UTILISATION OF ANTENATAL CARE SERVICES BY WOMEN OF REPRODUCTIVE AGE AT KYABUGIMBI HEALTH CENTER IV, BUSHENYI DISTRICT

DONE BY

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A DISSERTATION SUBMITTED TO THE FACULTY OF ALLIED HEALTH SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OFA DIPLOMA IN CLINICAL MEDICINE AND COMMUNITY HEALTH OF KAMPALA INTERNATIONAL UNIVERSITY

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DECLARATION

I hereby declare that this report is my original work and has not been presented for any other award at Kampala International University or any other college. I therefore submit it in for the fulfillment of the award of a Diploma in Clinical Medicine and Community Health at Kampala International University Western Campus.

SIGNATURE:.....

DATE:...../...../.....

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APPROVAL

This is to certify that this research report has been prepared under my supervision and has never been presented anywhere for other purposes and is now ready for submission to the faculty of Allied health sciences of Kampala International University Western Campus.

DR. BWAGA IBRAHIM

Sign.....

Date ……

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Finally, I give thanks to God who is my constant guide and source of strength, and is the reason behind every success in my life.

DEDICATION

This dissertation is dedicated to my beloved parents, Mr. Kaganda Dominic. S and Mrs. Nabbanoba Stephania.K and my beloved siblings, Adrian, Dorothy, Lydia, Junior, Florence, Cotrida and all other individuals who have given me a hand in the due course of my stay at school.

DEFINITION OF TERMS

Women of reproductive age; has been defined according to WHO as those between 15-49.

Maternal health; refers to the health of the mother during pregnancy, childbirth and the postpartum period (WHO 2014).

Gravidity; refers to pregnancy status and order of the current pregnancy.

Parity; refers to the pregnancy that has exceeded 28 weeks of gestation regardless of the outcomes.

Early utilization; Denotes attendance of ANC in the first trimester.

Late utilization; Denotes first attendance of ANC after the first trimester.

Trimester; refers to the different time intervals in which ANC visits should be conducted in and can be in terms of months or weeks as stipulated below:-

First trimester; runs from 1-3 months.

Second trimester; runs from 4-6 months.

Third trimester; runs from 7-9 months.

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LIST OF ACRONYMS

LMIC	Low and Middle Income Countries.
ANC	Antenatal care.
WHO	World Health Organization.
PMTCT	Prevention of Mather to Child transmission
ITN	Insecticide Treated Mosquitoes net
IPTP	Intermittent Preventive Treatment Prophylaxis.
SP	Sulfadoxine Pyrimethamine.
DH	Demographic and Health Survey.
LNMP	Last normal menstrual period
UNICEF	United Nations Children Education Fund
NMR	Neonatal Mortality Rates
PNMR	Perinatal Mortality Rates
MDGs	Millennium Developmental Goals
DHS	Demographic and Health Survey
EMOC	Emergency Obstetrics Care

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ABSTRACT

Introduction; According to WHO antenatal care is care received during pregnancy from skilled health personal's such as the goal oriented model recommended by the WHO which includes 4 to 5 visits for pregnant women who are not having medical problems .Antenatal care utilization is 65% in developing countries which is low as compared to the developed countries at 97%(WHO, 2007).

Objective; to assess the level of utilization of antenatal care services by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi district.

Methodology; A descriptive cross-sectional study was carried out at Kyabugimbi Health Center Four from January to April in Bushenyi districted and 100 respondents were used, data was presented in form of graphs, pie-charts and tables.

Results; Findings showed that of the 100 respondents 92% had utilized ANC services and 8% had not utilized any ANC service. Results further showed that there was an association between obstetric factors and utilization of ANC with 54.5% of those with gravidity >4 having utilized ANC late and 78.6% of those with gravidity 1-2 utilized ANC early, further there was an association between distance and utilization of ANC with those in a range of 0-5km having 75% utilizing ANC early and 5% of those in a range >10km utilized ANC late. Results also showed that 24% of those who came early from thought it was the right time and 17(18.3%) of those who came late had gotten problems with their pregnancy as also the highest reason for late attendance was financial difficulties with 32(34.7%).Furthermore results indicated that there was an association between services and utilization of which 91% of the most utilized was HIV and the lowest was TT with 62%. Finally there was an association between the level of education and ANC attendance of which 6(67%) of those with tertiary education attended ANC early as compared to the 2(77%) of those who attended late because of being illiterate.

Conclusion; From the study the major reason for late ANC utilization was financial difficulties and distance to the health facility which highly made the utilization of ANC services inadequate.

Recommendation; The study recommends women empowerment through support groups so as to enhance on their income levels so as to solve their financial constraints to enable early decision making on issues concerned with their pregnancies so as avoiding male over dependence.

CHAPTER ONE

INTRODUCTION

1.0 GENERAL INTRODUCTION

1.1 Background

According to WHO antenatal care is care received during pregnancy from skilled health personal's such as the goal oriented model recommended by the WHO which includes 4 to 5 visits for a pregnant woman who are not having medical problems .Antenatal care utilization is 65% in developing countries which is low as compared to the developed countries at 97%(WHO, 2007).

As it has been mirrored by WHO antenatal care is an important determinant of maternal mortality rates and one of the basic components of maternal care on which the lives of mothers and babies depend so a minimum of 4 visits by pregnant mothers should be made with one or more visits to a trained person during the pregnancy (WHO, 2010).

Although antenatal care is not its self very effective in reducing maternal mortality, according to WHO it presents an important opportunity for identifying threats to the mother and unborn baby`s health, as well as for counseling on nutrition, birth preparedness, delivery care and family planning options after birth(WHO, 2009).

In case of sub-Sahara Africa as stated by WHO, a model of antenatal care separates pregnant women into two groups ; those likely to need only routine antenatal care (some 75% of the total population of pregnant women), and those with specific health condition or risk factors that necessitates special care (25% of pregnant women). For this case or group additional visits should be conducted in addition with required special care (Edward Bbaale etal, 2011)

ANC interventions have been shown to be effective for the detection, treatment or prevention of conditions associated with serious morbidity or mortality and monitoring of chronic conditions such as anemia, screening for and treatment of infections including sexually transmitted infections and prevention of mother-to-child transmission of HIV (PMTCT) plus the use of insecticide treated bed nets (ITNs) and intermittent preventive treatment of malaria (IPTs) with sulfadoxine-pyrimethamine (SP).The risk is highest during too early (under 20years) and too late ages over 40 years (47 and 51 per 1000 pregnancies) respectively (Tann et al., 2007).

In most rural areas of sub-Saharan Africa, poor maternal health remains a major issue since health facilities do not provide full range of primary health care services, undermining access to reproductive health services which include basic and comprehensive Emergency Obstetric Care (EMOC) services (Tawiah, 2011; Magadi et al., 2003; Monir et al., 2009; Pearson et al., 2005; Lester et al., 2010) and For instance, approximately all Level II health centers (located at Parish level) promote, provide preventive and curative services in Uganda but do not provide adequate maternity services of which ANC is the care rendered during pregnancy (Ekabua&Njoku, 2011). In developing countries including Uganda, several factors prevent accessibility, including cost of services, distance to health services, lack of available transportation, high transportation costs, poor road conditions and uneven distribution of health care facilities and lack of independence by women to make decision on matters that directly affect their health .All of these factors increase travel time and the difficulty in accessing health service facilities. In rural Uganda, physical accessibility and acceptability remains a significant challenge to health care service delivery (David Okutu, 2012).

Furthermore, less than half of women (47%) attained at least four antenatal visits. This implies that more than half of women in Uganda attained less antenatal visits than is recommended by WHO and the national policy. Additionally, only 17% of pregnant women initiated their first visits during the first three months of pregnancy (Edward Bbaale, 2011).Traditionally, Ugandan women seek to handle birth on their own as it is a time when they can use their own power and make their own decisions which can also be a factor in such a high maternal mortality rate where many women report mistreatment from healthcare personnel as an additional reason to avoid seeking professional care during pregnancy and labor. A study also found that a majority of Ugandan women lack health literacy and in turn seek care in more traditional or homeopathic ways (WHO, 2012).

As per study conducted by Adoku Susan 2014 shows that 95% of the mothers in Bushenyi district attend at least once and 5% had not attended ANC services during pregnancy. This showed that ANC attendance rate among women is still lower than the national average of 97.3%.

1.2.0 Problem Statement

Although antenatal care (ANC) is not itself very effective in reducing maternal mortality, it provides an entry for interventions which give health workers the opportunity to detect risky conditions and therefore refer them for early management leading to better maternal outcomes, despite the importance of ANC visits, a study showed that only 17% of pregnant women initiated their first visits during the first three months of pregnancy (UBOS, 2007).

According to Asiimwe (2010), it was found out that in western Uganda, the ability of a woman to afford antenatal care (ANC) services has a significant association to the number of ANC visits she is likely to make. Women in rural areas of Uganda are two times less likely to attend ANC than the urban women. Most women in Uganda have registered late ANC attendance, averagely at 5.5 months of pregnancy and do not complete the required four visits. The inadequate utilization of ANC is greatly contributing to persisting high rates of maternal and neonatal mortality in Uganda. (Kawungezi et al, 2015). Therefore the need to assess the level of utilization of antenatal care services by women of reproductive age and determine whether the interventions made are efficient enough to reduce the maternal mortality rates recorded at Kyabugimbi Health Center IV, Bushenyi district.

According to the study conducted by Teddy Kyomuhangi, Samwiri Iranezeza and Biraro in 2015 in Kyabugimbi sub- count indicated that the in depth interviewers with mothers established that out of 99 mothers, 71(72%) were aware of the benefits of the ANC, but high knowledge did not correlate with the level of attendance . Mothers attendance at 4 ANC visits was low, only 42/99 (42%) despite intervention by VHTS. The majorities (51/99; 52%) of mothers were aware of the benefits of delivery in health facility but only 35% had done so.

1.3.0 Objectives of the Study

1.3.1 Broad Objective

To assess the level of utilization of antenatal care services by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi district.

1.3.2 Specific Objectives

1. To describe common antenatal care practices utilized by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi district.
2. To determine the factors associated with the early utilization of ANC services by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi district.
3. To determine the factors associated with late utilization of ANC services by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi District.

1.4.0 Research Questions

1. What are the common antenatal care practices utilized by women of reproductive at Kyabugimbi Health Center IV, Bushenyi district?
2. What are the factors associated with early utilization of ANC services by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi district?
3. What are the factors associated with inadequate utilization of ANC services by women of reproductive age at Kyabugimbi Health Center IV, Bushenyi district?

1.5.0 Study Justification

Despite the huge international efforts to promote and provide ANC, there has been little improvement in these statistics over the past decade. Almost 50% of women in LMICs don't receive adequate ANC services of which women's views can offer important insights into this problem and since the level of ANC utilization is still low at 42% at Kyabugimbi health center four this study will help stake holders on how to implement effective ANC utilization (Teddy Kyomuhangi et al, 2015).The study will also be used for planning purposes and mobilization of mothers for the utilization of ANC services which in return will help in the improvement of health of women of reproductive age in Kyabugimbi Community .

1.6.0 Scope of the study

1.6.1Time scope

The study was conducted between the months of December 2016 to June 2017.Detailed working schedule during this time scope is illustrated in the work plan in the appendix below.

1.6.2 Content scope

The study concentrated more on describing ANC service utilization factors associated with early ANC utilization and the factors associated with inadequate ANC utilization plus the common ANC practices utilized by women of reproductive age at Kyabugimbi Health Center four.

1.6.3 Geographical scope

The study was conducted at Kyabugimbi health Center IV in Bushenyi district in western Uganda and respondents included women of reproductive age who were utilizing their ANC services at the health center.

1.7.0 Conceptual frame work

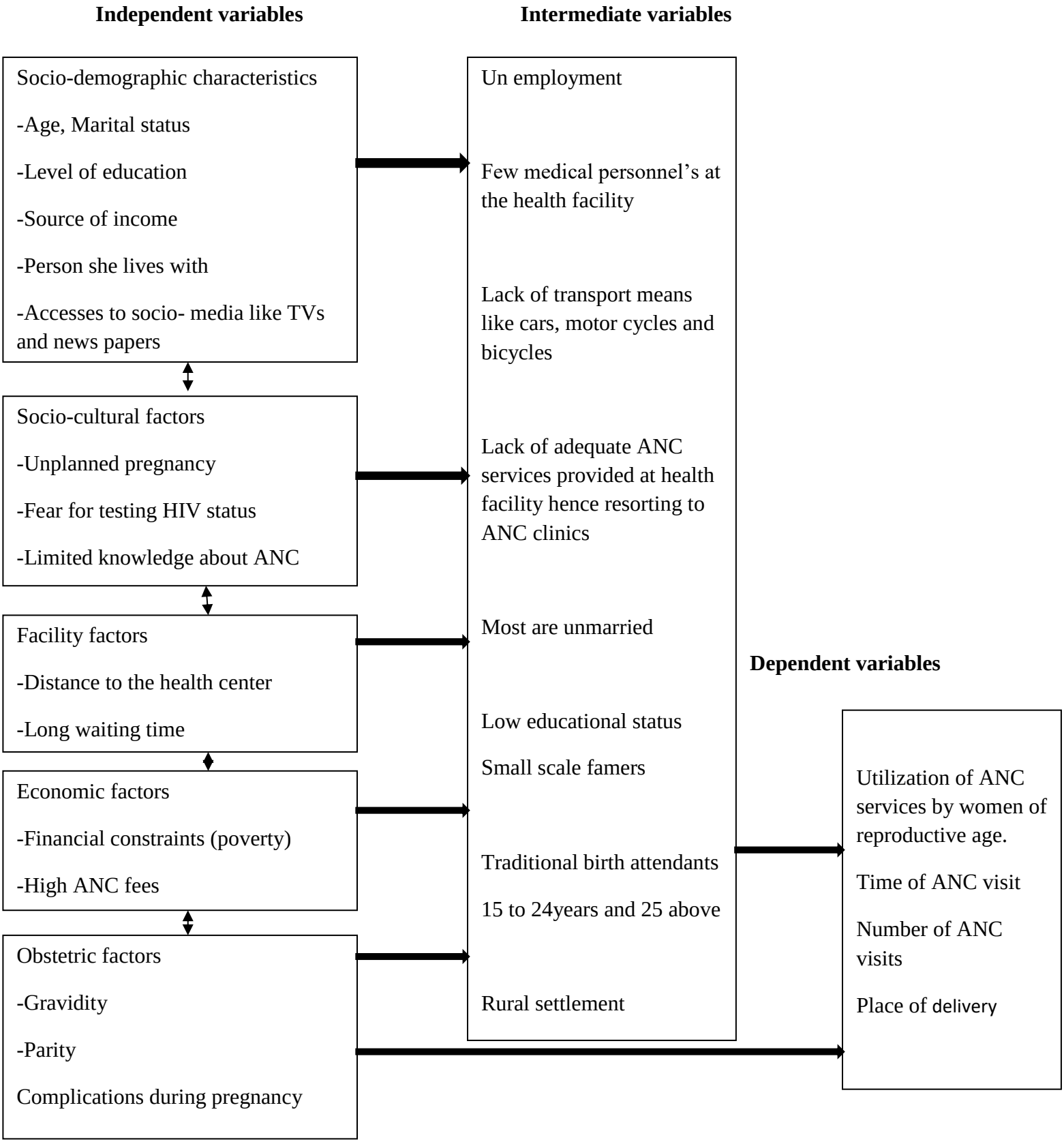

Figure 1

CHAPTER TWO

LITERETURE REVIEW

2.0 Introduction

2.1 Attendance of ANC

Antenatal care is an umbrella term used to describe the health care procedures and care rendered during pregnancy (Ekabua, &Njoku, 2011).WHO recommends that a woman without complications should have at least four antenatal care visits, the first of which should take place monthly during the first 28weeksand then the other visits thereafter take place every two weeks up to the 36th week (or until birth) (WHO, 2014b).

According to WHO figures, between 2005 and 2010 only 53% of pregnant women worldwide attended the recommended four antenatal visits in low-income countries, this figure (36%) was disappointing. Recent estimates indicates that the number of women in LMICs attending at least one antenatal appointment increased from 64% in 1990 to 81% in 2009, and those attending four or more times rose from 35% to 51% over the same period. However, major differences exist within and between continents, between countries, and between urban and rural population. (Bahilu Tewodrros et al, 2009)

Furthermore, across sub-Saharan Africa there is wide variation in ANC attendance, although 71% of pregnant women attend formal ANC at least once, only 44% attend ANC four or more times .More recent Demographic and Health Survey (DHS) data illustrate that the variation in timing of ANC initiation across sub-Saharan African remains notable: for example, 11% of women started ANC in the first trimester in Ethiopia (2011),16% in Nigeria (2008), 47% in Congo-Brazzaville (2005) and 55% in Ghana (2008). Moreover, amongst sub-Saharan countries, the trend over the last ten to 20 years in the proportion of women making at least four ANC visits varies markedly: DHS data indicate that in West Africa, eight of ten countries have illustrated increases, whereas, in Southern and East Africa, 6 of 11 countries have experienced declines within the first 4 months of pregnancy (David Okutu, 2012).

As stated by Lancet a minimum of 4 visits should be made as follows,

- First visit- early (0-16 weeks) in first trimester after missed two periods.
- Second visit-16 >28 weeks;
- Third visit- between 28>36 weeks;
- Fourth visit- after 36 weeks.

However, some women require more than four visits especially those who develop complications (lancet, 2010). Although progress has been made globally in terms of increasing access and use of antenatal visit, the proportion of women who are obtaining the recommended minimum of four visits is still too low. In Uganda, only 47% of Ugandan women receive antenatal care coverage and only 42%of births are attended by skilled health personnel. Among the poorest 20% of the population, the share of births attended by skilled health personnel was 29% in 2005/2006 as compared to 77% among the wealthiest 20% of the population (WHO, 2012).

Furthermore the regional differences in human resource distribution in Uganda have yielded maternal health differences in the country with a bias towards the central region. In the central region, 18% of women received ANC from a medical doctor compared to 4.3%, 4.5%, and 9% of women in the eastern, northern, and western regions respectively (Edward Bbaale,2011).Study in western Uganda among adolescent shows that 43% of adolescents make the WHO and UNICEF recommended 4 ANC visits, except for the small percentage variation (1%) and for the analysis that was based on older mothers, the findings agree with Ndyomugyenyi (1998) that estimated 42% of pregnant women in Uganda attend the required 4 ANC visits. (Kasabiiti Jennifer Asiimwe, 2009).

2.2 Services utilized during ANC

The study conducted in Nigeria shows that most common services rendered to the women at the ANC clinic were weight measurement 301(98%) and the receipt of deworming tablets 197(64.2%) was the lowest(4.5). The women were also given health education with the information received on diet 298(97.1%) highest, while information concerning HIV/AIDS was at 261(85.0%) (M.D Dairo et al, 2010).

According to all participants, in a study in western Tanzania, PMTCT services are widely supported in the Maasai and Watemi communities. Messages about the importance of skilled birth attendance are not relayed to couples during PMTCT counseling sessions (**MokeMagoma, 2010).** Women appreciated the information and advice received at the ANC. The main topics were care during pregnancy and care for the newborn. However, few women attended a health talk (14%), and other essential topics such as place of delivery, making an individual birth plan, family planning, malaria, and HIV/AIDS prevention received little attention. The ANC provision of abdominal palpation, tetanus vaccination and weight measurement were high (>90%), but provision of other services was low, e.g. malaria prevention (21%), iron (53%) and folate (44%)

supplementation, syphilis testing (19.4%) and health talks (14.4%).Eighty percent of women delivered outside a health facility; among these, traditional birth attendants assisted 42%, laypersons assisted 36%, while 22% received no assistance**(**Anna M van Eijk et al,2013).

In Tanzania all women were examined and received tetanus vaccination during their ANC-visits However, other preventive treatments, laboratory tests, and health education were not common, ranging from 67% for a blood pressure measurement to 3% for treatment for helminthiasis. 1 out of 5 women received malaria prevention (21%) or underwent a syphilis test (19%), and approximately half of the women received iron (53%) and folate (44%) supplementation. Among the 80 (14%) women who received health talks during ANC visits, the two most frequent topics were care during pregnancy (recommended diet, avoiding a heavy workload, importance of regular ANC attendance and a hospital delivery), and care for the newborn (e.g. diet, breastfeeding). Family planning (mentioned by 5 women), the use of bed nets to prevent malaria and HIV prevention were infrequent health education topics (MokeMagoma, 2010).

Women in Ghana reported having their arms 'tied', but did not properly link this with blood pressure measurement. Women described being injected and tested, but specific mentions of HIV testing were only made frequently in Malawi, and references to syphilis tests and hemoglobin analysis were rare overall(Linda Kalilani et al, 2013).

In Uganda, 76% of women in the central region received antenatal care from a nurse/midwife compared to 90%, 87%, and 80% of women, respectively, in the eastern, northern, and western regions. Looking at the antenatal care content, in the central region, 63% of women had their blood pressure measured compared to 47%, 50%, and 50% in the eastern, northern, and western regions respectively. Additionally, 22% of mothers in the central region had their urine samples taken compared to 9%, 11%, and 9% in the eastern, northern, and western regions respectively. In the central region 40% had their blood sample taken compared to only 16%, 28%, and 28% in the eastern, northern, and western regions respectively. Also in the central region 57% received a tetanus injection at least twice compared to only 45%, 54%, and 48% in the eastern, northern, and western regions respectively. Finally, 58% in the central region delivered with the assistance of medical personnel compared to only 40%, 27%, and 25% in the eastern, northern, and western regions respectively (Edward Bbaale, 2011).

2.3 Socio-demographic factors and ANC Utilization.

Research study in Nigeria shows that age has a significant association with use of ANC. Women who were 25 years or more 245(79.0%)] were more likely to attend ANC clinic than women who were less than 25 years 62(68.9%). Also in the same study, it was shown that majority (76.8%) of the respondents attended ANC clinic. Women in urban areas were more than 2 times likely to attend antenatal clinic than women in rural areas. Women who were Muslims or other religions were more than 2 times likely to attend ANC clinic than women who were Christians (M.D Dairo et al, 2010).

Study also shows that prime gravidae were more likely to seek advice and assistance and initiate ANC earlier. Nonetheless, these decisions were not taken alone but on the basis of advice from older women that hastened their first ANC visit. For prime gravidae, pregnancy disclosure influenced timing of ANC. Across all the study area, all types of respondent reported that adolescents and unmarried younger women hid their pregnancies and delay ANC to avoid the potential social implications of pregnancy; exclusion from school, expulsion from their natal home, partner abandonment, stigmatization and gossip. In contrast, older women did not make active efforts to hide their pregnancies. However, they would only directly disclose their pregnancy to close relatives and their husband (AnnaM van Eijk et al, 2013).

Research showed Married women [291(78.2%)] were more likely to attend ANC clinic compared to women who were single, separated or divorced [16(57.1%)].Educational status also showed a significant association with respondents having an education of secondary school and above 275 (82.1%) attending ANC clinic more compared to women who had an education of primary school and below32(50.0%)(M.D Dairo et al, 2010).Besides the results of full model showed that women with higher education levels were 2.35 times more likely to receive skilled attendance at delivery in comparison with illiterate women. Older women having more than 3 children, belonging to schedule tribes, to be Hindu and to be married to a low educated husband were associated with lower use of skilled attendance at delivery (Tej Ram Jat et al, 2011).

In Uganda mother's education is revealed to be significant in influencing the frequency of ANC. Mothers with at least secondary education are 6–11% more likely to attain at least four visits compared to counterparts with no education at all(Edward Bbaale, 2011).The results showed that women from richest quintile had 4.53 times more likelihood of receiving ANC during pregnancy in comparison with women from the poorest quintile of the society. The odds of reporting use of

ANC by women with higher secondary and above education were 2.57 times higher than that of illiterate women. Other predictors of the use of antenatal care were mother's age at last birth, husband's education, mother's occupation, birth order, and poverty index **(**Anna M van Eijk et al, 2006).

2.4 Factors for early ANC Utilization

A study in Ghana shows that, women gave reasons for attending ANC as monitoring the progress of their pregnancy or to check the position of the unborn child. Others gave reasons as to identify problems during pregnancy .In the same study in the Ashanti Region; women also highlighted the importance of taking the medicines provided during ANC to ensure the health of the pregnancy and the development of the baby. In addition, Ghanaian respondents, particularly in the Ashanti Region, viewed ANC as a normal part of pregnancy: attending the clinic was simply what women did. In Upper East Region of Ghana ANC was often considered compulsory, a result of the authority of health staff or the vague idea of it being the 'bi law' **(**Harry Tagboret al, 2013).

According to Frank Odhiambo et al; 2006, showed that most (87%) women decided for themselves to visit the ANC; the husband, mother or mother-in-law suggested attending the ANC for only a few (5%, 4%, and 2% respectively). Many women (67%) gave more than 1 reason to visit ANC; the reasons most frequently mentioned were: to check the position, condition or growth of the baby (83%); to detect maternal problems and to be treated when sick (55%); to get a tetanus injection (24%); and to get an ANC card (18%). Participants expressed the belief that medical staff in health facilities treats pregnant women better if they attend with an ANC card, particularly if the card shows evidence of multiple visits. Eleven percent of the women mentioned that they appreciated the health information the ANC provided in the form of talks or posters.

2.5Factors associated with inadequate ANC utilization

Study done in Tanzania shows TBAs and relatives are viewed by the Maasai and Watemi women of Tanzania as affordable (e.g., no transportation costs required), and able to meet their service expectations which include continual support and advice during pregnancy, delivery, and in the postpartum period, the provision of body massage throughout labor and delivery, and knowledge of a variety of delivery positions. In addition majority of Maasai women perceive digital vaginal

examinations performed at health units as painful, likely to damage the baby, and cause of labor retraction. Some Watemi women described digital examinations performed by male providers as dehumanizing. In contrast, Maasai women felt that TBAs perform digital vaginal examinations gently and only when the baby's head is crowning **(**MokeMagoma, 2010)

Maasai and Watemi participants explained that caesarean sections performed with no explanation provided in advance evoked fear in pregnant women that they will undergo unnecessary caesarean sections if they deliver in health units. Episiotomies and repairs of genital tears sustained during delivery also prevented Maasai and Watemi women from seeking skilled delivery care. Genital tears are viewed in the two communities as inevitable complications of childbirth that do not require medical intervention. **(**MokeMagoma, 2010).

Among women (83%) delivered outside of a health facility, 80% delivered in their own house, 18% in the house of a TBA and 3% on their way to a health facility. The most frequent reason for not attending a health facility for delivery was lack of means of transport, in particular at night (49%). Other important barriers were fast progression of labor (47%), and expense (28%). Fourteen percent of women did not think facility attendance was necessary; reasons given for this included previous uneventful home delivery, preferred home deliveries, or had made arrangements with TBAs or another person to attend the delivery. A small subset (3%) reported anticipation of unpleasant treatment at a health facility as a reason not to attend. 64% of those who delivered outside a health facility were aware of the potential risks, and could identify one or more complications that would occur(Frank Odhiambo et al, 2006)**.**

Study in Nigeria shows that respondents who neither sought modern nor traditional ANC during pregnancy gave various reasons for not seeking ANC care at all. Fourteen (58.3%) gave the inability to afford cost of ANC as the reason for not obtaining antenatal care at all. The other reasons reported by the women who did not seek ANC at all include the attitude of care givers (14.8%), the long time that will be spent in obtaining ANC 8(29.6%), those who did not think ANC was even important 16(59.39%), distance to venue of antenatal care 6(22.2%), religious reasons 1(3.7%) while others claimed they had no chance to attend 8(29.6%) (M.D Dairo et al, 2010).

In Uganda lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have hindered the increase in the utilization

of those services by women or a reduction in the high ratio of maternal deaths (Bantebya, 2003). Yet there has not been an increase in the utilization by women of emergency obstetric services at health facilities nor a corresponding significant reduction in maternal deaths. The proportion of women delivering in health units remains low and there is a gap between the numbers attending antenatal services and those delivering in health services (EQUINET, 2007).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

3. 1 Study Design

The study adopted a descriptive cross-sectional design, and was qualitative in nature in order to assess the level of utilization of ANC services by women of reproductive age. This study design was preferably selected because it involves systematic collection of information often under conditions of considerable control and the analysis of the information was done statically and required a low number of samples (Hunger, 1991, Oso, 2009)

3.2 Study Setting

The study was conducted at Kyabugimbi Health Center IV in Bushenyi district. It is located about 5 km from the main road on Mbarara-Kasese highway branching from Nyakabirizi trading center. Kyabugimbi is a town in Igara County, which is made of these villages, Buhumuro, Nyeibingo, Bugaara, Kyeigombe, Byezengye, Katikamwe, and Kakanju and bordered by Buhweju, Kyeizoba and Kakanju in Bushenyi District. The center was selected because of the low ANC services utilization which is at 42% (Teddy Kyomuhangi et al, 2015)

3.3 Study Population

The study population included all the women in a reproductive age bracket who were found at Kyabugimbi Health Center IV at the time of the study.

3.4 Sample Size Determination

The sample size was determined by Slovene Formula used for calculating sample size and was adapted from **(Garaez, 2013),** which is given by:

$$n = \frac{N}{1 + N(e^2)}$$

Where:

N= Population Size (55,545 women)

e= Margin of Error=0.1(10%)

n=desired sample size.

n=55545÷1+55545(0.1)2 n=99.998=100people

So the values which will be gotten after are to be substituted in the above formula and calculations done.

3.5 Sampling Procedure

A cross sectional descriptive study was conducted, with involvement of quantitative methods of data analysis.

3.6.0 Selection criteria

3.6.1 Inclusion Criteria

Women within the reproductive age who have ever been pregnant, currently pregnant, delivered, have either attended ANC or not and were willing to consent were chosen during the period of study.

3.6.2 Exclusion Criteria

All those outside the reproductive age were excluded.

Mothers who were sick or nursing sick children at the time of this study were excluded.

3.7 Definition of Variables

The major variables considerd in the study were dependent, intermediate and independent variables. The dependent variables was the time of antenatal visit, the number of antenatal visit and the place of delivery. The independent variables were socio-economic status of the mothers, maternal literacy, income of the husbands, and pastobstertic history.

3.8 Research Instruments

A simple questionnaire consisting primarily of closed ended formatted questions including dichotomous questions (e.g. yes/no), and multiple response for ease of completion and analysis was used. All questions were categorized accordingly.

3.9 Data Collection Procedures

The primary sources were obtained by moving out to the field and mobilizing all women of a reproductive age to come to the health facility for ANC health education so as to enable picking of first-hand information directly from the various respondents as well as observation of comment and use of self-administered questionnaires that were distributed to respondents for filling. A translator was identified to help with the interpretation of the questionnaires to the mothers so that they could understand the questions clearly and give an accurate response.

3.1.1 Ethical Considerations

Approval was sought from the faculty of Allied health sciences of Kampala International University for permission to conduct the study. Also letters of introduction were obtained from the faculty to introduce the researcher to local leaders who then in turn granted permission to conduct the study in the selected division.

- Informed consent was obtained from respondents before they are interviewed.
- Privacy and confidentiality for information provided was assured to all participants as that the information provided was to be used strictly for the purpose it was collected.
- The autonomy and right of participants to refuse to consent or give any information they feel uncomfortable was guaranteed.
- Participants' safety was assured, and disclosure of respondents' identity was avoided to minimize the risk of volunteering fears to provide information for the study.

3.12 Limitations for the study

1 The study only considered those women of reproductive age leaving out those >49years of which they may also provide information as concerned to the topic under study.

2 The study was sensitive and some of the respondents may not accept to answer some questions. To overcome this, the researcher gave thorough explanation to the participants before administering the questionnaires.

3.1.3 Plans for data dissemination

On completion of the report, it was disseminated to the school of Allied health sciences Kampala International Hospital Western Campus, Kyabugimbi Health Center Four,DVC KIU-WC,LCI Chairperson Kyabugimbi Community, DHO, District administrators my supervisor and a copy remained with the researcher for future reference and of which the data is in form of graphs, charts that are indicating the level of utilization of ANC services by women of reproductive age at Kyabugimbi Health Center Four in Bushenyi District.

CHAPTER FOUR

RESULTS

4.0 Introduction:

In this chapter, results were presented regarding service utilization, early attendance and late attendance of ANC services among women of reproductive age, the data is presented and analyzed inform of tables, graphs and pie charts illustrating the data background, characteristics of respondents as well as association between social demographics and variables.

4.1.1 Social Demographic characteristics of respondents.

The table shows the social demographics of women who were attending antenatal care at Kyabugimbi health Centre (N=100)

Table 1

Social demographic variable (N)

Variable	**Frequency**	**Percentage**
Age		
15-19	8	8
20-24	18	18
25-29	24	24
30-34	20	20
35-39	15	15
40-44	10	10
45-49	5	5
Total	100	100
Occupation		
Housewife	29	29
Famers	39	39
Business	20	20

Civil Servant	12	12
Total	100	100
Marital Status		
Married	34	34
Single	56	56
Divorced	8	8
Widowed	2	2
Total	100	100
Religion		
Christians	64	64
Muslims	35	35
Traditionalists	1	1
Total	100	100
Level of Education		
Primary	46	46
Secondary	42	42
Tertiary	9	9
None	3	3
Total	100	100
Level of income		
Low	52	52
Fairy high	38	38
High	10	10
Total	100	100

4.1.2 ANC care service Utilization

The figure below shows that of the 100 respondents that were sampled 92% had attended ANC Services at least once while 8% had not attended ANC services at all. Therefore the rest of the results were computed out of 92% of those that had utilized ANC services at least once

A pie chart showing the proportion of mothers in accordance to ANC Service Utilization

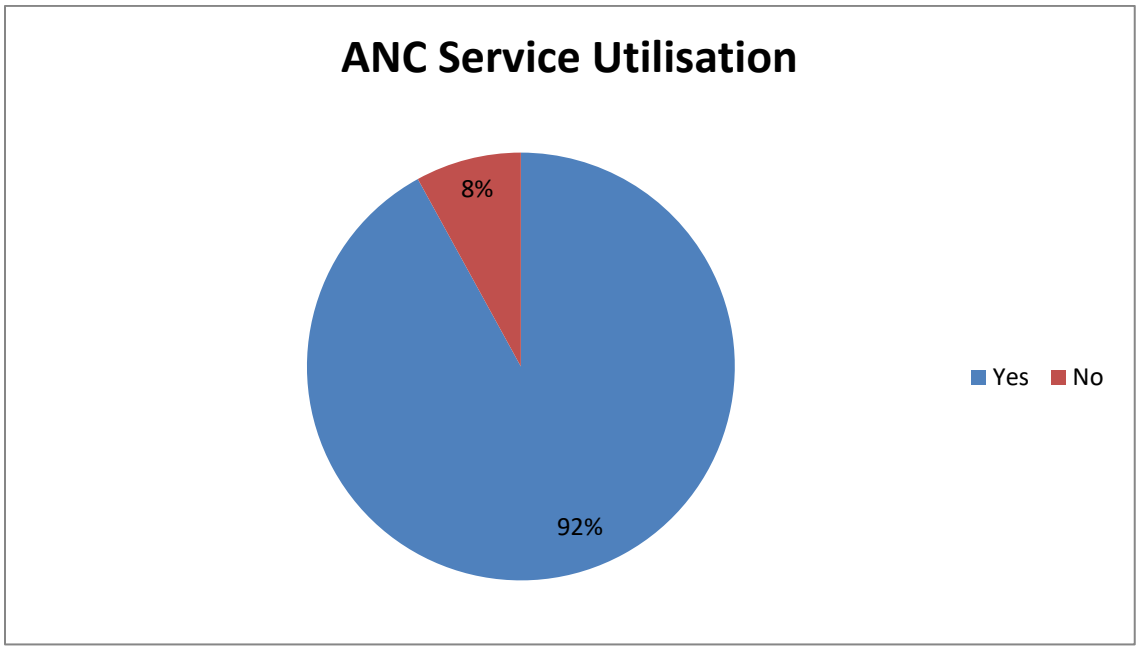

Figure 2

4.1.4 Association between Obstetric factors and Utilization of ANC Services.

The table below shows that 22(78.6%) of women who were gravida 1 and 2 utilized ANC early whereas 12(54.5%) of those who were gravida 4 and above utilized ANC late while 26(81.3%) of those who were Para 1-2 utilized ANC early and finally 14(51.9%) of those who were above Para 4 utilized ANC late.

Table 2

Obstetric factors and ANC Utilization.

		ANC Utilization	
Obstetric factors		**Early**	**Late**
Number of pregnancy(Gravidity)	1-2	22(78.6%)	6(21.4%)
	3-4	20(47.6%)	22(52.4%)
	>4	10(45.5%)	12(54.5%)
Number of children born to the mother(Parity)	1-2	26(81.3%)	6(18.8%)
	3-4	13(39.4%)	20(60.6%)
	>4	13(48.1%)	14(51.9%)

4.1.5 Association between Distance to the Health Facility and ANC Utilization.

The table below shows that there was an association between distance and ANC utilization with 30(75%) of those in a distance of 0-5 km having utilized ANC early while 32(61.5%) of those in a distance of >10 km having utilized ANC late.

Table 3

Distance to the health facility and ANC utilization.

Distance to the Health Facility	**ANC Utilization**	
	Early utilization	**Late utilization**
0-5km	30(75%)	5(9.6%)
6-10km	15(28.8%)	8(20%)
>10km	2(5%)	32(61.5%)

4.1.6 Reasons for early ANC Attendance.

The table below indicates that 22(24%) of mothers who came early thought it was the right time followed by 17(18.3%) of those who had developed a problem and lastly 11(12%) of those who had experienced friendly staff.

Table 4

Shows reasons for Early ANC Attendance.

Reasons for earl ANC Attendance	**Frequency**
Developed a problem	17(18.3%)
Wants a File	16(17.5%)
Was told to come	12(13%)
Good past experience	14(15.2%)
Friendly staff	11(12%)
It's the right time	22(24%)
Total	92

4.1.7 Reasons for late ANC Attendance.

These results below indicated that 32(34.7%) had late attendance because of financial difficulties followed by 23(25%) due to late decision making, 15(16.3%) due to limited knowledge about ANC, 12(13%) had to get permission whereas 6(6.5%) was exposure to mass media and lastly 4(4.3%) due to TBA's.

Table 5

Reasons for late ANC Attendance.

Reasons for late ANC Attendance	Frequency
Limited knowledge about ANC	15 (16.3%)
Late decision making	23 (25%)
Traditional Birth Attendants	4 (4.3%)
Exposure to mass media	6 (6.5%)
Financial difficulties	32 (34.7%)
Getting permission to go for treatment	12 (13.0%)

A graph below indicates that 8% had not visited a health facility for ANC services, 52% had visited and utilized < 4 Visits and 40% had visited and utilized ≥ 4Visits.

A graph showing the number of times women had visited the Health Facility for ANC Services.

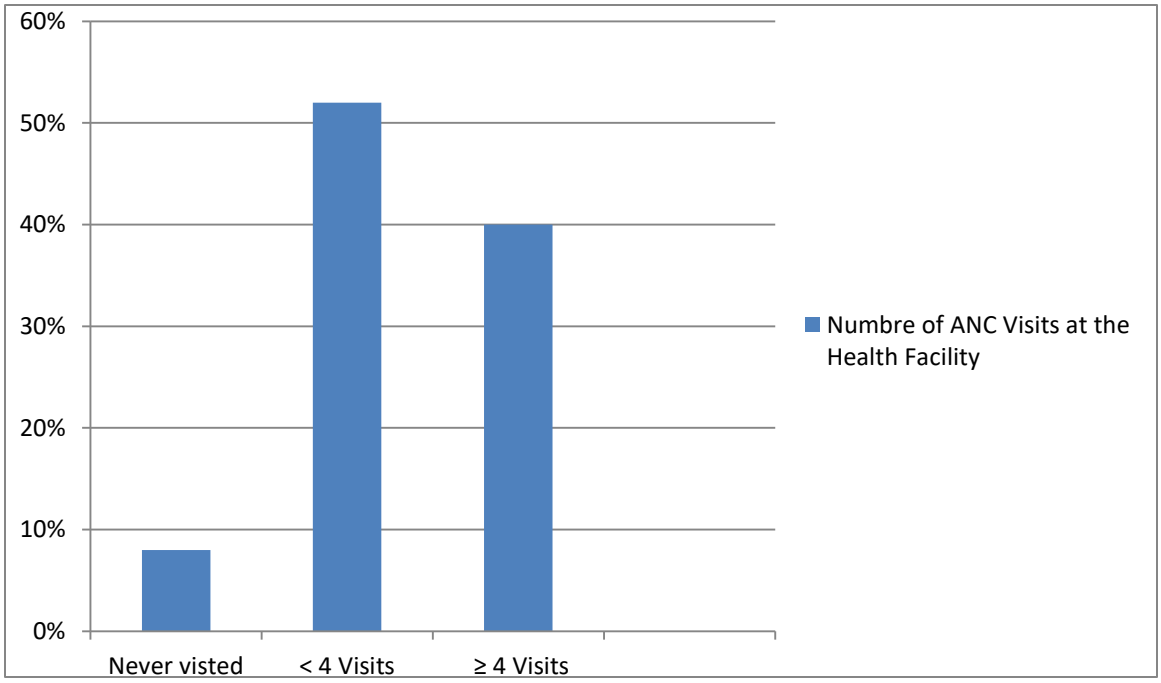

Figure 3

4.1.9 Factors that influence Women's access to ANC Services.

The figure below indicate that 29.3% of the women had accessed ANC services more due to their past pregnancy experience then followed by 25% due to distance to the health facility, 16.3% as support from the husband as 10.9% catered for Transport means whereas 10.9% included unplanned pregnancies and 7.6% was as result of friendly Health Workers.

Showing the factors that influence Women's access to ANC Services.

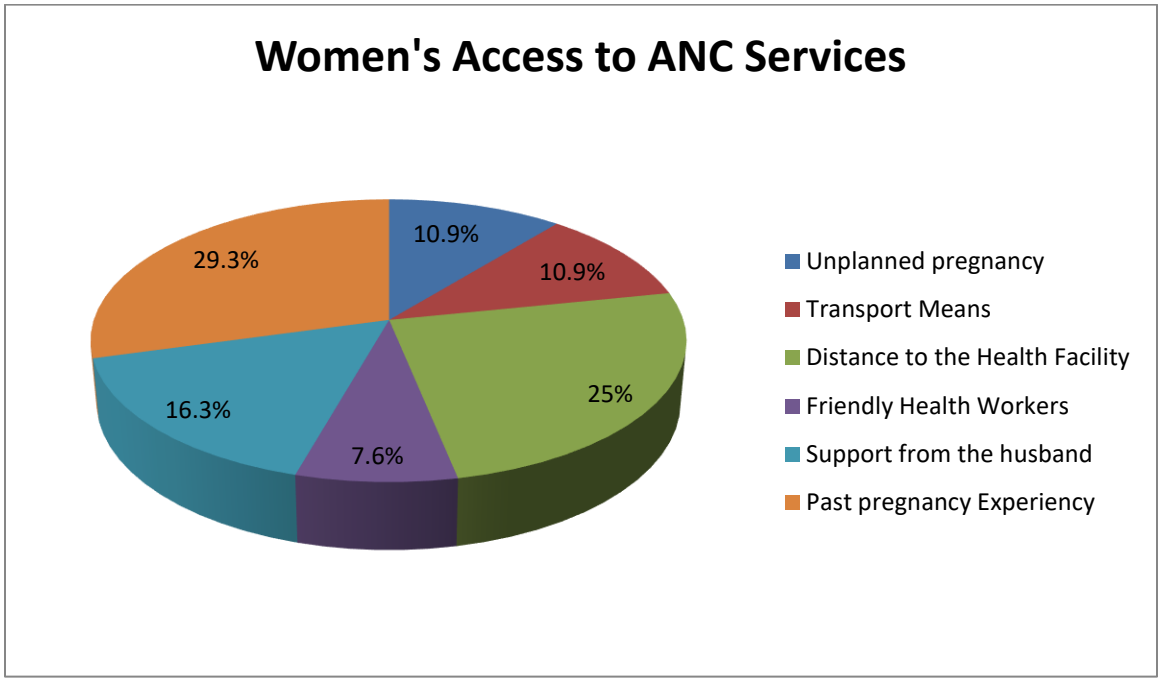

Figure 4

4.2.1 Association between the Services and their Utilization at the Health Facility.

The results below indicate that the mostly utilized service was HIV counseling with (91%) followed by Screening for Complications with (87%) then Intermittent Preventive Treatment with (82%) and lastly was Tetanus Injection with (62%).

Table 6

Service utilization at the health facility.

Services		**Frequency**	**Percentage**
HIV Counseling and Testing	No	1	1.1
	Yes	91	98.9
Given Iron and Folic Acid	No	14	15.2
	Yes	78	84.8
Tetanus Injection	No	24	26.1
	Yes	68	73.9
Intermittent Preventive Treatment	No	10	10.9
	Yes	82	89.1
Screening for Complications	No	5	5.4
	Yes	87	94.6
Health Education Talks	No	22	23.9
	Yes	70	76.1

4.2.2 Tabulation between age of the mother with First ANC Visit.

Results below show that 18(26.9%) of the mothers who came from 1-3 months were aged 25-29 years and 6(25%) of those from 4-6 months were aged 20-24 years whereas 1(100%) of those aged 45-49 years also attended from 7-9 months.

Table 7

Age of the mother and First ANC Visit.

	Month of First ANC Visit			
Age of the mother	**1-3**	**4-6**	**7-9**	**Total**
15-19	3(4.5%)	4(16.7%)	0(0%)	7
20-24	10(14.9%)	6(25%)	0(0%)	16
25-29	18(26.9%)	5(20.8%)	0(0%)	23
30-34	15(22.4%)	4(16.7%)	0(0%)	19
35-39	13(19.4%)	1(4.2%)	0(0%)	14
40-44	6(9.0%)	2(8.3%)	0(0%)	8
45-49	2(3.0%)	2(8.3%)	1(100%)	5
Total	67	24	1	92

4.2.3 Association between marital status and ANC Utilization.

The study findings showed that 25(78%) of married women had early utilization, 19(37%) of the single women had early utilization while 5(71%) of the divorced women had late utilization whereas the widowed had an equal utilization on both with 1(50%)

Table 8

Marital status and ANC Utilization

Marital Status	Early utilization	Late utilization
Married	25(78%)	7(22%)
Single	19(37%)	32(63%)
Divorced	2(29%)	5(71%)
Widowed	1(50%)	1(50%)

4.2.5 Association between educational levels with ANC utilization.

Findings below showed that 6(67%) of women with tertiary education had early utilization followed by 22(56%) of those who attended secondary education while 2(77%) of those that never attended school had late utilization.

Table 9

Education Level and ANC Utilization.

Education Level	Early utilization	Late utilization
Primary	15(37%)	26(63%)
Secondary	22(56%)	17(44%)
Tertiary	6(67%)	3(33%)
Never Attended School	1(33%)	2(77%)

4.2.5 Association between unplanned pregnancy and ANC utilization.

The table below shows that 34(59%) of women with unplanned pregnancy had late utilization while 23(68%) of those with planned pregnancy had early utilization.

Table 10

Unplanned pregnancy and ANC Utilization.

Unplanned pregnancy		Early utilization	Late utilization
Yes	58	24(41%)	34(59%)
No	34	23(68%)	11(32%)

CHAPTER FIVE

DISCUSSION

5.0 Introduction

In this chapter, the researcher made a presentation of the discussions of the study findings. In short, the research had described the study findings, meaning of the findings and reasons as to why those findings may be that way and made impressions of those findings. These have been arranged according to the specific objectives, conclusions and recommendations have been placed at the end of this chapter.

5.1 Attendances and timing of ANC services

World Health Organization recommends a minimum of four ANC visits (P.K. Singh, Rai, Alagarajan, and Singh, 2012) which should be initiated in the first trimester of pregnancy in this study, the overall ANC attendance was found to be 92% and 8% had not attended ANC services during pregnancy which is lower than the national average of 97.3% attendance of the first ANC visit recorded by the ministry of health between 2012 and 2013. The study found out that about 8% of the women never visited ANC clinic for any service at all. Banda, commented that regular antenatal care is necessary to establish confidence between the woman and her health care provider, to individualize health promotion messages, and to identify and manage any maternal complications or risk factors (Banda, 2013).The implication of this finding is that most of the mothers who do not attend ANC services risk having difficulty in their pregnancy or experiencing complications associated with pregnancy including transmitting HIV infections to their children in case they are HIV positive.

Results showed that 13% of women had to first seek permission from their spouses to go for treatment which highly expressed a degree of in equality and lack of powers for decision making about their health general which highly affects the bargaining power of women when they need to decide with their partners to seek maternal health services. This study is similar to that conducted by (Yakong, 2008; Abou-Zahr et al., 2003; Monir et al., 2009; Tawiah, 2011). This takes the decision making process away from the woman who is directly facing potential pregnancy complications (Mekonnen, 2003; Coast, 2006) meaning that. The above may be attributed to societal and familial expectations which may influence women's choice of care, and may lead to delays in seeking essential professional care services (Kasolo et al., 2000).

The strong effect of higher educational attainments is consistent with higher usage of maternal health care services which is similar to what other studies have found that education significantly influences the usage of antenatal care services. The mother's occupation in this case would provide a measure of the income or socio-economic status of the women and access to resources. Like other studies among Ghanaian and Nigerian women by Tawiah, (2011), this study also found that women self-employed/employees in the agricultural occupations are more disadvantaged than those in professional/technical/managerial/clerical occupations. In summary, the provision of a full package of antenatal care is inadequate. Coupled with poor coverage of four antenatal care visits, the lack of a comprehensive social security system makes the poor more vulnerable in terms of affordability and choice of health care provider. This situation calls for concerted efforts comprehensive enough to improve the attendance and quality of antenatal care.

The study established that there was an association between marital status and ANC service utilization of which most of the women in kyabugimbi 51 in total are un married with which was an indication of un planned pregnancies among these women in this area. The findings were similar to other studies such as that done by Matua, as cited by (Chabiva, 2009) which indicated that pregnant unmarried women shun ANC services for fear of being "promiscuous" on the other hand older women who have had an eventful of pregnancies and deliveries might see no reason for attending ANC services.

The study also revealed that ANC service utilization in women increases with age but later on experiences a decline. As per results it indicates that those aged 15-19(4.5%),20-24years(14.9%),25-29years(26.9%),30-34years(22.4%),35-39years(19.4%),40-44years(9%), 45-49years(3%) with these results it shows that the utilization was low for those age15-24years this was because some of them it was their first pregnancy and were not aware of the importance's of ANC services and most of them were under a fear that since they were under aged and the pregnancies were un planned that they could be criticized by the community and for those of 25-29 years it was high since they make up the largest group of the community and are the most group to become pregnant for those above 35 years their attendance declined since most were multiparous thus thought that had a lot of ideas on how to manage their pregnancies and there was no need to attend ANC services thus most of them resorted to TBA's and since the rate of getting pregnant reduces with age their numbers were limited.

5.2 Factors for late ANC service utilization.

The study findings showed that many of the respondents are low income earners and have gotten financial constraints 32(34.7%), so mothers fail to raise money for transport, lunch while at ANC clinic visit and lack what to put on like maternity dresses. This study was similar to that conducted by Mlilo-Chaibva, (Chaibva, 2009) who showed that poverty as one of the social factors responsible for the non-utilization of health services, including ANC since both studies included adolescent mothers and the un employed mothers.

It was clear from the study that distance from the health unit contributed 32(61.5%) of those who traveled long distances >10 km to the health facility which resulted into seeking ANC late and since Kyabugimbi is a village the transport means are also a hindrance to ANC in some areas of the community. This was similar to study conducted by Magadi and others (Magadi et al., 2004) in Kenya demonstrated that an increase in distance to the nearest healthcare facilities was associated with fewer antenatal visits. Moreover, uncomfortable transport, poor road conditions and difficulties in crossing big rivers have also been shown to be barriers to utilization of ANC in studies conducted in Zimbabwe cited by Banda (Banda, 2013) and in Pakistan (Mumtaz & Salway, 2005) .These findings were similar since they were all conducted from a rural setting.

The study revealed that 15(16.3%) attended ANC late because limited knowledge about ANC and this was because some it was their first pregnancy and were not well oriented about the importance's of ANC this was similar to a study which suggested that knowledge on ANC is critical in determining pregnant women's use of antenatal services (Simkhada et al., 2008).
Further 6(6.5%) of the women had late attendance due to lack of exposure to social medias this was because most of these ladies have gotten a low income profile which makes it difficult to afford the different media utilities live a television thus leaving them un mobilized and un educated about the benefits and importance's of early attendance of which it is similar to other studies that have shown that exposure to mass media particularly television and radio significantly predicts utilization of ANC. (Pallikadavath et al., 2004) and (Shah & Say, 21 2007) in studies done in India and Nepal, respectively, found that pregnant women who were watching television every week were more likely to use ANC.

The study also revealed that age is a factor to late ANC attendance as women below 25 years registered a late attendance as compared to those aged 25-35 years but later also developed a decline. A similar research study in Nigeria shows that Age has a significant association with use of ANC. Women who were 25 years or more 245(79.0%)] were more likely to attend ANC clinic than women who were less than 25 years 62(68.9%) (M.D Dairo et al, 2010). This was because some of them it was their first pregnancy and were not aware of the importance's of ANC services and most of them were under a fear that since they were under aged and the pregnancies were un planned that they could be criticized by the community and for those of 25-29 years it was high since they make up the largest group of the community and are the most group to become pregnant for those above 35 years their attendance declined since most were multiparous thus thought that had a lot of ideas on how to manage their pregnancies and there was no need to attend ANC services thus most of them resorted to TBA's and since the rate of getting pregnant reduces with age their numbers were limited which contributed to their late attendance's.

Results also revealed that mothers attended ANC late because of unplanned pregnancies 34(59%), this was because most of the women were single and therefore felt ashamed to disclose their pregnancy in public of which it was similar to that conducted by Paredes, Hidalgo, Chedraui, Palma, & Eugenio, 2005which suggested that pregnant women with unplanned pregnancies were found to make less and late ANC visits.

Results also showed that some women still attend to TBA's 4.3% or use complementary local medicine during their pregnancies. Though there are no locally conducted researches about these issues within Kyabugimbi, but there is adequate evidence from other areas that most of the mothers who do not attend ANC services resort to local healers. For instance, a study conducted by Anan and Jolly 2014 and published over the Journal of obstetrics showed that up to 57.1% of pregnant women surveyed had used complementary and alternative methods during their last pregnancy which highly influenced there late attendances after developing a problem.

Results also indicated that women who were under 25years of age most of them were un married and had gotten un wanted pregnancies so there was a fear to disclose the information about their pregnancy and this was similar to the study done in Uganda by Kawungezi et al., 2015.

5.3. Factors for early attendance of ANC Services.

The results showed that most of the mothers who attend ANC early 22(24%) thought it was the right time to attend ANC and 1718.3%) of those who had developed problems in their past pregnancy. This was similar to the findings of Frank Odhiambo et al, 2006 where mothers gave reasons for attending ANC as to detect maternal problems and to be treated when sick. This showed that most of the mothers attending ANC understand the role of ANC in minimizing risks during pregnancy.

The study also showed that those women who were in 0-5km and close to the health facility 30(75%) of them had their ANC visits early as compred to those in adistance 0f >10km of which 2(5%) had late utilization which also showed that distance is important to early utilization in which those who were far away from the health facility their utilization was late and less in number as to those close to the health facility. This study was similar with a study by (Magadi, Zwane, Ransjö-Arvidson, Ahlberg, & Thembi, 2002), which identified that long distance to the antenatal care facility is an obstacle to the antenatal care.

The findings revealed that women who had a tertiary education 6(67%) and secondary education 22(56%) as compared to those that never attended school 1(33%) were more likely to attend ANC early since they were more informed of the importance of ANC services as compared to the uneducated. M.D Dairo et al; 2010 also had a similar finding where educational status showed a significant association with respondents having an educational level of secondary school and above 275(82.1%) attending ANC clinic more compared to women who had an education of primary school and below 32 (50.0).These studies are similar because all considered secondary, primary level and the un educated.

Findings also showed that 25(78%) of the married women are more likely to attend ANC services early this is because these tend to receive support from their husbands in terms of finance and attending ANC visits together which motivates them to attend ANC early these were similar to a study conducted by Karolinska et al; 2012 which suggested that Some other women said that their husband brought them to health facilities for ANC and if they felt unwell during the pregnancy the husband would call for the HCPs or brought the women to health facilities.

Results also showed that 22(78.6%),26(81.3%) of those who were gravida 1and 2, Para 1 and 2 attended ANC early as compared to 10(45.5%), 13(48.1%) of those who were gravida 4, Para 4 and above this is because most of the mothers who are prime gravidas are at a risik of

complications this similar to a study were women who were pregnant for the first time faced higher risks of obstetric complications than women who were older (Reynolds et al., 2006). Also a study was done in England and Wales by (Kupek, Petrou, Vause, & Maresh, 2002) Primiparous women of high obstetric risk were 13.4% more likely to initiate antenatal care after 10 weeks of gestation than a low risk reference group, and 34.3% more likely to initiate antenatal care after 18 weeks of gestation.

Conclusion

According to the study ANC attendance of women of reproductive age at Kyabugimbi Health Center Four was low at 92% of which 52% had utilized less than 4 visits and 40% had utilized more or equal to the four visits.

Mothers who attended ANC early gave reasons that they knew the timing and the results also showed positive association with increase in maternal educational level. Those who did not attend gave reasons for using TBA's and they delivered at home safely without complications.

The women in this study are aware of the need for ANC services, although the existing challenge remains that avialabity of health facilities does not necessarily transform into optimal utilization. This therefore, calls for improvement in the quality of care at the health facility with subsequent innovative approaches to increase demand and utilization. However, the challenges of making pregnancy safer and addressing inequalities are not just new technologies or new knowledge about effective interventions but rather how to deliver these services and scale-up the coverage and utilization particularly to those who are vulnerable, hard to reach, marginalized and excluded.

Based on the findings of this study, It is evident that although women faced complexed challenges at individual, family and the health care system levels, they managed their health to the best of their ability. But the free Antenatal Care Services introduced in Ghana and the current voucher system being initiated in Uganda will further boost utilization of maternal health care facilities. This further increases their access to resources. They will then be able to make decisions on matters that directly affect their health.

Further research on women's health should be done on beliefs system, attitudes, experiences, also families and provider's perception about care received and health care delivery at all levels.

Information Education and Communication (IEC) programs should as well target and involve men them in reproductive health matters.

Recommendations.

Common ANC practice Utilization.

The MOH and other stake holders should come up with specific efforts targeting women of reproductive age in order to increase their utilization of ANC services.

People staying with these women should encourage them to seek ANC services in amore medical than herbal way.

Mothers should be advise to utilize the different ANC practices as stipulated by the WHO and MOH so as to avoid the arise of related complications during pregnancy .

Customization of ANC services should be encouraged in order to increase the utilization of ANC services and this will also enable to remove the fears of disclosing pregnancy by the teenage and adolescent mothers thus eliminating late ANC service attendance.

Training of health workers on clinical skills, as well as client provider interaction was suggested as critical to ensure high quality professional ANC and delivery services. Supplies and equipment's must be available to health workers and supportive supervision instituted to monitor service delivery standards'. Health workers in turn need to be supported through training and supervision to provide essential, adequate services to ANC attendees.

Early ANC Attendance.

Education and counseling should be provided to the women on matters concerned with pregnancy, labor and delivery. In particular, the danger signs of pregnancy and labor and the need for skilled delivery assistance should be emphasized.

Broad based educational and advocacy programmes are needed to dispel negative myths about seeking ANC at health units as well as to encourage social support for girls and women living with HIV to always visit health facilities. Consistent and reliable information on where and when services are available also needs to be disseminated to assist women to access treatment quickly. Radio programmes and outreaches' through faith based institutions may represent effective communication channels to reach women in Kyabugimbi community so as to enable early ANC attendance.

Although 98% of the women were aware of ANC services at Kyabugimbi Health Center Four, Utilization was low and at least 40% had attended four and more ANC visits as

recommended by the MOH. Therefore other stake holders should come up with specific efforts targeting women aged 15-49 years to increase their utilization.

Late ANC Attendance.

There is need to design an intervention targeting high parity mothers in order to improve on the number of ANC visits as recommended by the WHO and also avoid their late attendances.

The study identified that it was significant to provide women with education and counseling on pregnancy, labor and delivery. In particular, the danger signs of pregnancy and labor and the need for skilled delivery assistance should be emphasized. This means that women in Kyabugimbi Community in general should be encouraged strongly to deliver from a health facility so that they can receive emergency care promptly when needed.

TBA's also need to be informed about how pregnancy complications occurs and how it can be prevented and treated, since there were many misconception about them by hospital and clinical workers. TBA's need to be informed about when and where to refer women in case of prolonged obstructed labor and emergencies so as to avoid late attendances.

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APPENDICES.

Appendix 1: Data collection tool.

RESEARCH TOPIC: THE UTILISATION OF ANTENATAL CARE SERVICES BY WOMEN OF REPRODUCTIVE AGE AT KYABUGIMBI HEALTH CENTER IVINBUSHENYI DISTRICT.

INTERVIEWER ADMNISTERED QUESTIONAIRE

Date…….

Interviewer……..

Introduction

Purpose of the questionnaire: This questionnaire is developed as a data collection tool to be filled in by selected respondents. The data obtained from which shall be used only for research purposes in partial fulfillment of the award of a Diploma in Clinical Medicine and Community Health at Kampala International University Teaching Hospital. The investigator requests your participation in the capacity of a resource person basing on your experience in the subject of study. This data will be treated with the utmost confidentiality it deserves and will not be released to anyone/organization except for an academic purpose.

Appendix 1: Consent Form

Introduction: I am LUYIGA RAYMOND .K a student of Kampala international university. I am conducting a study to determine the utilization of ANC care services by women of reproductive age around kyabugimbi community from Kyabugimbi Health Center IV

I would wish to request for your voluntary participation to take part in this study. All the information gathered from this study will be treated with utmost confidentiality, and the records obtained shall be used for research purpose only. During the course of this study, you will be free to withdraw at any point, if you do not feel comfortable.

Please sign in the space provided below if you agree to take part in this study.

Thank you.

Signature of the respondent/thumb print .....dates.....

Section A: Bio data

Socio-demographic characteristics of the respondents

1. Name of the respondent

……

2. Area of residence

……

3. Sex

Female ☐

4. 4. Age

15-19☐ 20-24☐ 25-29☐ 30-34☐ 35-39☐ 40-44☐ 45-49☐

5. Occupation

House wife ☐ farmer ☐Business ☐vil servant ☐

Others, specify……

6. Marital status

Married ☐ Single ☐ Divorced ☐ Widowed ☐

7. Religion

Christian ☐ Muslim ☐ Traditionalist ☐

8. Level of education

Primary level☐ Secondary ☐ Tertiary institution☐ none ☐

9. Level of income

Low ☐ Fairly High ☐ High ☐

10a) Number of pregnancies you have had

1-2 ☐ 3-4 ☐ More than 4 ☐

b). Number of children born to you

1-2 ☐ 3-4 ☐ None ☐

11. How old is your pregnancy?

1-2 months ☐ 3-4 months ☐ 5-6 month ☐ 7-8 months ☐ 9 months ☐

12. Have you been using ANC services?

Yes ☐ No ☐

If no, what other alternatives have you been using?

……

13. a) How far is it from your home to this Health Facility?

0-5 km ☐ 6-10km ☐ more than 10 km ☐

b).What mode of transport have you used to this health facility?

……

14. a) What are the opening days for ANC at this facility?

Daily ☐ Weekly ☐ Twice a week ☐ don‘t know ☐ Monthly ☐

b). are the opening days convenient for you?

Yes ☐ No ☐

Give reasons for your answer above

……

15. What factors make a woman to delay to come for ANC services?

……

16. a) Do you know why a pregnant woman should go for antenatal care early in pregnancy?

Yes No

Give reasons why you go for antenatal care

……

b). State the problems a pregnant woman may face when she starts ANC late in pregnancy

……

17. Mention the antenatal care services that are offered to pregnant women at this health facility

……

18. In your view, state the factors that influence women's access to antenatal care services in your area

……

19. State the challenges faced by pregnant women in relation to accessing antenatal care services at Kyabugimbi Health Center IV.

……

20. State the number of times you visit the health facility for ANC services.

……

Thanks for your time

Appendix IV: Map of Bushenyi showing Kyabugimbi sub- county

APPENDIX IV: MAP OF UGANDA