

**ASSESSMENT OF AWARENESS OF THE CAUSES OF MATERNAL MORTALITY
AMONG WOMEN IN REPRODUCTIVE AGE IN BUSHENYI - ISHAKA
MUNICIPALITY**

BY

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**A RESEARCH SUBMITTED TO THE FACULTY OF CLINICAL MEDICINE AND
DENTISTRY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
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DECLARATION

I, **Gor Goody Kiritkumar**; Reg. No. **BMS/0069/72/DF**, do hereby declare that this research report entitled “Assessment of Awareness of the Causes of Maternal Mortality Among Women in Reproductive Age in Bushenyi - Ishaka Municipality” is my original work and has not been presented for the award of a degree, diploma or any other qualifications in any other university I’m aware of .

RESEARCHER

Signed Date.....

SUPERVISOR

Supervisor’s name

Signature.....date.....

DEDICATION

I dedicate this book to my beloved parents Mr and Mrs Gor, my siblings Sharduli, Harshil and Heenak and my friend Marvin Nderitu Gathigo for his support and input.

ACKNOWLEDGEMENT

I would like to pass my heartfelt gratitude to the following people who assisted me in one way or the other in the preparation of this research project.

My supervisor, Mr Magoi for his mentorship, positive support and guidance in the research project. To our course coordinator Mr Emorut, thanks for your expertise and the knowledge you instigated in us; forever we shall remember you.

To the entire staff of faculty of medicine and dentistry and staff of Kampala International University Teaching Hospital, much gratitude for your teaching and nurturing to make sure we achieved our prime objective in KIU.

To all of the above mentioned individuals, I must stand to say were it not for your support; I would have not reached where I am now; a millennium doctor!.

ABSTRACT

The study was carried out in Bushenyi-Ishaka municipality. The purpose of this study was to identify factors which influence mother's choice of delivery site. The respondents were mothers between the ages of 15-49 years with sane minds. There were 100 mothers in the quantitative data. The research showed that among the women that had delivered before most of them 80% were aware of the common causes of maternal mortality and 30% of those that had never delivered knew the causes of maternal mortality.

Among the causes the commonest causes that were known by the respondents were; Post partum hemorrhage, Abortion, post partum infections, Ante partum hemorrhage, pre-eclampsia and eclampsia and ruptured uterus. Most of the women 70% reported that they learnt the causes of maternal death from the clinics where they were attending antenatal services, 20% learnt from their mothers and 10% from their close friends and relatives.

General objective: To assess the level of awareness of the causes of maternal mortality in Bushenyi Ishaka municipality.

Research methodology: The research method that I used was a cross sectional study

Results: The study was conducted in Bushenyi Ishaka municipality among women in the reproductive ages 15 to 49 years to assess the awareness of the causes of maternal mortality. It showed that most of the women in the research area were aware of the most common causes of maternal mortality.

Conclusion: Following the outcome of the study, it is recommended that health centers and dispensaries to equip with emergency obstetric care facilities extend the free delivery services up to the district level. Develop a policy to promote safe motherhood activities. Most women were aware of the causes of maternal mortality.

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LIST OF ABBREVIATIONS

MMR	Maternal Mortality Rate
WHO	World Health Organization
UNCC	Uganda National Council for Children
M.O.H	Ministry of Health
HC	Health Centre
ANCS	Antenatal Health Care Service
TBA's	Traditional Birth Attendant
SMH	Safe Mother Hood
DDHS	District Director Health Services

DEFINITION OF TERMS

Antenatal Care- Planned program of medical management of pregnant women directed towards making pregnancy and labor a safe and satisfying experience.

Maternal mortality – this is the death of a mother due to a pregnancy related complication, which can occur during the pregnancy, during labor or after the delivery of the child.

Maternal mortality rate - the number of maternal deaths that occur as the direct result of the reproductive process per 100,000 live births.

Post-natal Care- Health care given to a mother and a baby during the first 6 weeks following delivery.

Traditional Birth Attendant- Is a person who assists women in child birth and who initially acquired the skills of delivering babies by herself or by working with other TBA' she is found more commonly in the rural areas.

Labor- The process of expulsion of the fetus through the birth canal. Normal labor starts at term, i.e. at 37-42 weeks of gestation.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

According to the world health organization report (1992), the high maternal mortality rate in Uganda indicates that most of the pregnant women who do not return for delivery are helped by non-medical untrained people during delivery. This is the major contributing factor to high rate of maternal mortality of 430/100,000 live births. This may be brought about by complications like; prolonged labor, obstructed labor, ruptured uterus, postpartum hemorrhage, ante partum hemorrhage.

Only 65% of women in developing countries receive Antenatal care services. [safe motherhood WHO 1998]. Although the debate about safety and women's right to choose between home and hospital delivery continues in developing countries, undesirable outcome of home delivery has been documented in developing countries (Ackermann-Lierbrich et al, 1996; Sorensen et al, 2003; Wagle et al, 2004 and Walvaren et al, 1999). Pregnancy should be supervised through regular checking and labor should be supervised by skilled hands if not, it will result to death of the mother and the baby which is a major issue in developing countries.

Low utilization rates of maternal health services are caused by a range of factors; distance from health services, costs including the direct fees as well as the cost of transportation, drugs and supplies, multiple demands on women's time, women's lack of decision in the family, social influence from the spouse, other relatives, TBA's, health workers, self efficacy and previous experience. The poor quality of services including poor treatment by the health providers also makes women reluctant to use health services.

1.2 Statement of the problem

The maternal mortality rate in Uganda is approximately 435 per 100,000 and only 41% of births are attended to by skilled personnel in Uganda (UDHS 2010/2011). Some of the causes are post partum hemorrhage, prolonged labor, obstructed labor, ruptured uterus, recto-vaginal fistula, eclampsia, intrauterine asphyxia in Uganda Bushenyi- Ishaka municipality being inclusive.

This picture is not different from Bushenyi district of 122/1000 live births Bushenyi-Ishaka municipality being inclusive. This verifies that delivering of mothers under skilled hands is still very low in the area(MOFEP 1992).

This high maternal mortality can be prevented if the mothers have knowledge about the importance of seeking delivery services at the right places and at the right time.

1.3 Research questions

What are the demographic characteristics of mothers in Bushenyi Ishaka municipality?

What are the common causes of maternal mortality in Bushenyi Ishaka municipality?

What is the distance of the health facility from mother's place of residence to the place of delivery in Bushenyi Ishaka municipality?

What are the socio-economic factors that determine the choice of delivery place in Bushenyi Ishaka municipality?

1.4 Hypothesis:

Most women in Bushenyi – Ishaka Municipality are aware of the common causes of maternal mortality.

1.5 General Objective:

To assess the level of awareness of the causes of maternal mortality among women in reproductive age in Bushenyi Ishaka municipality.

Specific objectives:

To determine the specific causes of maternal mortality in Bushenyi Ishaka municipality.

To establish the main cause of maternal mortality in Bushenyi Ishaka municipality.

To assess the knowledge and attitude of mothers towards attending antenatal care services in Bushenyi Ishaka municipality.

1.6 Scope of the study

The study mainly focused on the mothers in the catchment area of Bushenyi Ishaka municipality.

1.7 Justification of the study.

Most of the causes of maternal mortality in Uganda are preventable and manageable. Maternal mortality is a major burden in the developing countries. It results to the death of women who are in their reproductive ages and most of the times also results to the death of unborn and born children.

This research will help to identify the level awareness of the causes of maternal mortality.

To the health workers of Bushenyi Ishaka municipality, it will be easy for them to initiate policies about delivering under skilled hands because they will have the knowledge on why there's low turn up of deliveries in the health centers.

This research will also help the mothers to understand the importance of delivering from health centers. This will enable them to make positive decisions on the choices for delivery places.

Better still, this research will help me understand the process of conducting research fully. It is also part of my fulfillment for the Degree of Bachelor of Medicine and Surgery (MBChB).

CHAPTER TWO

2.0 Literature review

The causes of maternal mortality include post partum hemorrhage, ante partum hemorrhage, abortions, prolonged labor, obstructed labor, ruptured uterus, pre eclampsia and eclampsia and post partum infections.

2.1 Postpartum hemorrhage (PPH)

Postpartum hemorrhage (PPH) is the leading cause of maternal mortality. All women who carry a pregnancy beyond 20 weeks' gestation are at risk for PPH and its sequelae. Although maternal mortality rates have declined greatly in the developed world, PPH remains a leading cause of maternal mortality elsewhere.

The direct pregnancy-related maternal mortality rate in the United States is approximately 7-10 women per 100,000 live births. National statistics suggest that approximately 8% of these deaths are caused by PPH (Berg, 1996). In industrialized countries, PPH usually ranks in the top 3 causes of maternal mortality, along with embolism and hypertension. In the developing world, several countries have maternal mortality rates in excess of 1000 women per 100,000 live births, and World Health Organization statistics suggest that 25% of maternal deaths are due to PPH, accounting for more than 100,000 maternal deaths per year (Abouzahr, 1998).

The frequency of PPH in the developing world is more likely reflected by the rates given above for expectant management because of the lack of widespread availability of drugs used in the active management of the third stage (Abouzahr, 1998). A number of factors also contribute to a much less favorable outcome of PPH. The first is a lack of experienced obstetricians who might be able to successfully manage PPH if it occurred. Additionally, the same drugs used for prophylaxis against PPH in active management are also the primary agents in the treatment of PPH. Lack of blood transfusion services, anesthetic services, and operating capabilities also

plays a role. Finally, the previously mentioned comorbidities are more commonly observed in developing countries and conspire to decrease a woman's tolerance of blood loss.

High-quality evidence suggests that active management of the third stage of labor reduces the incidence and severity of PPH (Prendiville, 2000). Active management is the combination of (1) uterotonic administration (preferably oxytocin) immediately upon delivery of the baby, (2) early cord clamping and cutting, and (3) gentle cord traction with uterine countertraction when the uterus is well contracted (ie, Brandt-Andrews maneuver).

2.2 Pronged labor

Friedman's original research in 1955 defined 3 stages of labor. The first stage starts with uterine contractions leading to complete cervical dilation and is divided into latent and active phases. In the latent phase, there are irregular uterine contractions but slow and gradual cervical effacement and dilation. The active phase is demonstrated by an increased rate of cervical dilation and fetal descent. The active phase usually starts at 3-4 cm cervical dilation. The second stage of labor ranges from complete dilation to the delivery of the infant. The third stage of labor involves complete delivery of the placenta and fetal membranes. Abnormal labor constitutes any findings that fall outside the accepted normal labor curve.

2.3 Abnormal latent phase of labour

The latent phase of labor is defined as the period of time starting with the onset of regular uterine contractions and ending with the onset of the active phase (3-4 cm cervical dilation). The prolonged latent phase is defined as exceeding 12 hours in patients who are nulliparas or 8 hours in patients who are multiparas with the Cervix not dilated beyond 4 cm after this period of regular contractions

The most common reason for prolonged latent phase is entering labor without substantial cervical effacement. Another cause for abnormal labor is power, defined as uterine contractility multiplied by the frequency of contractions. A prolonged latent phase may result secondary to over sedation or upon entering labor early with a thickened or uneffaced cervix. It may be misdiagnosed in the face of frequent prodromal contractions. A prolonged latent phase is not indicative of dystocia in itself because this diagnosis cannot be made in the latent phase

2.4 Prolonged active phase of Labour

The active phase of labour is defined as prolonged when it lasts for more than 18 hours. Once in the active phase of labour the dilatation of the cervix should follow the alert line and should be at least 1cm/h. Once the labour deviates from this alert line and reaches the action line then the diagnosis of poor progress is made and action is needed. Causes of abnormal labour can be divided into three main causes: Powers i.e. uterine contractions, Passenger i.e. the foetus and the Passage i.e. the pelvis.

When there is failure to progress, problems such as the passenger (size of baby) and passage (abnormal shape/size of pelvis) should be excluded. Unfavourable pelvic diameters or a large baby may result in cephalo-pelvic disproportion. However, the foetus is more commonly the cause of 'relative' disproportion due to malposition or a deflexed attitude. In these cases the progress may be improved by further flexion and rotation of the head to the occipito-anterior position. Inadequate uterine activity has been recognised as the most common cause for poor progress in labour. The frequency of uterine contraction may be adequate, but the intensity may be inadequate. Disruption of communication between adjacent segments of the uterus may also exist, resulting from surgical scarring, fibroids, or other conduction disruption. Whatever the cause, the contraction pattern fails to result in cervical effacement and dilation.

Prolonged labour is also likely to occur in a first pregnancy and in elderly patients, in situations where the uterine muscle is grossly distended and fails to contract properly as in twin pregnancy, hydramnios (excess liquor amnii), presence of tumours in the uterine musculature like fibroids and where there is Excessive use of painkillers or anaesthesia to decrease the pain of normal labour. Cervical dystocia or stenosis (when the cervix fails to dilate) is another cause of prolonged active labour. With prolonged labour there may be signs and symptoms of maternal and fetal distress or obstructed labour. Of all cephalic deliveries, 8-11% are complicated by an abnormal first stage of labour. Dystocia occurs in 12% of deliveries in women without a history of prior cesarean delivery. Dystocia may account for as many as 60% of cesarean deliveries.

2.5 Prolonged Expulsive Phase /Delayed Second Stage

The second stage of labour may be delayed due to: Uterine inertia secondary to prolonged first stage, Malpresentations/malposition of the fetus, Undiagnosed contracted pelvis, Obstruction in the vagina or improper use of anaesthesia.

2.6 Social demographic characteristics

According to the safe motherhood survey, getting pregnant at a very young age contributes to the prevalence of maternal mortality. These mothers are children who have not benefited from family planning services either because of lack of knowledge about risks of home delivery or 18.5 years. Safe Mother Hood established that 57% of mothers had become pregnant at least once by the age of 19 years. (SFM93, 1994)

The goal of safe motherhood and child survival is the reduction of both maternal and perinatal mortality significantly. However, maternal mortality remains the health indicator with the widest disparity between developed and developing countries with the exception of Afghanistan, all countries with MMR of 1000 per 100,000 live births in the year 2000 were in sub-Saharan Africa, evidence based measures are needed to curb the prevailing high maternal mortality in developing countries (*MDG 2001*).

Although the debate on the safety and woman's right of choice to a home delivery versus a hospital continues in type developed countries, an undesirable outcome of home delivery such as high maternal and Perinatal mortality is documented in developing countries, in Tanzania it has been shown that home delivery conducted by unskilled attendants had Perinatal mortality rates three times higher than that of dispensary births with trained attendant. In Papua New Guinea, low rates of obstetric complications was found amongst seemingly normal pregnancies delivering at home (*Garber P. et al 2008*).

Also according to Uganda national council children council (UNCC), the level of education tends to influence the decision of mothers who go for antenatal care. It was found out that 75% of educated mothers attend antenatal care compared to 60% of illiterates that is if the health facility is less than 2km, the figure falls to 65% and 53% respectively if the distance is more than 5km. (UNCC1994, Adkison 1989), children and women a situation analysis (UNICEF **Kampala**).

2.7 Accessibility to antenatal services

Accessibility to antenatal services has both geographical and social components. Physical barriers and long distances to health units have for a long time been a barrier to service

utilization. In Uganda, population living within 5km of health facility offering comprehensive care that is; general outpatient services, inpatient maternity, maternal and child care, immunization and health education is only 27% (UNCC 1994). Physical barriers also include poor road network, poor transport means and actual geographical barriers, social aspect of accessibility as well.

In Indonesia, it was found out that 80-90% of the birth took place at home due to poor transport between the highlands and also the costs involved. A study in Tanzania showed that in home births conducted without birth attendant, the perinatal mortality was 3times higher than that of the hospital or dispensary births with trained personnel. In Uganda (Lira district) 32% of the deliveries took place in health units due to the long distance from the health units and the cost of transport. A great majority of individuals walk to the health units since public transport in rural areas is limited.

A community survey done in rural Uganda on birth plans and health facility based delivery showed that birth plans are an important tool in improving the rate of health facility based deliveries and thus essential in the fight against maternal mortality (Mulongo *et al*, 2000).

Millions of women in developing countries lack access to adequate medical care during pregnancy. Only 65% of women in developing countries attend antenatal care, 63% in Africa, 65% in Asia, and 73% in Latin America and Caribbean. Elsewhere, Ajayi (1980) also observed that medical services are inadequate and the few that are available are widely spaced. This has a direct effect on the health status of women as those who cannot afford to reach to the health units, will resort to local medicines and delivery at home with all its dangers.

However, it is cited that inaccessibility to trained staff is one of the contributing factors which influence choice of delivery sites.

2.8 Attitudes of mothers towards health personnel.

Women in many cultures are reluctant to use health services because they perceive health care providers to be rude, patronizing and insensitive to the context in which they live. They believe that interactions with health providers can be threatening and humiliating and women often feel pressured to make choices that conflicts with their own health and facility goals.

Health units often are not acceptable to mothers for various socio-cultural reasons. The level of health unit may be too low to satisfy the health needs of the mothers. The type and behavior of health workers who are prescribing, and patient's care practices, have in some areas found to be a hindrance. Perception of past experiences in health units like previous caesarean section, painful procedures and still births have also been found not acceptable to some societies. To others it may be the language, ethnicity and gender differences with health workers. UNCC 1994, found that insufficiency of staff and poor rapport between mothers was also one of the barriers to institutional delivery.

Some women have gone to the extent of saying they cherish delivery at home because of the great comfort given by the family and the friends. This is supported by the (population report 1998) that many women opt for home delivery because the environment is familiar unlike the feared hospital surroundings. Women fear to be attended to by midwives they do not know.

It is also believed that women tend to have more equal relationship and social acceptable dialogue with traditional birth attendants[TBA's]compared to biomedical trained midwives hence most mothers continue to deliver at home with the help of un trained attendants whom they trust.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

This will be a descriptive cross-sectional study. This will be the most appropriate study design because it will be less costly than cohort study. It will be a home appropriate study design that allows room for a short duration to do research. Using data collected directly from the correspondents by the use of questionnaires. It also allows for analysis of multiple variables.

3.2 Study area: Ishaka municipality-Bushenyi District

Ishaka is found in southwestern Uganda. It's one of the municipalities in Bushenyi district, its located in Igara county, approximately 76km by road west of Mbarara the largest city in the sub region. This location is approximately 12km by road west of Bushenyi the location of the district headquarters. It's the largest metropolitan in the district. The exact population of Ishaka is not known as of February 2010

3.2 Economic activities

It's fairly endowed with natural resources. The town has relatively low poverty levels among its residents. The economy of the town depends mainly on Agriculture. It's a source of food for the population, subsistence income for most of the families and provides direct employment for 86.7% of the town population.

Majority of people are involved in subsistence agriculture with some engaged in commercial productions of crops including; coffee, tea, sweet bananas and matoke. Ranching for beef and dairy farming for milk production are widely practiced on both subsistence and commercial sales.

The language mainly spoken in the area is runyankole

3.3 study population

The participants will be mothers who have at least one child because they have an experience where they gave birth from and thus have a reason as to why they chose that site.

3.4 Sample Size.

Sampling size will be calculated using Kish and Leslie formula

$$N = \frac{Z^2 PQ}{d^2}$$

N=desired sample size

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

P=proportion of mothers delivering under unskilled hands in Ishaka municipality which is 59% but in the calculation will use approximately 60% that is 0.6.

Q=1.0-p, where p is 0.59

Therefore Q will be 1.0-0.6=0.4

D=Required precision of 10% which is 0.1

Therefore=92

Desired sample size 92.

3.5 The sampling method

In the study, simple random sampling method will be used in the municipality whereby two wards will be chosen and also use purposive sampling in choosing of the mothers for the study.

3.6 Inclusion and Exclusion Criteria.

3.6.1 Inclusion criteria

Respondents will be women in the reproductive age that is from 15 to 49 years.

3.6.2 Exclusion criteria

Women:- (a) with mental disabilities because they will not give accurate information

b) below 15 years of age because they are too young and women above 50 years.

3.7 Data collection

Data concerning awareness of causes of maternal mortality will be collected with the use of questionnaires which will be filled by women in the reproductive age in Bushenyi Ishaka Municipality. It will be a self administered questionnaire with open and closed ended questions. Any clarity will be sought from the researcher by the respondent.

3.8 Data analysis

The data will be checked for completeness and analyzed using Microsoft excel and word. The results will be presented using tables, figures, pie charts and graphs.

3.9 Ethical consideration

To ensure acceptability into the community and to carry out the proposed research, a letter was obtained from the faculty of clinical medicine and dentistry - Kampala International University addressed to the administrative authority of the area of study who will introduce the researcher to the respondents in the community.

3.10 Consent

Verbal consent will be obtained from the study participants after explaining to them the details of the purpose of study and how the researcher will use the information obtained.

3.11 Data quality control

To eliminate errors due to wrong interpretations, the following shall be done,

- a) Editing of the questionnaires shall be done while still in the field so that any missing information is dealt with before the researcher leaves the field.
- b) Randomization shall be used in the field when choosing study participants
- c) Research assistant will be trained in data collection, use of questionnaires.

3.11.1 Pre-test

The pre-test questions was given to a few mothers to assess the acceptability of data collection tool [questionnaires] to the participants, all necessary adjustments will be made to ensure adequate data quality.

3.12 Dissemination of results

Copies of the research will be distributed to the school of nursing, the school library and one copy will be retained by the student.

3.13 Study limitations

The following are expected limitations;

- a) Language barrier
- b) Financial constrains
- c) Lack of cooperation on some respondents
- d) Time limitations.

CHAPTER FOUR

4.0 RESULTS

The study was conducted in Bushenyi Ishaka municipality among women in the reproductive ages 15 to 49 years to assess the awareness of the causes of maternal mortality.

4.1 Social demographic characteristics

Table 1: The age and tribe of mothers (separate the tables)

Age group			Tribe		
Characteristics	Frequency	Percentage	Characteristics	Frequency	Percentage
15-24	21	21	Banyankole	90	90
25-34	49	49	Baganda	6	6
35-44	22	22	Bakyiga	2	2
45-49	8	8	Bahima	2	2
Total	100	100	Total	100	100

Majority 49% of the mothers were between the age of 25-34 years and about 90 (90%) of mothers were Banyankole.

Table 2: Shows the religious status and marital status of mothers

Religious status			Marital status		
Characteristics	Frequency	Percentage	Characteristics	Frequency	Percentage
Catholics	40	40	Married	70	70
Protestants	25	25	Single	15	15
Muslims	30	30	Separated	8	8
Others	5	5	Widow	7	7
Total	100	100	Total	100	100

Table 2 shows that the majority of mothers 30 (30%) were Muslims and 70 (70%) were married.

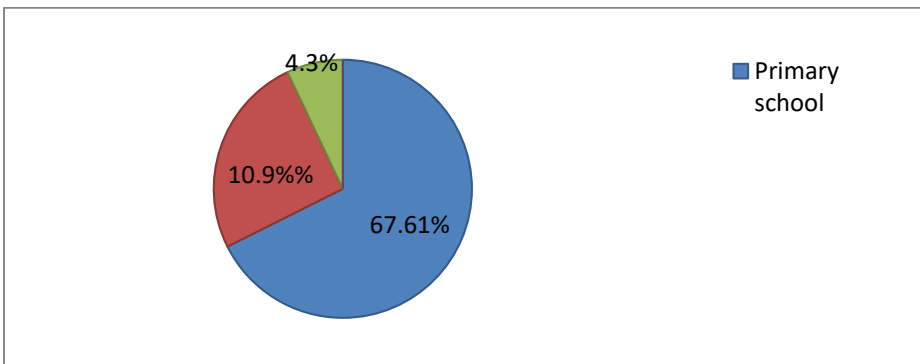
Table 3: level of education

Level of education	Frequency	Percentage
Never went to school	70	70
Primary	20	20
Secondary	6	6
Tertiary	4	4
Total	100	100

The table shows that majority of the women 70% did not attend school.

FIGURES SHOWING EDUCATION LEVELS IN RELATION TO PLACES OF DELIVERY

Figure 2: Home deliveries



Mothers who had attained primary level of education only (67.61%) were found to have had home deliveries more compared to the rest who had attained secondary level of education and higher.

Figure 3: Hospital deliveries

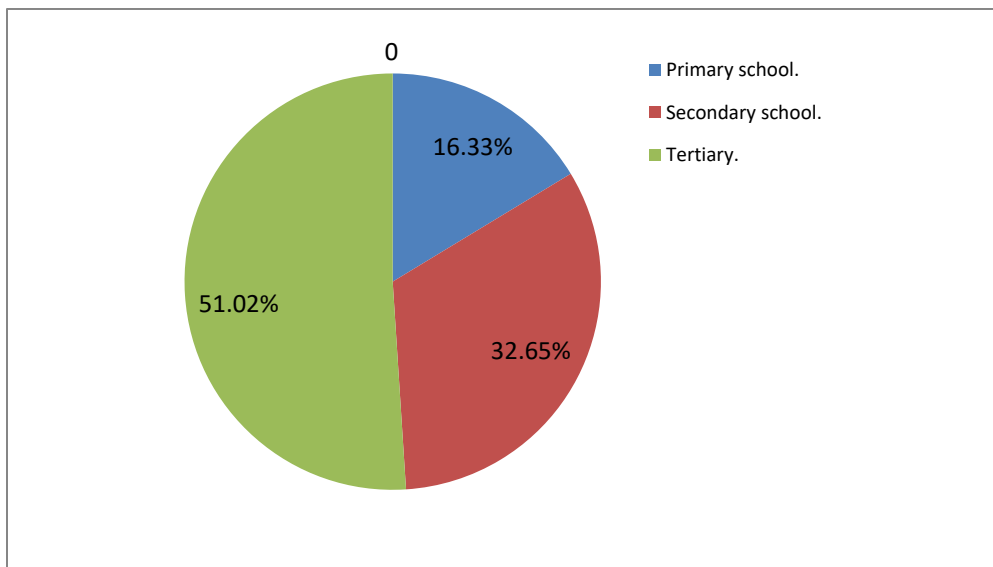


Table 4: Shows the occupation of the mothers

Occupation	Frequency	Percentage
Employed	8	8
Business	10	10
Peasant	44	44
Cultivator	38	38
Total	100	100

Table 4 shows that about half of the mothers 44 (44%) earned their income from peasant farming.

Table 5: Common Causes of Maternal Mortality

Cause	Frequency	Percentage
Postpartum hemorrhage	40	40
abortions	21	21
Postpartum infections	16	16
Antepartum hemorrhage	10	10
Others	5	5
Total	100	100

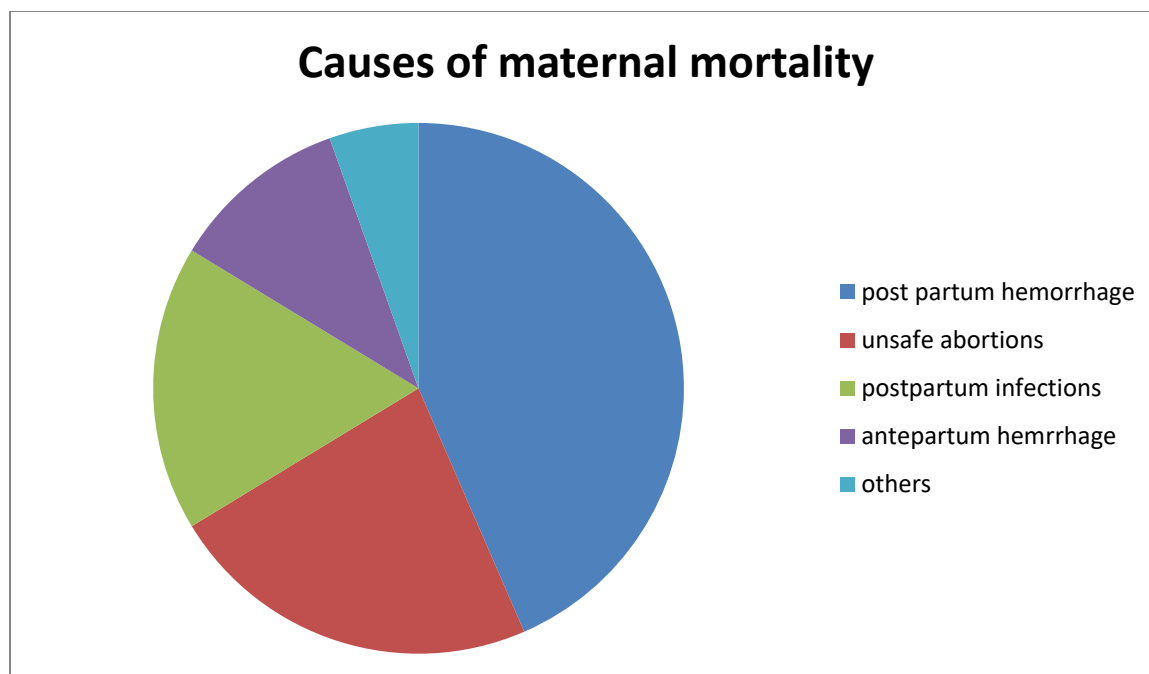


Table 5: The distance travelled from home to health units.

Distance	Frequency	Percentage%
0-1 km	10	10
2-3 km	41	41
4-5 km	49	49
Total	100	100

About 49(49%) of the mothers move a distance of 4-5 km from their home to the health unit and 41(41%) move a distance of 2 - 3 km.

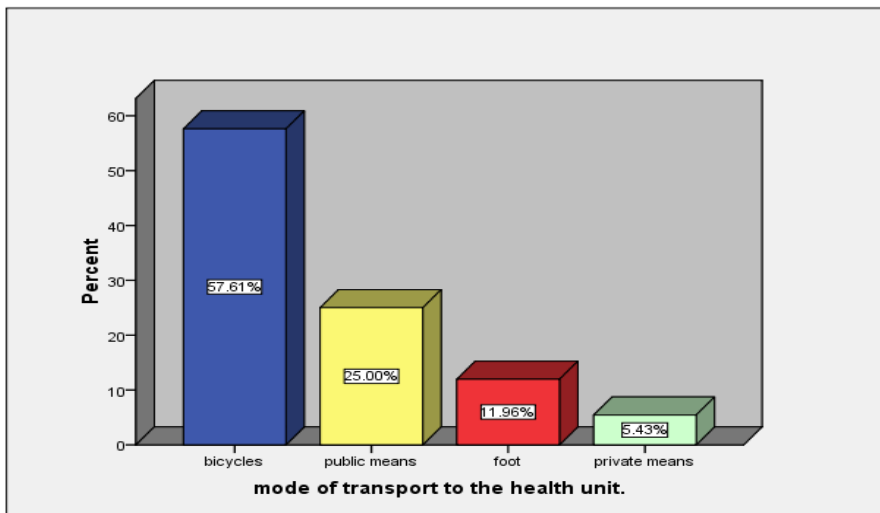
Table 6: Showing the Site of Last Delivery.

Place	Frequency	Percentage%
At home	25	25
At traditional birth attendants home	38	38
Health unit	27	27
Others(relatives)	10	10
Total	100	100

About 27(27%) of the mothers have their deliveries on the health units. The rest do not.

Figure 4: The mode of transport used by the mothers from home to the health unit

FIGURE 2 SHOWS MODE OF TRANSPORT TO THE HEALTH UNIT



The most available means of transport used by mothers is bicycles 57 (57%) from their homes to places of delivery, 23 (23%) used public means, 15 (15%) came on foot and 5 (5%) used private means from their homes to places of delivery.

Table 7: Factors Preventing Mothers from Delivering from Health Units

Factor	Frequency	Percentage%
Distance	18	18
Lack of money	18	18
Lack of transport	13	13
Lack of knowledge	14	14
All the above	37	37
Total	100	100

CHAPTER FIVE

5.0 Discussion of Results

5.1 Demographic characteristics of mothers

All the mothers were between the age group of 15-49 years. The majority of them were between the age group of 25-34 years, which is the most reproductive age for women in Uganda.

The majority percentage of the mothers of the mothers were banyankole by tribe and of course this is true for ankole region in western Uganda, a big proportion Pof the mothers were Muslims followed by Catholics by religion.

Many of the mothers had attained primary education 70(76.1%) and only 8(8.7%) of them reached secondary level of education. This can assist very much in developing the basic health messages for the target groups.

majority 40(43.5%) of the respondents were peasant farmers.

5.2 Attitude of mothers towards heath personnel

There is generally a positive attitude of mothers towards health personnel. About 56(60.9%) admitted that health personnel were helpful as compared to 36(39.1%) who said they were inefficient due to their low number and also provided poor treatment which made them reluctant to use health services. However they also complained that there were no enough drugs and medical equipment in the health centre.

5.3 The main socio economic factors that determine the choice of delivery site

The majority of the mothers attended antenatal services and their services were being offered from the health centre 3 and health centre 2 although the biggest percentage never got antenatal services as a routine. The findings are not in agreement with safe motherhood (1988).

A good number of mothers had their husbands influencing the choice of delivery site and this was mainly related to the distance moved from home to the health facility, means of transport to be used, income of the family and cultural reasons. These findings confirm what was identified in Zana Nigeria. And also safe motherhood (1998)explains that low utilization rates of maternal services are caused by arrange of factors; distance from health services, costs, drugs and

supplies, multiple demands on women's time, women's lack of decision making power within the family.

The study also showed that the majority of the women 46(50%) moved a distance of more than 6km from home to the nearest health centre.

This has an implication in that the distance of more than 6km for a mother to deliver is necessarily too long which may result into other complications that may lead to death. The study confirms the findings by Ebanyat (1993)

The findings of the study also showed that most pregnant women use bicycles as a means of transport from home to the health unit. This is the most common and cheapest means of transport in rural areas in given sub country since public transport is limited.

Socioeconomic standing, distant from the district hospital according to this study was found out that it had a great determinant on place of delivery, this tallies with the results of study on socioeconomic and physical distance to the maternity hospital as predictor of place of delivery suggested that mothers who were of low socioeconomic status delivered at home more frequently in developing countries like Nepali (Good Burn et al - Bangladesh).

The findings of the study confirms that the key factors preventing mothers from delivering at health facilities in a given sub county were a combination of distance, lack of money, lack of transport and lack of knowledge of risk of home delivery.

CHAPTER SIX

6.0 Conclusions and Recommendations

6.1 Conclusions

The results of this study show that efforts to improve national percentages of births with skilled attendants needs to focus on the rural areas. However a skilled attendant at birth without a functioning health delivery and referral system will not have much impact on maternal mortality. The distance from the health facility, educational level clients, choice of companion during delivery, transport costs to the health facility, availability of free service and hospitality of medical staff all have a significant association with the choice or place of delivery.

A multidisciplinary approach involving all healthcare providers with a focus on community based participatory approach (Bottom – Up approach) is needed to reverse the worsening trends in maternal mortality. Health care providers need to develop a policy document on birth plans and to harmonize paternal and maternal roles in safe motherhood activities. The role of men in safe motherhood activities need to be in focus as we continue to strengthen the primary care systems.

Decentralizing maternity services and fast tracking community based midwifery program could help reduce the impact distance seems to have in reducing skilled attendant at birth.

6.2 Recommendations

Equip all health centers and dispensaries with emergency obstetric care facilities and adequately staff them so that they can operate in 24 hours basis.

Fast track the community midwifery program to fill the gap left by traditional birth attendants. This will involve recruiting unemployed trained midwives and retiring midwives from the MOH in this program.

Strengthen the referral system so that women who deliver at home can easily and quickly be transported to the health facility in the event of obstetric complication.

Strengthen the vital registration systems as well as health facility records to allow monitoring and evidence based decision making. Community based demographic surveillance system (DSS).

Develop a policy on the role of men in safe motherhood activities, and harmonize the existing maternity and paternity leaves.

Extend the free delivery services up to district hospital level to cater for emergency obstetric referral such as emergency caesarian section.

Promote other safe motherhood activities such as family planning, post abortion care services, PMTCT of HIV, gender equality and FANC.

The local chairman and sub county chiefs should be encouraged by local government to routinely mobilize people to repair local roads while awaiting assistance from donors, NGOs or the government itself.

The midwives need regular training and promotions by the government for the purpose of motivation and their number should be increased as well as their wages.

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CONSENT

I am Gor Goody Kiritkumar a medical student at Kampala International University. I am doing a research study to assess the awareness of the causes of maternal mortality in Ishaka municipality-Bushenyi district. Be informed that your participation is voluntary and you are free to withdraw anytime you wish. The study will require you to give your answers as faithfully as possible to the questions below. Any information you give will be used for the potential benefit of the community and will be kept in strict confidentiality .Thank You.

Name of the respondent.....Date.....Signature.....

Researcher.....Date.....Signature.....

Appendix 1

QUESTIONNAIRE

Section A: Social Demographic Data.

Tick or circle the right answer.

1. Age (years): 15-24 ☐ 25-34 ☐ 35-44 ☐ 45-49 ☐

2. Tribe.....

3. Religion.....

4. Marital status:

a) Married.....

b) Single.....

c) Separated.....

d) Widow.....

5. Education level:

a) Never went to school

☐

b) Primary

☐

c) Secondary

☐☐

e) Tertiary

6. How do you earn your living?

a) Employed

☐

b) Business

☐

c) Peasant

☐

d) Cultivator-Subsistence farmer

☐

7. Have you ever heard of the following conditions?

a) Abortion (miscarriage)

☐

b) Post partum hemorrhage (bleeding after delivery)

☐

c) Antepartum hemorrhage (bleeding during pregnancy)

☐

d) Prolonged labor

☐

e) Pregnancy induced hypertension

☐

f) Any other conditions associated with pregnancy

.....

.....

.....

If yes? Where did you hear it from?

while attending antenatal services

☐

mother

☐

Close friend or relative

☐

8. How many children do you have?

9. If you have children, did you experience any of the condition mentioned above?

☐

10. If you have ever been pregnant, did you attend antenatal care services?

☐

11. How far is the nearest health unit from home?

a) 0-1 km

☐

b) 1-5 km

☐

c) 6-10 km

☐

d) Others (specify).....

12) How long does it take you to reach this unit?

a) Less than an hour

b) 1-2 hours

c) More than 2 hours

d) Others (specify).....