

**A REVIEW OF MORBIDITY PATTERN OF POST NATAL CLINIC IN KITAGATA
HOSPITAL-UGANDA.**

BY

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UGANDA

DECLARATION

I do hereby declare that this work is of my own effort and in case of any consultation the references are quoted. It has not been presented for any award in any college or university.

NAME OF RESEARCHER

SIGNATURE

DATE

.....

NAME OF SUPERVISOR

SIGNATURE

DATE

.....

DEDICATION

I dedicate this document to my beloved family members at large for all their encouragement and support in my life and my dear friends whom consider a family too, classmates and lecturers.

God bless them.

ACKNOWLEDGEMENT

I acknowledge Kampala International University – Western Campus for giving me the chance to do a degree in medicine and surgery. I would also pass my sincere gratitude to the faculty of clinical medicine and dentistry staff for the support during the training. Special thanks to my supervisor. Appreciation to my parents and relatives, classmates and friends for total support during the course.

May God bless all of you.

LIST OF ABBREVIATION

AIDS; Acquired Immune Deficiency Syndrome

AMREF; African research foundation

PNC; Post Natal Care.

APH; Ante Partum Hemorrhage.

DDHS; District Director of Health Services.

Hb; Hemoglobin.

H/C; Health Center

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ABSTRACT

A retrospective study was carried out. Carried out in Kitagata hospital in Bushenyi district October 2013.

The study's main objective as assessment of morbidity pattern of post natal clinic in Kitagata hospital.

A total of 100 respondents reports/records were randomly chosen from already existing records, analyzed manually in excel and calculators and presented in tables and figures.

The researcher concluded that despite most mothers attend post natal clinic but they still have post natal complications because of few health centers and health workers hence no enough health facilities therefore government should save this situation.

CHAPTER ONE

1.1 BACKGROUND INFORMATION

The analysis of maternal deaths has long been used for the evaluation of women's health and the quality of obstetric care. Around 10 to 20 maternal deaths per 100 000 live births are observed in countries in the European Union. Over the last decade the identification of cases of severe maternal morbidity has emerged as a promising complement or alternative to the investigation of maternal deaths. Although obstetric complications are sometimes presented as a relatively easy alternative to maternal deaths, difficulties remain in their definition and identification. A number of terms are in use to describe incidents of severe maternal ill health including life-threatening complications, severe maternal morbidity or near-misses (Gwyneth, 2005).

Conceptually, morbidity during pregnancy represents part of a continuum between the extremes of good health and death. On this continuum, a pregnancy may be thought of as being uncomplicated, complicated, severely complicated or life threatening. From these conditions, the woman may recover, she may be temporarily or permanently disabled, or she may die (Gwyneth, 2005)

The main difficulty in designating where a woman is positioned on this continuum lies in the definition of the threshold of severity above which morbidity becomes severe or even life threatening. Whereas this threshold is easy to define for some conditions (e.g. few will disagree that a ruptured uterus is life threatening), it is not straightforward for others (e.g. what is the threshold for severe vaginal bleeding or for prolonged labor?)(Gwyneth, 2005).

An added difficulty is that the threshold above which an adverse obstetric event becomes life threatening may be context specific. The probability of a woman dying depends not only on the woman's capacity to cope with a complication, but also on the access to and the quality of the care she receives. For example, a blood loss of 500 ml may not be life threatening in a non-anemic healthy woman, but might put the mother's life at risk if she is severely anemic. Finally, some diagnoses of severe obstetric complications may be particularly dependent on physician's judgment. For example, cephalopelvic disproportion (CPD) in particular is difficult to ascertain. In the USA in the 1980s, there were six times more caesarean sections for CPD than

in Ireland among women with a comparable risk status. But these differences were believed to reflect cultural factors rather than real differences in the epidemiology of CPD (1). For all of these reasons, it is unlikely that standard, universally applicable definitions of severe morbidity can be proposed. (Gwyneth, 2005).

CPD is common in Uganda as well but it is more likely to have more incidences in areas with people who are short like the people in the mountains as seen in people from Rwenzori Mountains.

1.2 STATEMENT OF THE PROBLEM

Post natal is a period from the first day after birth/delivery up to six weeks post delivery. During this period both the mother and the newborn are at risk of contracting with a number of infections, among these can be communicable and non communicable diseases which can be due to infection from the mothers or others can be inherited.

The findings of this study are expected to be of importance to the study area as a source of reference to the real picture of post natal morbidity among mothers and newborns. The study is also expected to increase the pool of knowledge on the morbidity of post natal period in Uganda especially in Kitagata hospital.

1.3 STUDY OBJECTIVES

Main objective

To review the morbidity pattern of post natal clinic in Kitagata hospital-Uganda.

Specific objectives

To assess the percentage distribution of conditions seen in the post natal clinic in Kitagata hospital.

To establish the possible causes of increased morbidity pattern in post natal clinic, Kitagata hospital.

To determine possible means of reducing the morbidity prevalence in post natal clinic of Kitagata hospital.

1.4 STUDY JUSTIFICATION

The study was to generate the necessary information on the morbidity pattern of post natal clinic in Kitagata hospital-Uganda. These statistics is to be applied in the local government with an aim of improving health services in the study area. The study is also to enable us establish the level of obstetric care in the hospital. Little had been done in the area to determine the causes of post natal morbidity. The study has enable us create a database that is to be useful in studying the trends of conditions in post natal care.

1.5 STUDY QUESTIONS

What are the causes of post natal morbidity?

What is the role played by poverty in the increase of post natal morbidity among mothers and newborns?

Do the health care programs of the ministry of health Uganda have a hand in the prevalence of post natal morbidity in Kitagata hospital?

CHAPTER TWO

2.0 LITERATURE REVIEW

Post natal period is the period after delivery which ranges from the first day after delivery to up to sixth week post delivery. During this time a number of conditions have been seen common among the mothers and the newborns. Among the commonly seen condition are both infectious and non infectious diseases which include; malaria, gastroenteritis, upper respiratory tract infections, hypertension, puerperal sepsis among other many conditions. Below is a review of some commonly seen conditions of post natal period.

2.1 Puerperal fever

Streptococcus pyogenes is responsible for most cases of severe puerperal fever. It is commonly found in the throat and nasopharynx of otherwise healthy carriers, particularly during winter. (Loudon, 2000). Puerperal fever (from the Latin *puer, male child (boy)*), also called childbed fever, can develop into **puerperal sepsis**, which is a serious form of septicaemia contracted by a woman during or shortly after childbirth, miscarriage or abortion. If untreated, it is life-threatening. (Loudon, 2000). The most common infection causing puerperal fever is genital tract sepsis. Other types of infection that can lead to sepsis after childbirth include urinary tract infection, breast infection (mastitis) and respiratory tract infection (more common after anesthesia due to lesions in the windpipe). (Loudon, 2000)

A famous victim of puerperal fever was Jane Seymour, third wife of Henry VIII of England. She died two weeks after the birth of Henry's only surviving son, the future Edward VI of England. Other significant victims were Isabella Beeton and Mary Wollstonecraft (1759-1797), author of *Vindication of the Rights of Woman*, who died a few days after giving birth to William Godwin's daughter, who grew up to be Mary Shelley, author of *Frankenstein*. Puerperal fever is now rare in the West due to improved hygiene during delivery, and deaths have been reduced by antibiotics. (Loudon, 2000)

2.1.1 Causal organisms

The most common causative agents in inflammation of the inner lining of the uterus (endometritis) are *Staphylococcus aureus* and *Streptococcus*. Group A *Streptococcus* (abbreviated to GAS, or more specifically the *Streptococcus pyogenes*) is a form of

Streptococcus bacteria responsible for most cases of severe hemolytic streptococcal illness. Other types (B, C, D, and G) may also cause infection. Group B Streptococcus (abbreviated to GBS, or more specifically Streptococcus agalactiae usually causes less severe maternal disease. Other causal organisms, in order of prevalence, include staphylococci, coliform bacteria, anaerobe bacteria, chlamydia bacteria, mycoplasma and very rarely, Clostridium welchii. (Holmes, 1983)

There are several strains of GAS (Group A Streptococcus). Some strains usually cause skin infections, they are more common in warm climates, and they usually cause local rather than systemic effects. Other strains, in particular Streptococcus pyogenes attack the throat and cause severe infections. The human nasopharynx is the main reservoir of Streptococcus pyogenes and infection is more common during winter and it is rarely found in the normal vaginal flora. It is likely that most puerperal hemolytic infections arise from this reservoir in the patient or attendants.

Group B Streptococcus GBS (Streptococcus agalactiae) causes pneumonia and meningitis in neonates and the elderly, with occasional systemic bacteremia. They can also colonize the intestines and the female reproductive tract, increasing the risk for transmission to the infant. All pregnant women between 35 and 37 weeks gestation should be tested for GBS. (Holmes, 1983)

2.1.2 Incidence of Puerperal fever

The incidence of puerperal sepsis shows wide variations among published literature. Puerperal fever or childbed fever in the 18th and 19th centuries affected, on average, 6 to 9 women in every 1000 deliveries, killing 2 to 3 of them with peritonitis or septicemia. It was the single most common cause of maternal mortality, accounting for about half of all deaths related to childbirth, and was second only to tuberculosis in killing women of childbearing age. A rough estimate is that about 250,000–500,000 died from puerperal fever in the 1700s and 1800s in England and Wales alone. (Holmes, 1983)

2.2 Malaria

Millions of women become pregnant in malaria-endemic areas of Africa, and similar numbers are exposed to malaria in Asia, Oceania, and South America.¹ Malaria is an important cause of severe anemia in pregnant African women, and by this mechanism malaria causes an estimated

10,000 maternal deaths each year. Moreover, malaria infections result in 75,000–200,000 low birth weight (LBW) babies each year, due to combinations of preterm delivery (PTD) and fetal growth restriction (FGR). Effects on miscarriage and stillbirth are unknown, but adequate malaria control alone could prevent 3–8% of infant deaths. (Ribera. 2007)

To tackle this enormous burden, first, insecticide treated nets (ITNs) decrease parasite prevalence in all gravidities, decrease LBW and stillbirth in first to fourth pregnancy, and show trends toward benefits against anemia and clinical malaria. Second, intermittent preventive treatment in pregnancy (IPTp), using regular treatment doses of the antimalarial sulphadoxine–pyrimethamine (SP) has been shown to decrease peripheral and placental parasitemia, and to increase maternal hemoglobin and infant birth weight, especially in primi- and secundigravidae. Unfortunately, high-level coverage with SP IPTp and ITNs has not yet been achieved. The development and evaluation of programs to prevent malaria in pregnancy and after pregnancy can be facilitated by a better understanding of the pathogenesis of malaria. (WHO, 2008)

2.3 Malnutrition

Malnutrition has been present in the world for a long time. In the early part of this century, it receive little attention from the health services because the connection between nutrition and health was not well recognized; and medical worker ignorance about nutrition has been major factor in the slow development of nutrition services. Since 1945, however governments and agencies for nutrition research and food production have set much time, attention and money aside, (African medical & research foundation, 1997).

Protein calorie malnutrition is a direct result of inadequate dietary protein coupled with a deficiency intake of the carbohydrates and lipids necessary to provide an adequate energy source. A secondary form of this condition arises when disease prevents absorption of nutrients from the intestine or provides an increased nutritional demand. It should be recalled that a lack of carbohydrates and lipids results in the oxidation of endogenous protein complication that leads to wasting. These states are found not only in children and adults in endemic areas of restricted food supply, but also in many as 25% of hospitalized adult patients, because of the increase nutritional need associated with the underlying disease. The manifestation of protein energy deficiency varies depending on the individual and his or her state of development. In facts and

children are particularly susceptible because of their requirements for growth (African medical & research foundation, 1997).

There are two ends of the spectrum of protein calorie malnutrition, reflecting the relative imbalance between the components of the diet. A deficiency of calories from all sources leads to Marasmus whereas a diet deficient in protein alone is associated with kwashiorkor. Marasmus and kwashiorkor as well as their intermediate states are often complicated by deficiency on vitamin and minerals, (Rubin and Farber, 1988).

Protein energy malnutrition being the commonest type of malnutrition in third world countries, it causes a range of conditions which differ in their sign and severity. A child may be underweight stunted and failing to grow but may appear normal, a child may look thin, severely wasted and edematous which is a how of Marasmus and kwashiorkor.

2.4 Meningitis

Haemophilus meningitis is most frequently caused by Haemophilus influenzae type b, also known as Hib. Before effective vaccines became available and widely used, Hib was the most frequent cause of bacterial meningitis in children 5 years of age and younger. (McCracken et al, 2003).

Meningococcal meningitis, caused by Neisseria meningitidis, is primarily a disease of young children, with the incidence of cases declining in those older than 1 year of age. The disease is most common during winter and spring. In some persons, the bacteria can cause a severe blood infection called meningococcemia. Pneumococcal meningitis, caused by Streptococcus pneumoniae (pneumococci), generally strikes infants, the elderly and individuals with certain chronic medical conditions. In general, 5 percent to 10 percent of cases are fatal; however, in persons with significant underlying disease the fatality rate can be 20 percent to 40 percent. (Chaudhuri, 2008).

Meningitis is not highly contagious. Both viral meningitis and bacterial meningitis can be spread through direct contact with nose and throat secretions. Healthy persons, who have no signs of illness, can have these bacteria in their nose or throat and spread them to others. Sharing a glass, cup or eating utensil, coughing or sneezing into the face of another person, or sharing a cigarette

are examples of how contact with another person's respiratory secretions might occur. (Chaudhuri, 2008).

2.5 Sickle Cell.

Sickle cell anemia is one of the first diseases to be understood at the molecular level. The amino acid valine is substituted for glutamic acid at the sixth position of the b-globin chain, due to a GAG to GTG codon mutation. The resultant sickle hemoglobin (Hgb S) has a unique tendency to aggregate and form long strands of rodlike polymers on deoxygenation, with the subsequent morphological changes limiting the red blood cells ability to traverse the microcirculation. Sickle trait (Hgb AS) red blood cells can also undergo polymerization with morphologic sickling at 0% oxygen saturation. The amount of polymerization with complete deoxygenation is reflective of hemoglobin S concentration, approximately 35% and 70% for Hgb AS and Hgb SS respectively. (Rodgers, 1997)

The Hgb-S gene is inherited in an autosomal co-dominant pattern. Sickle cell trait has a prevalence of 8 to 14 percent in the African American population and 0.046 percent in Americans not of African descent. It is fairly well accepted that pathological changes are confined to the renal and splenic vascular beds. Hematuria and hyposthenuria are the two renal pathological processes most often associated with sickle cell trait. Both are self-limiting and are associated with no significant morbidity in this population. Hematuria is still such a relatively rare occurrence such that when it occurs, another etiology should be sought. (Rodgers, 1997)

It appears prudent to recommend that individuals with sickle cell trait avoid heavy exercise at altitudes of 10,000 feet or higher as hypobaric hypoxemia increases the risk of splenic infarction. Gradual exercise conditioning and acclimatization to the altitude hypoxia would decrease the risk. Individuals with sickle cell trait should avoid situations that may lead to exertional heat illness, which appear to be the major cause of excess mortality. Sufficient hydration should be maintained above levels of intake dictated by thirst, especially before, during and after exercise. Conditioning programs should start slowly and build up gradually from levels easily tolerated to that which is near maximal effort for the individual. (Rodgers, 1997)

Even though there is a plausible causal relationship, there is no direct evidence that the pathogenesis of these exercise-related deaths involve microvascular obstruction by rigid

erythrocytes. The lack of published data on diving in those with HgbAS is probably due to several factors. Relatively few blacks worldwide dive using scuba gear, while the vast majority of divers free-dive for sustenance (conk, lobster, crabs, etc.) usually less than thirty feet. Also, African and Caribbean nations clearly have had more pressing clinical problems to place limited research allocations. As economic conditions improve for blacks in the Diaspora, especially in the U.S. with the worlds largest black middle class, diving with scuba gear for sport and work has increased (unpublished data-National Association of Black Scuba Divers). Clearly, there is a dire need for research into the possible effects of diving with scuba equipment in those with the sickle cell trait. (Rodgers, 1997)

2.6 Typhoid fever

With an estimated 16–33 million cases of annually resulting in 500,000 to 600,000 deaths in endemic areas, the World Health Organization identifies typhoid as a serious public health problem. Its incidence is highest in children and young adults between 5 and 19 years old. (Giannella, 1996)

Typhoid fever, also known as *Salmonella* Typhi or commonly just typhoid, is a common worldwide illness, transmitted by the ingestion of food or water contaminated with feces from an infected person. The bacteria then perforate through the intestinal wall and are phagocytosed by macrophages. *Salmonella* Typhi, more correctly called *Salmonella enterica enterica* Typhi, then alters its structure to resist destruction and allow them to exist within the macrophage. This renders them resistant to damage by PMN's, complement and the immune response. The organism is then spread via the lymphatics while inside the macrophages. This gives them access to the reticuloendothelial system and then to the different organs throughout the body. The organism is a Gram-negative short bacillus that is motile due to its peritrichous flagella. The bacterium grows best at 37 °C/99 °F – human body temperature. (Giannella, 1996)

2.7 Diarrhea

Diarrhea is defined as passing of loose stool three or more times in 24 hours. Acute diarrhea lasts less than 14 days while persistent diarrhea last longer than 14 days. They further define the causes of diarrhea due to bacteria or viruses inside the gut i.e. infectious diarrhea, which includes the following. Rotavirus, which accounts for 50% of children diarrhea. Escherichia coli, which

accounts for 25%. *Vibrio cholera* associated with cholera accounts for 5-10%. *Campylobacter*, which accounts for 15% of infant diarrhea, *Yersinia*, which causes for 10% of diarrhea cases. Protozoa infection due to giardiasis and amebiasis. Sometimes diarrhea can be caused by infections outside the gut such as malaria or tonsillitis. (Linda, 2003)

According to Ann Burgess and others (1994), it states; “Germs in food or water are the main cause of diarrhea. Diarrhea, particularly persistent diarrhea, (lasting more than two weeks) is an important cause of under nutrition in young children. It reduces nutrient absorption, increases nutrient loss, and may reduce appetite. To control, give colostrums and breast milk which “immunize”. Against some types of diarrhea germs reaching or breeding in food or water; prevent or treat dehydration and continue breastfeeding. (Linda, 2003)

It further states that measles increases the need for vitamin A and is an important cause of vitamin A deficiency and blindness in young children. It often causes growth failure. Many children get serious diarrhea and other infections after measles because measles weakens the immune system for several months. Undernutrition, particularly vitamin A makes measles worse. To control, immunize, give children with measles at least one high dose of vitamin A and feed well. (Linda, 2003)

CHAPTER THREE

3.1.0 STUDY AREA/METHODOLOGY

3.1.1 AREA OF STUDY

Bushenyi district is in the South Western of Uganda. It's bordered by Kasese in the North, Kamwenge in the North East, Mbarara in the East, Rukungiri in the West and Ntungamo in the South. The district has a total land of 3949 square kilometer and a population density of 181 persons per square kilometer and a total population of 738,355 (as per 2002 population and housing census). It's mainly inhabited by Banyankole; Bushenyi has a tropical type of climate with rain season in January, April, May, June, September, October, November and half of December. Dry season is in February, July and August. The soils are fertile for food crops like Matooke, Beans, Maize, Tea, Coffee, Cotton are main cash crops for the District.

The district has five (5) counties namely;

Buhweju, Bunyaruguru, Igara, Ruhinda, Sheema. The biggest is Igara while Buhweju is the smallest. The study area is Kitagata hospital.

3.2 STUDY DESIGN

The research was a retrospective type of research where the pre-existing data in the hospital records was used.

3.3 STUDY POPULATION

The study population was including the post natal mothers who attended post natal clinic at Kitagata hospital October 2013

3.4 SAMPLE SIZE

The sample size was determined by the existing number of cases which was seen in the post natal clinic in Kitagata hospital.

3.5 SAMPLING PROCEDURE

This was a random selection of information from already existing hospital data by use of a data collection form. This was information on the most recent clients of post natal clinic. The records office gave relevant information in relation to the study for the last one year, the data collection

was open to all clients who attended the post natal clinic of the study area regardless of the tribe, religion, race, and political affiliation until the intended sample was achieved.

3.6 PRETEST

To ensure minimal or no anomalies in the data collection form, the data collection form was pre-tested in a nearby health center iv. This was done in sheema health center iv a nearby health center to Kitagata hospital whose inhabitants share many things in common with Kitagata hospital, including socio economic and cultural practices.

3.7 DATA COLLECTION METHODS

The researcher used the already formulated data collection form which contained the summary of the particulars of the study. However, two research assistants were trained prior to the exercise to do data assessment from the hospital data. Among other materials, which were used were; pens, papers, calculator, which aided in easy data collection.

3.8 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

The data was collected using data collection form based on the objectives of the study. This data was then grouped and analyzed. It was then represented in the form of short statements, pie charts, bar graph, tables and other appropriate methods. The procedure was made easy by use of simple electronic calculators and computers. Later the result or outcome of the study was based on the already analyzed data.

3.9 ETHICAL CONSIDERATION

Respect for respondent's cultures, taboos, socio and economic status was highly observed to avoid violation of one's rights. Total confidentiality of information from records was maintained. A cordial approach was used to ensure humility. Information to the relevant authorities was acquired prior to onset of the exercise to ensure that intrusion into someone's privacy will be avoided. This was made possible by use of a letter from Kampala International University faculty of clinical medicine and dentistry which was an introductory to the community.

3.10 STUDY LIMITATIONS AND SOLUTIONS

Unstable weather conditions interrupted the study however the researcher made prior arrangements and used umbrellas whenever there was need. Financial strain was a problem but

with the assistance of parents it was solved. Cooperation from the hospital administration was uncertain since some may decide not to cooperate

CHAPTER FOUR: RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter consists of results of data collection, which were analyzed in terms of tables, pie charts and bar graphs. It involved editing coding and tabulation of data.

4.2 AGE OF RESPONDENTS

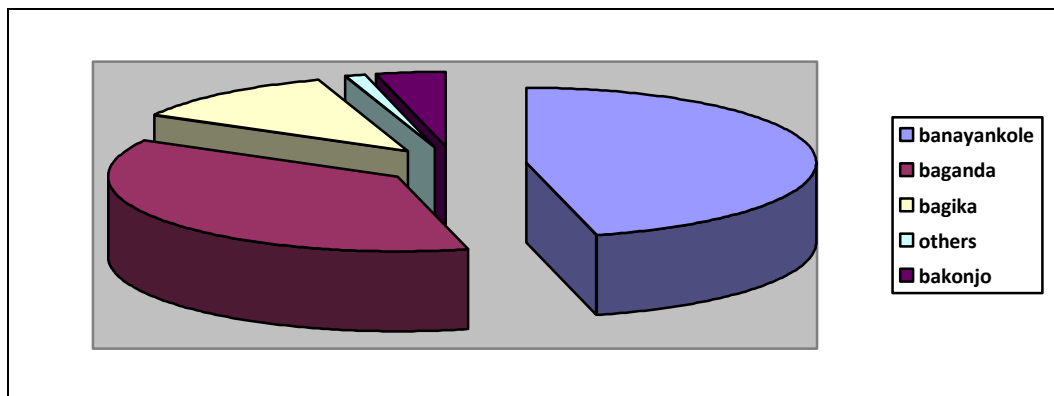
Table 1; Age distribution of the respondents

AGE IN YEARS	NUMBER OF RESPONDENTS	PERCENTAGE%
15-24	13	13
25-34	41	41
35-44	24	24
45-54	22	22
TOTAL	100	100

According to the table above, most of the respondents were aged between 25-34(41%), followed by the age range of 35-44(24%), age of between 45-54, (22%) of the total respondents, while the young mothers within 15-24, (13%)

4.3 TRIBE OF RESPONDENTS

Figure 1; Tribe of the respondents



Most of respondents by tribe were Banyankole 46(46%) followed by Baganda 37 (37%) bagika 12(12%), bakonjo 4(4%) and lastly others 1 (1%)

4.4 LEVEL OF EDUCATION

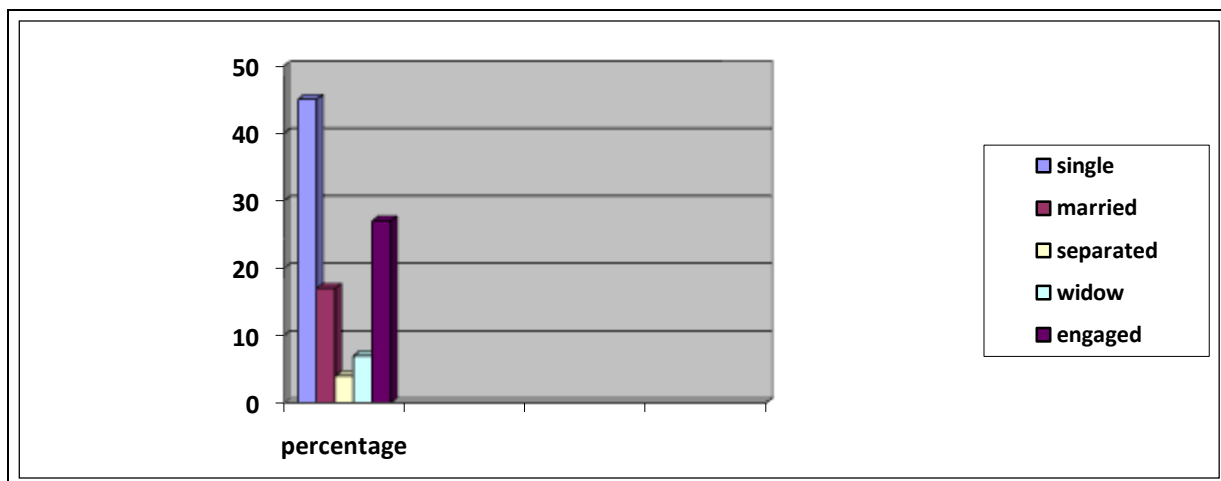
Table 2: level of education of the respondents

EDUCATION LEVEL	FREQUENCY	PERCENTAGE (%)
No formal education	6	6
Primary	11	11
Secondary	24	24
Tertiary	59	59
TOTAL	100	100

The table above shows that the majority of the respondents 59(59%) had tertiary status of education, 24(24%) who had the secondary school education, 11(11%) had at least a primary level of education and finally 6(6%), Who never had any formal education.

4.5 MARITAL STATUS

Fig. 2: Marital status of the respondents

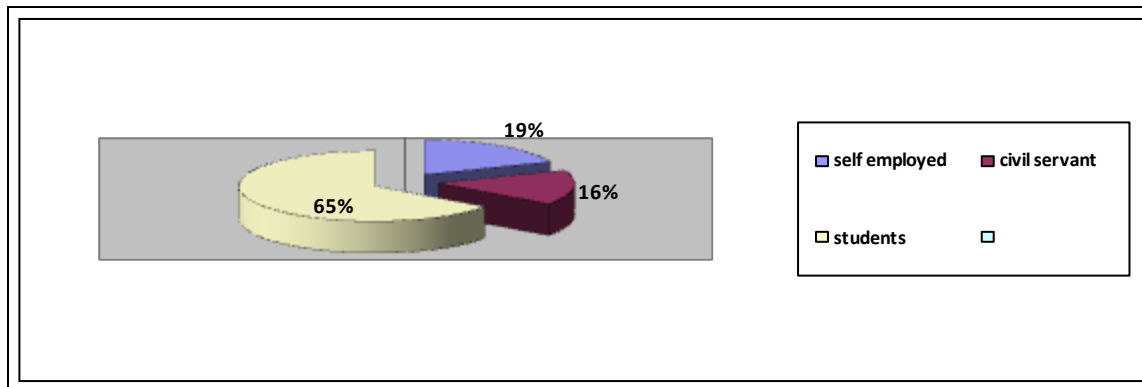


From the findings, most of the respondents were young female who were single 45(45%) followed by the engaged respondents who were 17(17%), the third category were the married

who were 17(17%), the other category was the widowed female who were 7(7%) and finally we had those who separated from their partners and they represented 4(4%).

OCCUPATION OF THE RESPONDENT

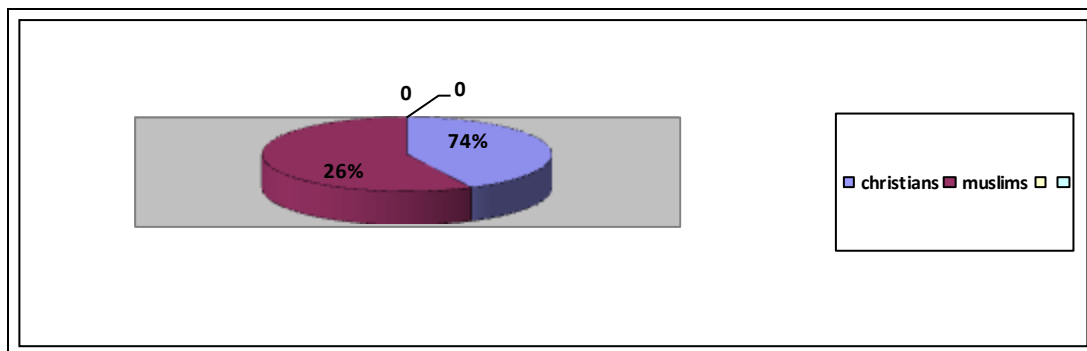
Fig. 3: respondent's occupation



Most of respondents 65(65%) were students followed by the 19(19%), self employed and finally 16(16%) we had civil servants who were interviewed.

4.7 RELIGION OF RESPONDENTS

Fig. 4 Respondent's religion



The majority of respondent by religion 74(74%) were Christians while the minority 26(26%) were Muslims.

PART B: OCCURANCE OF CONDITIONS

OCCURANCE OF PPH

Table 3: occurrence of post partum hemorrhage

PPH	FREQUENCY	PERCENTAGE (%)
May-July	1	8
August-October	2	17
November-January	4	33
February-April	5	42
TOTAL	12	100

The table above shows the distribution occurrence of post partum hemorrhage among the clients who attended post natal clinic in Kitagata hospital, during the period of February-April there were 5(42%) cases. November to January was 4(33%) cases, august-October was 2(17%), and finally may-July was 1 (8%) cases.

OCCURANCE OF MALARIA

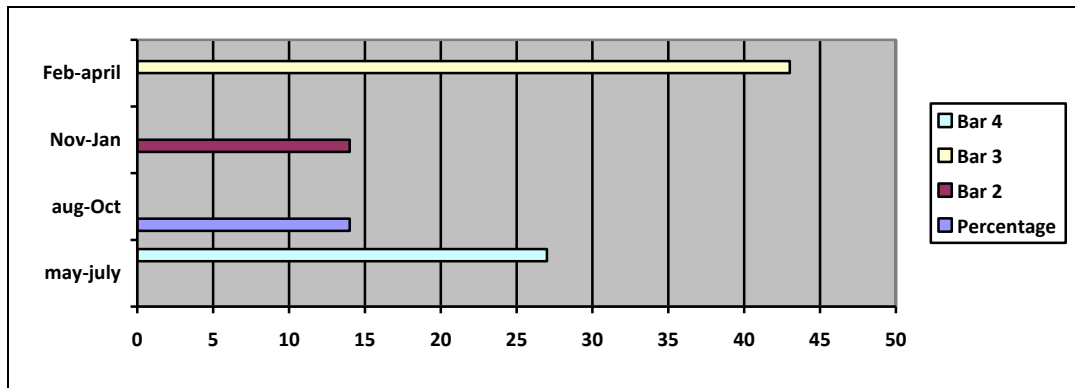
Table 3: Distribution occurrence of Malaria

MALARIA	FREQUENCY	PERCENTAGE (%)
May-July	14	10
August-October	42	29
November-January	54	38
February-April	34	24
TOTAL	144	100

The months of November to January had the biggest number of malaria cases 54(38%), followed by august to October 42(29%), then February to April 34(24%), and finally may to July 14(10%).

OCCURRENCE OF PUERPERAL SEPSIS

Fig 5: Distribution occurrence of puerperal sepsis



CHAPTER FIVE

DISCUSSION OF THE FINDINGS, CONCLUSION AND RECOMMENDATION.

This chapter discusses the study finding. According to the study findings in chapter four respondents by age indicates that majority of respondents 41(41 percent) were between the ages of twenty five to 34 years of age because this is the age which is reproductively active and most of them are pre exposed to post natal complications then thirty five to 44 years were 24(24 percent) and lastly age of between fifteen and 24 who most of them are not married but are also exposed to post natal complications.

The respondents by sex indicated that all respondents were females, 100 (100 percent) who are pre exposed to post natal complications.

Most of respondents in terms of tribe were Banyankole 46(46 percent), because they are the habitants of the area of study, followed by Baganda 37(37 percent), Bajika 12(12 percent), Bakonjo 4(4 percent) and lastly others 1(1 percent)

Respondents by education level shows that most of respondents fifty nine(fifty nine percent) had tertiary education which shows that at least they have ever heard of post natal complication or they know about post natal complication, causes and management, followed by 24(24 percent) who had secondary education, which shows that they had some knowledge on post natal complications, primary level of education were 11(11 percent and finally without formal education were 6(6 percent) which means that they have no knowledge on post natal complications.

Respondents by occupation shows that majority of respondents sixty five(sixty five percent) were students followed by self employed 19(19 percent) and 16(16 percent) were civil servants who have knowledge on post natal complications and there effect.

Respondents by religion shows that most of respondents 80(80 percent) were Christians, followed by 20(20 percent) of the respondent were Muslims, this shows that most of the residents are Christians who are either pre – exposed to post natal complication, or are victims of post natal complications.

According to the records shows that there are occurrence of different conditions during different months of the year PPH mostly occurred in the months of between February and April 2010 with five(42 percent) followed by 4(33 percent) in the months of November to January this is because by this months either people are planting or harvesting and mothers after delivery are working hard because of poverty and are exposed to post natal complications like PPH. Then there was reduced cases of PPH in the months of May to July 1(18 percent) and August to October 2(17 percent)

Malaria mostly occurred in the months of November to January fifty four (38 percent) and months of August to October 42(42 percent), because this is the rainy season and most months cannot afford the use of mosquito nets and hence exposed to malaria, but there was a reduction in malaria infection in the months of May to July 14(14 percent) and February to April 2013.

Puerperal Sepsis was high in the months of February to April 2013 Forty five cases and months of May to July because it's the time when people are busy either planting or harvesting hence no time to take care of themselves or mothers who have delivered

CONCLUSION

Majority of respondents more than 70 percent have knowledge on what is post natal clinic its advantages and complications as a result of not attending post natal clinic. Because they said that in post natal clinic they are told about complication after delivery, prevention of this complications and control of this complications.

They mention some of the predisposing risk factors as;

Poor hygiene after delivery.

Poverty no money to buy sanitary towels.

Delivery at home.

Lack of regular medical check ups both ANC and PNC.

Over bleeding especially after delivering at home.

RECOMMENDATION.

Government should encourage health education on causes and prevention and control of post natal complications.

People should be medically checked regularly before and after delivery.

People should use mosquito nets.

People should be treated of other conditions like vaginal bleeding immediately after delivery.

Eradicate poverty by the government.

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APPENDIX I: DATA COLLECTION FORM
A REVIEW TO THE MORBIDITY PATTERN OF POST NATAL CLINIC IN MOROTO
HOSPITAL-UGANDA.

PART A: SOCIO DEMOGRAPHIC DATA

Age of the respondents.....

Level of education

Marital status

Occupation

Religion

Sex

PART B: KNOWLEDGE.

	Prev. no.												
Condition	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	total
1.PPH													
2.malaria													
3.peurperal sepsis													
4.diarrhea													
5.neonatal sepsis													
6.anaemia													
7.pneumonia													
8.malnutrition													
9.HIV													
10. PID													

