

A QUALITATIVE RESEARCH STUDY INVESTIGATING COMMUNITY KNOWLEDGE AND PERCEPTION
OF THE SAFE MOTHERHOOD ISSUES IN TORORO DISTRICT EASTERN UGANDA

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DECLARATION.

I Syongola Willis (REGISTRATION NUMBER: BMS /0025 /71 /DU) do here by declare with the highest degree of certainty and to the best of my knowledge that this work is my original work and that it has never been submitted for any academic award.

SYONGOLA WILLIS

.....

Student.

APPROVAL BY THE SUPERVISOR

This is to approve that this research study carried out by Syongola Willis was done under my supervision and is ready for submission

MR. TANAYEN JULIUS KIHZEE

Date

.....

.....

Supervisor.

DEDICATION

This research dissertation is dedicated to all the “mothers” most especially my wife- mrs Syongola Aidah who got me a heir by giving birth to Ethan Syongola (four months old).

ACKNOWLEDGEMENT

Great thanks to the respondents who participated in the study, and the research assistants who helped in collection of the data. I would also like to thank the local council (LC 1) chairmen for their cooperation .

LIST OF ABBREVIATION

ANC - ANTENAL CARE

WHO - WORLD HEALTH ORGANISATION

CHAPTER ONE

1.1 INTRODUCTION

The Safe Motherhood Initiative is a worldwide effort that aims to reduce the number of deaths and illnesses associated with pregnancy and childbirth. Maternal mortality is a major cause of death and disability among women of reproductive age. 500,000 women die every year from complications related to childbearing. (WHO 2010) Many more women are injured, some severely, from childbirth complications. Maternal mortality and morbidity adversely affect the health and welfare of children, families, and communities.

Improving maternal mortality has received recognition as a global priority as evidenced by its inclusion in the Millennium Development Goals (United Nations 2004). Among problems experienced by women related to child-bearing, maternal mortality is the “tip of the iceberg.” Maternal morbidity, defined as illness and/or disability caused by pregnancy-related complications, is more prevalent and widespread than maternal mortality. The World Health Organization (WHO) estimates that 52 million women suffer from morbidity related to the five direct obstetric causes of maternal death, with millions more suffering from morbidity related to non-fatal outcomes of obstetric complications as well as indirect causes of death (AbouZahr C 2003).

A woman dies from complications in childbirth every minute – about 529,000 each year -- the vast majority of them in developing countries. A woman in sub-Saharan Africa has a 1 in 16

chance of dying in pregnancy or childbirth, compared to a 1 in 4,000 risk in a developing country – the largest difference between poor and rich countries of any health indicator.

This glaring disparity is reflected in a number of global declarations and resolutions. According to estimates from UNICEF, Uganda's maternal mortality ratio, the annual number of deaths of women from pregnancy-related causes per 100,000 live births, stands at 435 (UNICEF 2010) after allowing for adjustments. Women die as a result of complications during and following pregnancy and childbirth and the major complications include severe bleeding, infections, unsafe abortion and obstructed labour.

Uganda is slow in its progress in the fifth goal of improving maternal health in its Millennium Development Goals. With the 2015 target for maternal mortality ratio at 131 per 100,000 births and proportion of births attended by skilled health personnel set at 100%, Uganda has a long battle in reaching its intended goals.

Problem Statement

Death and illness related to pregnancy and childbirth are significant health problems in developing countries. The World Health Organization (WHO) estimates that 529,000 women die from complications related to pregnancy and childbirth each year, with 99% of these deaths occurring in developing countries (World Health Organization, UNICEF et al. 2004). Maternal mortality ratios can be up to 200 times higher in developing countries when compared to developed countries, resulting in the largest health disparity between the developed and the developing world yet reported (Koblinsky 1995). In sub-Saharan Africa, the cumulative risk of maternal death over a lifetime due to complications related to pregnancy, abortion and

childbirth is one in every 16 women, compared with one in every 3,800 women in developed world.

Safe mother hood is the key to improving the poor maternal and child health statistics. It is therefore important to know and understand community perceptions and knowledge about safe motherhood. To the best of my knowledge no studies in Tororo district have addressed community's knowledge and perception on safe motherhood.

1.3 Objectives

1.3.1 General objective

To investigate community knowledge and perception of the safe motherhood issues in Tororo district eastern Uganda.

1.3.2 Specific objectives

1. To determine the levels of knowledge and perceptions of safe motherhood amongst women and men in Tororo district.
2. To determine the factors that affect care seeking for perceived maternal complications amongst communities in Tororo district.
3. To determine the relationship between socio-demographic characteristics and knowledge about safe motherhood in Tororo district

1.4 Research Questions

- i. What are the levels of knowledge and perceptions of safe motherhood amongst women and men in Tororo district.
- ii. What are the factors that affect care seeking for perceived maternal complications amongst communities in Tororo district.
- iii. What is the relationship between population characteristics and knowledge about safe motherhood in Tororo district

1.6 Significance of the Research

The findings from this study have policy and programmatic implications. Resources for maternal health are scarce in developing countries, especially with the competing demands for resources to combat HIV/AIDS, malaria, and tuberculosis. Thus, information to inform policy makers on improvement of resource allocation and service delivery in a bid to promote safe motherhood hence movement towards the attainment of millennium development goal number five.

CHAPTER TWO

LITERATURE REVIEW

Each year, more than half a million women die during pregnancy and childbirth—making pregnancy-related complications among the greatest killers of women of reproductive age in developing countries (WHO 2005). Of all the health data monitored by the World Health Organization, maternal mortality demonstrates the greatest disparity between poor and rich countries: the lifetime risk of a woman dying during pregnancy or childbirth is much higher in the poorest countries than in the richest (one in 12 for women in east Africa compared with one in 4,000 in northern Europe). Within countries, poor, uneducated, and rural women suffer disproportionately compared to their educated, wealthy, and urban counterparts: in Kenya, for example, just over 23% of women in the lowest wealth quintile have access to skilled assistance during childbirth, while almost 78% of women in the highest wealth quintile are attended by a doctor or a nurse/ midwife (Gwatkin 2004). Urban–rural differences also affect whether a woman receives adequate care during pregnancy and childbirth: in Peru, over 80% of urban women have a skilled provider attend their delivery, whereas less than 20% of rural women receive such care (Langer 2004). In addition to the risk of dying during pregnancy and childbirth, women can suffer from short- and long-term maternal disabilities and illnesses. According to the 2005 *World Health Report*, 20 million women each year will experience maternal disability, which can range from fever and depression to severe complications such as obstetric fistula and uterine prolapse. The exact magnitude and scope of

maternal morbidity is unclear, due to underreporting, poor recordkeeping systems, and definitional/ classification problems. Investing in maternal health saves individual women's lives and safeguards their wellbeing. It also affects the health and well-being of entire societies. Research indicates that the health of newborns is closely linked with the health of their mothers. About 30–40% of neonatal and infant deaths result from poor maternal health and inadequate care during pregnancy, delivery, and the critical immediate postpartum period. Data also suggest that a mother's death affects the overall well-being of her surviving children: in Bangladesh, the surviving children of a deceased mother are three to ten times more likely to die within two years (Strong 1992). In Tanzania, children living in homes in which an adult woman died during the previous 12 months spent half as much time in school as other children. The impact on children's health and survival was not significant when an adult male died (Ainsworth and Over 1994). In addition to the impact on infants and children, a woman's death affects her family's well-being and society as a whole. After a woman dies, her family is less able to care for itself, and forfeits any paid/unpaid wages she contributed to the household. Her death increases the chances of her family facing poverty and malnutrition. Data suggest that the death of an adult woman has a significant effect on household consumption in the poorest households for at least a year following her death (Greene and Merrick 2005). Investing in maternal health provides long-term benefits for the entire health delivery system. Elements that are essential for effective maternal health care, such as adequate human resources, effective communications and referral mechanisms, and an efficient supply of equipment, drugs, and consumable goods such as gloves and syringes, also have a positive impact on a range of non-obstetric services, including the handling of accidents, trauma, and

other emergencies. In addition, pregnancy and childbirth are often the first point of contact for a woman in the health system; antenatal care can provide an opportunity to address other reproductive health concerns, such as family planning and STIs, as well as other illnesses or conditions including tuberculosis, malaria, and HIV/AIDS.

According to the 1993 World Bank *World Development Report*, safe motherhood is among the most cost-effective strategies for low-income countries. In 2005, researchers assessed the costs and benefits of interventions for maternal and newborn health, and determined that strategies at the community and primary care levels (community-based newborn care, antenatal care, and skilled care during childbirth) to lower maternal and newborn deaths are highly cost-effective (Adam et al 2005). Safe motherhood is fundamentally a matter of human rights; all women are entitled to good health and high-quality health services. Maternal deaths are linked to women's low status in society, and their lack of decision making ability and economic power. In order for women to be able to enjoy safe pregnancy outcomes, they need to be accorded the same opportunities to health, education, and employment as their male counterparts.

The death of a woman during her reproductive years has negative consequences for her children and family. In Bangladesh, if a mother dies, her children less than 10 years of age have a mortality rate three to five times higher than children whose mother is alive or whose father has died. In Tanzania, if a mother dies, there are detrimental educational effects on the children, especially for secondary education (World Bank 1999).

The World Health Organization defines a maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management,

but not from accidental causes” (World Health Organization 1992). The five principal direct causes of maternal mortality are severe bleeding/hemorrhage (accounting for approximately 25 percent of maternal deaths), infection/sepsis, unsafe abortion, eclampsia/hypertension, and obstructed labor. Other direct causes (ectopic pregnancy, embolism and others) account for eight percent of maternal deaths, while indirect causes such as anemia, malaria, tuberculosis and heart disease account for 20 percent of maternal deaths (World Health Organization 1998).

The vast majority of maternal mortality is avoidable. The major causes of death are known, and 80 percent of these deaths could be prevented with appropriate management and treatment (World Health Organization 2005). Obstetric complications that lead to maternal morbidity and mortality cannot be predicted; therefore, receiving care from a skilled provider (doctor, nurse, or midwife) has been identified as the single most important intervention in safe motherhood programs (Starrs A 1997). In developing countries, use of skilled care remains low, with less than half of women giving birth with a skilled provider at last delivery (48%) (Demographic and Health Surveys 2004).

Thaddeus and Maine (1994) outlined three factors that contribute to maternal morbidity and mortality: 1) the delay in deciding to seek care if a complication occurs, 2) the delay in reaching care, and 3) the delay in receiving care from a medical facility. These delays are influenced by social and cultural factors, accessibility of services, and quality of obstetric care. The Three Delays framework has been widely used to structure safe motherhood programs (Thaddeus S and Maine D 1994).

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY AREA

Tororo District is a district in Eastern Uganda. Like most other Ugandan districts, it is named after its "chief town", Tororo. Tororo District is bordered by Mbale District to the north, Manafwa District to the northeast, the Republic of Kenya to the east, Busia District to the south, Bugiri District to the southwest and Butaleja District to the northwest.

The 2002 national census estimated the population of Tororo District at 398,600 with an annual population growth rate of approximately 2.7%. It is estimated that the population of the district in 2010 is approximately 493,300.

3.2 STUDY POPULATION

The study involved male and female consenting adults of Tororo district.

3.3 STUDY DESIGN

A descriptive prospective cross-sectional study design was employed in conducting this research study.

3.4 SAMPLE SIZE

The sample size was obtained from Krejcie, Robert V., Morgan, Daryle W table of, determining sample size for research activities to be 210 respondents.

3.5 DATA COLLECTION

Stratified random sampling was used when selecting participants for the study. Two strata of males and females were used. Almost equal numbers of participants were recruited into the study from each of the strata. Trained research assistants were recruited to help in the process of data collection.

3.5.1 Data collection tools

Structured interviews which were administered by the researcher and research assistants were used to collect data about knowledge and perceptions of safe mother hood among the recruited respondents.

3.6 DATA ANALYSIS

Data collected during the study was analysed with the help of a stastician using SPSS version 17. The results have been presented in form of pie charts, graphs and tables

3.7 INCLUSION CRITERIA

To be included in the study, a participant had to fulfill the following.

- i. give informed consent to participate in the study
- ii. Had to be at least 18 years of age
- iii. Had to be a resident of Tororo district

3.8 EXCLUSION CRITERIA

Those who are not in the right state of mind eg the mentally ill, drunk were not recruited into the study.

3.9 ETHICAL CONSIDERATIONS

Clearance was obtained from Kampala International University Research and Ethics Committee.

Informed consent was sought and obtained from the participants. Privacy, confidentiality and anonymity were strictly observed.

CHAPTER FOUR

RESULTS

TABLE 1: DISTRIBUTION OF GENDER BY AGE

GENDER	AGE GROUP				Total
	18-25	26-35	36-45	ABOVE 45	
FEMALE	23 21.1%	43 39.4%	28 25.7%	15 13.8%	109 100.0%
MALE	27 26.2%	43 41.7%	28 27.2%	5 4.9%	103 100.0%
Total	50 23.6%	86 40.6%	56 26.4%	20 9.4%	212 100.0%

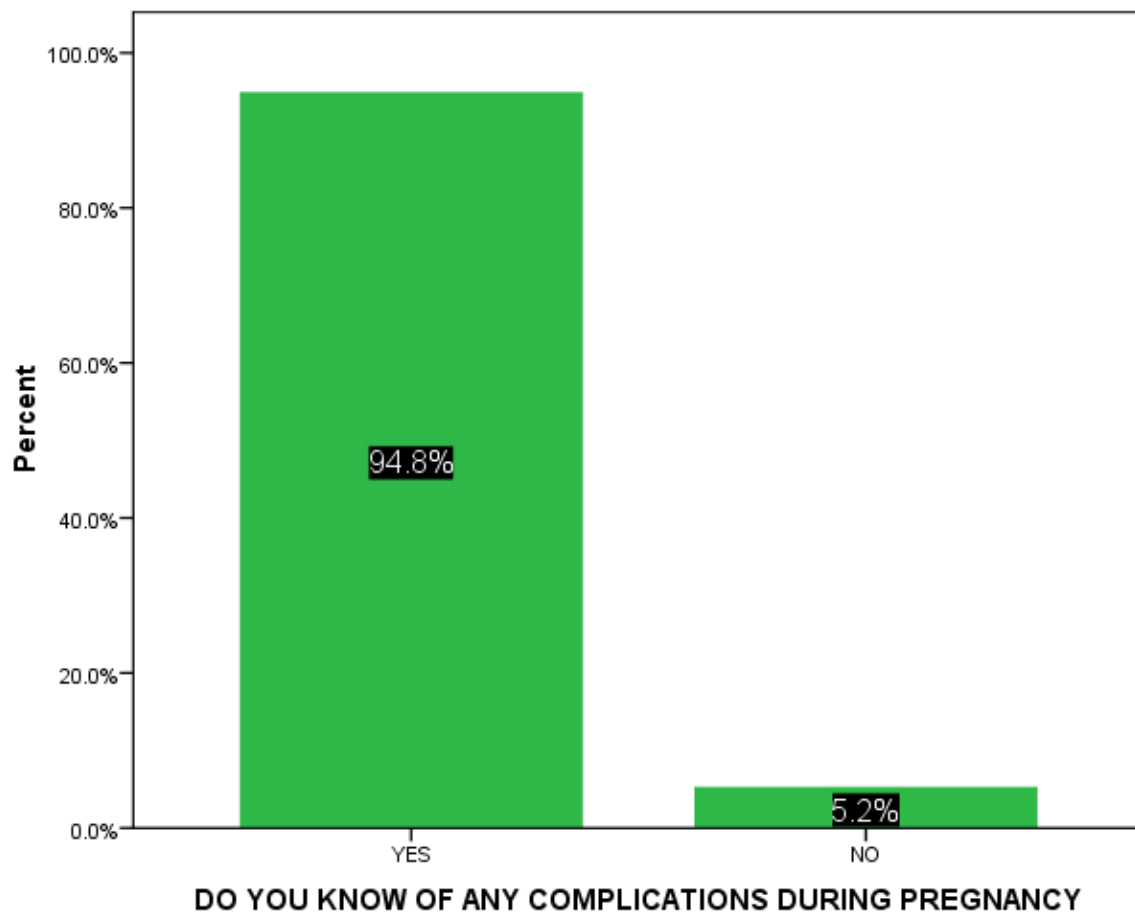
TABLE 2: DISTRIBUTION OF GENDER BY MARITAL STATUS

GENDER	MARITAL STATUS				Total
	SINGLE	MARRIED	SEPERATED / DIVORCED	WIDOW/ WIDOWER	
FEMALE	27 24.8%	72 66.1%	7 6.4%	3 2.8%	109 100.0%
MALE	24 23.3%	73 70.9%	2 1.9%	4 3.9%	103 100.0%
Total	51 24.1%	145 68.4%	9 4.2%	7 3.3%	212 100.0%

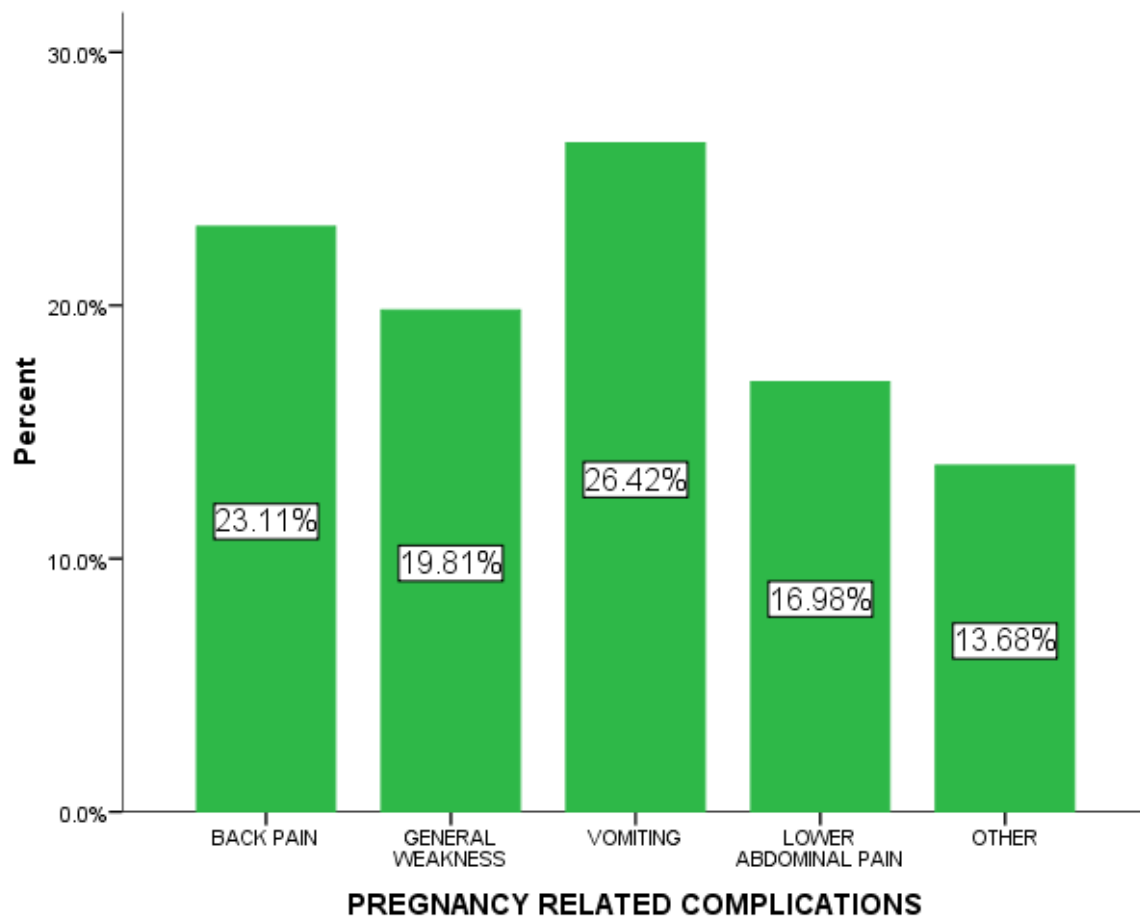
TABLE 3: DISTRIBUTION OF GENDER BY HIGHEST LEVEL OF FORMAL EDUCATION ATTAINED

GENDER	HIGHEST LEVEL OF FORMAL EDUCATION ATTAINED				Total
	NONE	PRIMARY	SECONDARY	TERTIARY	
FEMALE	24	26	35	24	109
	22.0%	23.9%	32.1%	22.0%	100.0%
MALE	18	45	36	4	103
	17.5%	43.7%	35.0%	3.9%	100.0%
Total	42	71	71	28	212
	19.8%	33.5%	33.5%	13.2%	100.0%

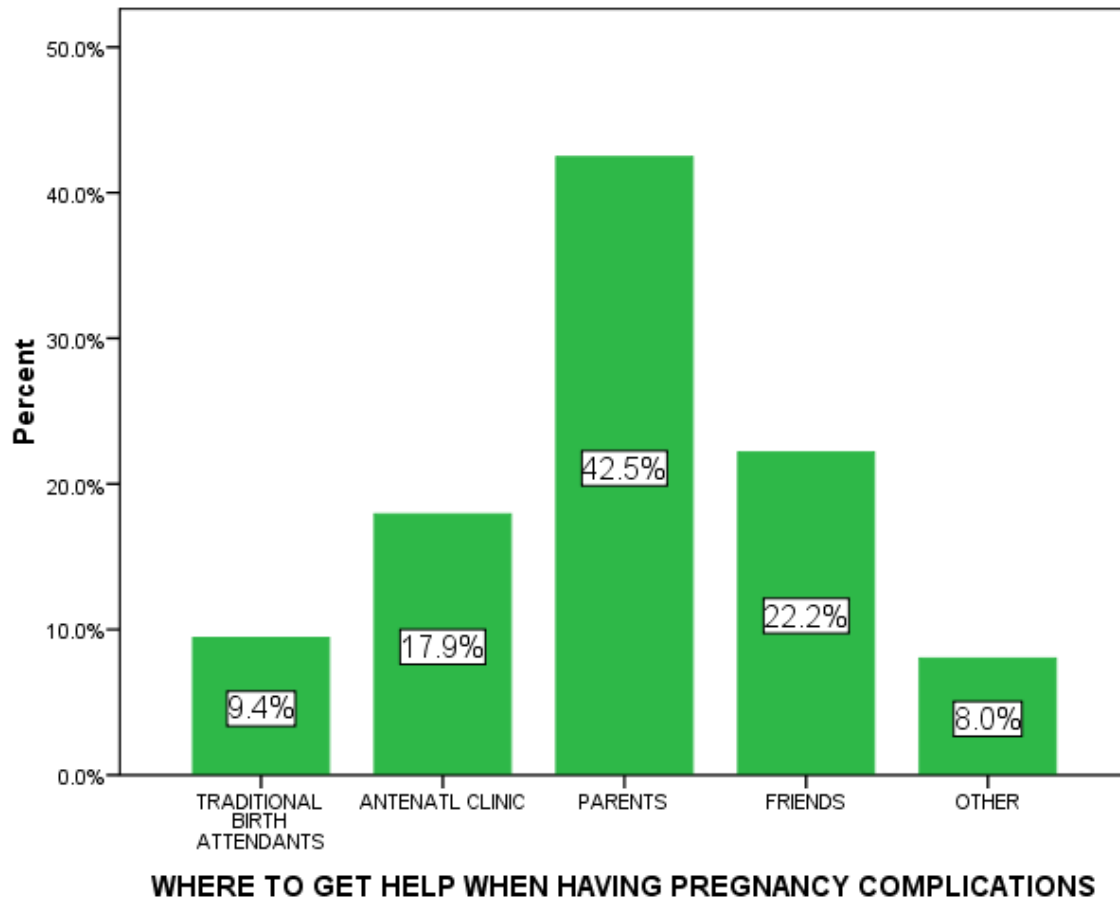
GRAPH 1: KNOWLEDGE ABOUT PREGNACY RELATED COMPLICATIONS



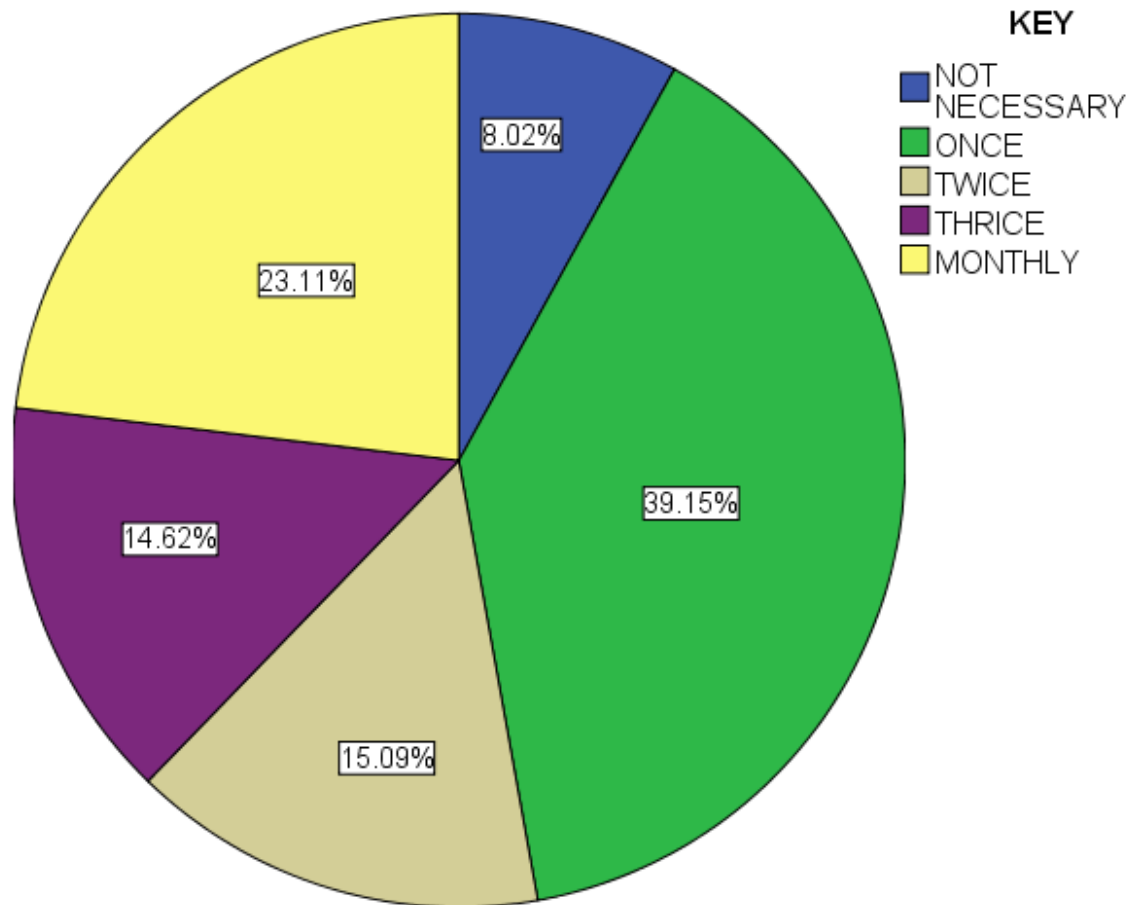
GRAPH 2: LISTING OF PREGNANCY RELATED COMPLICATIONS



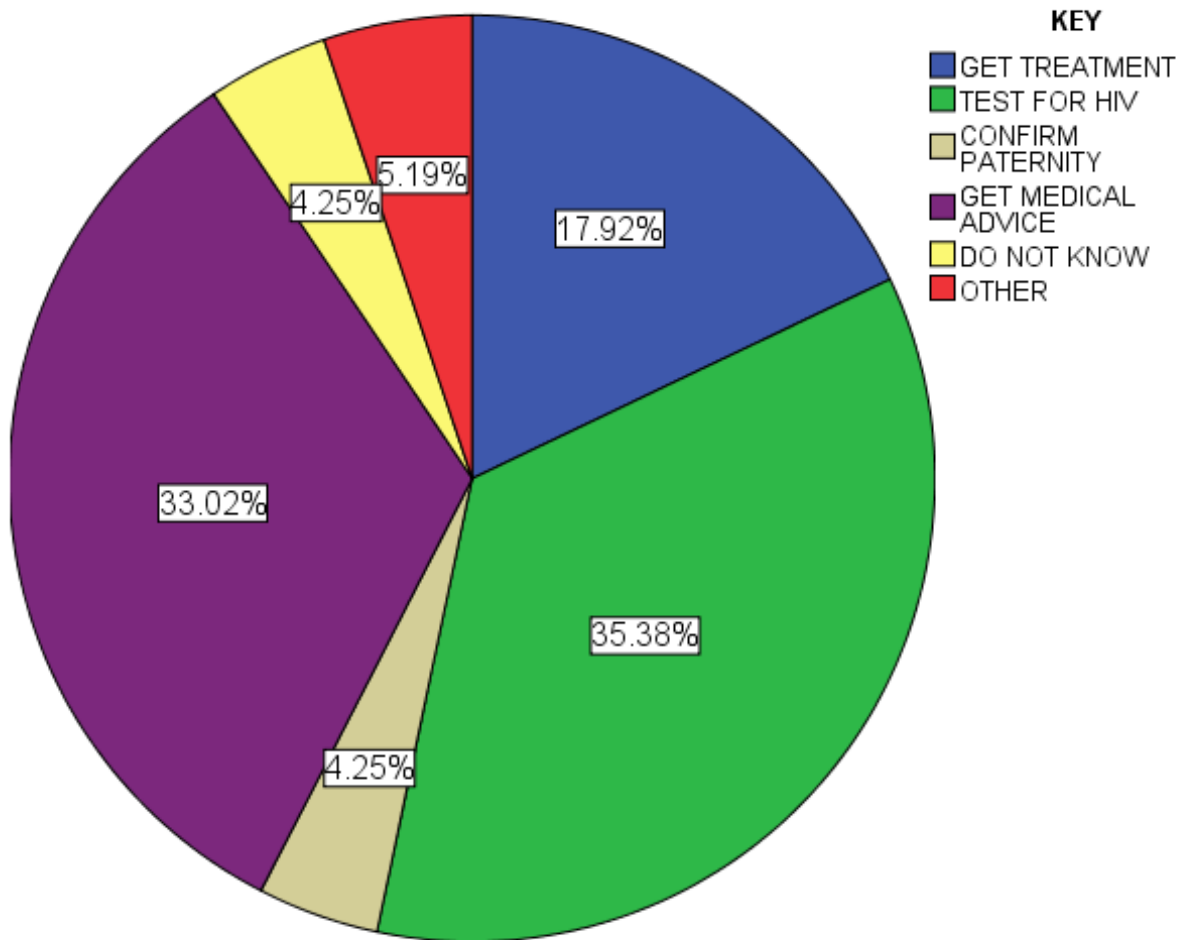
GRAPH 3: KNOWLEDGE OF WHERE TO GET HELP



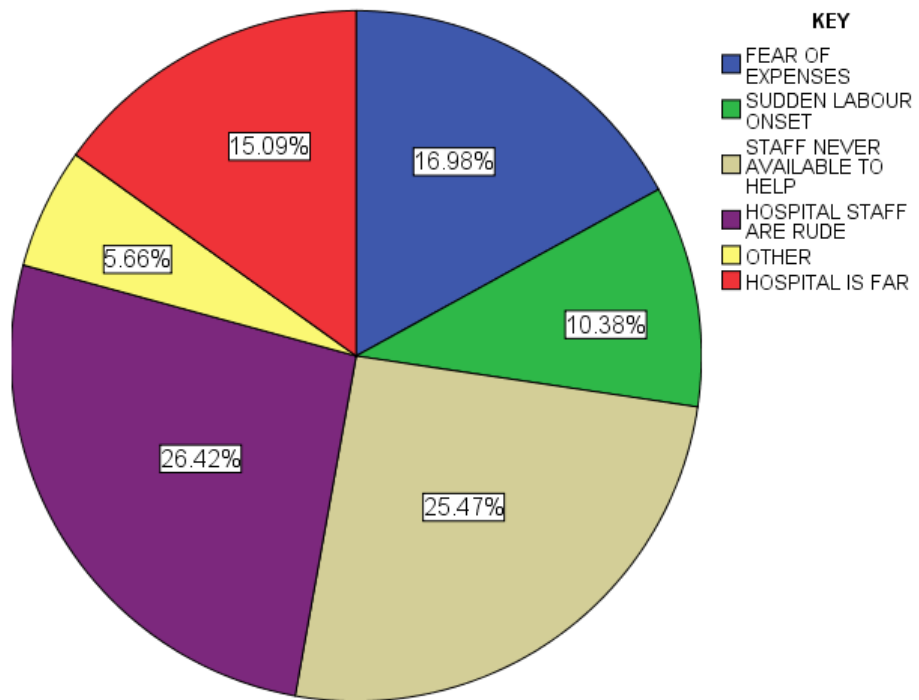
PIE CHART 1: NUMBER OF TIMES TO VISIT ANTENATAL CLINIC



PIE CHART 2: KNOWLEDGE OF WHY ANTENATAL CLINIC IS ATTENDED



PIE CHART 3: WHY WOMEN DELIVER OUTSIDE HOSPITALS



PIE CHART 4: WHY WOMEN DO NOT ATTEND ANC

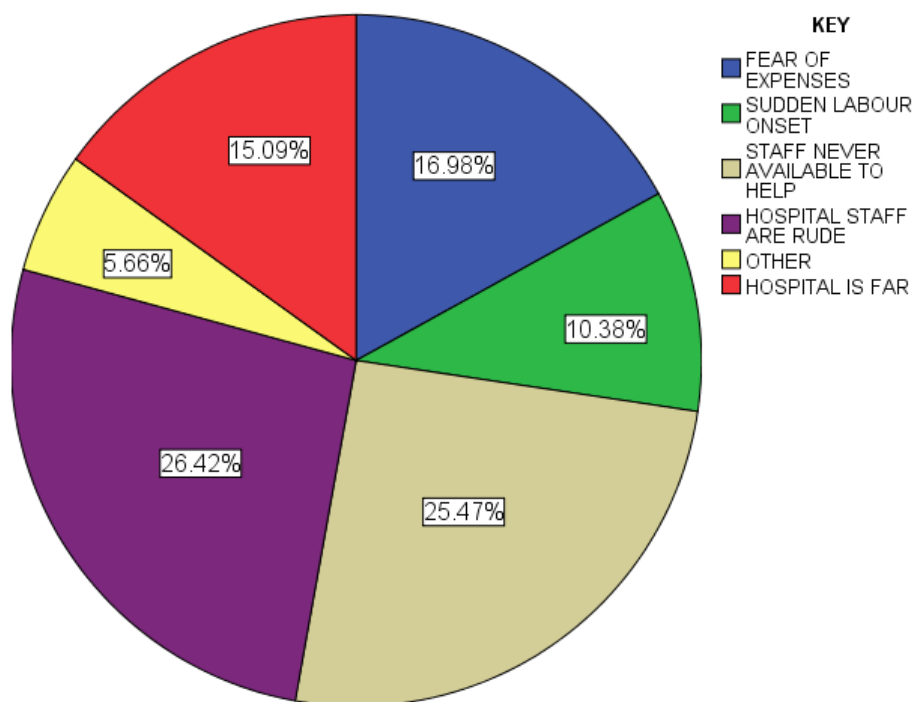


TABLE 4: GENDER SPECIFIC DISTRIBUTION OF KNOWLEDGE ABOUT PREGNANCY RELATED COMPLICATIONS

GENDER	PREGNANCY RELATED COMPLICATIONS					Total
	BACK PAIN	GENERAL WEAKNESS	VOMITING	LOWER ABDOMINAL PAIN	OTHER	
FEMALE	34	27	27	12	9	109
	31.2%	24.8%	24.8%	11.0%	8.3%	100.0%
MALE	15	15	29	24	20	103
	14.6%	14.6%	28.2%	23.3%	19.4%	100.0%
Total	49	42	56	36	29	212
	23.1%	19.8%	26.4%	17.0%	13.7%	100.0%

TABLE 5: GENDER SPECIFIC DISTRIBUTION OF KNOWLEDGE ABOUT MINIMUM NUMBER OF TIMES TO VISIT ANC

GENDER	MINIMUM NUMBER OF TIMES TO VISIT ANTENATAL CLINIC DURING PREGNANCY					Total
	NOT NECESSARY	ONCE	TWICE	THRICE	MONTHLY	
FEMALE	6 5.5%	40 36.7%	20 18.3%	16 14.7%	27 24.8%	109 100.0%
MALE	11 10.7%	43 41.7%	12 11.7%	15 14.6%	22 21.4%	103 100.0%
Total	17 8.0%	83 39.2%	32 15.1%	31 14.6%	49 23.1%	212 100.0%

TABLE 6: WHY SOME WOMEN DELIVER OUTSIDE HEALTH FACILITIES

GENDER	WHY SOME WOMEN DELIVER OUTSIDE HEALTH FACILITIES						Total
	FEAR OF EXPENSES	SUDDEN LABOUR ONSET	STAFF NEVER AVAILABLE TO HELP	HOSPITAL STAFF ARE RUDE	OTHER	HOSPITAL IS FAR	
FEMALE	24 22.0%	5 4.6%	29 26.6%	38 34.9%	0 .0%	13 11.9%	109 100.0%
MALE	12 11.7%	17 16.5%	25 24.3%	18 17.5%	12 11.7%	19 18.4%	103 100.0%
Total	36 17.0%	22 10.4%	54 25.5%	56 26.4%	12 5.7%	32 15.1%	212 100.0%

TABLE 7: WHY SOME WOMEN DO NOT ATTEND ANC CLINIC

GENDER	WHY SOME WOMEN DO NOT ATTEND ANTENATAL CLINIC					Total
	WASTE OF TIME	LONG DISTANCES TO HEALTH FACILITIES	RUDE HOSPITAL STAFF	STAFF NEVER AVAILABLE	OTHER	
FEMALE	11 10.1%	29 26.6%	26 23.9%	27 24.8%	16 14.7%	109 100.0%
MALE	10 9.7%	26 25.2%	34 33.0%	26 25.2%	7 6.8%	103 100.0%
Total	21 9.9%	55 25.9%	60 28.3%	53 25.0%	23 10.8%	212 100.0%

TABLE 8: KNOWLEDGE ABOUT PREGNANCY RELATED COMPLICATIONS

HIGHEST LEVEL OF FORMAL EDUCATION ATTAINED	PREGNANCY RELATED COMPLICATIONS					Total
	BACK PAIN	GENERAL WEAKNESS	VOMITIN G	LOWER ABDOMIN AL PAIN	OTHER	
NONE	6 14.3%	10 23.8%	18 42.9%	8 19.0%	0 .0%	42 100.0%
PRIMARY	18 25.4%	5 7.0%	13 18.3%	14 19.7%	21 29.6%	71 100.0%
SECONDARY	25 35.2%	19 26.8%	9 12.7%	14 19.7%	4 5.6%	71 100.0%
TERTIARY	0 .0%	8 28.6%	16 57.1%	0 .0%	4 14.3%	28 100.0%
Total	49 23.1%	42 19.8%	56 26.4%	36 17.0%	29 13.7%	212 100.0%

TABLE 9: MINIMUM NUMBER OF TIMES TO VISIT ANC VERSUS EDUCATION LEVEL

HIGHEST LEVEL OF FORMAL EDUCATION ATTAINED	MINIMUM NUMBER OF TIMES TO VISIT ANTENATAL CLINIC DURING PREGNANCY					Total
	NOT NECESSARY	ONCE	TWICE	THRICE	MONTHLY	
NONE	4 9.5%	19 45.2%	5 11.9%	9 21.4%	5 11.9%	42 100.0%
PRIMARY	5 7.0%	29 40.8%	10 14.1%	6 8.5%	21 29.6%	71 100.0%
SECONDARY	8 11.3%	21 29.6%	16 22.5%	16 22.5%	10 14.1%	71 100.0%
TERTIARY	0 .0%	14 50.0%	1 3.6%	0 .0%	13 46.4%	28 100.0%
Total	17 8.0%	83 39.2%	32 15.1%	31 14.6%	49 23.1%	212 100.0%

TABLE 10: WHY VISIT ANC CLINIC

HIGHEST LEVEL OF FORMAL EDUCATION ATTAINED	WHY VISIT ANTENATAL CLINIC						Total
	TO GET TREATMENT	TEST FOR HIV	CONFIRM PATERNITY	GET MEDICAL ADVICE	DO NOT KNOW	OTHER	
NONE	7 16.7%	5 11.9%	1 2.4%	24 57.1%	5 11.9%	0 .0%	42 100.0%
PRIMARY	23 32.4%	19 26.8%	2 2.8%	18 25.4%	0 .0%	9 12.7%	71 100.0%
SECONDARY	9 12.7%	39 54.9%	2 2.8%	19 26.8%	0 .0%	2 2.8%	71 100.0%
TERTIARY	0 .0%	12 42.9%	3 10.7%	9 32.1%	4 14.3%	0 .0%	28 100.0%

Total	39 18.4%	75 35.4%	8 3.8%	70 33.0%	9 4.2%	11 5.2%	212 100.0%
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TABLE 11: EDUCATION LEVEL VERSUS WHY SOME WOMEN DELIVER OUTSIDE HEALTH

FACILITIES

HIGHEST LEVEL OF FORMAL EDUCATIO N ATTAINED	WHY SOME WOMEN DELIVER OUTSIDE HEALTH FACILITIES						Total
	FEAR OF EXPENSES	SUDDEN LABOUR ONSET	STAFF NEVER AVAILABLE TO HELP	HOSPITAL STAFF ARE RUDE	OTHER	HOSPITAL IS FAR	
NON E	10 23.8%	5 11.9%	2 4.8%	0 .0%	7 16.7%	18 42.9%	42 100.0%
PRIM ARY	13 18.3%	4 5.6%	17 23.9%	25 35.2%	5 7.0%	7 9.9%	71 100.0%
SECO NDA RY	8 11.3%	5 7.0%	25 35.2%	26 36.6%	0 .0%	7 9.9%	71 100.0%
TERTI ARY	5 17.9%	8 28.6%	10 35.7%	5 17.9%	0 .0%	0 .0%	28 100.0%
Total	36 17.0%	22 10.4%	54 25.5%	56 26.4%	12 5.7%	32 15.1%	212 100.0%

TABLE 12: KNOWLEDGE ABOUT WHY SOME WOMEN DO NOT ATTEND ANC VERSUS EDUCATION LEVEL

HIGHEST LEVEL OF FORMAL EDUCATION ATTAINED	WHY SOME WOMEN DO NOT ATTEND ANTENATAL CLINIC					Total
	WASTE OF TIME	LONG DISTANCES TO HEALTH FACILITIES	RUDE HOSPITAL STAFF	STAFF NEVER AVAILABLE	OTHER	
NONE	0 .0%	8 19.0%	9 21.4%	25 59.5%	0 .0%	42 100.0%
PRIMARY	2 2.8%	26 36.6%	27 38.0%	9 12.7%	7 9.9%	71 100.0%
SECONDARY	16 22.5%	19 26.8%	22 31.0%	5 7.0%	9 12.7%	71 100.0%
TERTIARY	3 10.7%	2 7.1%	2 7.1%	14 50.0%	7 25.0%	28 100.0%
Total	21 9.9%	55 25.9%	60 28.3%	53 25.0%	23 10.8%	212 100.0%

CHAPTER FIVE

DISCUSSION OF FINDINGS

From the study results, there were almost equal numbers of female and male respondents. 70.9% and 66.9% of males & females respectively were married. Most of the respondents had attained primary or secondary level of formal education.

Knowledge about safe motherhood.

Of the 212 respondents, 94.8% had knowledge about atleast one complication that can develop during pregnancy. This shows that a great proportion of the population are aware of complications that can develop during pregnancy. However, 5.2% still did not know of any complications. Most of these (98.2% were singles). All the respondents who reported no knowledge about complications were males. This shows that females are well aware of the complications that can develop during pregnancy. At 31.2 %, back pain was the most commonly reported complication amongst the females while vomiting at 28.2% was the most reported among males.

There was scanty knowledge about where to get help in case of a pregnancy related complication. The greatest number (42.5%) say they would seek help from their parents. While the lowest (8.0%) would seek for such help from other sources. Only 17.9% would seek help from an antenatal clinic. This number is so low. The reason for seek help from parents could be because they feel their parents have been through such conditions before and may offer the best help. It could also be that they feel the parents are always there for them. Findings from a

similar study conducted in Zimbabwe by Elltons et al 2003, revealed that rural communities opted to seek help from traditional birth attendants (67.3%) and friends (11.2%).

About the knowledge as to why women attend antenatal clinic, most of the respondents (39.15%), know that a woman should attend atleast once. This in most cases may be the time the women visit to confirm if they are pregnant, or may attend just to satisfy their conscience.

Community perceptions

35.38% believe that the main reason reason for attending the antenatal clinic is to test for HIV. Because of the high level of stigma related to HIV still prevalent in this region, many mothers may end up hesitating to attend the clinics as they do not want to have their HIV status disclosed. This was closely followed by getting medical advice at 33.02%.

CONCLUSION

Generally, the knowledge of the study population about safe motherhood is severely lacking. While many may be knowing the right thing to do, their perceptions about doing it will have a great negative impact on safe motherhood and hence hinder or set back the attainment of millennium development goal number five. Although there are a number of government programs that have been put in place to promote safe motherhood in the district, it appears like not much has been achieved.

RECOMMENDATIONS

- i. More community based programs should be initiated to help augment those already in operation

- ii. More funding should be availed to programs working to promote safe motherhood
- iii. Newer approaches in promoting safe motherhood activities should be devised to supplement or replace the ones that are already in use
- iv. Community involvement is key in attainment of safe motherhood

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APPENDIX I

INFORMED CONSENT FORM TO PARTICIPATE IN THE STUDY

A QUALITATIVE RESEARCH STUDY INVESTIGATING COMMUNITY KNOWLEDGE AND PERCEPTION OF THE SAFE MOTHERHOOD ISSUES IN TORORO DISTRICT EASTERN UGANDA

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

My name is SYONGOLA WILLIS **REG NUMBER:** BMS /0025 /71 /DU a student of bachelor of medicine and surgery of Kampala International University. I am doing research on **“knowledge and perception of the safe motherhood issues in Tororo district”**. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or any of my research assistants.

Type of research

In this study, you will be guided through a series of questions regarding safe motherhood which you will be asked to respond to appropriately

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Confidentiality

The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the study at any time that you wish without your job being affected.

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me on my telephone number 0702557534

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant:

Signature of Participant:

Date:

APPENDIX II: Questionnaire

Sex Female ☐ Male ☐

Age (In years)

Highest level of education attained

None ☐ Primary ☐ Secondary ☐ Tertiary ☐

Current marital status

Single ☐ Married ☐ Widow/Widower ☐ Divorced ☐

1. How do you get to know of pregnancy?

Missed monthly periods ☐ Visit health facility to confirm ☐

2. What issues do you discuss during the period of pregnancy and at birth?

- where to attend ANC and deliver from and why ☐
- when to start ANC attendance and how often ☐
- maternal nutrition ☐
- traditions surrounding pregnancy ☐
- preparation for the baby ☐

3. Who is the first person to be told about pregnancy

- husband,/ boy friend

☐

- mother,/ mother in law or

☐

4. Where should one help during pregnancy?

Traditional birth attendant ☐

Antenatal clinic ☐

Parents ☐

Friends ☐

Other ☐

5. Do you know of any complications that can develop during pregnancy?

Yes ☐

No ☐

6. If yes please list them

.....

.....

.....

7. Do you know the reasons for practicing safe sex during pregnancy?

Yes ☐

No ☐

If yes list them;

.....

.....

8. At least how many times is a pregnant mother supposed to attend antenatal clinic

during pregnancy.

ONE ☐

TWO ☐

THREE ☐

FOUR ☐

MONTHLY ☐

9. Why are pregnant mothers advised to attend antenatal clinic?

To be treated ☐ Test for HIV ☐ To know the father of the child ☐
To get medical advice ☐ Do not know ☐ Other ☐

10. Why is it important to deliver in a health facility?

It is safe ☐ They have trained personnel ☐ Do not know ☐

11. What are the effects of domestic violence on safe motherhood.

.....
.....

PERCEPTIONS

12. Why do some women deliver outside health facilities?

Fear of expenses ☐ Abrupt onset of labour ☐
Traditional birth attendants are better ☐ Hospital staff are rude ☐
Other ☐

13. Why do some women not attend ANC?

Waste of time ☐ Rude staff ☐ Staff never there ☐
Distance is long ☐ Other ☐

APPENDIX: III PROPOSED BUDGET FOR THE STUDY

ITEM	COST OF UNIT (USHS)	NUMBER OF UNITS	AMOUT (UGX)
Transport	5,000	7	35,000
Feeding	12,000	10	120,000
Typing	500	50	25,000
Printing	15,000	4	60,000
Research assistant	20,000	7	140,000
Data analysis	70,000	1	70,000
TOTAL			450,000

APPENDIX IV: TABLE FOR DETERMINING SAMPLE SIZE FROM A GIVEN POPULATION

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size

"S" is sample size.

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APPENDIX V: MAP OF TORORO DISTRICT

