# FACTORS INFLUENCING SAFE DELIVERY SERVICE UTILIZATION IN SELECTED HEALTH FACILITIES IN MASINDI DISTRICT

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**BMS/0029/133/DU**

**A RESEARCH PROPOSAL SUBMITTED TO KAMPALA INTERNATIONAL UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY**

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**NOVEMBER 2018**

**DECLARATION**

I **ANITA PRISCILLA MURUNGI**, declare that this research proposal titled***Factors affecting Safe Delivery Service Utilisation in selected health facilities in Masindi District*** is my own work except where acknowledged in the text. No part of this work has been submitted for any degree or any other qualification in this university or any other higher institution of learning and that all my sources have been acknowledged and adequately referenced.

Signature: _____ Date: _____

ANITA PRISCILLA MURUNGI

## APPROVAL

I hereby certify that this work herein was done under my close supervision, guidance and thereafter submitted to the designated authorities for assessment with my approval.

Signature: ..... Date: ……..

DR. JIMMY BEN FORRY
(RESEARCHSUPERVISOR)

## ACKNOWLEDGEMENT

Writing a report is never an easy task and with this in mind, I would like to acknowledge my supervisor for his scholarly guidance throughout the development of the proposal and my research assistants for their unwithering dedication during the data collection process. It was indeed a collaborative effort by many people whether mentioned by name or not.

The ultimate credit goes to God Almighty, the saviour and guide of my life. To him be glory both in heaven and earth, forever and ever amen.

First my most sincere appreciation goes to my supervisor Dr Jimmy Ben Forry who tirelessly guided me through to see that this work was finished on time.

Secondly, my appreciation goes to my blessed parents Mr. and Mrs. Wandera for their support and prayers throughout my life. May the blessings of God sustain their life and health so that they can reap the fruits of their labours deservedly.

Thirdly, I wish to extend my sincerest thanks to Dr Bunyata Samuel Gift for his support, encouragement and guidance during the writing, and guiding me in the data analysis process.

## DEDICATION

I dedicate this report to my Family THE WANDERAS who showed love and for their continuous encouragement. Without them I would not be the person I am today. God bless you all.

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## LIST OF ACRONYMS

**MDGs:** Millennium Development Goals

**AIDS:** Acquired Immunodeficiency Symptoms

**HIV :** Human Immunodeficiency Virus

**DHS:** Demographic and Health Survey

**MOH:** Ministry Of Health

**WHO:** World Health Organization

**NHP I:** National Health Place I

**NHP II:** National Health Place II

**NGO** : Non-Governmental Organisation

**NDP** : National Developmental Plan

**ICPD:** International Conference on Population and Development

## DEFINITIONS

**Traditional birth attendant**: Non formally trained and community-based providers of care during pregnancy, childbirth and the post-natal period.

**Maternal mortality**: Death of a woman as a result of: being pregnant, labour mismanagement or post-natal period.

**Labour**: The process of childbirth, especially the period from start of uterine contractions to delivery.

**Pre-eclampsia**: A condition in pregnancy characterised by high blood pressure, sometimes with fluid retention and proteinuria.

**Haemorrhage**: Escape of blood from a ruptured blood vessel, especially when profuse.

**Obstructed labour:** When even though the uterus is contracting normally, the baby does not exit the pelvis during child birth due to physical block

# CHAPTER ONE: INTRODUCTION

## Background

Millions of women die worldwide as a result of complications arising from pregnancy and childbirth. Sub-Saharan Africa alone accounts for forty-seven percent of the deaths (WHO 2005; Ronsmans& Graham 2006). Furthermore, for every woman who dies, approximately twenty more are attributed to pregnancy or childbirth related injuries and this finding has more profound effects on their families' lives as a whole (WHO 2004).

Increasing the population of women who deliver in a health facility can be important s to reduce maternal mortality in low-income settings. It is globally recognized that one of the main challenges to achieving Millennium Development Goals (MDGs) of a global reduction of maternal death by 75% by 2015 is; the low portion of women who deliver with skilled birth attendant, and deliveries in health facilities can ensure that women are attended by skilled personnel.

The development of the second National Health Policy (NHP II) has been informed by National Development Plan for the period of 2010/11-2014/15, the 1995 Constitution of the Republic of Uganda and the new global dynamics. The NDP places emphasis on investing in the promotion of people's health and nutrition which constitute a fundamental human right of all people. Their task was to review the NHP I adopted in 1999, determine the elements of policy which were still appropriate and needed to be carried forward in the new policy and identify new and emerging issues that required policy guidance. The focus of NHP II shall be on health promotion, disease prevention and early diagnosis and treatment of disease. It will specifically prioritize the effective delivery of the Uganda National Minimum Health Care Package(UNMHCP), more efficient use

of available health resources, strengthening public and private partnerships for health and strengthening of health systems.

Safe delivery refers to intentionally giving birth with assistance of a medical professional or birth attendant. Anattendant should have a range of skills, be able to identify problems, recognize complications early,perform essential basic interventions and make referrals for appropriate care when necessary. Skilled attendance at delivery is advocated as "the single most important factor preventing maternal deaths"(is one of the indicators for Millennium Development Goal 5.)

Each year more than 500,000 maternal deaths occur worldwide, four million new-borns die and another three million babies are stillborn and nearly all these deaths take place in low income and middle income countries and most could be prevented with current medical care (et al C Ronsmans, WJ Graham A global picture of poor-rich differences in the utilisation of delivery care) in Most obstetric complications occur around time of delivery and cannot be predicted. et al C Ronsmans, WJ Graham A global picture of poor-rich differences in the utilisation of delivery care) Therefore it's important that all pregnant women access. Maternal mortality is persistently high in Uganda. Access to quality emergency are (EmOC) fundamental to reducing maternal and new-born deaths and s a possible way of achieving the target of the millennium development goal. Pregnant women and their parents who are HIV-positive or think they may be infected should consult a trained health worker for counselling on reducing risk of infecting the baby during pregnancy, childbirth and breastfeeding and caring for themselves and the baby.

The average population growth for Sub-Saharan Africa is about 2.1%. Uganda is one of the countries in the world with high annual growth rate of 3.4% and the total fertility rate of 6.9% children per woman of child bearing age. (United Nations Development Programme2004:3)

proving that about 1.2 million women become pregnant every year. Of these 180,000 will get complications while 500 per 100,000 live births will actually die (Ministry of Health, 2005b:8)

Sub-Saharan Africa is particularly relevant given the overriding influence of religion on social fabric of Africans and the unacceptability of high levels of maternal mortality in the region. The need to achieve the stipulated reductions in maternal and child mortality levels by two-thirds as per MDG2015 has inspired vigorous research though there are gaps that need to be filled if more holistic and appropriate interventions in line with those goals are to be implemented. This study will serve the above purpose given its constructs and attributes.

**Problem statement**

Almost two decades since initiation of safe motherhood initiative, maternal mortality is still soaring high in most developing countries. In 2000, WHO estimated a lifetime risk of maternal death 1 in 16 Sub-Saharan Africa while it was only 1 in 2800 in developed countries. This huge discrepancy is due to differences in access and use of maternal health care services especially in East African countries such as Uganda. There is high maternal and child mortality rate this study will aim to determine the rates of uptake of safe delivery services by pregnant women in Masindi district and the associated factors.

**Objective**s

**1.3.1 Broadobjective:** To determine the socioeconomic and cultural factors influencing safe delivery service utilisation

### 1.3.2 Specific objectives:

1. To identify safe delivery services.

2. to determine the level of knowledge on safe delivery services provided.

## RESEARCH QUESTIONS

1. What are the socioeconomic and cultural factor influencing safe delivery service utilisation?

2. What safe delivery services have been put in place, and are they being utilised?

3. What is the level of knowledge on safe delivery services provided?

## SCOPE OF STUDY

### Subject scope

The scope of study is determining factors influencing choice of delivery services among health facilities in Masindi District.The relationship between socioeconomic and cultural factors and their influence of utilisation of safe delivery services has more to be desired because it is believed that these may have led to an increment in the number of maternal and child death rates and people may not be aware of what's at hand.

### Geographical Scope

The study will be carried out in Masindi District which is found in Western Uganda, in Bunyoro sub-region and covers an area of 2,594.6 square kilometres (997.9 square miles). It is bordered by Nwoya District to the north, Kiryandongo District to the east, Nakasongola and Nakaseke Districts to southeast, Kyankwanzi District to the south, Bulisa District to the northwest and Hoima District

to the southwest. This is an area of interest as it gives a broader picture on the factors as they affect low income areas and since this district is among the few rural areas with these vast factors that affect safe delivery service utilisation.

**Time scope**

This study is estimated to take about 5 months, of which the first month will be seeking permission from the local council and district medical officer in charge, to solicit funds. The next prepare an appropriate questionnaire and visit the few health centres that will have given permission. The months that follow there after that will involve collecting data and analysis.

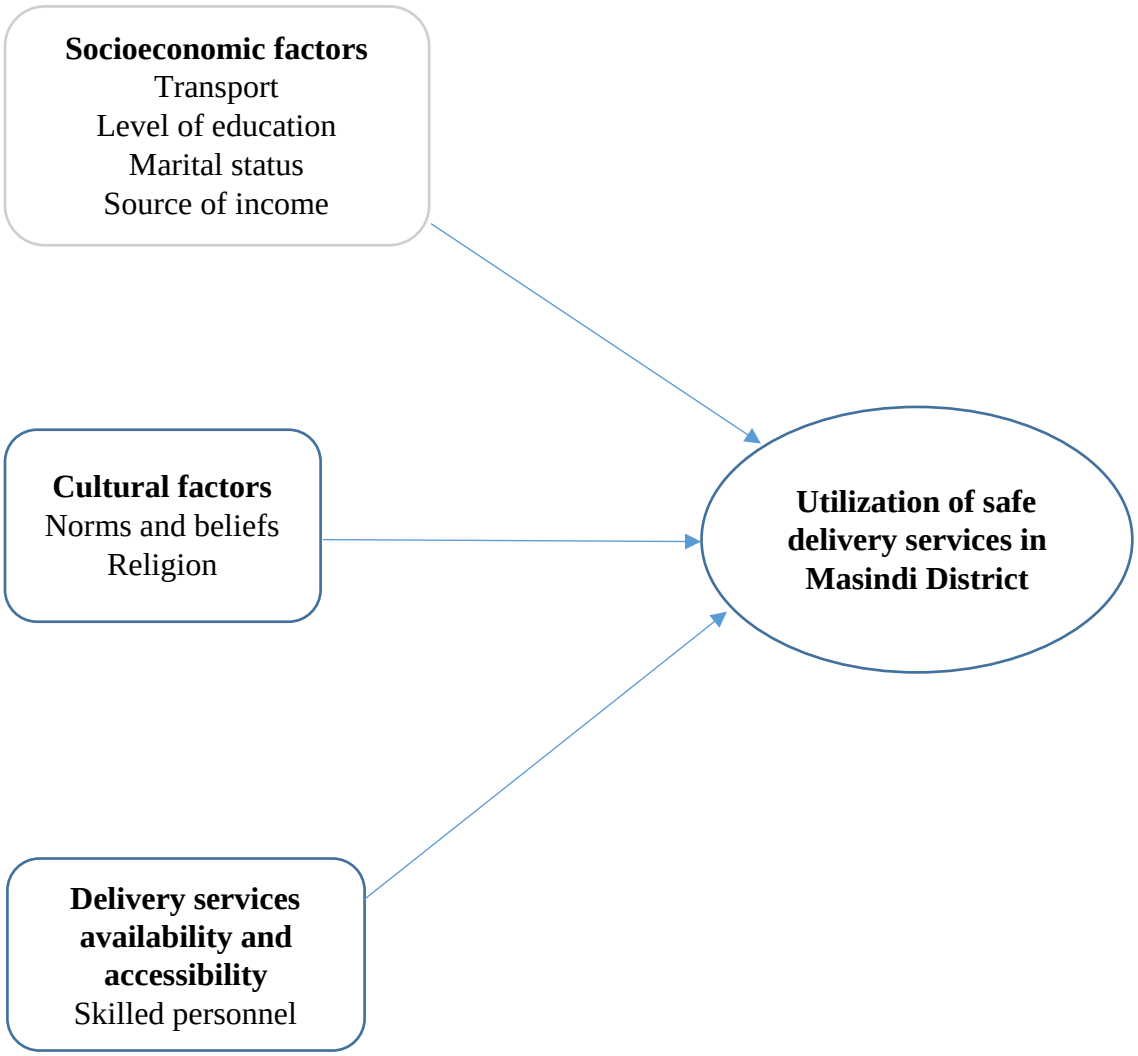
**Justification**

This study has not been sufficiently discussed or researched in Uganda, and significantly the use of skilled care in this district is still lacking and is below the target set by ICPD+ of attaining 80% of deliveries attended by skilled personnel by 2005. However, there are still some gaps that still need filling:

1. To equip the people in the selected health facilities of Masindi district with knowledge about the role of socioeconomic and cultural factors influencing safe child birth practices and the advantages.

2.To improve coverage of health facilities, raising awareness of both men and women on the danger signs of pregnancy/ delivery and strengthen counselling on facility delivery and individual's best preparedness.

**Conceptual Framework**



# CHAPTER TWO: LITERATURE REVIEW

## Availability and accessibility to safe delivery services

People in poor countries and areas tend to have less access to health services than those in better off countries and areas. Articles on disparities between low and middle income countries using a framework incorporating quality, geographical accessibility, financial accessibility and acceptability of services.

In Uganda, lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have not yielded an increase an increase in utilisation of those services by women or reduction in high ratio of maternal deaths. A study was done in Hoima District a rural district near Masindi District, whose aim was to enhance understanding of why when faced with complications of pregnancy or delivery, women continue to choose high risk options leading to severe morbidity and even their own deaths. The findings demonstrated that adherence to traditional birthing practices and beliefs that pregnancy is a test of endurance and a maternal death a sad but normal event, are important factors. Use of primary health units and referral hospital was a last resort.

DHS data from 40 countries collected between 1995 and 2003 documented that more than 50% of neonatal deaths occur after home birth without skilled care attendance (Lawn et al 2005 Walravel et al 1995) documented that home births without trained attendant resulted in three times higher perinatal mortality than those in health facilities with trained attendants in rural Tanzania. Socioeconomic variables and physical distance from health facility influence place of delivery (Elo1992: Nwakohy1994; Bolam et al 1998; Yanagisawa et al 2006) in Tanzania for instance 84

% of women who gave birth at home intended to deliver form health facilities but couldn't because of distance and transportation problems (Bicego et al 1995).

Based on the gender framework (Rathgeber and Vlassoff 1993; Tanner and Vlassoff 1998) this study will combine the understanding of gender issues relating to health and help-seeking behaviour with epidemiological knowledge concerning the place of delivery. This framework consisted of; available cash, and opportunity cost of action for example transportation. Secondly social activities which included health roles within households, decision power within household and use of health services.

Some of the factors that lead people into going to traditional birth attendants are the belief that the health workers neglect the mothers and treat them poorly, or due to a bad previous experience, some people complain of poor means of transport to the health facilities, and inability to afford requirements such as gloves, cotton wool and sometimes the men tend to control all the finances and dominate on making the decision (Loes Keyser and Hellen Hintijens 2012).

**To determine safe delivery services have been put in place, and are they being utilised**

In technical constitution held 10 years ago, Safe motherhood initiative it was clearly stated that "Having a health worker of midwifery skills present at childbirth, backed up with transport in case of emergency referral is perhaps most critical intervention for making motherhood safe. “This is used as one of the important indicators to monitor progress towards the achievement of the Millennium Development goal of reducing maternal mortality ratios. The target set at the International Conference of Population and Development+5 (ICPD+), is to have more than 80% of deliveries assisted by skilled birth attendants globally by 2005, 85% by 2010 and 90% by 2015. (Ackermann-Liebrich et al 1996; Sorensen et al 2000; Wogle et al 2004 and Walraven et al 1995).

Other pillars of safe motherhood that have been put in place at MulagoHospital (Jane Nabunnya et al 2013) like; family planning- which includes various contraceptive methods and treatment of involuntary infertility and allow individuals to anticipate and attain a desired number of children (WHO 2013).

Ante-Natal Care-the programme of medical management of pregnant women directed towards making pregnancy and labour a safe and satisfying experience with an outcome of a healthy baby and mother (Sentumbwe and Mugisa 2013). Here pregnant women receive treatment for anaemia, urinary tract infections, pre-eclampsia, immunisation, against Tetanus, HIV information is displayed on the walls advising on voluntary testing and treatment.

Clean and Safe Delivery- presence of skilled attendants in a health facilities using clean supplies (surgical gloves, cotton wool, syringes) in delivery of a baby.Post abortion Care-Treatment and counselling. STD-HIV control- Messages on the walls about voluntary testing, counselling and treatment. Screening women helps prevent mother to child transmission(PMTCT)

**To determine the level of knowledge on safe delivery services provided**

Of more than 130 million births occurs each year, an estimated 303,000 result in mothers' death, 2.6 million is still born and another 2.7 million in new born deaths within first twenty-eight days of birth. WHO formed a safe child birth check-list, and this check-list addresses major causes of maternal death such as haemorrhage, infection, obstructed labour. The check-list also addresses the cause of neonatal deaths e.g. asphyxia, infections, complications related to prematurity.

Prenatal care provides an important entry point for pregnant women into the health care system and offers te unique opportunity to organise the necessary services for pregnant women in order to ensure a healthy pregnancy, safe delivery and a healthy mother-baby pair. WHO recommends a

series of perinatal services based on the four visit model, to be offered to pregnant women depending on the gestational age and needs of the individuali.e. Focused Antenatal Care(FANC). This targets unique challenges of each pregnant woman and includes health promotion and disease prevention and at times people learn more about safe child birth services provided and how they can access them.

Safe motherhood voucher programme coverage of health facility deliveries among poor women in South-Western Uganda, where there is use of vouchers hence placing purchasing power in the hands of targeted consumers to improve up take of health care services in low-income settings, this encourages more women of child bearing age to get interested in the services being provided hence increasing the knowledge. You can measure success of such interventions by seeing extent to which the programmes have succeeded in reaching the target population.

Although motherhood is often positive and fulfilling experience for many women in low-income settings it is associated with suffering, ill-health and even death (World Health Organisation2012). A key factor influencing the uptake of appropriate health services is access which is defined along three dimensions; availability, acceptability and affordability of the services (Thiedeet al.2007). Utilisation of a service depends on how it's perceived by the community and its individuals. These dimensions affected the poor more than the rich (Campbell and Graham 2006; Ronsmans and Graham: Hill et al 2007; Peters et al2007; Mahmood 2010) asthe lifetime risk of dying during or following pregnancy in Sub-Saharan Africa is 1 in 39 compared with 1 in 3800 in the developed world (WHO 2012)

There have also been several multimedia campaigns and health education on the benefits of safe child birth services and community outreaches have also been put in place.

# CHAPTER THREE: METHODOLOGY

## Study design

This was a cross sectional research design. I was not be able to study the entire Uganda therefore this particular study design provided a snapshot of the current situation nationwide.

**Study population**

The study will focus on women of reproductive age in Masindi District and their utilisation of safe delivery service.

**Study criteria**

**Inclusion criteria**

Includes women within reproductive age between 15-44years who have had a child within the last 5 years and are at outpatient department for non-obstetric or gynaecological cases.

**Exclusion criteria**

Includes all women below 15 years and above 44 years who have not had a child within the last 5 years and are at the hospital for obstetric or gynaecological cases.

**Study setting/site**

Masindi District is found in Western Uganda, in Bunyoro sub-region and covers an area of 2,594.6 square kilometres (997.9 square miles). It is bordered by Nwoya District to the north, Kiryandongo District to the east, Nakasongola and Nakaseke Districts to southeast, Kyankwanzi District to the south, Bulisa District to the northwest and Hoima District to the southwest. This district has an estimated population of approximately 352,400 during the 2012 mid-year population census of the district, 50.1%of this population were males and 49.9% females. In Masindi is one district hospital, two health centres. Eight health centres that the government. NGO and private, bringing total of forty-three.

**Sampling technique**

The sampling technique adopted a non-scientific method of convenience based on ease of accessibility, except for the general government hospital where the research adopted a scientific technique of systemic random sampling due to the homogeneity of the participants in the sample.

**Sample size determination**

The study recruited 10 females of reproductive age from each of the selected health centres to include a total of 50 women that participated in this study.

$$\text{SAMPLE SIZE (n)} = \frac{Z^2\, p\, (1 - p)}{d^2}$$

Where:

n =sample size

Z= a standardized normal deviate value equal to 1.96

P= estimate of women who are to be interviewed

d= margin of error which correspond to the level of precision of results desired

**Research instruments**

The study will employ the use of a standardized questionnaire developed from earlier studies related to safe delivery service utilisation and factors influencing it. The questionnaire will be divided into two major parts focusing mainly on socioeconomic and cultural factors and their influence on safe delivery service utilisation.

**Data processing and analysis**

The primary data from the questionnaires will then be coded for entry into the computer system. The raw data will be extracted from the questionnaires by entering the results in an excel sheet. The data will then be organized, coded and filtered using SPSS software. Both descriptive and

inferential statistics techniques will be employed to analyse the coded data. Data will be first analysed using descriptive statistics and cross tabulation.

**Ethical considerations**

Before commencement of the research activities, permission to conduct the study will be obtained from the Research Ethics Committee of the faculty of clinical medicine and dentistry at Kampala International University, Western Campus. A written permission will be obtained from the district health officer of Masindi district. Also a permission letter will be obtained from the medical supretenand of the different health centers and also an introduction letter will be obtained from the in-charge of the Obstetrics ward in the selected health centers.

Furthermore, for a researcher to obtain the required information from his respondents, he ensured the trustworthy and confidentiality of whatever information given by the respondents. Every gathered data was treated with confidence and respect. Also respondents were free to accept or deny the chance of participating in the study as none of them would be accused in either way.

Furthermore, the researcher ensured that in interview questions there is no hidden agenda apart from the one stated in the introductory part of the interview sheet. And the researcher ensured that there would neither be psychological harassment nor intimidation done to respondents.

**Dissemination of results**

Copies of the final results will be submitted to:

i) KIU TH library for future reference

ii) Personal copy for reference and further dissemination of results in seminars, meetings and workshop.

# CHAPTER FOUR: RESULTS

Findings presented in this chapter are the result of responses from 50 respondents according to the sampling procedures explained in the previous chapter.

**Characteristics of respondents**

32% of the respondents were below 25 years, reflecting on the young age of the mothers. The majority of respondents where Christians 64 percent, 18 percent were Muslims and 18 percent were other domains and non-believers.

Seven in ten of the respondents are married or have ever been married. Three in ten of the respondents have never been married. Two in five are currently staying with their partners.

A majority of respondents live in rural areas (70 percent) and the remaining 30 percent live in urban areas.

Sixteen percent of the respondents have never received any formal education. Majority of the respondents only having attained primary education.

Table 1shows the different age groups of the 50 females who were interviewed and their background characteristics.

| **Age ranges** | **Marital status** | | | | **Religion** | | | **Residence** | | **Education** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Married** | **Single** | **Separated** | **widowed** | **Christian** | **Moslem** | **Oth Ers** | **Ur Ban** | **Rural** | **No Educ** | **pri** | **Sec** | **tertiary** |
| 15-24 | 07 | 08 | 01 | 00 | 10 | 03 | 03 | 06 | 10 | 02 | 09 | 04 | 01 |
| 25-34 | 08 | 07 | 07 | 01 | 15 | 04 | 04 | 05 | 18 | 03 | 11 | 05 | 04 |
| 35-44 | 06 | 00 | 03 | 02 | 07 | 02 | 02 | 04 | 07 | 03 | 02 | 03 | 03 |
| **Total** | 21 | 15 | 11 | 03 | 32 | 09 | 09 | 15 | 35 | 08 | 22 | 12 | 08 |

**Safe delivery utilization**.

Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness to the mother, baby or both. (Van

lerberghe and Brouwere 2001; WHO 2006). Nearly more than half. (54 percent) delivered from health facility by skilled health professionals during their last pregnancy.

Eighty-seven percent of births to urban mothers during their last pregnancy were held at the health facility by a skilled health provider compared to 69 percent of births to rural women.

The like hood of a delivery to take place at the health facility corresponded to level of education. 50 percent of those with no level of education delivered from a health facility.79 percent of respondents with any level of education delivered from a health facility. 73 percent of those with primary education, 75 percent of those with secondary education and 100 percent of those who attained tertiary education all delivered from a health facility. A similar relationship is apparent with wealth.

Ninety-two percent of mothers who delivered from the health facility during there last pregnancy attended antenatal care at least once or more. The more the number of times of antenatal care attended during pregnancy the more likely one would deliver from the health facility.

The older the individual was the more likely one was to deliver from health facility.

Table 2 showing relationship between age with marital status, place of delivery and number of times of ANC.

| **Age** | **Marital status** | | | | **Number of times ANC** | | | | **Place of delivery** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **married** | **single** | **separated** | **divorced** | **0** | **1** | **2 to3** | **>4** | **Facility** | **Home** | **TBA** |
| **15-24** | 07 | 08 | 01 | 00 | 05 | 06 | 03 | 02 | 11 | 04 | 01 |
| **25-34** | 08 | 07 | 07 | 01 | 02 | 04 | 11 | 06 | 16 | 03 | 04 |
| **35-44** | 06 | 00 | 03 | 02 | 01 | 03 | 05 | 02 | 10 | 01 | 00 |
| **Total** | 21 | 15 | 11 | 03 | 08 | 13 | 19 | 10 | 37 | 8 | 05 |

Table 3 Relationship between places of delivery with residency, education, marital status.

| **Place of delivery** | **Residency** | | **Level of Education** | | | | **Marital status** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Urban** | **Rural** | **No education** | **primary** | **Secondary** | **Tertiary** | **Married** | **Never married** | **separated** | **Widowed** |
| **Health facilty** | 13 | 24 | 4 | 16 | 9 | 8 | 20 | 6 | 9 | 2 |
| **Home** | 2 | 6 | 2 | 4 | 2 | 0 | 1 | 5 | 1 | 1 |
| **TBA** | 0 | 5 | 2 | 2 | 1 | 0 | 0 | 4 | 1 | 0 |
| **Total** | 15 | 35 | 8 | 22 | 12 | 8 | 21 | 15 | 11 | 3 |

Table 4. Relation between numbers of times of ANC compared to place of delivery.

| Place of delivery | Number of times of ANC during last pregnancy | | | |
|---|---|---|---|---|
| | never | Once | 2 to 3 | >4 |
| Health facility | 3 | 7 | 17 | 10 |
| Home | 3 | 4 | 1 | 0 |
| TBA | 2 | 2 | 1 | 0 |
| Total | 8 | 13 | 19 | 10 |

## CHAPTER FIVE: DISCUSSION

The aim of the discussion is to determine factors affecting safe delivery service utilisation among the women of reproductive age in Masindi Regional Referral Hospital, Bwijanga health centre IV and three other health centres. The data is analysed and presented according to research questions on questionnaire.

**Socioeconomic and cultural factors are affecting the use of safe delivery services**

Response to the above question, respondents revealed that in rural areas, tragically people die unnecessarily. This is a concept known and recognized throughout the world that the inhabitants of urban areas tend to be more exposed to better facilities as compared to those in rural areas.The reasons are not only linked to health care costs that often reflect health systems most technologically advanced and rich resources. Over the past two to three decades, our understanding of poverty has broadened from a narrow focus on income and consumptions to a multidimensional notion of education, health, Social and political participation and rights, personal security and freedom, and environmental quality.

Thus poverty encompasses not just low income, but lack of security, and powerlessness. Multidimensional poverty is a determinant of health risks, health-health outcomes. An estimated 31 percent of respondents who leave in rural areas were not able to access health facilities at delivery during their last pregnancy. From the study it has also been noted that 95 percent of women who are married are more able to access the services, provided that most of them had support from their partners unlike the 41 percent that is unmarried or no longer married that showed a marked reduction in the ability to access the services provided during the last pregnancy. Mothers who were employed

are abler to support themselves through antenatal care and able to attain transport that can be of help when there is need to access delivery services from a health facility.

It also came to notice that most women who had cultural beliefs such as use of herbs for pelvis widening and herbs to reduce pain during contractions, and those who also believed that their babies were better off delivered by traditional birth attendants, or by the help of their grandparents who have had a similar experience. The constant belief that health workers were unfair and harsh and unfriendly as seen among 18 percent of the respondents. The conservative nature of some people in fear that everyone who goes to the health facility has to undergo caesarian section which has led to death of their fellow women and some find it as a sign of weakness and cowardice not to deliver vaginally at home like any other strong woman would.

**Knowledge and awareness of the safe delivery services provided**

The inequality of distribution of required medical equipment at different health centers as noted among 22 percent who did not appreciate the fact that everything even at a government facility had to be bought at the time of delivery such as gloves, razorblades, catheters, cannulas. The role of Antenatal care has also been mandated in the choice of place for delivery as 92 percent of women who attended antenatal care later returned to deliver at health facilities as per the awareness on the advantages of hospital delivery. Women that attended school, 79 percent deliver from health facilities and that is in response child health education given at different levels of education and more emphasis put especially on secondary school students on the merits of delivering child in a health facility and the demerits of the outcome of doing otherwise.

In addition, it has come to attention that 78 percent that had communication devices such as radios, internet and televisions were more aware of the services provided in the health facilities, antenatal care and so much more with regards to safe delivery services.

**Study limitation**

This study was limited by several factors during the field work. Some of those limitations includes: lack of mutual cooperation from some respondents and fear to expose the real magnitude of malaria impacts in their communities.

Also the volume of qualitative data analysis was time consuming.

Furthermore, some respondents didn't give accurate information. All these hindered the successful progress of the work

Financially**,** the researcher met some constraints due to the fact that collection of some data required much finance and the researcher wasn't capable of meeting them all.

## CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

The previous chapter provided a presentation and analysis of the qualitative data and discussed the themes and subthemes that emerged from the data. This chapter will provide an overview of the entire study. Firstly, a concise summary of the literature review will be given. This will be followed by a summary of the empirical study and a section on the synthesis of the research findings. It will highlight the similarities and contradictions between the literature review and the empirical study. Then a conclusion to the study will be drawn based on the research questions. The limitations of the study will be explained and finally the chapter will conclude with recommendations and suggestions for further research.

Health providers such as the government and other private organizations should see to it that all the services put in place are favorable for the population they are trying to attract and that provision of services should not only be aimed at those who can afford but may also involve those who are unable to fend for themselves and yet still have an interest in making use of the health facilities available. The government should see to it that health facilities are further extended to the rural areas or that there should be services provided to be able to transport the poor at a totally no cost to deliver them to health centers and back to theirvillages.

Mass education of the population on the merits of delivering from a health care facility to both the mother and the child.

To all the health workers due to the knowledge attained through studies they should know that not all people have been exposed to the same form background so they ought to educate the mothers that come to the hospital instead of being unkind to them and in addition ensure that all equipment required for delivery is available at the health facility.

Also design a training program for managers, and technical staff to support and sustain the interventions. Define specific indicators of the success or failure of the interventions at specific time points. Develop a specific plan for reporting on the outcomes of interventions. Develop a process for adjusting the program in response to successes and/or failures of interventions. Implementation of the program and annual report and analysis of outcome variables.

People are required to be vigilant about their health and to be curious when it comes to new developments in the health sector. Alertness during radio and television talk shows on general health improvement. Husbands should support their wives through the pregnancy for example going for antenatal together and also accompanying them to the health facility at the time of delivery.

One study alone may not be able to give a clear picture on what has been done or what is to be done, so it is advised that more studies are done in relation to this so there is continuous assessment of the usage of health facilities and improvements put in place if any.

The burden of people that attained safe delivery services entirely depended on the socio economic and cultural factors along with beliefs and traditions that run among the people. It is also important to note that the services provided were not fulfilling as the poor were not catered for, also to note the behavior of health workers and how they were treating women needs more to be desired.

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# APPENDICES

## APPENDIX I: WORKPLAN

| Activity | Time frame |
|---|---|
| Proposal development | First month |
| Seek permission from local council and district medical officer | Second month |
| Prepare questionnaires and visit health centres | Third month |
| Collect data and analyse it | Fourth month |
| Discuss findings and fill in the gaps | Fifth month |

## APPENDIX II: CONSENT FORM

**CONSENT FORM FOR QUANTITATIVE RESEARCH PROJECT**

**TOPIC:** The socioeconomic and cultural factors affecting safe delivery service utilisation in selected health facilities in Masindi District.

**STATEMENT OF CONSENT**

I ……, hereby give my consent to allow ***ANITA PRISCILLA MURUNGI*** obtain the relevant information required from me regarding the above mentioned topic. I have given this consent when in proper health and under no form of coercion.

**By signing below, you are indicating that you;**

- ➢ Have read and understood the information document regarding this project.
- ➢ Have had any questions answered to your satisfaction.
- ➢ Understand that if you have any additional questions you can contact the research team.
- ➢ Understand that you are free to withdraw at any time, without comment or penalty.
- ➢ Agree to participate in the survey.

**Name: .....**

**Signature:**_____

**Date: .....**

**NOTE:** Please keep the copy of the information sheet and return the signed consent form to the Investigator

Thank you

**Please tickthe relevant box below:**

I agree to receive a short summary of key findings at the end of the study. ☐

I do not agree to receive the study key findings. ☐

## APPENDIX III: PROPOSED BUDGET

| **Item Description.** | **Quantity** | **Unit Cost ( @ )** | **Amount (shs)** |
|---|---|---|---|
| Pencils | 10 | 100 | 1000 |
| Notebooks | 5 | 3000 | 15000 |
| Tallying Sheets | 1 Ream | 18000 | 18000 |
| Ruled Paper | 1 Ream | 12000 | 12000 |
| Printing Paper | 1 Ream | 17000 | 17000 |
| Laptop Computer | 1 | Already available | Already available |
| Refreshments | 110 | 2000 | 220000 |
| Miscellaneous | | | 200000 |
| **TOTAL** | | | **483000** |

## APPENDIX IV: STUDY QUESTIONNAIRE

Dear respondent,

We are a team of individuals from Kampala International University School of Health Sciences that is interested in assessing the socioeconomic and cultural factors affecting safe delivery service utilisation. This questionnaire has been designed to be used as a tool for data collection after which relevant analysis will follow in order to draw logical conclusions and be able to make appropriate recommendations.

We sincerely hope that you will support our noble cause by agreeing to be part of our survey and in so doing filling this questionnaire. None of your responses will be revealed to any third parties not involved in the study without proper coding to maintain your privacy.

**NOTE:**

- Don't indicate your name on any part of this document.
- You have the liberty to consult about any part you do not understand fully.

We kindly request you to be honest in all your responses so that the data collected will give the actual picture representing the impact of knowledge and practices on the uptake of cervical cancer screening.

We will be humbled by your Co-operation.

**1. Name of the respondent**

……

**1.1. Area of residence**

……

**Date of birth/ years:……**

**2. Do you know to write and read?**

1. Yes

2. No

**3. If yes, what is the level of education that you have attained?**

1. No formal education

3.Primary education

4. Secondary education

5. Tertiary education

6. Other specify …….

**4. What is your religion?**

1. Muslim

2. Christian

3. Other specify ……

**5. What is your marital status?**

1. Single

2. Married

3. Divorce

4. Widow

**6. What is your occupation?**

1. House wife

2. Farmer

3. Business

4. Employed

5. Other specify…….

**7. What is your husband's Occupation?**

1. Unemployed

2. Peasant farmer

3. Business

4. Self employed

5. Employed

**8. How much money is made in the month?**

1. Less than 100,000

2. 100000- 500,000

3. Above 500,000

**9.How many children did you give birth? ……**

**10. Who is the head of the house hold?**

1. Yourself

2. Your husband

3. Other specify ……..

**11. When did you have your last birth? …….**

**12. Have you ever attended Antenatal clinic in your last pregnancy?**

1. Yes

2. No (If no skip to question 15)?

**13. If yes, how many times did you attended in the last pregnancy? ……**

**14. If no why?**

1. I didn't see any importance of antenatal clinic

2. Long distance to health facility from home.

3. High cost of services.

4. Unfriendly environment

5. Other specify …….

**15. Where did you deliver your last baby?**

1. Own home

2. TBA's home

3. Health facility

4. Other specify…….

**16. what is the source of health education?**

1. Radio

2. Television

3 . internet

4 Telescope

5. VHTS

**17. What is the means of transport when a pregnant mother referred to district hospital?**

1. Own transport

2. Public transport

3. Ambulance

4. Other specify ……..

**18. Is there any traditional habit in your community that should be done beforedelivery?**

……

……

**19. Is there any traditional issue that prevents women to deliver in health facilities at community?**

……

……

……

**20. What is your recommendation for improving services in your health facility?**

1. Increase number of health workers
2. Improve availability of drugs and supplies
3. The health workers should respect the women
4. We need ambulance
5. Other specify ……..

## APPENDIX V: MAP OF MASINDI DISTRICT