphasized (Macro International Inc., 2007; Tann et al. 2007).

2.1.2 Postnatal care

Every year in Africa, at least 125,000 women and 870,000 newborns die in the first week after birth, yet this is when coverage and programs are at their lowest along the continuum of care (WHO, 2005a). The fact that 18 million women in Africa currently do not give birth in a health facility poses challenges for planning and implementing postnatal care (PNC) for women and their newborns. Regardless of place of birth, mothers and newborns spend most of the postnatal

period (the first six weeks after birth) at home Lawn et al, 2006. Postnatal care (PNC) programs are among the weakest of all reproductive and child health programs in the region (PMNCH, 2012).

Effects on women: Half of all postnatal maternal deaths occur during the first week after the baby is born, and the majority of these occur during the first 24 hours after childbirth. (WHO, 2000a) the leading cause of maternal mortality in Africa – accounting for 34 percent of deaths – is hemorrhage, the majority of which occurs postnatally. Sepsis and infection claim another 10 percent of maternal deaths, virtually all during the postnatal period. (Save the Children, 2005a) HIV-positive mothers are at greater risk of postnatal maternal death than HIV-negative women. (Banks. E., et al, 2006) Access to family planning in the early postnatal period is also important, and lack of effective PNC contributes to frequent, poorly spaced pregnancies. This is a stressful time for new mothers, so emotional and psychosocial support should be available to reduce the risk of depression.

Effects on newborns: Sub-Saharan Africa has the highest rates of neonatal mortality in the world and has shown the slowest progress in reducing newborn deaths, especially deaths in the first week of life. Each year, at least 1.16 million African babies die in the first 28 days of life – and 850,000 of these babies do not live past the week they are born. (Save the Children, 2004b) Asphyxia claims many babies during the first day, and the majority of deaths due to preterm birth occur during the first week. Thirty-eight percent of babies in sub-Saharan Africa die of infections, mainly after the first week of life (Conde- Agudelo, et al, 2005). The majority of these deaths are low birth weight (LBW) babies, many of whom are preterm. In addition, long term disability and poor development often originate from childbirth and the early postnatal period.

Effects on children: At least one in four child deaths occur during the first month of life. These deaths often take place before child health services begin to provide care, usually at six weeks for the first immunization visit. Low coverage of care in the postnatal period negatively influences other maternal, newborn, and child health (MNCH) programs along the continuum of care. For example, the lack of support for healthy home behaviors, such as breastfeeding, can have ongoing effects for the child in terms of under nutrition. Additionally, newborns and mothers are frequently lost to follow up during the postnatal period for prevention of mother-to-child transmission (PMTCT) of HIV. (Pojda J, e tal, 2000)

Good care during the postnatal period both at home and with strong links to referral facilities is crucial for reducing maternal and newborn deaths and can help support the initiation of key healthy behaviors, which have lasting beneficial effects. Attendance to postnatal care in Uganda is the very low, only 2 percent of mother reported to have received PNC service with one hour of delivery while 13 percent received a postnatal checkup within six days (UDHS, 2011).

2.2 Client/individual related factors

Mothers' age and birth order influence choice of where to seek healthcare services especially during delivery. Young and low order births women are more likely to attend ANC and also deliver at the health facility than older and higher order births women. The last Uganda Demographic Health survey indicated that birth to mothers less than 20 years of age and first order birth (67 percent and 74 percent) were more likely to be assisted by a skilled person. This fundamentally reduced with increase in age and higher birth order; for instance mothers in the age categories of <20, 20-34 and 35-49 showed 65.8 percent, 56.5 percent, and 51.1 percent percentages respectively. Similarly 73.1 percent of the first order births took place in health facilities compared to 47.6 percent of mothers with sixth order births (UDHS, 2011). However, (Kinungu D, 2003) in a study conducted in Jinja District Eastern Uganda found no association between ANC and age/parity. The situation in Kasese district may be different given the geographical terrain of the area. There is need to understand this clearly.

Education status of mothers is likely to influence choice of uptake of maternal health services by mothers. Mothers with secondary education or higher education are more likely to attend at least four ANC and also deliver in a health facility than mothers with lower level and those with no education background. For example, recent figure from the UDHS 2011 showed a general picture of mothers in Uganda no education, primary education and secondary plus education showing delivery from home at 62.4 percent, 44.9 percent and 17.9 percent respectively. Education determines how much information a mother has access, most times illiterate or semi illiterate mothers may miss information often written by health workers simply because they can't read. This contradicts Kinungu's study (2003) in Jinja District of Uganda that found no association between mother's level of education and referral delays. Instead, delay in referral was found to be associated with low level of education of husbands.

Perceptions of mothers about the quality healthcare services offered by health facilities, affects the utilization of such services. For instance women in Malawi preferred to deliver at home because although medical setting were accessible to some and free of charge, they perceived it as being low quality and unsafe (WHO, 2007). It therefore prudent to assess the how mothers in Kasese perceive the quality of maternal healthcare services provided in their health workers.

Economic status of women influences access to healthcare services. A study in Mulago hospital (D. Kaye., et al, 2003) showed that many of the late referral for the ‘near misses cases’ had a low socio-economic status and this was explained to be a lack of economic power that made women dependant on husbands/men for their decision making even for healthcare many women sought consent and/or financial assistance from husbands before seeking care.

In a study that was undertaken in Rakai district of Uganda, about the utilization of maternity services, it concluded that accessibility to a maternity facility influenced choice of delivery site (Amooti & Nuwaha (2008:203). Similarly Hodgkin (1996:333), while in Kenya also looked at characteristics affecting where pregnant women deliver from. Le Bacq and Rietsema (1997: 357) too conducted a similar study in Zambia. These studies ascertain that distance to a maternity centre was a significant factor that affected the choice of site of delivery and utilization of hospital maternity services. This is compounded by poverty at household level.

2.3 Health facility factors influencing access to maternal health services

Shortages of personnel, drugs and equipment can have serious effects relating to utilization of health services. Kinungu (2003) in his study conducted in Jinja health units in Eastern Uganda found an association between delays in mothers’ turn up for delivery and shortage of trained staff, basic drugs, supplies and equipments. A similar study in South Africa- Kwazulu Natal, observed heavy workload, long hours, inadequate equipment or facilities, and personal danger causing demoralization and traumatized of staff and lead them to take their frustration out on patients hence compromising the quality of healthcare (Jewkes R, 2009 pg 12).

Maternal mortality ratio (MMR) is closely associated with quality of healthcare services access by women and for every death, there are about 100 near misses which are further closely linked to adverse poor or no access to maternal healthcare at all (Lawn et al., 2009; D. Kaye et al., 2003). In poor resource countries, most of the maternal, perinatal and new born deaths occur at

home where delivery with skilled care is grossly limited and quality of care is undermined (Sines et al., 2006; Khatun & Rahman, 2007; Lassi et al., 2010).

Maternal morbidity and mortality in childbirth is a matter of utmost importance in public health. Part of the problem lies in violence committed by health workers in childbearing or abortion services, which affects health-service access, compliance, quality, and effectiveness (d'Oliveira AF, et al, 2002). According to the WHO report (WHO, 1999) there are four forms of violent abuse by doctors and nurses: neglect and verbal, physical, and sexual abuse. These forms of violence recur, are often deliberate, are a serious violation of human rights, and are related to poor quality and effectiveness of health-care services. This abuse is a means of controlling patients that is learnt during training and reinforced in health facilities. Abuse occurs mainly in situations in which the legitimacy of health services is questionable or can be the result of prejudice against certain population groups.

In Uganda, although an increase from 43 percent (UDHS, 2006) to 57 percent (UBOS 2011) of deliveries that take place in health facilities has been observed, the country still lags on this indicator. The problem does not lie only in access to hospital delivery or resources since avoidable deaths and serious complaints about quality of treatment occur in cities—where most births take place in hospital and in relatively well resourced facilities (WHO, 2008). Part of the problem lies in violence committed by health workers, which affects health-service access, compliance, quality, and effectiveness (WHO, 2008). There is therefore a need to understand how the attitude, practices of health workers in general impact on the quality of services offered to mothers in the district.

Access to health facility is determined by the availability and also affordability of the services offered. The major reason given by mother for not seeking care during and after pregnancy was generally financial constraints 75 percent (D. Kaye et al, 2003, UBOS, 2007). However, other access challenges were linked to long distance to facility; transport/commuting changes; absence of female service provider and lack of drugs at the health facilities. In a study carried out by Bernis et al (2003) in Uganda it was observed that unless skilled care is made available at an affordable cost, poor mothers will continue missing care at the time of most need, i.e. during pregnancy when complication emerge, during birth and immediately after birth. WHO (2007)

noted that even when services were officially free, hidden costs may add up to a substantial part of a family's monthly income

Demands put on the mothers by health facilities as required by policy may act as barriers to healthcare utilization. For example, the Chinese women tended to avoid formal maternal care to prevent being discriminated by healthcare workers because of not following policy that restricts number of births (WHO, 2007). The Reproductive Health Policy in Uganda demands that men accompany their wives during antenatal care, delivery and postnatal care. There is need to understand whether this is not a barrier to health facility care utilization in Kasese district; for example the issue of HIV/AIDS counseling and testing at the ANC clinics which demand for the presence of both partners in order to access the services.

Antenatal care services provided at the health facilities do influence delivery in the healthcare and attendance to PNC. The 2011 Uganda Demographic Health Survey revealed that 68.5 percent of the women that delivered from the health facilities had attended ANC at least four times, while only 33.2 percent of the delivery at the facilities was by women who didn't attend antenatal care at all (UDHS, 2011). There is need to understand whether the education program is effective in conveying the necessary information that can encourage safe delivery in health facility and attendance to PNC by mothers. Antenatal care as for provided an opportunity to screen mother at risk of developing severe complications (Bernie et al, 2003). This raises the question whether or not the education sessions conducted during ANC visits are usually done properly since almost 95.5 percent of the pregnant women in the western region attended ANC at least once, but only 42 percent delivered at in health facilities (UDHS, 2011). The question here is whether or not attendance to ANC provides adequate opportunity for creating enough awareness to encourage delivery in the health facilities.

Postnatal care is vital for both the health of the mother and newborn child. Postpartum is required immediately after delivery up to 42 days following delivery. The first two days after delivery are critical because most of the maternal and neonatal deaths occur during this period. According to the recent finding only 2 percent of mothers received a postnatal checkup with the first one hour of delivery and only 13 percent received postnatal checkups within six days after delivery. Therefore there is need to understand whether each low attendance is due to health facility factors or not.

2.4 Community factors influencing access to maternal health services

Cultural and religious influences determine a lot whether to use the formal or informal health care. In India, continued woman's linkage with her family gave them power to move freely even from their places of marriage, making it easy to access skilled healthcare. In Jamaica, women didn't want to be treated as ill during uncomplicated pregnancies, therefore shunning ANC services. For the non white South Africans, antenatal care has no meaning apart from acquiring the ANC card to enable women access care during delivery (WHO, 2007). The period following birth in Africa is often marked by cultural practices. Understanding these beliefs and practices is an important part of ensuring effective and timely care. Many communities throughout Africa observe practices that keep mothers and babies indoors for the first month after birth – a period of seclusion. Families are wary about visitors coming in close contact with newborns (Embree JE, et al 2000 cited by PMNCH, 2007). If mothers or babies become ill during the period of seclusion, seeking formal health care is often delayed. Yet, sick babies often die within a few hours and delays can be fatal. There is need to understand cultural and religious practices that hinder mother from accessing healthcare services during pregnancy, delivery and post partum periods.

Women's empowerment is crucial in ensuring safe delivery in a health facility where skilled care is available. Women are among the voiceless that are frequently uninformed about the need for skilled care about how to access such care even when it does exist (Bernis et al, 2003). Such a situation is always dictated by culture and society; women are often treated as lower or weaker sex. There is need to understand whether women are aware of this issues that affect and can make decision on them and take steps.

In a study (Downe S et al, 2008) to assess the barriers to ANC for marginalized women in high income countries, it was found out that attendance to depended on the weighing up and balancing out the perceived gain or losses which depended much more on knowledge, awareness, and information available to a woman to be able to make meaningful informed discussions.

In Egypt, the higher use of skilled care during delivery was achieved through awareness creation targeting decision makers at household level. This led to increased number of women and families that sought skilled care (Bernis et al, 2003). Kinungu (2003) in a study carried out in Jinja health units in Uganda, noted that mothers who waited for their husbands and other persons

to make decision of seeking obstetric care were more likely to delay to seek care in the health facilities. In Benin, women who wanted to go for ANC visits had to negotiate for cash with their husbands to pay for their visits. This led to anger and quarrels and women were not given adequate cash to meet medical treatments (Bantebya, 2003).

The presence of TBAs, traditional medicine persons and relatives in the community greatly influence utilization of health facilities. A study conducted in Rakai District in Uganda revealed that the reasons for mothers going to TBAs and traditional medicine persons were associated with socio-economic and cultural factors; economic because of low cost incurred, ease of access in terms of distance/transport involved and ease of approachability. TBAs also provide traditional herbs and drugs to mother (AMREF 1997 cited in Kinungu, 2003).

In Hoima district located in western Uganda, findings demonstrate that adherence to traditional birthing practices and beliefs were important factors in influencing utilization of health facilities during pregnancy, delivery and after delivery; 41 percent of women who delivered from home said they did so because they trusted the use of traditional medicines called “muti” and also didn’t like the notion that health workers (whom they described as strangers) would dispose off their placentas (Bantebya, 2003).

CHAPTER THREE: RESEARCH METHODS

3.0 Introduction

This chapter describes the methodology that was used to assess factors that affect utilization of Antenatal and Postnatal care services in Kasese District in September, 2013. It describes the design of the study, population targeted by the research, the sampling frame, method of sample size determination, sampling techniques, data collection techniques, tools and how they were pre-tested for validity and reliability and also the inclusion and exclusion criteria for the research. This chapter also has describes how data analysis was done and how variables were measured.

3.1 Study design

A descriptive cross sectional study was used to conduct both qualitative and quantitative methods of data collection to assess factors that affect utilization of Antenatal and Postnatal care services in Kasese District. The study was cross-sectional because both the dependant and independent variables were collected at the same time and place.

3.2 Study area

The study was conducted in Kasese District which is located in mid-western Uganda and bordered by Democratic Republic of Congo to the south, Rubirizi in the South East, Bundibugyo and Ntoroko in the West and North West respectively. Kabarole district is to the North while Kamwengye is in the west. Kasese is the main Municipal centre in district and is located approximately 310Km by road, Midwest of Kampala, the capital city of Uganda and the largest city in the country. The district has a population of 801,790 with males being 49% while female are 51% (Uganda Population Secretariat, 2011)

3.2.1 Study population

The study targeted female of reproductive age (15-49) in Kasese district who have had pregnancies in the last one to two years from the time of the interviews.

3.2.2 Study unit

The study units were households who had females of reproductive age (15-49) who had had pregnancies in the last one to two years from the time of the interviews.

3.3 Sample size determination

The study used Kish- Leslie (1965) formula for survey sampling to calculate the sample size

$$n = Z^2pq/d^2$$

Where n = the maximum required sample size for mother age 15-49 years delivering in or out of health facilities.

Z = Z score corresponding to 95% level of significance (1.96)

p = estimate proportion of mother aged 15-49 utilizing maternal health services in Kasese district is 40% (0.42), (UBOS, 2011)

$$q = 1-p$$

d = precision desired in this case is 5% (0.05)

Substitution to the formula above;

$$n = (1.96 \times 1.96) \times 0.40 \times 0.60 / (0.05 \times 0.05)$$

Therefore the sampling size (n) = 364 respondents

In order to cater for missed respondents an extra 3% of the sample size of the respondents were sampled and added to the calculated sample size. This means that a total of 376 respondents formed the sample size for this research study.

3.4 Sampling procedure

3.4.1 Quantitative Data

The study used the modified WHO EPI clusters sampling method in the selection of the study respondents. The clusters were the catchment areas for the Health centers that are meant to providing maternal health services from the four Health Sub District (HSD); Bukonzo West, Bukonzo East, Busongola North and Busongola South. For each HSD two health centers that are meant to provide maternal health services as per the Ministry of health standard guidelines were used to form catchment areas hence making a total of eight catchment areas from which selection

of respondents will be done. Equal number of households were randomly sampled from each catchment area (cluster) sampled. This meant that 47 households were selected for the study, but only if they had females aged (19-49) who have had pregnancies in the last two years.

To select the study household, the research team identified and moved to the center of the cluster/health facility. The community leaders tossed a pencil or bottle to determine the direction of initial movement. To identify the first the household to be included in the study, the starting points were selected randomly and the selection of households followed odd number {i.e. 1, 3, 5, 7 ...}. In each selected household the head of the household/spouse was asked if there were a mother between (19-49) years of age who had had a pregnancy in the last two years. In case the household had more than one person with a pregnancy, the research would write a pairs of numbers and one of the numbers would given to each respondent. The rest of the numbers would be put in a raffle and after mixing, the first number to picked by the respondent would be the person chosen to participate in the study. If a household sampled hadn't had any pregnancy in the last two years or wished not to participate in the study, then the team moved to the next nearest household to the right that fitted the requirements. A total of 47 eligible mothers were randomly selected for interview from the eight clusters making a total sample size of 376 respondents.

Composition of the sampled clusters

Cluster/Health sub district	Health center catchment areas	Number of sampled respondents
Busongora North	Kitswamba HC IV	47
	RMS HC III	47
Busongora South	Bugoye HC III	47
	Kasese Municipality HC III	47
Bukonzo East	Musyenene HC III	47
	Nyabugando HC III	47
Bukonzo West	Ihandiro HC III	47
	Karambi HC III	47
Totals	08	376

3.4.2 Qualitative data

A purposive sampling method was used for the Focus Group Discussions and one focused group discussions (FGDs) was conducted in each catchment area (cluster). The FGD targeted (7-13) mothers or husbands whose wives are receiving or not receiving healthcare services from any the maternity units within the cluster. In order to identify participants from both categories of mothers utilizing or not utilizing maternal services from health facilities, guidance was sought from community opinion leaders, local leaders, and religious leaders especially those that were female simply because these persons were assumed to be knowing the right people of both categories.

Cluster/Health sub district	FGD number	Health center catchment areas	Number of respondents that participated in the FGD
Busongora North	FGD1	Kitswamba HC IV FGD	12
	FGD2	RMS HC III FGD	11
Busongora South	FGD3	Bugoye HC III FGD	09
	FGD4	Kasese Municipality HC III FGF	10
Bukonzo East	FGD5	Musyenene HC III FGD	11
	FGD6	Nyabugando HC III FGD	08
Bukonzo West	FGD7	Ihandiro HC III FGD	12
	FGD8	Karambi HC III FGD	11
Totals		08	84

Key Informant Interviews were held with the focal persons at the maternity clinics, the in-charges of health facilities, the medical superintendants, logisticians, the District Health Officer and the chairmen Local council III, and Sub-county chiefs.

3.5 Data collection techniques and tools

The study used both qualitative and quantitative data collection approaches to collect information from respondents. For quantitative data collection, structured questionnaires were administered to the sampled respondents. In order to collect qualitative data Focus Group Discussions (FGDs) and Key Informant Guides (KI) were administered to the mother, local leaders, health workers and a number of other community gate keepers for in-depth information on perceptions, attitudes and practices affecting utilization of ANC and PNC in their respective localities.

3.5.1 Quantitative data collection

All structured questionnaires were administered in local language by a pair of interviewers. The paired of interviewers had a female who understood at least two of the local languages. Data collection was most restricted to mothers who had had pregnancies not more than two years before the study to minimize bias. The head of the selected household where a mother had had a pregnancy in the last two years was called and asked for permission to interview the mother in that household and in the event that only the mother was available, permission was sought from her and only those that accepted to take part in the interview process were asked questions.

3.5.2 Quality control

In order to maintain quality, all 15 enumerators were trained in the tools and ways of how to accurately record what the respondents had given without altering anything. Tools weren't translated in local language but all questions were translated into the local language during the training, so that all of them understood how to ask the same questions on their own in the local languages. Enumerators were given manuals and guidelines for reference when conducting interviews. All tools were pre-tested before getting adopted for the research. Only mothers who had had pregnancies in the past two years and less were considered to avoid bias.

3.5.3 Inclusion and exclusion criteria

Exclusion:

Mothers: Sick mothers, women who had delivered more than two years prior to the study or those that didn't consent to the interview were excluded. The sick mothers/mothers with sick babies were excluded due to the toll the interview would place on them.

Inclusion: Mothers aged 15 to 49 years with pregnancies or with children between one and years and those attending antenatal care, postnatal care or not were included in the study. Only mothers who gave written consent were interviewed. Community leaders, Health workers and other community gate keepers who didn't consented to the interview were not interviewed.

Health workers: trained and providing antenatal or delivery services or postnatal care services and consent to participate were interviewed.

3.6 Data management and analysis

3.6.1 Data management

Data processing started immediately after interviews of each of each of the respondents. The researcher went through each questionnaire to ensure that every applicable question had been answered and recorded and editing done where necessary. Data was coded for the open ended questions after studying the responses given by the respondents. These were classified into categories.

Data collected was computed using STATA software and entry was done concurrently with data collection to avoid piles of work. The data was edited, coded, and processed using SPSS 11.5 statistical package.

3.6.2 Data analysis

The quantitative data was analyzed using SPSS 11.5 statistical package. Univariate analysis was done to generate frequency tables and other descriptive parameters. Data analysis started with computing the percentages of mothers who got antenatal care services from the health facilities which formed the first dependent variable, and also computed the proportion of mothers and their newborn children less than 24 months attended to services like immunization, postnatal checkups as per WHO definition formed the second dependent variable (PNC). Multivariate

analysis using categorical regression model analysis was used to examine the association between the dependant variables and the independent socio demographic, health facility and community characteristics. In the logistic regression analysis, the first response variable (ANC) had four outcomes; whether a woman attended zero, one, two, three or four or more ANC from health facilities during her last pregnancy. Similarly, the second dependent variable was framed to have four outcomes; whether the woman and her last born child completed the required PNC services (like immunization, postnatal checkup) or not and how many visits were made. Since the interest is in identifying the probability of facing the outcome variable, the dependent variables were coded as 1, 2, 3, and 4+ if the event happened and zero if the event didn't happen. The logistic regression coefficients were used to inform association between the independent variable whether it increased or decreased the chance of ANC/ PNC given a 5 percent level of significance. Independent variables with p-values were less than 0.05 were considered predictive within the study.

3.7. Study variables

3.7.1 Independent variables

Individual/client variables;

Mother's age; Religion; Ethnicity; Education of women; Mother's occupation; Husband occupation; Family income; Marital status; Birth order; Death of previous children.

Health facility factors

- Distance to health facilities
- Quality of service provided (privacy, attitude of health workers, violence and abuse by health workers, and adequacy of space for ANC, labor, hygiene and sanitation).
- Cost incurred (Demand for other requirements for ANC, delivery and PNC by health facilities.
- Service delivery variables; level of education of health workers and their understanding of maternal healthcare service delivery.

Community related variables;

- Community structures to promote women rights; Cultural practices; Community awareness; Community perceptions (real or unreal feelings or fears to attendance to ANC, delivery and PNC services at health facilities). These include perceptions of risk of health facility deliveries and non health facility deliveries; community knowledge of risks when there is failure to seek healthcare; accessibility of TBAs in the community (including physical and financial accessibility); reasons for receiving maternal healthcare services from TBAs and other persons.

3.7.2 Dependent variable

Dependent variable combinations of maternal healthcare services received during pregnancy, delivery and after delivery these will include;

- Antenatal care service (ANC) utilization.
- Postnatal care service (PNC) utilization.

3.8 Ethical consideration and dissemination of results

3.8.1 Ethical considerations

The research study sought consent at various levels. The study sought approval from University Research Ethical committee. At district level consent was obtained from local leaders (LCs) and, District Health Office. For respondents to participate, consent was sought from them. Those that felt not interested were excluded from the study. If respondent sought not to divulge any information on a particular aspect or wished to stop any level, their wishes were granted and such information was not utilized for the study. Total confidentiality was respected and information was purposely for research purposes. All respondents were recorded by numbers and not their names so as to hide their identity.

3.8.2 Dissemination of results

The results of the study are submitted to the Institute of Policy and Management of International Health Science University (ISHU). After approval, copies of the findings and recommendations are to be presented to the district officials and representatives of the CSOs working in the areas of maternal and child health with the district of Kasese. A paper will be published in a peer-

reviewed journal to increase the scope of readership. Presentation of the study results will also be made at various conferences and workshops.

CHAPTER FOUR: RESULTS

4.0 Socio-demographic characteristics of the women

As shown in Table 1, the final number used in the analysis was 370 respondents, of which the majority 252/370(68.1%) were aged 20-34 years, 62/370(16.8%) were 35-49 years and only 56/370(15.1%) were below 20 years of age. Majority of the respondents 310/370 (83.8%) were married/cohabiting and 30/370 (8.1%) either divorced or not married. Most of the respondents belonged to a religious grouping with Anglican forming the largest denomination at 45.9% while Islam was the least practiced region with 3.8%. Most respondents 93.5% had attended school at least to some level with primary level being the most level attained at 49.7% and secondary level being the least level attained at 5.7%. Ethnically, majority 88.1% of the respondents were from the Bakonzo tribe. Most of the women 58.6% engaged in some form of income. Peasant farming by women was the chief source of income at 41.8% followed by petty business with 39.4%. Most of the husbands 33.9% engage in peasant farming and 24% are employed salaried earners, pastoralism is the least form of income earning venture. Majority 48.8% of the households reported incomes less than 100, 000/= Ug shillings per month and a little as 3% earn more than 500,000/= Ug shillings per month. Most respondents 47.8% had 2-3 children and only 6.7% had six and more children.

Table 1: Social demographic characteristics of 370 women in Kasese District

Variable	N	Percent
Age (years)		
<20	56	15.1
20-34	252	68.1
35-49	62	16.8
Marital status		
Married/cohabiting	310	83.8
Divorced/separated	30	8.1

Not married	30	8.1
Religion		
Anglican	170	45.9
Catholic	138	37.3
Pentecostal	26	7.0
Muslim	14	3.8
SDA	18	4.9
Attendance to school		
Yes	346	93.5
No	21	5.7
Education Level		
Primary(p1-p2)	175	49.7
O 'level(s1-s2)	131	37.2
A 'level(s5-s6)	20	5.7
Tertiary	25	7.1
Ethnicity		
Mukonzo	326	88.1
Munyankole	14	3.8
Mutooro	15	4.1
Munyabindi	13	3.5
*Other (Musoga)	2	.5
Mother Occupation		
Yes	217	58.6
No	148	41.4
Mother's type of occupation		
Peasant farming	118	41.8
Pastoralist	3	1.1
Salaried work	31	11.0
Tailoring	18	6.4
Business	111	39.4
**Other(crafts, weaving)	1	.3

Husband's occupation

Peasant farmer	113	33.9
Pastoralist	3	.9
Salaried work	80	24.0
Boda-boda	61	18.3
Casual labor	60	18.0
Business	16	4.8

Average Family income

<100000p/m	177	48.8
100000-199000p/m	100	27.5
200000-499000p/m	71	19.6
>500000p/m	11	3.0

Number of pregnancy/gravidity

1	89	24.5
2-3	171	47.0
4-5	77	21.2
6+	27	7.4

Number of children/Parity

1	77	24.4
2-3	151	47.8
4-5	67	21.1
6+	21	6.7

*Others = Musoga, Mugwere, Acholi. **Others= Crafts, weaving)

4.1 Proportion of women utilizing Antenatal and PNC care services in Kasese District

The proportion of women's attendance to ANC PNC care in Kasese is at 98.4% and 38.2% respectively. This clearly confirms that ANC is well utilized that PNC amongst the same population of women

Figure 1 Shows attendance to ANC during pregnancy among 370 women in Kasese District.

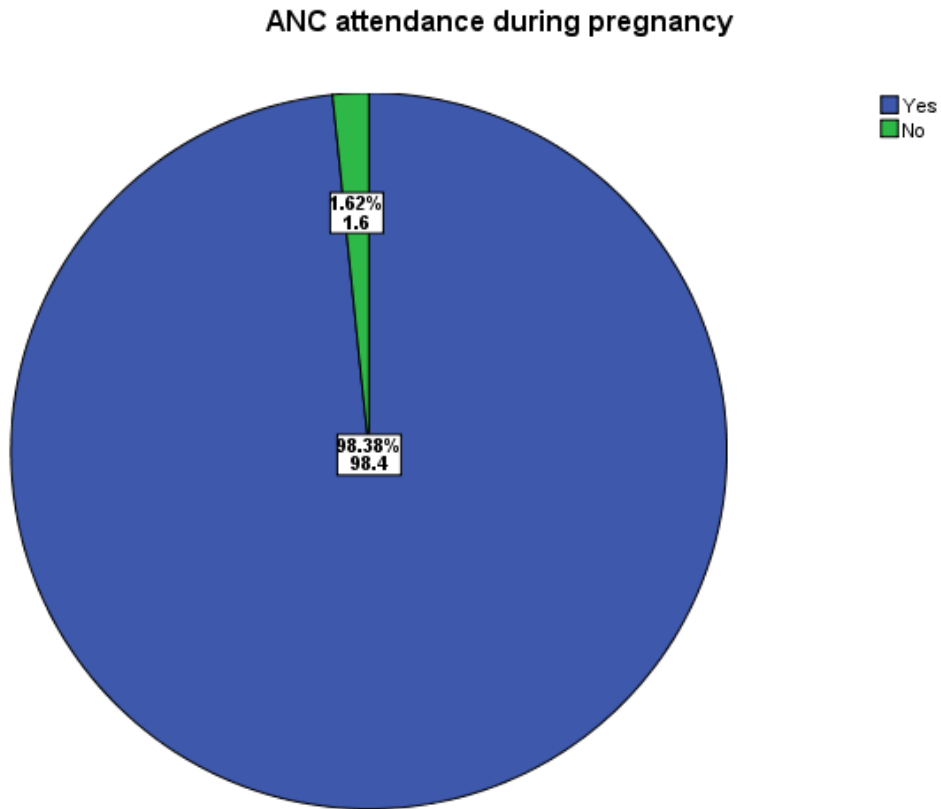
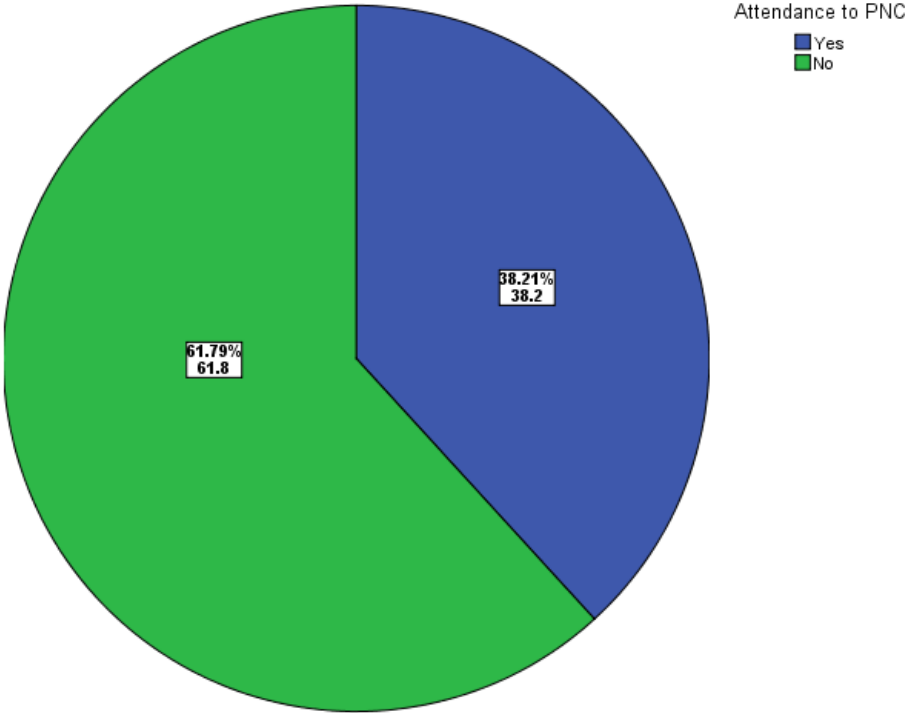


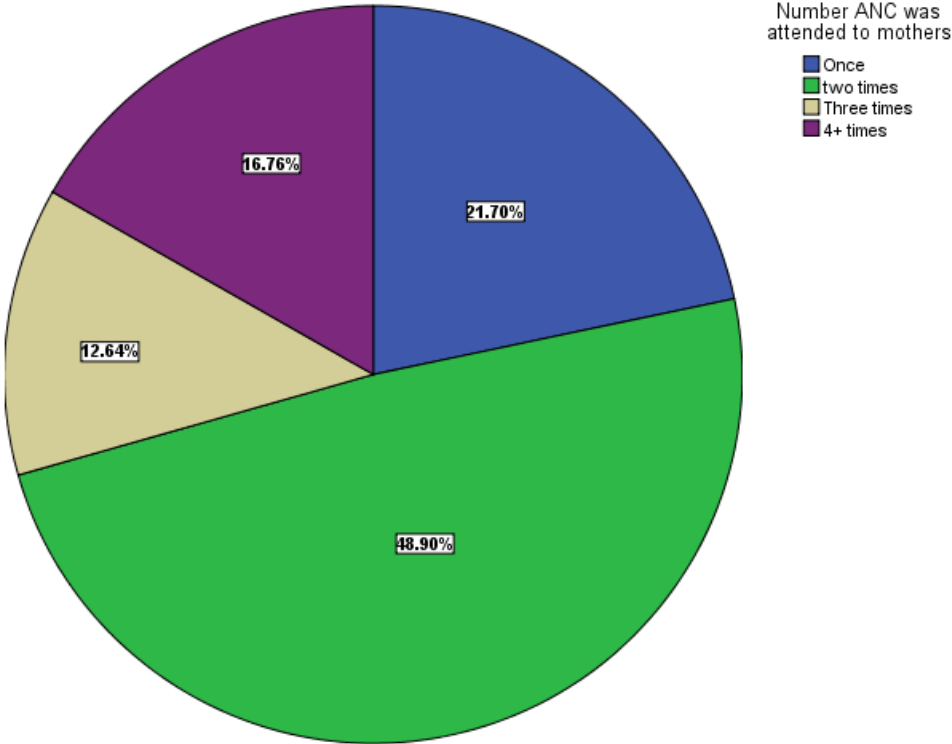
Figure 1, shows utilization of Antenatal care services by women interviewed in Kasese district at 98.4% however only 16.8% had utilized at least four visits which are recommended by the Ministry of Health and World Health Organization.

Figure 2 Shows attendance to PNC amongst 364 women in Kasese District



From figure 2, it shows clearly that utilization of postnatal care is very minimal only at 38.2% of the women. Majority of the respondent 228(61.8%) had not attended PNC

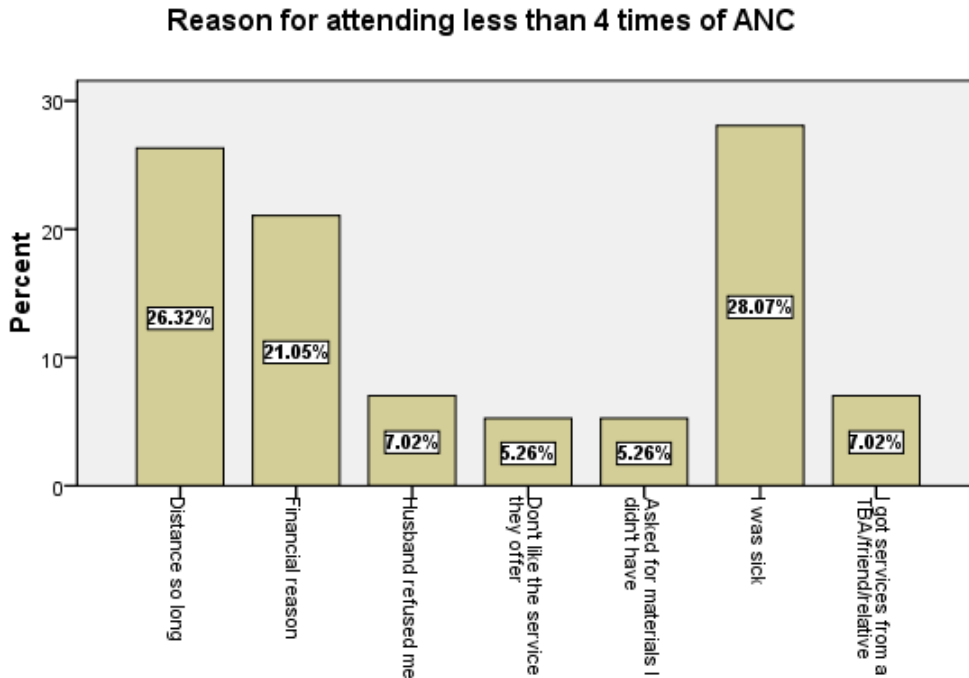
Figure 3 Shows attendance to the recommended four ANC visits among 364 women in Kasese District.



Results in Figure 3 reveal that only 61 (16.8%) of the respondents has attended at least four visits during pregnancy, a number recommended by WHO with majority 48.9% only attending twice. The least number of respondents 12.64% had attended three times of the ANC visits.

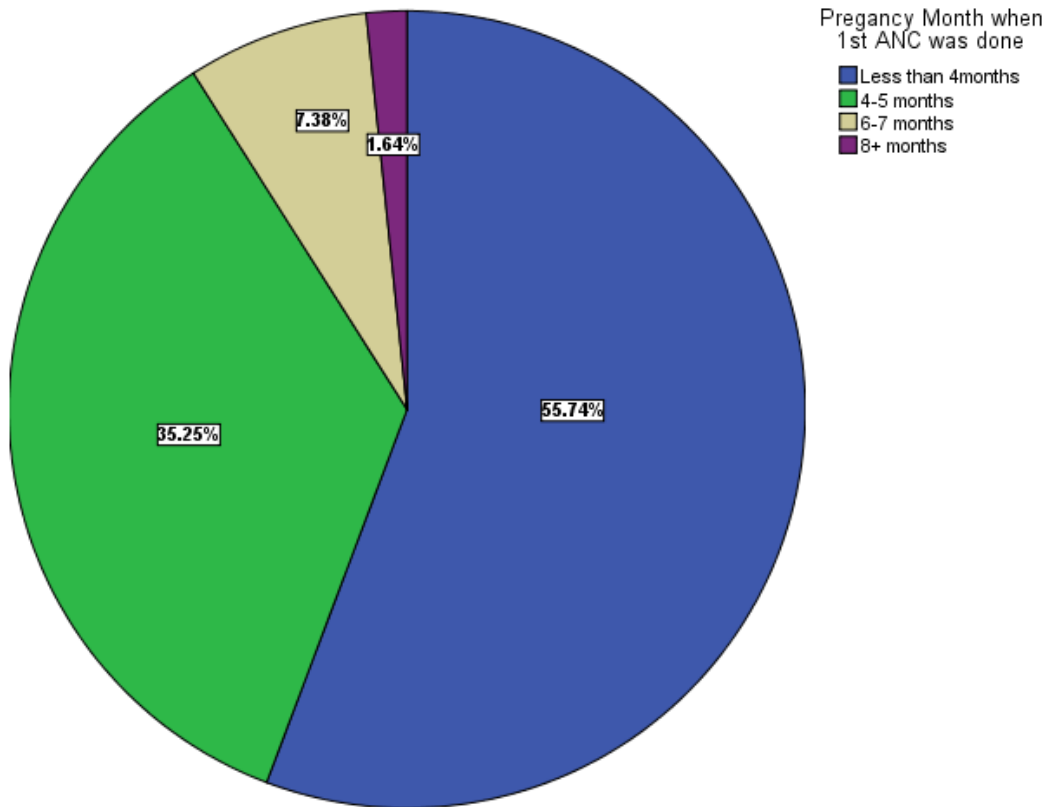
4.2 Individual/client factors influencing utilization of both ANC and PNC in Kasese District

Figure 4 Reason for attending less than 4 times of ANC among 97 women in Kasese District



In Figure 4, highlights reasons for attendance to the less than the recommended number. Sickness was given as the main reason 16/57(28.07%) followed by distance being too long 15(26.32%). Only 5% reported their reason was because they hadn't acquired the required materials asked for by the health workers.

Figure 5 Shows gestation age for first ANC visit among women in Kasese District



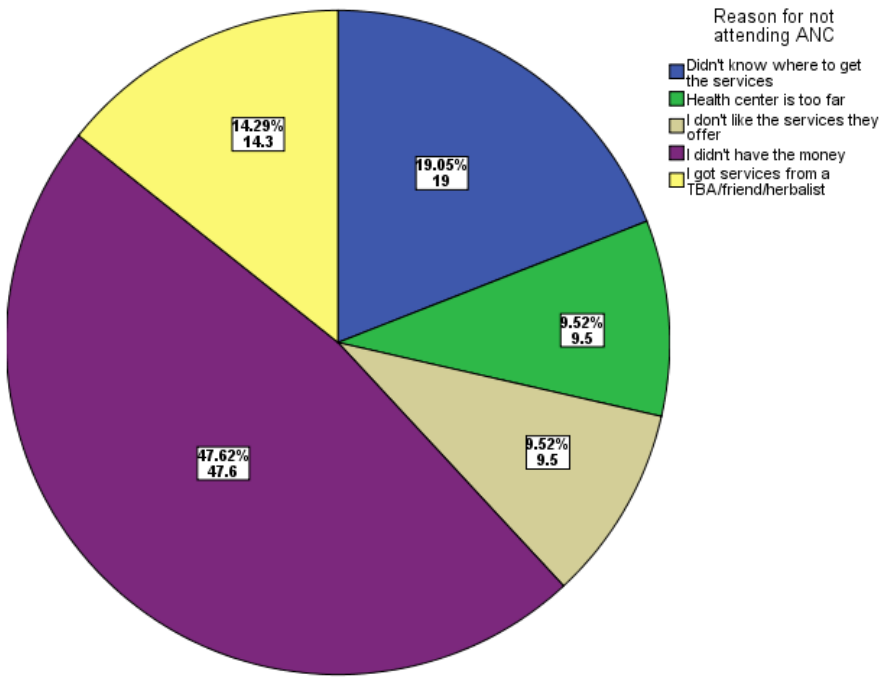
From figure 5 above majority of women 55.74% attended their first ANC at less than four months of the pregnancy followed by 35.75%. Attendance to ANC at gestation of eight and above months was the least at 1.64%.

Table 2: Knowledge of risk associated with not attending ANC among 364 women in Kasese

Variable	N	Percentage
Knowledge of risk of not attending ANC		
Knowledgeable	228	61.6
Not knowledgeable	142	38.4

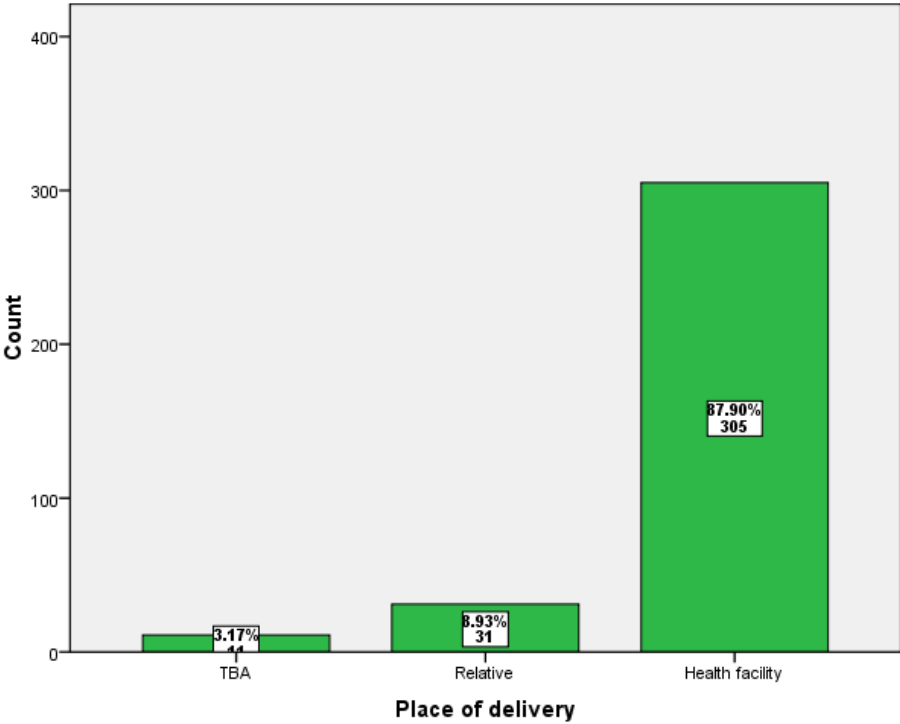
In Table 1, majority of women 228/364(61.6%) were knowledgeable about the risk of not attending ANC from health facilities and only 38.4% showed lack of knowledge in the importance of attendance to ANC.

Figure 6 Shows reason for not attending ANC at all among women in Kasese District.



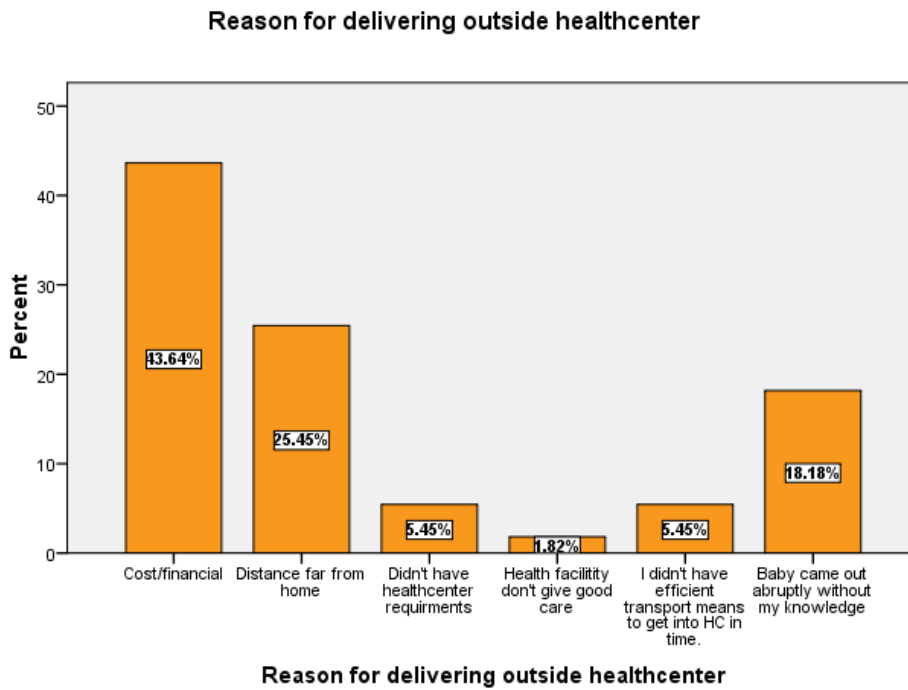
Although most women reported to have attended at least one visit of ANC in the district, the few that didn't attend any ANC reported lack of money 37.6% as their major reason followed by having accessed services from TBAs 14.3% as the other reason. Both distance and disinterest in the services provided were the least sighted reason at 9.5%.

Figure 7 Showing choice of place of delivery by mothers in Kasese District.



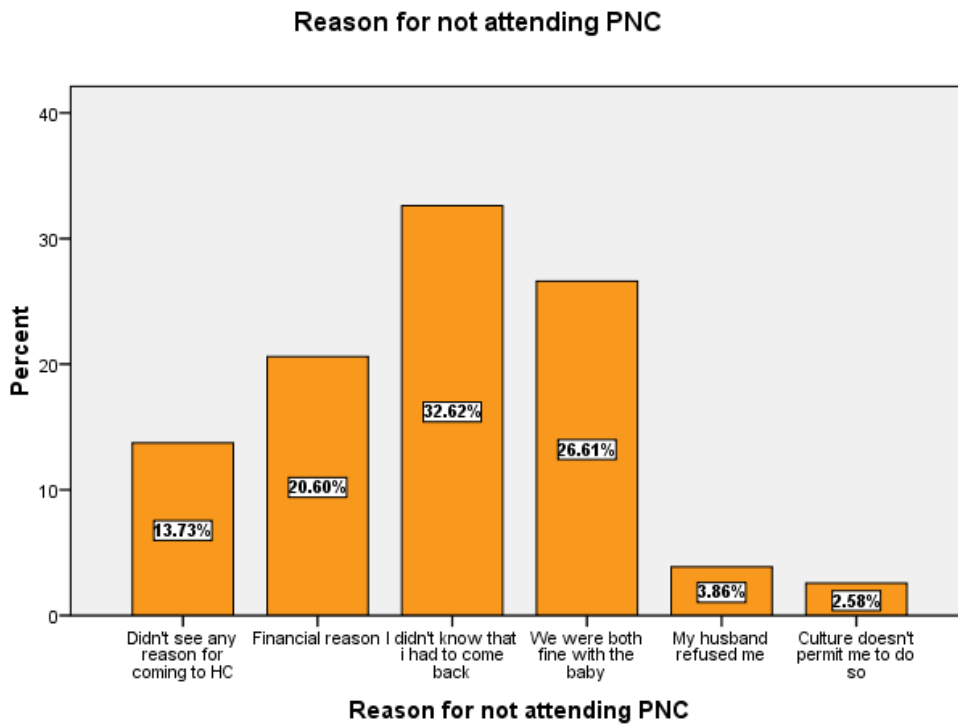
Majority of women, 87.9% reported their choice of delivery as a health facility and the least choice place for delivery being TBAs at 0.17% of the respondents.

Figure 8 shows reason advance my mother for choice of delivery outside Health facilities



A good number of mothers 43.64% reported financial reasons as their most influencing factor, followed by distance 25.45%. Lack of health center requirements 1.82% was the least reason advanced as an influencer for delivering outside the health facilities.

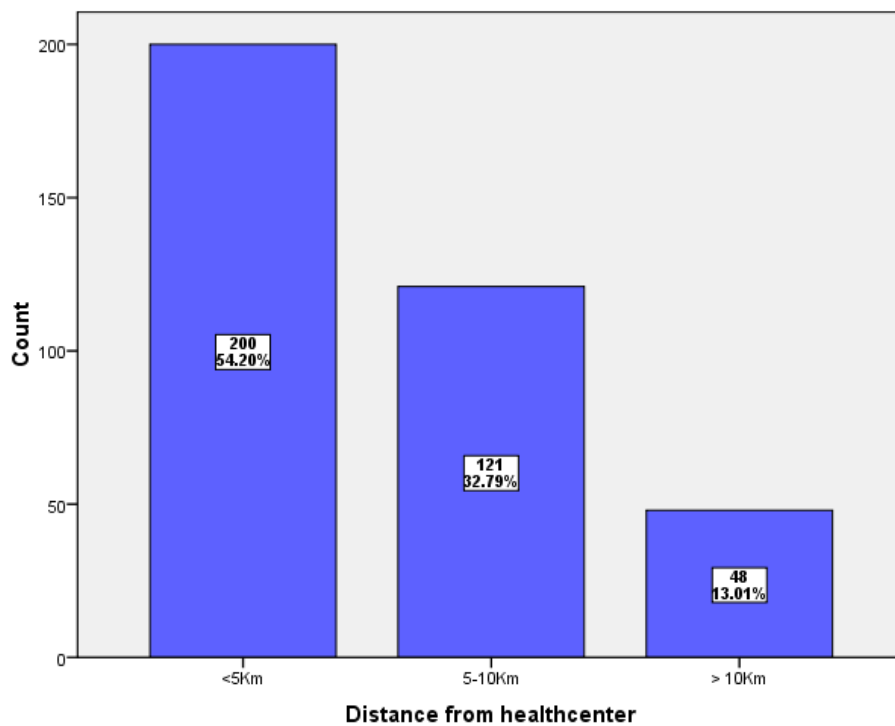
Figure 9 shows the reason given by women for not attending PNC services in Kasese District



From figure 5, most women 32.62% reported not to have known whether they were meant to come back for PNC services after delivery followed by 26.61% reporting that there not coming for PNC was because they were fine with their babies. Culture was the least reason given as hindrance for women not attending PNC services in Kasese district at only 2.58%

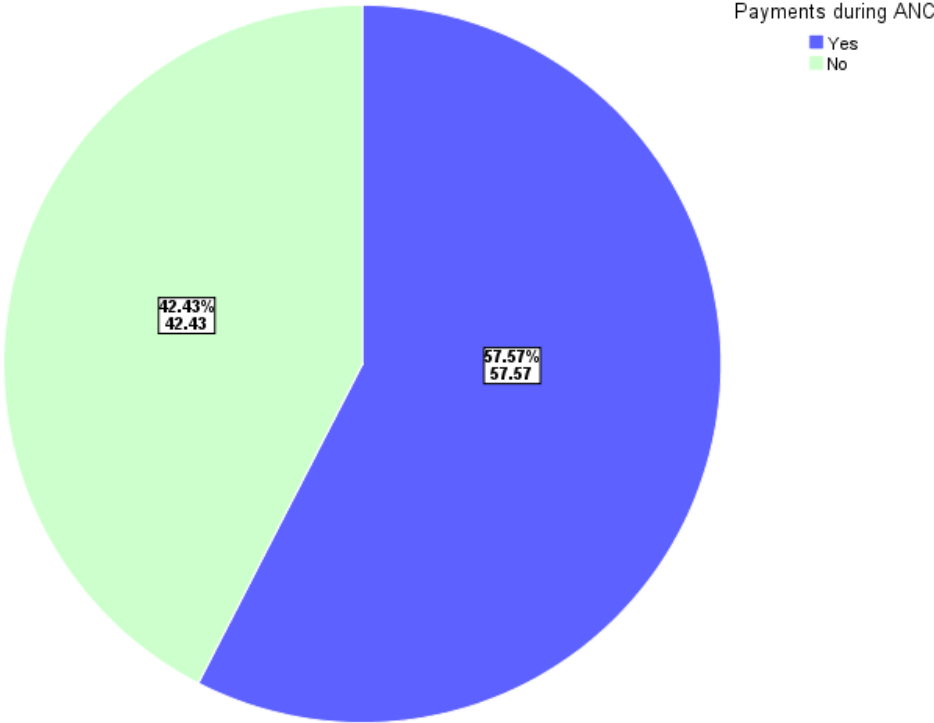
4.3 Health facility factors influencing utilization of ANC and PNC services among women in Kasese District

Figure 10 shows Distance of Health facility from Respondent's Household in Kasese District



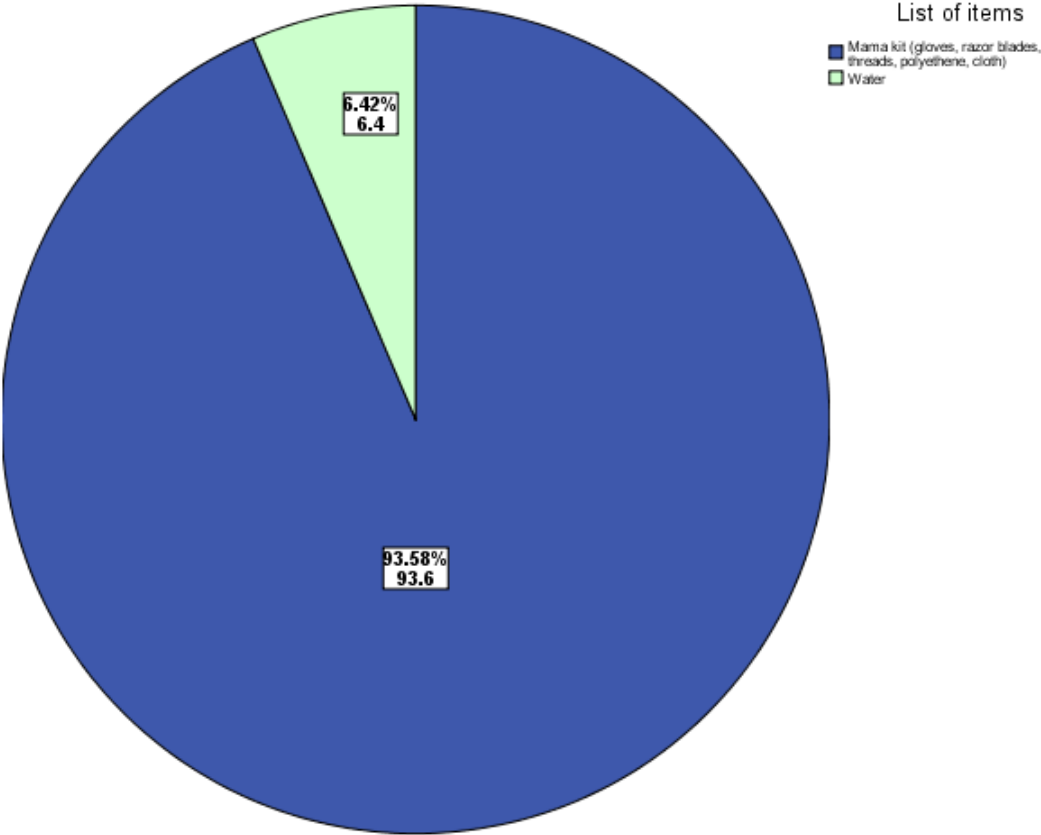
In figure Majority of respondents 64.28% live less than five Km from the health facilities utilized for maternal health service and only 13.0% live more than ten Km.

Figure 11 Shows existence of payment schemes during mothers visit for ANC



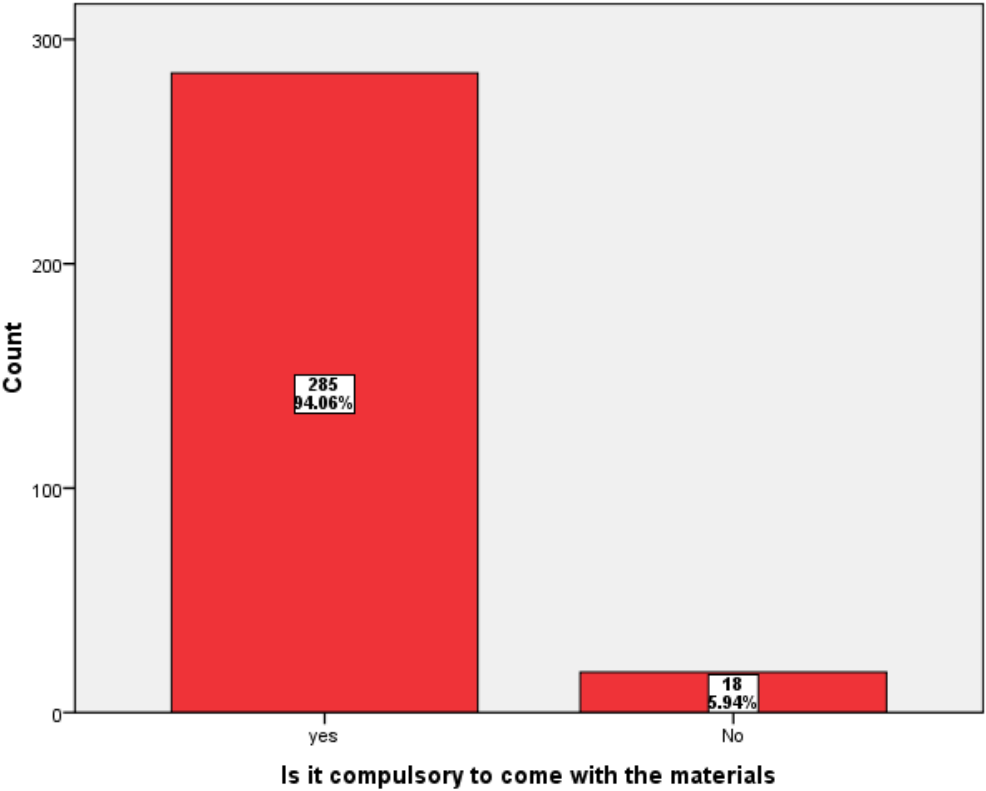
From figure 11 above, majority 57.57% of mothers reported the existence of some form of payment during ANC service utilization. Only 42.43% acknowledged non existence of payment requirements during utilization of ANC services.

Figure 12 Shows materials Mothers are required to have during ANC visit to Health facilities in Kasese District



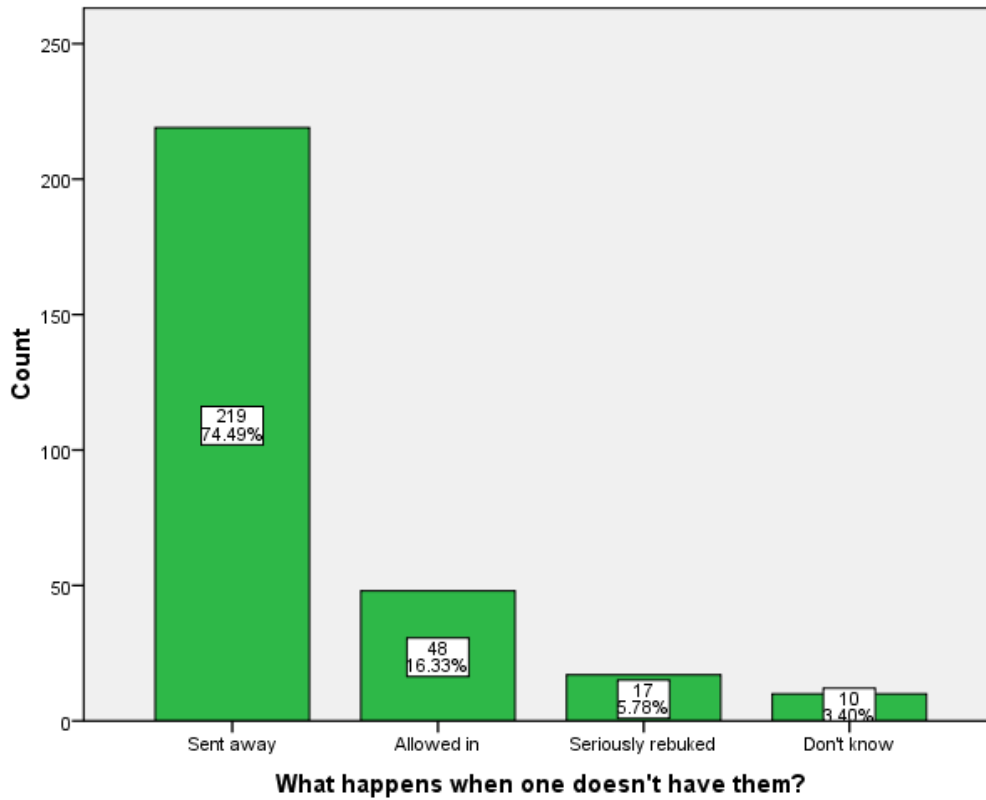
From figure 12 above, majority 93.6% of the mothers reported mama kits (gloves, razor blades, threads and polyethene materials) a must requirement they have to buy before utilizing ANC services, only 6.4% noted that health facilities require them to purchase water which is required for their services.

Figure 13 Shows response from mothers on whether the material requirements are compulsory



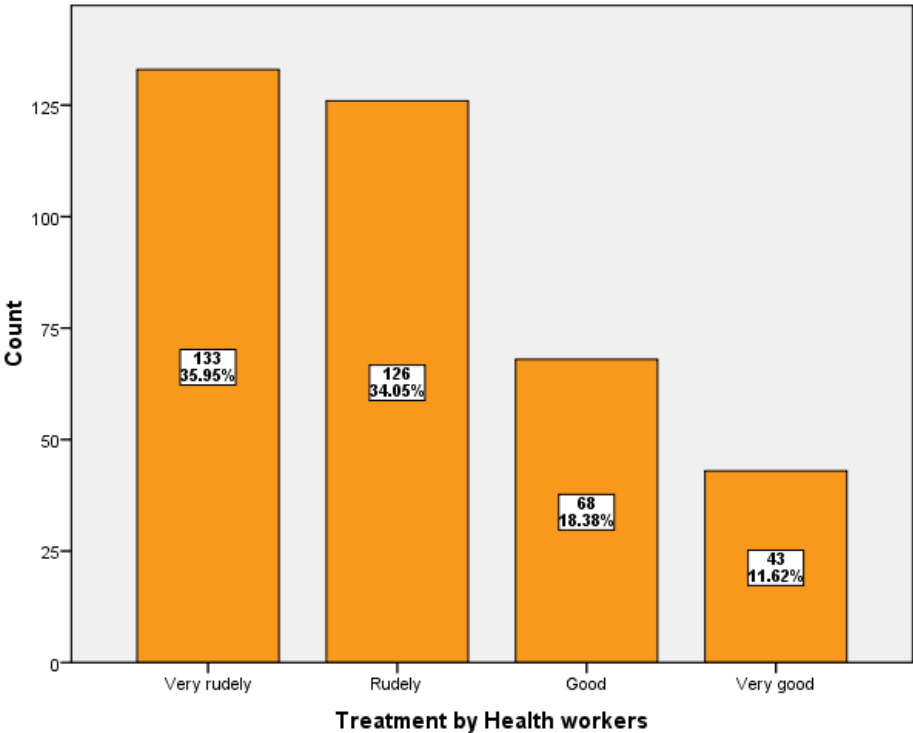
From the figure 13, majority 94% of women reported that, it was compulsory to come with the materials mentioned above, only 6% of women had reported that materials were not compulsory for one to attend ANC services.

Figure14 Shows what happens in case a mother fails to come with the required materials for ANC



From figure 14 above, majority 74.5% of mothers reported they often get sent away if they report for ANC without the required materials, only 5.8% reported that health workers rebuke them for not having these materials.

Figure 15 Shows response by mothers on how Health workers treat them when they go for ANC and PNC services in Kasese District



From figure 15, it was revealed that rudeness was wide spread in the health facilities with most mothers 36% reporting that health workers treated them so rudely followed by 34% who said health workers were rude. Only 11.6% of the respondents reported that health workers treated them very good.

Figure 16 Shows response of mothers on what they feel about privacy within Health facilities

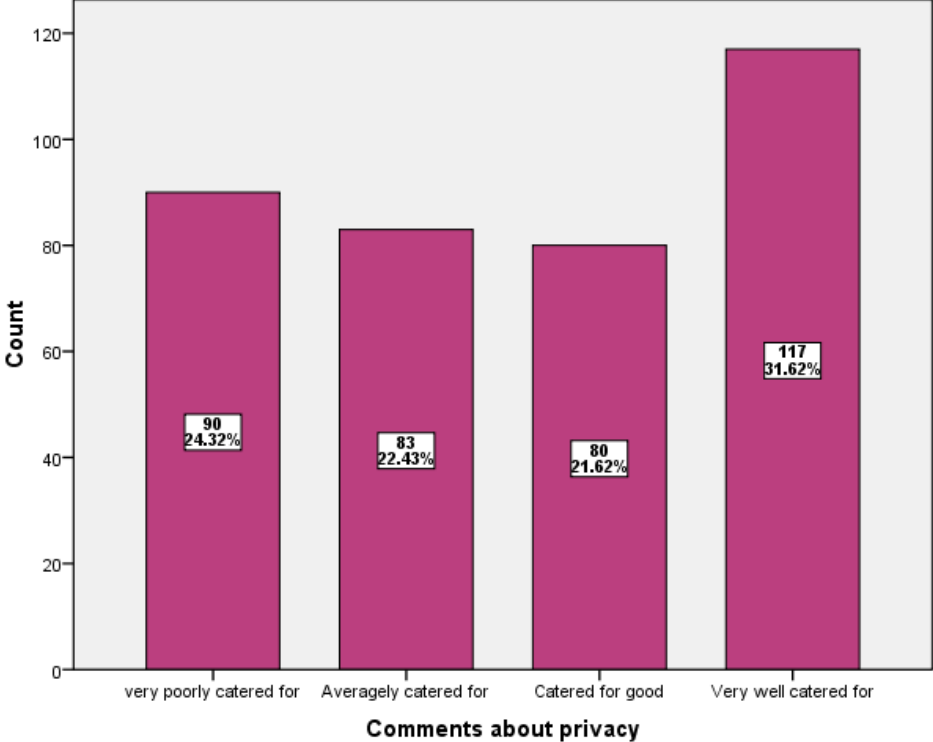
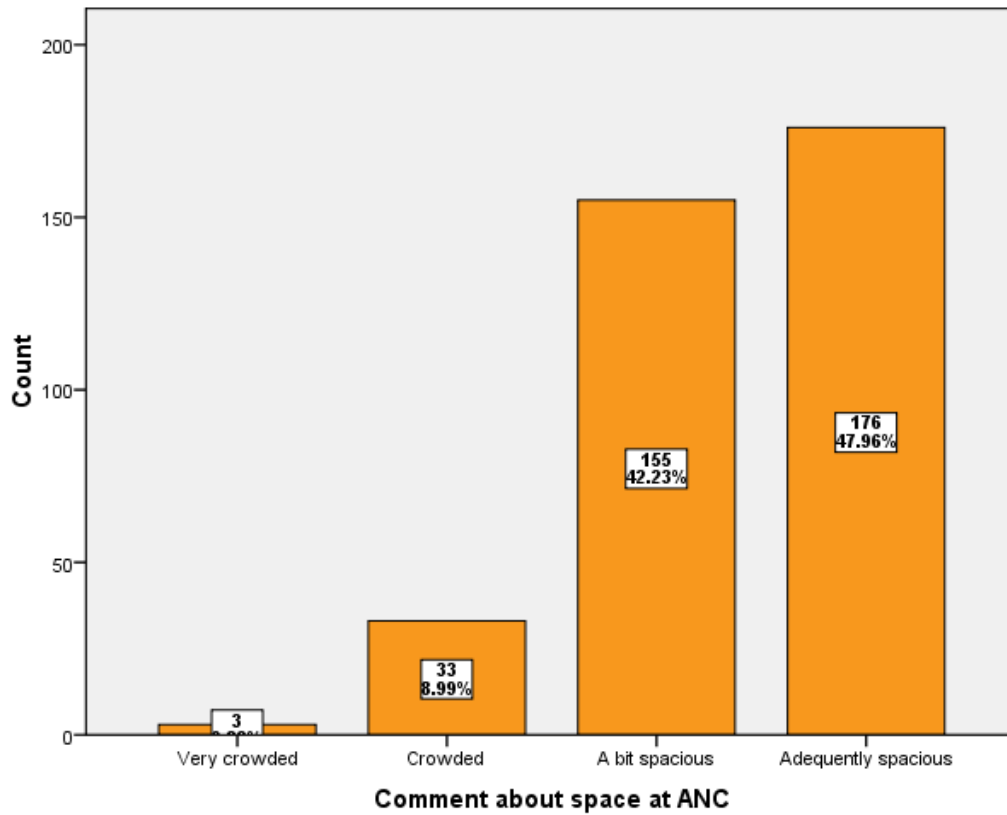


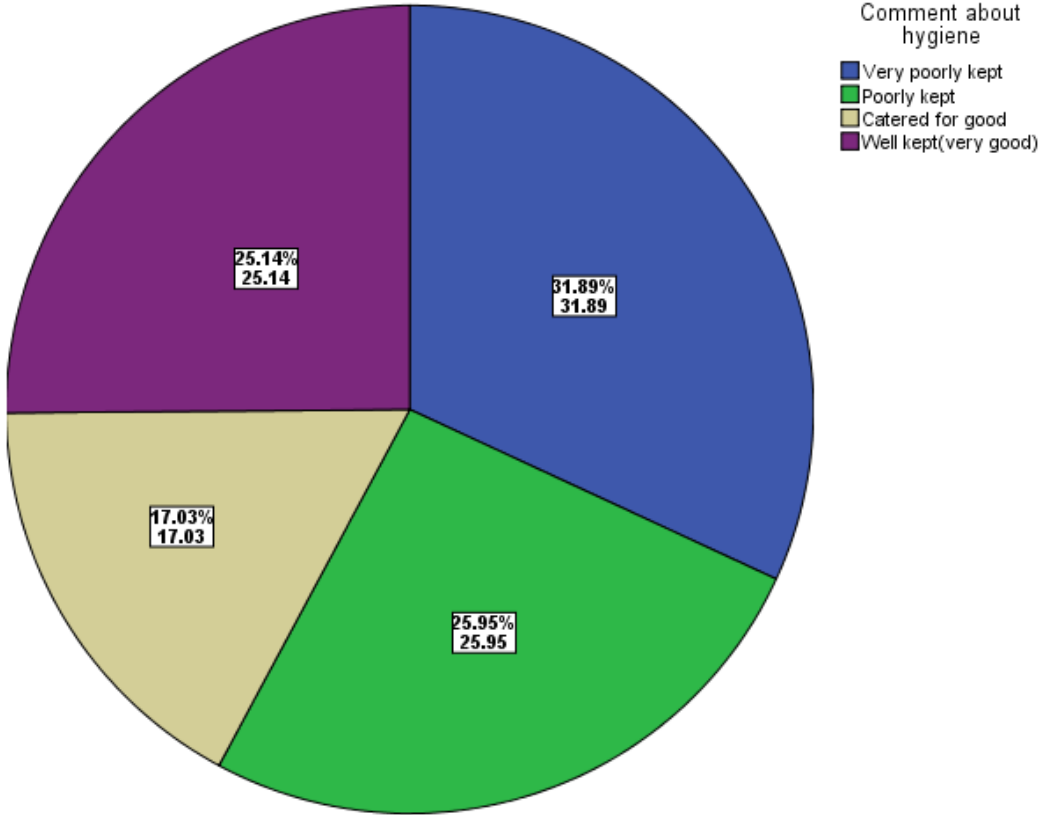
Figure 16 shows, most women 31.6% felt that privacy was very well catered for at their health centers, however there were also a good number of women 24.3% who felt that their privacy was poorly catered for within health facilities.

Figure 17 shows mothers comments about space at ANC and PNC facilities



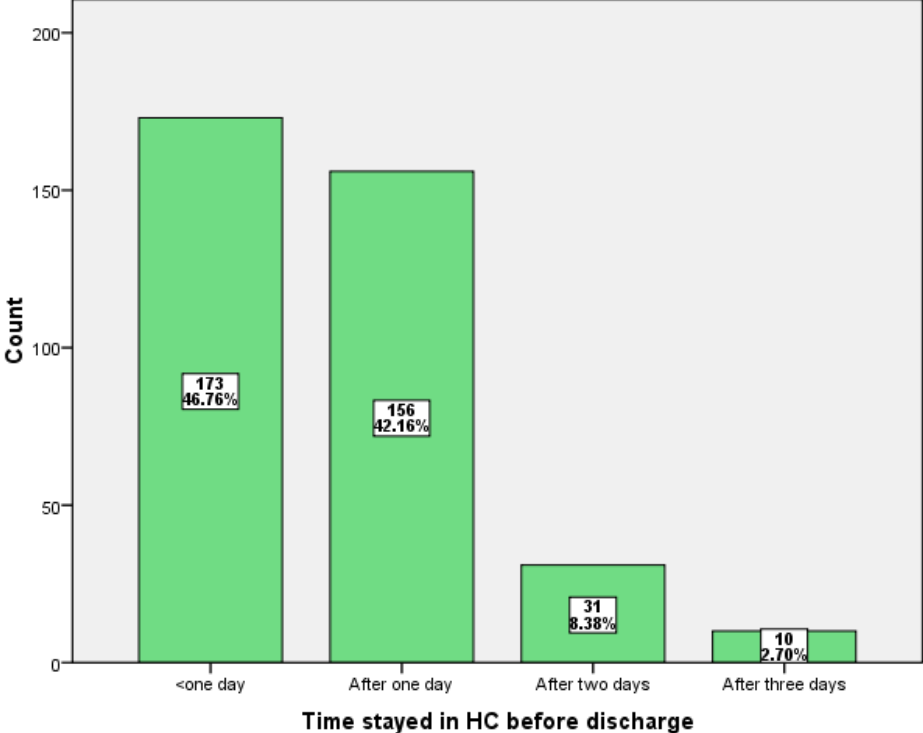
From the figure 17 above, most mothers 48% reported that ANC spaces within health facilities were adequately spacious for provision of ANC, while a small 1% reported that the spaces left for ANC were so overcrowded.

Figure 18 shows mothers responses on Hygiene within health facilities



The figure 18 above shows 32% of mothers feel the hygiene in their health facilities is so much poorly (very poorly) kept while closer number 26% also feel their hygiene is poorly kept. Only 25.1% feel that their environment at health facilities is well kept (very good).

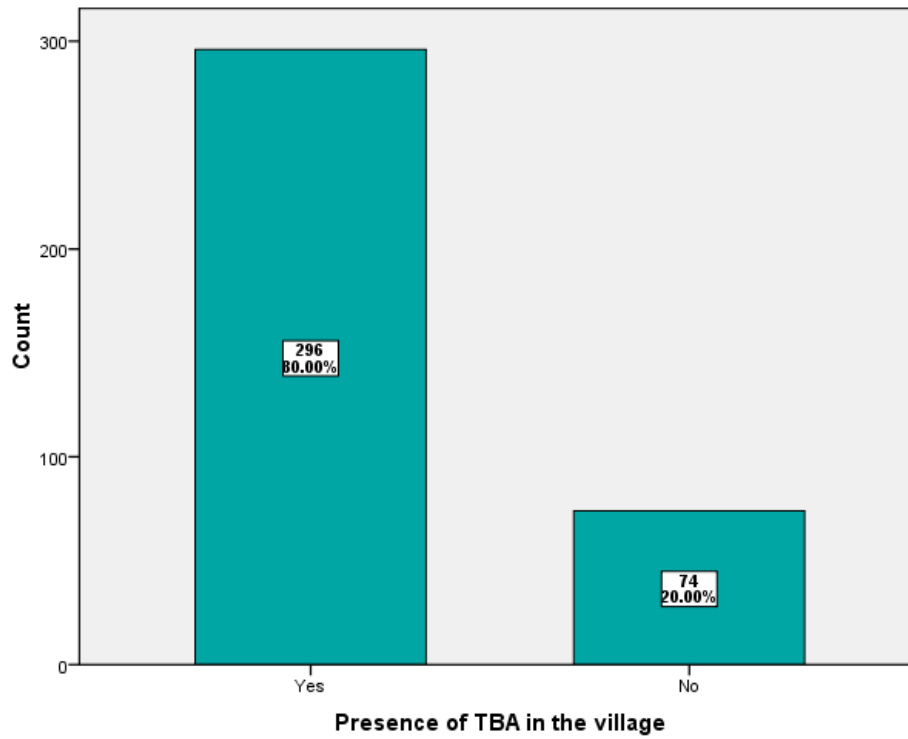
Figure 19 Shows time mothers spent in Health facilities after delivery within Kasese District



From figure 19 above, 46.8% of mothers were discharged less than one day after delivery. Only 3% of mothers stayed than three days after delivery.

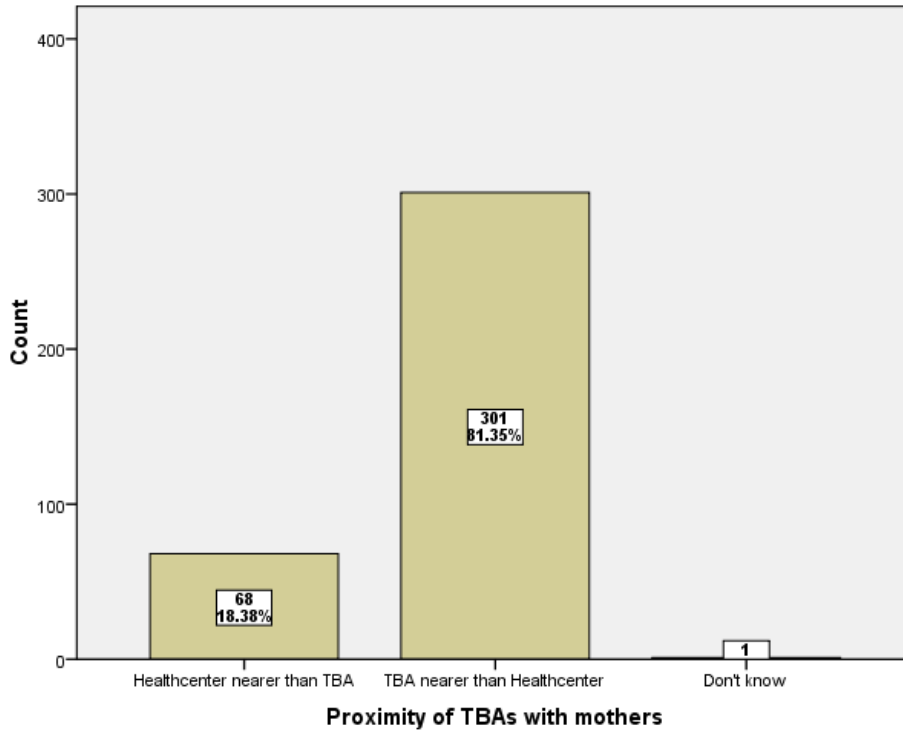
4.4 Community factors influencing utilization of ANC and PNC services

Figure 20 Shows responses on the presence of TBAs in the community



From the above figure, majority 80% of women confirmed existence of TBAs in their communities. Only 20% noted that TBAs were not available in their communities.

Figure 21 Shows proximity of TBAs with mothers in Kasese District



From figure 21 above, majority of 81.4% of women reported TBAs were much nearer in their communities than health centers, only 18.4% reported health facilities to be closer to them than TBAs.

Figure 22 Shows mode of payment to TBAs in Kasese District

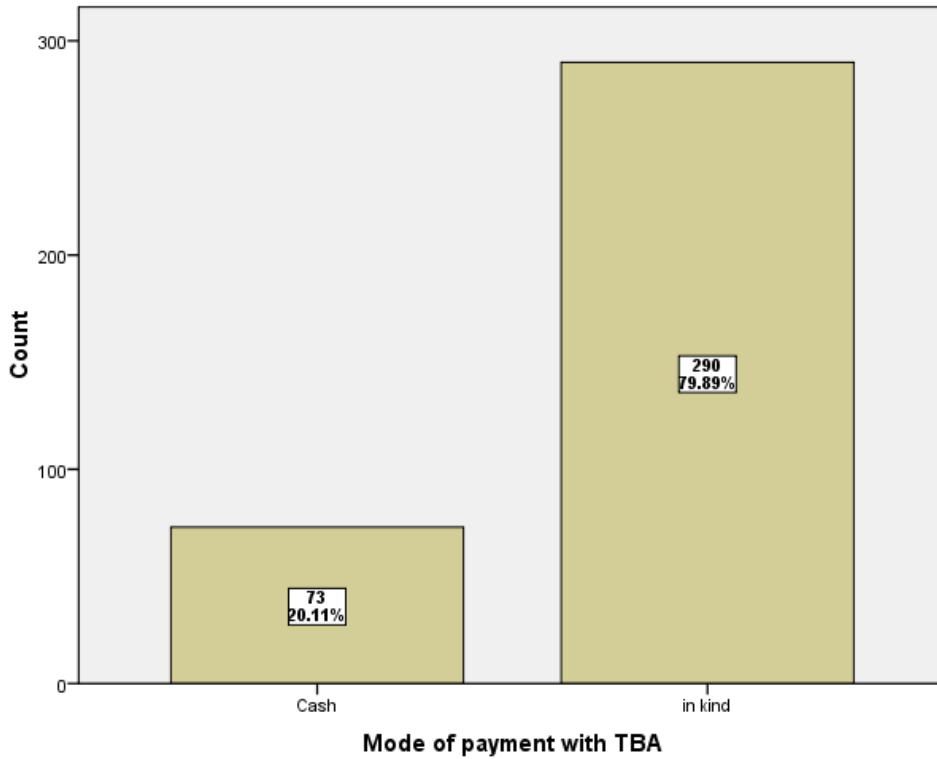


Figure 22 above shows majority 80% of women pay in-kind to TBAs whenever they seek services and only 20% reported to paying in cash whenever they sought services from the TBAs.

Figure 23 Shows comparison of charges paid between TBAs and HC in Kasese District

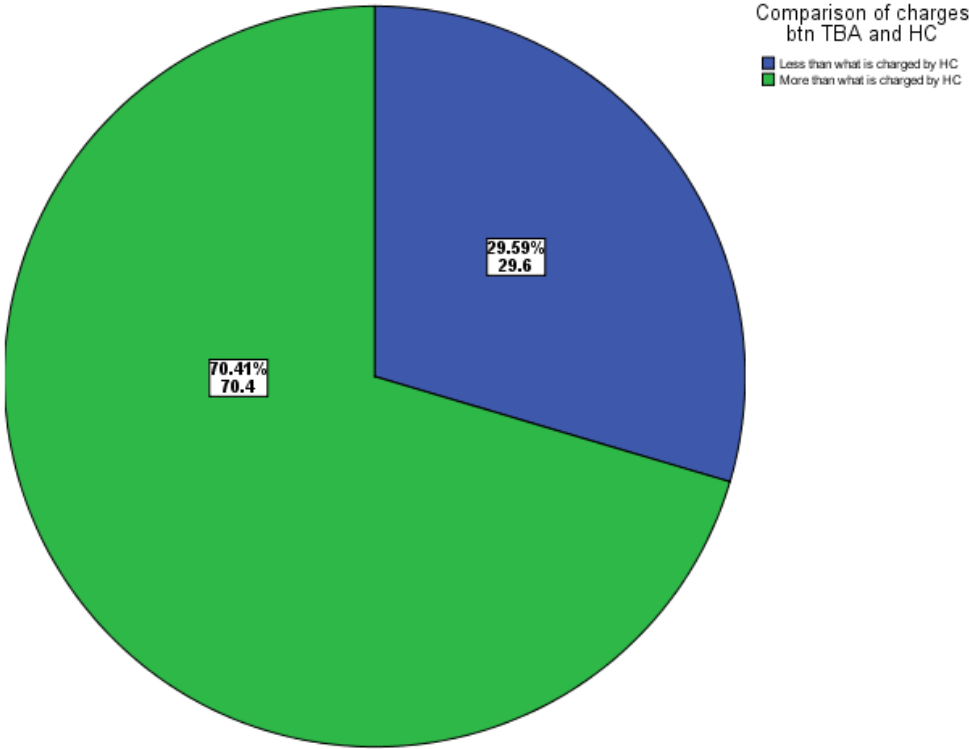
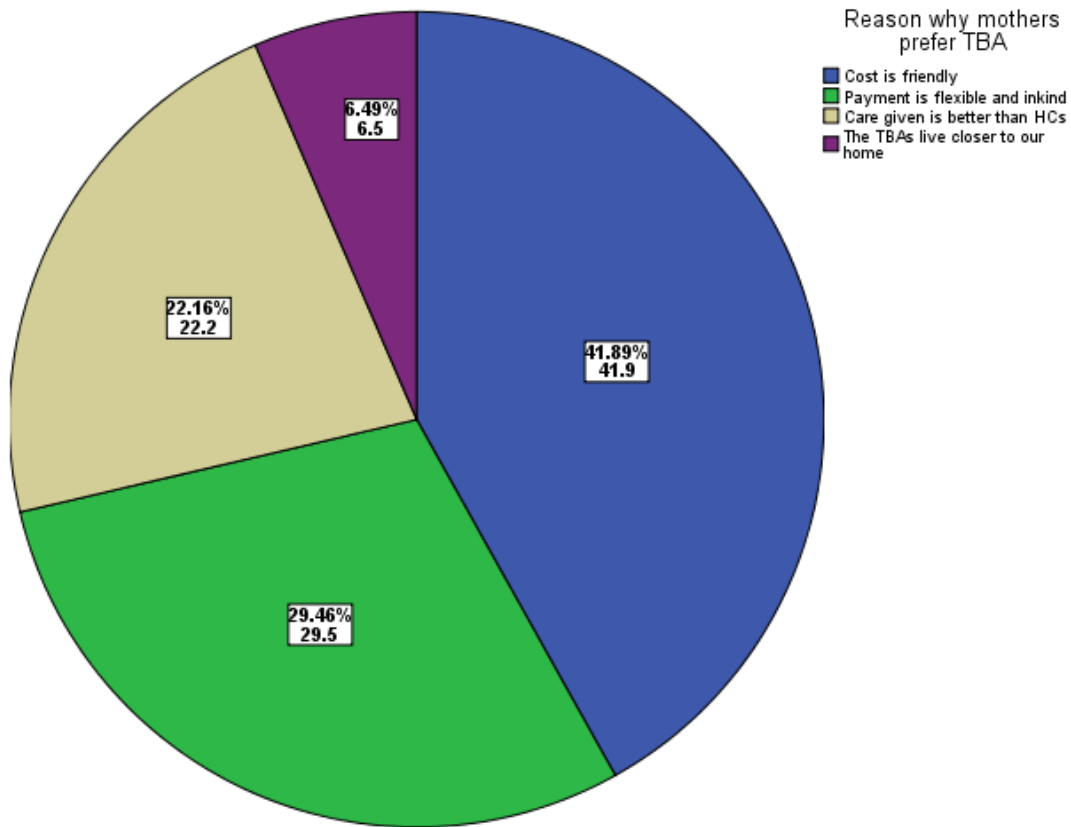


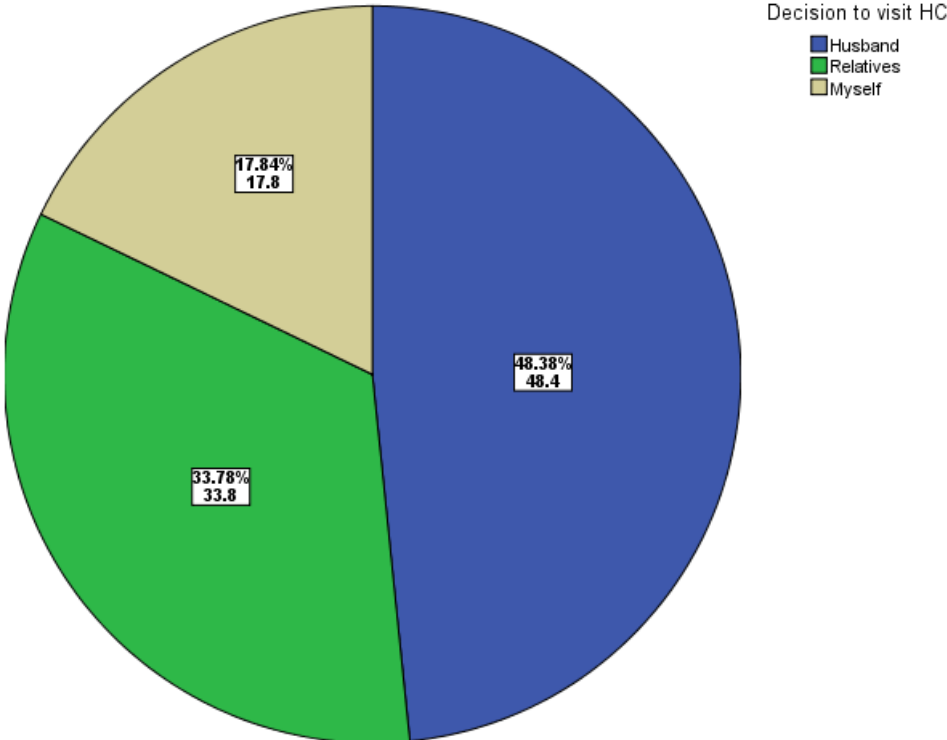
Figure 23 above highlights comparisons of charges paid by mothers when accessing services from their TBAs and health facilities. Majority 70.4% of mothers reported that TBAs charged more than what health centers charge. Only 29.6% of mothers reported health TBAs to be charging less than health facilities.

Figure 24 Shows reasons mothers prefer services from TBAs than Health centers.



From the figure 24 above, most mothers prefer services from TBAs due to the reason that their cost is friendly, followed by 29.5% who noted that the mode of payment being mainly in-kind makes them prefer them to health centers, only a small number 6.5% of mothers preferred TBAs due to their being close to their households.

Figure 25 shows who decides for mothers to attend ANC and PNC services in Kasese District



From figure 25 above, most mothers 48.4% reported their husbands as the decision makers for them to utilize health facilities followed by relatives with 33.8% and only 17.8% of mothers reported that the decision is made by them to utilize health services.

Figure 26 shows opportunities for mothers to receive awareness/training message on MNCH in Kasese District.

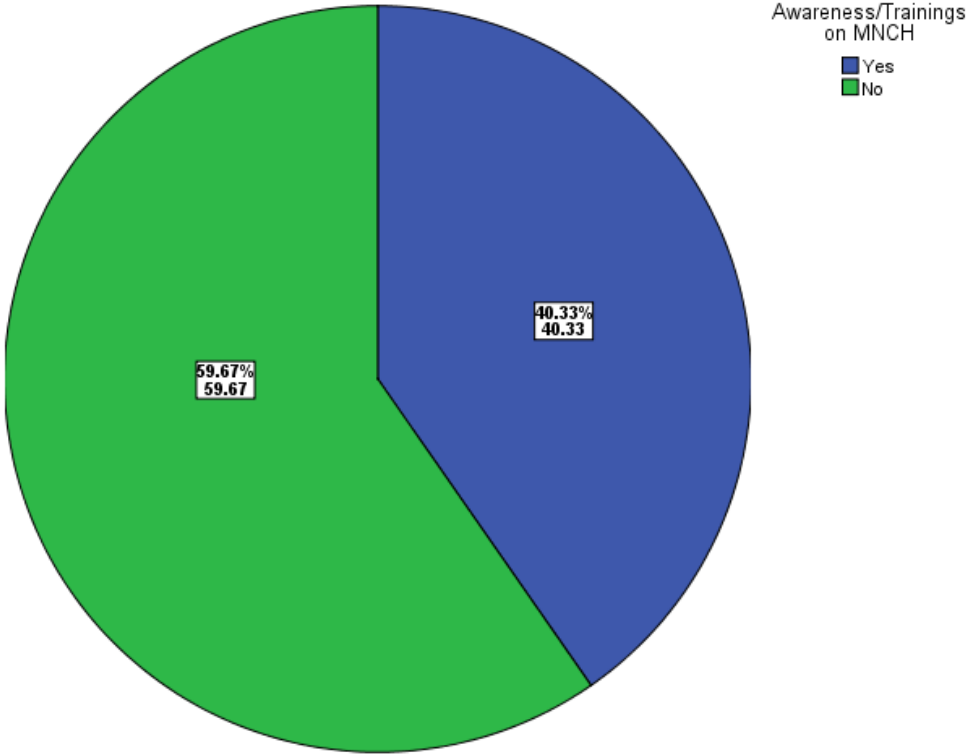
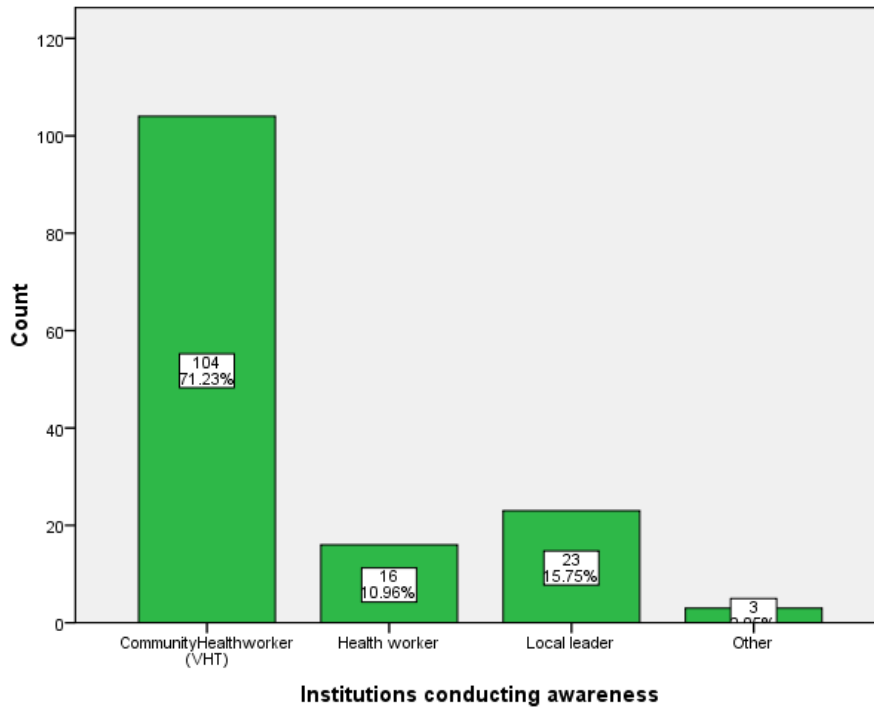


Figure 26 above highlights opportunities available in the communities to access information related to MNCH issues. Majority 59.67% of women reported absence of any opportunities for them to access information on MNCH. Only 40.33% reported existence of such opportunities in their communities to make them aware of information on MNCH.

Figure 27 shows institution providing awareness on MNCH in the communities within the District of Kasese



In figure 26 above, majority 71.2% of mothers received their information and awareness on MNCH from VHTs followed by 15.8% from local leaders. Only 11% of mothers noted health workers as their source of information and awareness on MNCH in the district.

Result Interpretation

Table 3 shows results from logistic Regression from social demographic and individual characteristics and attendance to ANC

	Standardized Coefficients		P-value
	Beta	Std. Error	
Age	-.136	.064	.030*
Marital status	.100	.062	.079
Religion	-.190	.062	.107

Level of Educ attained	.234	.071	.001*
Mother occupation	-.430	.068	.030*
Husband occupation	.238	.063	.014*
Average family income	.857	.067	.000**
Number of children	-.015	.064	.020*

***P-value < 0.05, **P-value < 0.001**

From the table above age of the mother is significant and negatively associated with utilization of ANC services and has a negative *beta* value (b=-.133, p=0.03). This implies that as the age of the mother increase, the less likely she became in utilization of ANC services. Level of education was found to be significant with a positive *beta* value (b=.234, p=0.01). This means as women advance in education, the more likely they become in utilization of ANC services increases. Husband's occupation was found to be statistically significant (b=.238, p=0.014). This implied that mothers with working husbands were more likely to utilize ANC services. Family income is significantly associated with attendance to ANC (b=.857, p=0.00) with a higher positive *beta* value. This implies that when family incomes increase, the more likely they become to utilize ANC services increase. Mothers' occupation is significantly associated with utilization of ANC services and has a negative *beta* value (b=-.130, p=0.03). This means that being employed hinders mothers from utilizing ANC services i.e. as mother get employed, the less likely they become to utilize ANC services. Number of children was also found statistically significant (b=-.015, p=0.002) with a negative *beta* value. This implied as mothers acquired more children the less likely they became to attend to ANC services.

Table 4 shows results from logistic regression from socio demographic and individual characteristics and number of PNC utilized

	Standardized Coefficients		P-value
	Beta	Std. Error	
Age	.114	.126	.440
Marital status	-.163	.108	.107
Religion	.257	.104	.145
Level of Educ attained	.780	.101	.000**
Mother occupation	.257	.103	.049*
Husband occupation	.101	.105	.469
Average family income	-.077	.104	.647
Number of children	-.265	.128	.040**

***P-value < 0.05, **P-value < 0.001**

Analysis of the socio demographic and individual variables and their association with utilization of PNC revealed that only three independent variables (level of education attained, mothers' occupation and number of children) had a statistical significance on the utilization of PNC services. Level of education was significant and its coefficient is positive (b=.780, p=0.00) meaning that highly educated women were more likely to utilize PNC services. Mother's occupation significantly influenced PNC utilization (b=.257, p=0.049). This means that mothers that had any form of employment were more likely to utilize PNC services. Mother's Number of children was significant with its coefficient being negative (b=-.265, p=0.04). This means that utilization of PNC services reduced with increase in the number of children a woman had. As mothers acquired more children, they became less likely to utilize PNC services.

Table 5 shows results from logistic regression from Health facility variables and number of ANC attended.

	Standardized Coefficients		P-value
	Beta	Std. Error	
Distance from health center	-.012	.053	.828
Payments during ANC	-.035	.053	.511
Treatment by Health workers	.568	.053	.001**
Comments about privacy	-.025	.054	.806
Comment about hygiene	.110	.054	.442
Comment about space at ANC	.042	.055	.450

***P-value < 0.05**

From the table above client handling/treatment was the only significant health related factor that influence utilization of ANC services (b=.568, p=0.001). The positive coefficient implies that with improved quality of handling and treatment by healthcare providers, more mothers utilized ANC services.

Table 6 shows logistic regression from Health facility variables and number of PNC attended

	Standardized Coefficients		P-value
	Beta	Std. Error	
Distance from health center	-.425	.087	.020*
Treatment by Health workers	.117	.086	.175
Comments about privacy	.035	.086	.688
Comment about hygiene	-.078	.087	.455
Comment about space at ANC	.130	.089	.095
Time stayed in HC before discharge	-.494	.087	.000**

***P-value <0.05, **P-value <0.001**

From the figure above two independent variables were significantly influence utilization of PNC services in the District. Distance from the health center and house of the mother significantly influence utilization of PNC services (b=-.425, p=0.02). The negative coefficient implies increase in distance between health centers and household of mothers reduce their capacity to utilize PNC services. Time stayed in hospital after delivery was found significant (b=-.494, p=.000) with a negative coefficient. This means that the earlier mothers are discharged after delivery, the high the likelihood that they would attend more PNC services.

Table 7 shows logistic regression from community variable and attendance to ANC

	Standardized Coefficients		P value
	Beta	Std. Error	
Presence of TBA in the village	-.027	.145	.854
Proximity of TBAs with mothers	.185	.145	.207
Mode of payment with TBA	.216	.134	.113
Reason for use of TBA	-.091	.139	.653
Reason why mothers prefer TBA	-.195	.135	.114
Decision to visit HC	-.060	.142	.838
Awareness/Trainings on MNCH	.464	.144	.030*

***P-value < 0.05**

From table 7 above, analysis of community factors influencing ANC service utilization revealed awareness/training opportunities within their community was significantly associated with ANC utilization (b=.464, p=0,03). This means that with more awareness and training of public on MNCH related issues, increases utilization of ANC services.

Table 8 shows logistic regression from Community variable and attendance to PNC

	Standardized Coefficients		P-value
	Beta	Std. Error	
Presence of TBA in the village	.346	.260	.213
Proximity of TBAs with mothers	.132	.303	.672
Mode of payment with TBA	.169	.218	.457
Reason for use of TBA	.407	.234	.093
Reason why mothers prefer TBA	-.130	.226	.805
Decision to visit HC	-.695	.256	.220
Awareness/Trainings on MNCH	.592	.242	.000**

****P-value <0.001**

From table 9, above, analysis of community factors influencing PNC service utilization revealed awareness/trainings on MNCH was the only significantly associated to PNC service utilization (b=.592, p=.000). The positive coefficient reveals that increasing opportunities for awareness and training with communities increase mothers' ability to attend PNC.

4.5 Results from the qualitative study

In assessing factors influencing utilization of both Antenatal and postnatal care services in Kasese district in September 2013, FDGs were used to collect mothers views about issues relating to them as individuals, the community as well as the health facilities where they access healthcare services. The FGD questionnaire contained eight questions and all FGD groups were asked the same questions and all group members were given ample time to make their opinions heard. In order to collect the views of the district leadership, opinion leaders and health workers, Key informant interview guides were designed and used to get views from the District Health

Officer (DHO), In-charge of six health centers, Four local council leaders and three sub county chiefs. The KI guides were made of mainly three questions which also had subquestions basing on the three thematic areas of the study, i.e. Individual factors; community factors and health facility related factors that influence utilization of antenatal care and postnatal care services. All interviews were tape-recorded, and verbatim responses to each of the questions were translated and transcribed for those who weren't communicating in English.

4.5.1 Results for the FGDs

Almost all respondents interviewed 83 out of 84 knew about antenatal care and indeed had participated in some kind of antenatal care visit. However nearly (41 out of 84 women) half knew why they should attend to the ANC visits and what are the recommended number of visits one has to make during pregnancy. **One woman in FGD2** said; *“for me I attend just because I have seen other women go there every time they are pregnant, but I don't really know the main purpose.”* Another **woman in FGD4** said; *I didn't attend any ANC for all my six children and I don't see the need for mothers to go there, it is a wait of money which most times we don't have.* All respondent acknowledge that they often use the health facilities most especially for their children's health and malaria is the major reason why they come for treatment especially for their children.

The second question about the general feeling about the quality of services provided in the health facilities; all the women confessed that the services are still way below their desired level of quality especially in aspect of hygiene (dirty toilets, absence of clean water), infrastructure (there is no privacy in rooms, no enough beds, and no electricity), abusive healthcare workers. As noted by one man in **FGD5** *“I often come here with my wife whenever she is pregnant, but even getting where to sit is a big problem, most of the time the nurses come late and leave so early. When you complain they shout at you and question why you are not the ones giving the treatment yourselves”.* Another woman said *“a month ago, a health worker treated me badly when I was pregnant and had come to deliver in this facility. She never greeted me and went ahead to ask why I got pregnant since I was failing to walk. I was too heavy. This hurt me”.*

On the question of TBAs all 84 respondents agreed that they use services from TBAs especially getting the herbs from them which they all said are good in improving ensuring that the unborn baby is safe. TBAs are near to the mothers and often they give free services (checkups) to the

pregnant mothers and in the event that there is an emergency, they are the first people to give care to the pregnant women. **A woman from FGD6 noted that** *“herbs help me to stop vomiting and also improve my appetite especially for meat products.”* Another lady confessed to be giving herbs to the pregnant women, *“I don’t understand why you people (western medicine) discourage us from using herbs, but even some of the nurses ask us if we are using herbs and if not they do encourage us to us them. Herbs are good at enlarging the pregnant woman’s girdles so that she can deliver well and also ensure that the mother and her newborn are not disturbed by bad spirits.”* **Another woman FGD2** said *“when you have no money to go to the health center, the TBAs are close they help us and don’t even ask for anything.”* All women acknowledged the vital role of the TBAs in their communities especially in monitoring their pregnancies and newly born babies however most 61 out of 84 wouldn’t recommend their fellow women to deliver from the TBAs mainly due to complications that may arise during delivery which TBAs may not be able to handle and the issue of HIV which some TBAs are suspected to be having due to their high exposure.

On the question barriers to utilizing ANC and PNC services, respondents were asked to identify the various barriers at individual; community and health facility level then after they were asked to rank them according to the severity of influence. From the following issues were identified in descending order of influence.

Level	Barrier
Client/personal	<ul style="list-style-type: none"> <li data-bbox="440 1293 1429 1717">• Poverty; this was understood as the absence/lack of money to meet the costs needed during ANC and postnatal care. All respondents confessed this was their major problem and hindrance to utilizing services. One woman noted FGD1 <i>“I am just a peasant farmer, all I grow feeds my family and it is not enough. Whenever I need to go to the health center I don’t have money to even meet the cost of transport let alone drugs they ask, so I chose not to go there but instead to either buy something from the nearby drug show or use herbs from the TBA.”</i> <li data-bbox="440 1734 1429 1879">• Male involvement; due to negative masculinities within the communities men were socialized not to get involved in issues relating to women’s health especially pregnancy and childcare. However women feel absence

of male support denies them the opportunity to utilize healthcare services, since it men who earn income and most women are mere housewives depending on their husbands for any form of support especially during pregnancy. **A respondent from the FDG8 said** *“whenever I get pregnant and it reaches a time of going to the clinic (health center) my husband becomes so tough especially when I ask for money for transport, he even leaves us at home a goes to his second wife. What I resolved is not to ever disturb him, I just wait until the time comes to give birth, if I have people to help me go to the health center I go, but most times it’s my mother in-law who often comes to support me.”* **Another woman FGD7 said** *“men are not responsible these days, they only make babies and disappear to towns to look for money and often send so little which is not enough to meet all the requirements. Often I go to the garden dig for the food and most times when I pregnant or just delivered I can’t go to the health center because I have no one to leave at home to care for my other children or support me in the garden my husband says all that is work for women so I just accept my fate.”*

- **Awareness of the need for ANC/PNC;** the knowledge about the importance of ANC/PNC to both women and children is not so well understood by the women. Most women noted they go just for checkup and majority said nurses simply ‘touch-touch their belly’ without doing much so they see no point in wasting their time go for checkups. **A respondent in FGD4 noted** *“these nurses don’t explain to us why we should come, when you come for checkup, they only touch your belly, ask whether you’re feeling fine, if yes, they just write on your card when you should come back. So I don’t see what much they do when I come, it a wastage of my little money, I would rather come once and wait when I am ready to deliver.”* **A respondent in FGD2 noted** *“I only come once to the health center to get the card (maternity card) because when you don’t have it, midwives refuse to work on you at the time of delivery. After I get the card I simply go back home and wait for the time of*

	<p><i>delivery. I don't need to come all the time for the checkups; it's too expensive for me."</i></p>
<p>Health facility</p>	<ul style="list-style-type: none"> <p>• Quality of service; all respondents noted the quality of services obtained from health centers to be inadequate. Respondents attributed it to the following aspects; inadequate staffing which causes too much waiting time, poor handling of clients by health workers were noted as the major concerns followed by drug stock outs often there are not drugs in the centers, absenteeism of the health workers. One respondent in FGD1 commented on the waiting time and nurses attitude <i>"I often go to the health center when I am so sick and wait for a long time to meet the nurse, and when she comes she is so rude often insults you as if we are not human beings. Even when one is poor like us, at least we deserve to be treated with respect. These people need to treat us kindly we also understand their challenges of understaffing but it's not our making."</i> Another respondent in FGD4 noted drug stock outs <i>"when you take your sick child or when you're sick the health worker checks you and writes the medicine on a paper and asks that you go to Kasese Town to buy it from the pharmacy and yet we hear the health workers steal our medicines, is that fair? We are poor people, how do they expect us to have money whenever we fall sick?"</i></p> <p>• Infrastructure (like running water, toilets, spaces, beds, etc) in health centers; most health centers don't have functional infrastructure to handle the big numbers of clients they receive every day. Respondents noted the crumbling infrastructures of the district health centers are not in any way conducive for mothers to attend their ANC and PNC services from them. A respondent in FGD2 highlighted the plight of the infrastructure of her health center <i>"in our health center, most times there is no running water, whenever once goes there and she gets admitted, one has to carry a jerrican of water or fetch water from a spring which is also very far. If you have no person to help you, you can't have water, you just accept to remain dirty until good people help you."</i></p>

	<p>Another respondent acknowledged the hygiene situation <i>“how do you expect us to go to health centers which don’t have clean toilets, bed have either dirty old mattress or don’t have anything, the wards have a lot cob web and smelly, the compounds are littered with all sorts of rubbish. Whose responsibility is it to maintain the hygiene of the health centers? Most times the health workers don’t care at all, they only report for duty and go without considering that patients need a clean environment, most times we get coughs and diarrhea from this center.”</i></p>
<p>Community</p>	<ul style="list-style-type: none"> • Transport to the Health centers; respondents mentioned that ability to access health centers is hindered by absence of transport means to reach centers in the right time. Most parts of Kasese are not accessible by road due to the mountainous nature of the area. One woman in FGD6 <i>“it’s so difficult to reach health centers in most of the villages where we come from, especially when it’s a rainy season. Roads are so impassible and there are no any means of transport other than walking very long distances which you can’t do when pregnant.”</i> One woman in FGD2 <i>“I wish our leaders would help us at least and get us a quicker means of transport especially for the expecting mothers, but here when we want to go to the health center you just look for a ‘boda-boda’ which isn’t comfortable and when you have an emergency at night you just can’t find any means to take you to the health center.”</i> • Responsive leadership; majority of the respondents mentioned the non responsiveness of their leaders to plan for them at all levels sub-county, district and national levels. A respondent in FGD3 put it clearly <i>“our leaders only remember us when they are looking for votes from us, that when we see them. After voting them no one ever remembers us until the next elections. We hear there is a lot of money but we can never know what that money does, because we don’t see it come to help us in our communities.”</i> Another in FGD4 respondent said <i>“if our leaders care about us, why then no one has rehabilitated our health center for all these years, there is no water, the roof is leaking and health workers</i>

	<p><i>never attend to their duties in time. Whose responsibility is it to ensure that these persons do their duties?"</i></p> <ul style="list-style-type: none"> • Corruption; most respondents the decay of the moral fabric in all their communities, this is responsible for the increasing corruption tendencies in most of the institutions. One respondent in FGD1 said <i>"it's not true that our country is so poor not fail even to buy medicine for our children, but all the monies are stolen by those who are meant to keep it for us. Recently money meant to renovate the maternity unit was misused and nothing was done to all those that were involved."</i>
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4.5.2 Results from the Key Informants

Interviews were conducted with four categories of persons. These included the district health leadership represented by the District Health Officer; political leadership represented by LC III chairpersons; and health workers from the health centers

District Health Officer (DHO): noted change on both access to ANC and PNC within the district in the last five years from averagely 59% to the current 97%. However he noted the biggest challenge currently is attendance to the right number of ANC and a very attendance to PNC within the district. The DHO noted the major reason for poor access at individual level is tagged to the poor health seeking behavior of mothers and also the limited awareness about the dangers associated with failure to seek care.

At the health facilities, the DHO noted staffing challenges especially of midwives; absence of housing support for health workers especially midwives to live nearby the centers; poor attitude of health workers to healthcare and absenteeism from work. He noted *"all the above is rooted in funding challenges to the healthcare system within the district, where all resources come from the central government and sometimes delay or the funded items are not those set as priorities by the district. This complicates our capacity to minimize some of the challenges we indeed know that they are happening almost perpetually."*

At community level, the DHO noted that the public still believe in TBAs especially during pregnancy but he also noted that the quality of services provided by the workers is still not to the

best desirable standard. *“Some mothers report mistreatment, abuse and violence from health workers and for a lack of evidence we can’t sometimes do anything.” “Mothers only come to attend the first ANC, and after that they go back to their communities and use the services of TBAs who give herbs and all sorts of things which we can never know their efficacy.”*

LC III leaders; three local leaders were interviewed from Karambi, Ihandiro and Bugoye sub-counties were interview to give their opinions about factors the influence utilization of ANC and PNC service generally in Kasese as a district but also in their respective sub-counties.

LC III Karambi noted health workers staffing being so low in all the health facilities within the sub-county especially with the most critical carder ship of midwives, doctors and clinical officers. He also noted most health centers have not been renovated in a very long time; the infrastructure is not conducive to attract women in them. *“For instance none of the health centers in my sub-county has access to clean water, so how do you expect them to maintain cleanliness?” “Of course we can’t underrate the attitude of health workers we have today, they seem not so committed to their. Most come late for work and if not indulge in perpetual absenteeism without permission, therefore to me it a leadership issues with those centers.”*

LC III Ihandiro noted that on top of the known challenges similar to other health centers in the district, Ihandiro communities are challenged because of the mountainous nature of the area. *“Most parts of the sub-county are not accessible by roads because of the mountainous nature of the landscape; it’s hard for pregnant women to access these health facilities without means of transport.” “But again we political leaders have not been given space to hold the health workers accountable, since we don’t hire them. Everything was centralized; at least if the oversight function was done by the district through us, we could do a better job to hold these health workers accountable.”*

LC III Bugoye noted that they are constrained with limited resources to fix the dilapidated infrastructure within the sub-county especially renovating maternity wards, ensuring that centers have clean running water and fencing off the health facilities. He also lamented about the attitude of husband who don’t get involved in support their families. *“We often meet mothers who come to us for support because their husbands have abandoned them, sometimes these husbands don’t do so out of their intentions but the poverty and polygamy may push them to abandon especially*

the pregnant wives because it is during such periods that they are much more vulnerable.” I also noted the uncoordinated workings of the various institutions within the district, and yet if there was coordination most bottlenecks would be solved. “For instance, the police are supposed to follow-up on household abandonment by husbands or issues of domestic violence but most times they give flimsy excuses and hence such cases go on unabated. This aggravates the situation within households and perpetuates inability to utilize healthcare.”

Health center In-charges; A total of 15 managers of the fifteen health centers were interviewed and all of them noted that their morale is so down owing to the unending promises of salary increments and housing from government. One In-charge from Hiima Health center said, *“can you imagine the monies I get, can’t even feed my family yet I am expected to transport myself to home to the health center, a cost which my salary can’t meet. Why can’t they build for us houses so that we stay near and help the mothers when they come.” They are only accusing us of neglected and incompetence and yet they can’t look at their failures as our leaders.”*

At family level the health workers noted absence of male/husbands involvement in support of their wives which is exacerbated by poverty and cultural practices by polygamy at household level. One health worker from Bugoye put it this way, *“we often get mothers who come with nothing. They can’t even buy a razor blade which is 200/= . Why do you blame us for the wrongs of people who have failed at least to plan for their coming child?”*

Mothers don’t fully understand why they should attend ANC or PNC services. Most mothers that come for PNC often come because the children are sick or when they are worried of their children. It is never upon their health status. Their thinking is that PNC is for children, therefore if their children are fine, they see no reason of attending PNC. One health worker in Kitswamba Health center said. *“Most mothers are biased to believe whatever their mothers’ in-laws or TBAs tell them. How then would you explain why mothers come only to pick ANC cards and never come back until time for delivery and only attend PNC because their children are sick or not feeling well?”*

The issues of cost sharing is existing especially in Private not for profit (PNFP). The In-charge Nyabugando Health center commented; *“all mothers who are asked to pay for some of the materials like ‘mama kits’ don’t come back again, either go away and never come back or attend*

at government facilities which in most cases don't give adequate care due to limited staffing and overcrowding."

The issue of multi-gravidity was noted by the health workers as a hindrance to attending ANC by mothers. The In-charge Musyenene noted that mothers with many children often don't attend ANC. *"We often receive delivery cases of grand multi-gravida with sometimes twelve children births who have never attended ANC at all. Most think that after having a good number of children they know it all, so seeking healthcare when they are not sick makes no point to them".*

CHAPTER FIVE: DISCUSSION

5.0 Introduction

This chapter gives meaning to the generated results and it attempts to explain the trends and reasons for the trends. The discussion chapter gives probable answer to the research questions in chapter three. The discussions will follow the sequence of the research questions, starting with the first question that inquired about the proportion of women attending ANC and PNC; question two that sought to identify the social demographic factors influencing utilization to ANC and PNC; question three that sought health facility based factors that influence utilization of ANC and PNC and lastly question four at sought to identify community related factors that influence utilization of ANC and PNC in Kasese District.

I. Proportion of ANC services in Kasese District

The study has revealed that the level of ANC service utilization is relatively higher (about 98.4 percent) compared to the mid western regional level of 90 percent. However, this figure should be interpreted cautiously due to two reasons: first, the study collected information on ANC service utilization in relation to the most recent birth during the 24 months preceding the survey, and hence, it is difficult to look into consistency in the use of these services between successive births. Secondly, most women might have visited the service to get treatment for their health problem instead of deliberately seeking the ANC services.

A though attendance to at a single ANC visit seems very high (98.4 percent) only 16.8% of women completed the recommended four visits a figure lower than the one for the mid western region of whose average is 40% (UDHS, 2011). The results showed that women 55.7% and 35.2% attended their first ANC either in the first or second trimesters respectively contrasting another study conducted in Entebbe Municipality where most women attended their first ANC during fourth trimester 56% and third trimester 37% respectively (Macro International Inc., 2007; Tann et al. 2007). This failure to make the required ANC visits at the recommended gestation schedules, puts the lives of these expectant mothers and their children at risk simply because the essence of ANC which includes: a) Identification of pre-existing health conditions; b) Early detection of complications arising during pregnancy; c) Health promotion and disease prevention; d) Birth preparedness and complication planning; e) Intermittent preventive

treatment of malaria during pregnancy [IPTp] can't be achieved if mothers attend less than four visits of ANC or when the visits are not timed to fit the recommended gestation age requirements. This could explain the high maternal mortality and morbidity in Uganda.

II. Proportion of PNC service utilization:

The study revealed PNC was one of the least utilized maternal health services by women. Only 37.9% of women had received PNC services after deliveries in health centers. Majority 61.3% of the mothers had never utilized any form of PNC services from a qualified healthcare provider. However this was an improved situation when compared to results from the UDHS report 2011, which showed access to PNC at only 2% and 13% for mothers and newborns one hour and six days respectively. This study was only limited to identifying those that attended or not attended PNC, it didn't examine in detail how PNC is utilized for instance; at what stage after delivery. The poor utilization of postnatal care service has often been attributable to the unpredictable onset of labor, making it difficult for women to travel long distances as well as some factors associated with cost of delivery of care and understanding the relevancy of postnatal care to the women and their children. Most mothers thought because their children were not sick, they saw no reason of utilizing postnatal services.

Individual/client factors influence ANC and PNC service utilization in Kasese District

In view of addressing the second objective, attempt was also made to examine the associations between various individual variables and the two main study variables (ANC and PNC). The study identified five variables for ANC and three variables for PNC with strong significant associations. Three variables were found to be common denominator variables influencing both ANC and PNC in the study area, namely; level of education, mother being employed and number of children ever born. The findings are similar to finding of a population based study in southern Ethiopia (Regassa N, 2011) which revealed literacy status, children ever born, and radio listening frequency as factors influencing ANC and PNC utilization. However this finding are unique in such a way that unlike other studies that have shown mothers' employment as a positive predictor to utilization of ANC, this study revealed the opposite that mother's employment status was a negative predictor to ANC utilization but a positive predictor for PNC utilization. This

difference between ANC and PNC utilization under the same predictor reveals a unique and new discovery.

I. Utilization of ANC;

Utilization of ANC was found to be significantly associated to age of the mother; level of education; average family income and number of children.

Age of mothers and children ever born showed similar trends with utilization of ANC services. Older women and those with a high parity were found less likely to attend ANC services than their young counterparts. This may be attributed to women assuming experience with increasing age, and number of children therefore their interest to utilize ANC services becoming minimal. It could also be because risky pregnancies are often among the young and the prime gravida women. Pregnancies for young prime gravida or lower gravida often present with dare conditions which may threaten the young mothers hence enhancing their willingness to access ANC services. The findings are consistent with (Regassa N, 2011; and UDHS, 2011) in Southern Ethiopia where young mothers and those with lower gravidity being more likely to utilize antenatal care services.

Level of mothers' education was found significant, in that more educated women were much more likely to utilize ANC services. This may be attributed to the factor that education empowers women to be less dependants, and confident to take decisions for their lives also educated women often have access to more information which in most cases is written in English. This is consistent with other studies Simkhada et al (2008) found mother's education significant associated with utilization of ANC by women in poor resourced countries. Ochako R et al (2013) found similar results in Kenya among young less educated women less likely to utilize ANC services.

Mothers' employment status was found to be a negative predictor to ANC utilization. This means that working mothers were less likely to utilize ANC services. This may be attributed to the factor that women currently are contributing financially to their families than ever before therefore most are now committed more time to engage in their employment than find time to attend to ANC so as to improve their income.

Average family income was the strongest predictor of utilization of ANC services. Mothers whose families had less income were less likely to attend ANC services. This may be attributed

to the factor families with good income would be able to meet some of the direct and indirect costs need to utilize ANC services for instance like transport. The low income was because majority of women and their husband engaged in substance agriculture which couldn't generate substantial resources to meet all the health needs of the families. This study was in agreement with a study by D. Kaye., et al, (2003) that showed that many of the late ANC referrals were from families with low socio-economic status.

II. PNC service utilization

Level of education of the mother was significantly associated with utilization of PNC services. Utilization of PNC services increased with increase in mothers' education level. This like ANC service utilization could be because well educated women are often empowered to know what they and their children need especially in terms of health. Most often they have control and power over their decisions to utilize health services but also may have better incomes than there illiterate counterparts. This study agrees with other research findings; SimKhada B, et al (2008); Ochako R, et al (2013); and Regassa N, (2011) which showed education as a key predictor in the utilization of PNC services.

Mothers' employment status unlike with ANC, under PNC, mothers' employment status was a positive predictor to PNC service utilization. This could be because employed mother were earning more income and therefore able to afford requirements both financial and otherwise which are a requirement for PNC.

Number of children ever born (parity) was significantly associated with utilization of PNC services. Low parity mothers were more likely to utilize PNC services than the higher parity mothers. This like ANC may be due to mothers with more children assuming more knowledge and experience in after going through high number of deliveries. Sometimes lower parity mothers feel naïve about childcare health often seeking knowledge and support from health facilities. This is consistent with SimKhada B, et al (2008); Ochako R, et al (2011); and Regassa N, (2011) which showed parity as a key predictor in the utilization of ANC services in that higher parity mothers were less likely to utilize PNC services

Health facility factors influencing utilization of ANC and PNC services in Kasese

In order to address the third objective, an attempt was also made to examine the associations between various explanatory variables and the two main study variables (ANC and PNC). The study identified one variable for ANC and two variables for PNC with strong significant associations.

I. ANC service utilization

Utilization of ANC was found to be significantly associated with only one health facility related predictor namely treatment/handling of mothers by health workers during ANC. Mothers that reported mistreatment by health workers were less likely to utilize ANC services. This is because mothers often shun health facilities where they often experience violence. The findings concurred with (d'Oliveira AF, et al 2002) that mistreatment of mothers by health workers affects utilization of maternal health services.

II. PNC service utilization

Utilization of PNC services was significantly associated to distance from the health facilities that mothers often covered regardless of the means of transport. Mothers that live far away from health facilities were found less likely to utilize postnatal healthcare services. This can be attributed to the poor connection roads within the district and coupled by the mountainous terrain of the area; mothers would find it difficult to navigate long distance with their newborns on poor and sometimes non existing roads. The study contended with Tinker et al, 2006; PMNCH, 2006 and Bhutta which all confirmed a good referral mechanism and an efficient ambulatory system key in improving not only PNC but a wide range of interventions in developing countries. The study was limited in such a way that it didn't examine the different models of transport mothers' use to access health facilities and how these influence services utilization.

The study revealed new findings about discharge time of mothers after delivery at health facilities. Mothers that had been discharged early were much inclined to utilize PNC services than those that stayed longer in the health facilities after delivery. This could be attributed to the fact that those that stay longer in health facilities imagined that they had acquired all the PNC services they and their children need, therefore they seemed to have felt no need to attend any more PNC services. Often mothers who stay longer in health facilities are those that have had complicated obstetric deliveries or whose infants developed complication during or after delivery

which may necessitate them to pay high financial cost. Often when they get discharged, they are not able to meet any further costs therefore fail to utilize PNC services.

Community factors influence utilization of ANC and PNC services in Kasese district

When addressing the forth objective, attempt was also made to examine the associations between various explanatory variables and the two main study variables (ANC and PNC). The finding revealed opportunity for awareness/training on MNCH as a single denominator predictor from the community that was influencing utilization of ANC and PNC services.

ANC service utilization

The study revealed that existence of opportunities for awareness and training within the communities was the only significant predictor and it positively influenced utilization of ANC services. Mothers that reported having received information or training on MNCH related issues were much more likely to utilize ANC services that those that reported not to have received any awareness opportunity. This could be because when mothers are informed and aware of why they have to attend ANC, some of their misconceptions are minimized hence enabling them to utilize the services. This was similar to a study by Downe S et al, (2008) to assess the barriers to ANC for marginalized women in high income countries, that found out that attendance to ANC depended on weighing up and balancing out the perceived gain or losses which depended much more on knowledge, awareness, and information available to a woman to be able to make meaningful informed discussions.

PNC utilization

Just like with ANC, the existence of opportunities for awareness and training within the communities was strongly significant and positively influenced utilization of ANC services. Mothers that reported having received information or training on MNCH related issues were much more likely to utilize more PNC services that those that didn't receive. This means that being informed and aware of the need for PNC improves mothers' receptiveness to utilizing PNC services. A study in Southern Ethiopia by N Regassa (2011) revealed that presence of opportunities for information access improved utilization of PNC services. This was hinged on

the fact that mothers that had opportunity to listen to the radio were more inclined to utilize PNC services.

5.2 Methodological/study limitations

The findings of this study must be considered with care and caution because; the findings of the study can only be generalized to women in Kasese District. There could have been any information bias created by the research assistants and probably the way questions were formulated (information bias) resulting into underestimation of utilization of the four visit model of ANC and PNC by the women. However these research assistants were trained and the questionnaires were pretested to improve on clarity, so therefore the information bias may have been minimized.

The participants could have given responses that the researcher wanted to hear. However these respondents were probed to ascertain whether what they were telling was the actual truth.

The need to translate respondents' comments affects the degree to which transcripts can be considered as accurate representation of what was actually said. To help mitigate this problem, transcripts were reviewed for accuracy by the onsite research assistant, and revised when necessary. In addition, emphasis in analysis was placed on overarching ideas rather than specific word choices or phrasing. Interview and focus group data may be subject to bias, because they are based on self-reporting and respondents were asked to discuss events and decisions that had happened in the past. Nevertheless, the use of qualitative methods enabled me to gain insight into attitudes, beliefs, practices and contextual factors that would not have been captured using only survey methods.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter offers the conclusions and recommendation of this study in line with its objectives

6.1 Conclusions

Basing of the information collected from the eligible 364 households and taking into account all the discussions generated from the FGDs and informant Interviews, and being mindful of all the methodological pitfalls of cross sectional study design, this study has come up with the following plausible conclusions on ANC and PNC service utilization and policy implications;

While women's utilization of ANC service seems to be good (about 98.4 %), a very small percentage (16.8%) of the women fully attending the required four visits of ANC services. In relation to this, it is worthy to emphasize that age, educational level and number of children born had are the key determinants of both ANC and PNC service utilization among the study population. The implication of this finding is that unless their this a concerted effort to support girl child education, women empowerment initiatives and also work on ensuring that the unmet need for family planning is met in rural areas, it will be difficult to attain the desired level of ANC and PNC service utilization.

The study realized that the only a small percentage 38.2% utilize PNC services. Failure on the part of the women to use the PNC services can be explained by women lack of education and complacency created when having more children, but one never overlooks poverty as a key underlying driver to poor a services utilization. This calls for policymakers and program implementers at grassroots level to consider providing outreach based PNC services in areas closer to the homes of those that need the services so as they can overcome financial, psychological and socio-cultural barriers to care-seeking outside the home during the early postnatal period.

Finally, there is need to enhance the capacity of the healthcare providers to give adequate care that respects the right of the mothers, eliminate all forms of rights violation and also create wider

awareness mechanisms that can enable mothers to understanding their rights and responsibilities as well as those of their duty bearers.

6.2 Recommendations

1. There is need by both state actors at all levels of government and non-state actors (like CSOs) to support the education of the girl child so that we could sustainable ensure that women in the long run have a decent education. In return the education will strengthen women's social esteem and confidence to live their desired lives.
2. The fact that incomes influence service utilization and majority of the people are engaged in less productive peasant agriculture. call for real practical and poor centered initiatives to fully address the question of poverty in the communities.
3. Sustainable community awareness strategies need to be developed especially using channels like radio which can enable regular and correct dissemination of needed information on enhance service utilization within the district.
4. There is need to have ambulatory referral mechanisms so that the women especially those that can't affording the existing transport means are supported to reach healthcare centers in time.

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APPENDICES

APPENDIX 1- Interview Questionnaire

Questionnaire

I am conducting a study on the Continuum of Care for Maternal and Newborn Health in Kasese district: Determining the Gap and its Influencers. The of the study is to provide information for the District Health Management Team to design interventions geared at increasing health facility access to the continuum of maternal healthcare services.

You have been selected randomly among many women of your category and participation is voluntary. You will be interviewed for about 40 minutes on issues regarding access to maternal healthcare services in your area. Participation is entirely voluntary and you are free to refuse to answer any questions and there will not be any penalty whatsoever from anybody including higher authorities from the district. The information you will provide is solely for research purpose and will be treated in a confidential manner. No names will be mentioned during data collection, analysis and report writing. For any questions or clarification please contact Danny Gotto Devito on 0701172668.

Interviewer code:	Interviewers name:
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A) Respondent's background information

1. Date of Interview:
2. Name of village LC I:
3. Mother's code:
4. Mother's MNCH health facility:

INDIVIDUAL SOCIODEMOGRAPHICS/CLIENT FACTORS
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Q#	QUESTION	ANSWER CODE	GO TO OR SKIP TO
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Q 1.	How old are you now?	<ol style="list-style-type: none"> 1. <20 2. 20-34 3. 35-49 	
Q 2.	What is your marital status?	<ol style="list-style-type: none"> 1. Married/Cohabiting 2. Divorced/Separated 3. Not married 	
Q 3	What is your religion?	<ol style="list-style-type: none"> 1. Anglican 2. Catholic 3. Pentecostal 4. Others (specify)...97 	
Q 4	Have you ever attended school?	<ol style="list-style-type: none"> 1. Yes 2. No 	If NO skip to Q 6
Q 5	What is the highest level of education attained?	<ol style="list-style-type: none"> 1. Primary (P1-P7 2. O' level (S1-S4) 3. A' level (S5-S6) 4. Tertiary 5. Other (specify)....97 	
Q 6	What is your ethnicity/tribe?	<ol style="list-style-type: none"> 1. Mukonzo 2. Munyankole 3. Mutooro 4. Munyabindi 5. Mwamba 6. Muganda 7. Other (specify)...97 	
Q7	Occupation: In addition to your housework, do you do any other work for which you are paid cash or in-kind?	<ol style="list-style-type: none"> 1. Yes 2. No 	If No skip to Q 9
Q 8	Which of the following best describes the work you are involved in?	<ol style="list-style-type: none"> 1. Peasant farming 2. Pastoralist 3. Salaried work 4. Tailoring 	

		5. Business 6. Other (specify)...97	
Q 9	What is the occupation of your husband? (please ask this question if respondent answered alternative (1) in Q 3)	1. Peasant farming 2. Pastoralist 3. Salaried work 4. Boda boda 5. Casual labor 6. Others (specify) ...97	
Q10	What is your average family income per month? (please help respondent to come up with a figure basing on each income source)	1. <100,000 p/m 2. 100,000-199,000 p/m 3. 200,000-599,000p/m 4. >500,000p/m	
Q11	What is the gravidity of the most recent pregnancy you have had (or have)?	1. 1 2. 2-3 3. 4-5 4. 6+	
Q13	If delivered; how old is the child now?	1. < six months 2. Six – 12 months 3. 13- 24 months 4. >24 months	
Let me now ask you questions relating to the time when you were pregnant. Please try to remember this period accurately.			
Q14	When you were pregnant, did you attend Antenatal care (ANC) from a health center? Please if client is pregnant ask whether she attends ANC	1. Yes 2. No	If No skip to Q19
Q15	Where did you go for the services? If client is pregnant ask where she receives ANC services (Name the H/C)	1. H/C II 2. H/C III 3. H/C IV 4. Hospital	
Q16	How many times have you done the	1. Zero	If less than

	ANC visits?	<ol style="list-style-type: none"> 2. 1 3. 2-3 4. 4+ 	4 times ask Q17
Q17	Why did you come less times? Probe for more than one reason (You may tick more than one answer)	<ol style="list-style-type: none"> a) Distance is long b) Financial reason c) Husband refused me d) Didn't like the service they gave me e) Asked for materials I didn't have f) I was sick g) I got service from TBA/relative/friend. h) Cultural reasons (specify) 	
Q18	How many months was your pregnancy at time of the 1 st ANC visit?	<ol style="list-style-type: none"> 1. < 4 months 2. 4-5 months 3. 6-7 months 4. 8+ months 	
Q19	Why didn't you attend for your ANC services	<ol style="list-style-type: none"> 1. I didn't know where to get services 2. Health centers are so far 3. I don't like the services they offer 4. I did not have money to go there. 5. I got services from TBA/friend/herbalist. 6. Culture and traditions don't permit me to attend ANC 	
Q20	Are there any risks associated with not attending ANC	<ol style="list-style-type: none"> 1. Yes 2. No 	If No skip to Q24

Q21	<p>If yes, what are the risks?</p> <p>If score has a, b, c, d; Tick “knowledgeable”</p> <p>If score misses one of a, b, c and e; Tick “Not knowledgeable”</p>	<p>a) Over bleeding</p> <p>b) Obstructed labor</p> <p>c) Other infections</p> <p>d) Complications</p> <p>e) Death of the mother</p> <p>f) Death of the child</p> <p>g) Mental illness to mother</p> <p>h) Mental illness to child</p> <p>i) Physical injuries to mother.</p> <p>j) Physical injuries to child</p> <p>k) Others (specify).....</p> <p>1. Knowledgeable</p> <p>2. Not knowledgeable</p>	
Q22	<p>How do you rate the quality of service given to you during ANC?</p>	<p>1. Poor</p> <p>2. Average</p> <p>3. Good</p> <p>4. Very good</p>	
Q23	<p>Please would you like to give reason(s) for the answer above in Q22?</p>	<p>1. Given adequate treatment.</p> <p>2. Health workers treated me well.</p> <p>3. It was not expensive</p> <p>4. Other (specify)</p>	
Q24	<p>During this latest pregnancy, did you use any form of traditional herbs</p>	<p>1. Yes</p> <p>2. No</p>	
Q25	<p>If yes/no, why?</p>	<p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p>	
Q26	<p>During your pregnancy, did you ever receive any form of healthcare from a</p>	<p>1. Yes</p> <p>2. No</p>	

	TBA/herbalist/spiritual healer?		
Let me ask you now questions relating to the time of giving birth			
Q26	Where did you deliver from	<ol style="list-style-type: none"> 1. TBA 2. Relative 3. Health facility 4. Self at home 	
Q27	If respondent attended any of ANC (refer to Q14) and delivered outside health facility, ask why (reasons)?	<ol style="list-style-type: none"> a) Cost/financial. b) Distance far from home c) Didn't have h/c requirements. d) Health facility don't give good care e) Other (specify)..... 	
Q28	Are there any risks associated with delivering outside health facilities	<ol style="list-style-type: none"> 1. Yes 2. No 	If No skip to Q31
Q30	<p>If yes, what are the risks?</p> <p>(I) If scored from (a, b, c, e): Tick "Knowledgeable</p> <p>(II) If missed one of (a, b, c, e) Tick "Not Knowledgeable</p>	<ol style="list-style-type: none"> a) Bleeding b) Obstructed labor c) Other infections d) Complications e) Death of mother f) Death of child g) Mental injuries to mother h) Mental injuries to child i) Other physical injuries to mother j) Other physical injuries to child k) Others (specify) <ol style="list-style-type: none"> 1. Knowledgeable 2. Not Knowledgeable 	
Q31	Please where did you learn about these	a) Health worker (nurse,	

	risks?	midwife) b) Radio c) Community Health worker d) Radio e) Community leader f) Friend g) Others (specify)	
Q32	Are there risks associated with delivering in health facilities?	1. Yes 2. No 3. I don't know.	
Health facility factors: Lets now talk about issues regarding health facilities			
Q33	How far is the nearest health facility from your home?Km	1. <5Km 2. 5-10Km 3. >10Km	
Q34	Can you access the health facility anytime in case of ANC or labor?	1. Yes 2. No	
Q35	If no, please give reasons	a)..... b)..... c).....	
Q36	Are there any cash payments for delivery in the health facility?	1. Yes 2. No	
Q37	If yes, how much do you pay?shs	
Q38	Are there some requirements you are needed to provide for delivery in the health facility?	1. Yes 2. No	If No go Q41
Q39	If yes, please list them	a) b) c) d) e) f)	

Q40	Is it a must for every woman to come with these requirements?	1. Yes 2. No	
Q41	What happens if one doesn't have the requirements?	1. Sent away to look for it 2. Allowed in 3. Seriously rebuked 4. Others (specify)	
Let's turn a bit to the issues about your relationship with the health personnel and maternity ward			
Q42	How do you describe the way the health worker handled you during ANC and delivery?	1. Very rudely 2. Rudely 3. Good 4. Very good	
Q43	I would like you to identify the title of the health personnel who handled you as described in Q42 above	1. Nursing Assistant 2. Midwife 3. Nurse 4. Medical doctor	
Q44	What are your comments about the issue of privacy during ANC and Delivery	1. Very poorly catered for 2. Averagely catered for 3. Catered for good 4. Very well catered for	
Q45	What are your comments about the hygiene in the labor room?	1. Very poor kept 2. Poorly kept 3. Catered for good 4. Well kept (very good)	
Q46	What are your comments on the space in the labor room?	1. Very crowded 2. Crowded 3. A bit spacious 4. Adequately spacious	
Q47	How long were you in the health facility before discharge?	1. <one day 2. After one day 3. After two days	

		4. After three days	
Let talk about the care you received after delivery			
Q48	After giving birth did you come to health facility for any care for you or the child in the last six months?	1. Yes 2. No	
Q49	How many times have you come back for any care from health workers for you or your baby in the last six months	1. Zero 2. Once 3. Twice 4. Thrice	
Q49	If no, why?	1. Didn't see any reason for coming to h/c 2. Financial reason 3. I didn't know that I had to come back 4. Other (specify)	
Q50	Are there any risks associated with not come to health facility after delivery	1. Yes 2. No	
Community factors: Let know talk about issues regarding the community life			
Q51	Are there TBAs/herbalists in your area giving any form of care to pregnant women?	1. Yes 2. No	
Q52	How far is the nearest TBA or Herbalist from your home? Refer to Q33Kms	1. Health center nearer to responded than TBA 2. TBA nearer respondent than TBA	
Q53	If delivered with TBA, did you pay for the services	1. Yes 2. No 3. In kind	If In kind go to 54
Q54	If you paid in cash, how much was it ----- shs	1. Less than what is charged by health center	

	(please refer to Q37 to guide you.	2. More than what is charged by health center	
Q55	If in kind, what did you give? Please list them.	a)..... b)..... c)..... d)..... e).....	
Q56	If delivered from TBA or at home, are there reasons why you prefer TBA or home to a health facility?	1. Yes 2. No 3. No idea	If no or no idea, go to 58
Q57	If yes, please give reasons why?	a)..... b)..... c)..... d)..... e).....	
Q58	Can you tell us who decides for when and where to access healthcare services during pregnancy, delivery or after delivery?	1. Husband 2. Relatives 3. Myself 4. Friends 5. Others (specify)	
Q59	In your community was there any public education program on safe motherhood practices? Say attending ANC, delivering in health facilities, attending PNC?	1. Yes 2. No	
Q60	If yes, who conducted it?	1. Community Health worker (VHTs) 2. Health workers 3. Local leaders 4. Others (specify)	

Thank you for participating in this study

APPENDIX II: Key Informant interview guide for DHO, In-charges of health and community leaders

I am conducting a study on the factors influencing access to ANC and PNC in Kasese district. The purpose of the study is a requirement for my post graduate studies but also it will provide information for the District Health Management Team and other Civil Society Agencies to design interventions geared at increasing health facility access to the continuum of maternal healthcare services.

You have been selected randomly to give your views regarding this study and participation is voluntary. You will be interviewed for about 40 minutes on issues regarding access to maternal healthcare services in your area. Participation is entirely voluntary and you are free to refuse to answer any questions and there will not be any penalty whatsoever from anybody including higher authorities from the district. The information you will provide is solely for research purpose and will be treated in a confidential manner. No names will be mentioned during data collection, analysis and report writing. For any questions or clarification please contact Danny Gotto Devito on 0701172668.

1. As a health worker/DHT/community leader how rate access women's healthcare services particularly the following areas
 - a) ANC
 - b) PNC
2. As a health worker/DHT/community leader what are the issues influencing women's access to the following services
 - a) Individual/mother level (please comment about the mothers themselves and how they have perpetrated the status quo)
 - b) Health facility level (please comment about quality of services given and how it has hindered women's access to these services)
 - c) Community level (please comment about the community's role in contributing to this gap in access to maternal healthcare services).
3. Are there any challenges you are facing hindering dealing with some of the issues you have highlighted above.

APPENDIX III: Focus Group Discussion (FGD) for women attending MNCH services at facility

Name of facility: _____ Date: _____

Moderator: _____ Language: _____

Time: Start _____ End _____

I am (we) conducting a study on the Continuum of Care for Maternal and Newborn Health in Kasese district: Determining the Gap and its Influencers. The of the study is to provide information for the District Health Management Team to design interventions geared at increasing health facility access to the continuum of maternal healthcare services.

I am (we) grateful you have accepted to be here with us as we try to understand the issues of care of women while receiving medical services in this facility and the general attitude of health workers towards patients. Feel free and give us your opinions. Everyone has their own thinking that may differ from the rest; so let's respect that. We are voice recording and taking notes to be able to keep track of all that is being discussed. Your name will not appear anywhere in the report or publication. All information in this discussion will be kept confidential.

Questions

1. How often have you visited this facility in the last one year (please specify the service(s) you came to receive)?
2. What is the general feeling about the care you have received at the maternity unit today during
 - a) Antenatal care
 - b) Postnatal care
3. Do you have TBAs in your communities and how many of you have had a chance to get some help from TBAs?
4. How would you compare the quality of care provided by the health workers and TBAs in your community?

- 5 Would you recommend a friend to go and access any form of healthcare during pregnancy or after delivery from a TBAs and why?
- 6 What issues (at the health facility) would prevent/hinder a woman from accessing healthcare services especially during
 - a) Antenatal care,
 - b) Delivery care
 - c) Postnatal care
- 7 What issues (at the community and individual level) can prevent/hinder a woman from accessing healthcare services especially during
 - a) Antenatal care
 - b) Delivery care
 - c) Postnatal care
- 8 Do you have any issues affecting you as regards access to healthcare as a woman? Please share with us.

I am so grateful for your participation, may you have a safe journey home