ASSESSING FACTORS AFFECTING MATERNAL HEALTH SERVICES AMONG RURAL WOMEN IN UGANDA
CASE STUDY: KABWOHE HEALTH CENTRE IV

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A POSTGRADUATE DISSERTATION PRESENTED TO SCHOOL OF ARTS & SOCIAL SCIENCES, DEPARTMENT OF GOVERNANCE AND PEACE STUDIES, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE MASTERS OF ARTS IN LOCAL GOVERNANCE AND HUMAN RIGHTS

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DEDICATION

This work is dedicated to all members of my family for their strong sense of understanding and commitment to preserve our strong family ties and values, even under some of the most difficult circumstances imaginable. In a special way, I dedicate the study to my children; Ariana Kaheeru, Alvin Kaheeru and Ariella Kaheeru for their patience and appreciation when I was trying to balance studies and family obligations even when they needed my attention most. To my dear husband Mr. Simon Robert Kaheeru for rallying behind me throughout this project.

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May the Almighty God reward all of them abundantly. Any errors and omissions in the report are entirely mine.

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ABBREVIATIONS AND ACCRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DV	Dependent Variables
IV	Independent Variables
MDGs	Millennium Development Goals
NHS	National Health Service
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Plan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHTs	Village Health Teams
WHO	World Health Organization

ABSTRACT

Studies about maternal health in Uganda point out that the maternal health of rural women constitutes 80% and there is still a gap in accessing maternal health services. This study assessed factors affecting maternal health services in government health facilities in Uganda taking Kabwohe Health Centre IV, in Sheema district as a case study. Specifically, the study examined how social, economic and cultural factors among rural women influence accessibility to maternal health services, the obstacles leading to constant increase of maternal issues among health workers sought possible solutions to the problems.

The study adopted a predominantly qualitative approach adopted a study used a Case study design of Kabwohe Health Center IV. Data was collected from 80 respondents using interview and semi structured questionnaires methods. Data was analysed thematically using themes and sub-themes.

The study revealed that factors such as poor transport facilities, lack of health equipment, beliefs and insufficient quality of staff that hinders the delivery of maternal health service at Kabwohe health centre IV. The study recommended that government and stake holders ensure recruitment and training of more health workers, improve on the transport systems and generally equip the health facilities in order to uplift the health services so that maternal health services are greatly implemented. Alternative ambulance services (motorcycles) should be placed at lower health centres to ferry women that need to access health centres for maternal health services. Vigorous awareness and sensitisation meetings on rights and responsibilities should be considered for both men and women to demand for their rights knowing what services they expect from government facilities.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

Maternal health is crucial in reducing the new born mortality rate and it is a way to eliminate child mortality. The most concern about safe motherhood is the wave effect that comes with caring for mothers. A baby whose mother dies during childbirth rarely survives. There are limited chances for babies whose mothers die within the first six weeks after childbirth to survive. Maternal health can significantly impact the state of the new born mortality rate as stated by the United Nations (Musoke, 2002). This implies that the lack of health care for the mother during pregnancy and childbirth also leads to tragic rates of infant mortality (March of Dimes Foundation 2009) and as Johnson (2010) posits these deaths are directly linked to inadequate or nonexistent maternal health care for millions of women everywhere. Thus efforts to reducing the new born mortality rate create an environment in communities that values human life from conception, and eliminates needless new born deaths.

The Ugandan case indicated that maternal health of rural women constitutes 80% and there is still a gap in accessing maternal health services (Musoke, 2002) yet this is a fundamental right (Right to health) as stipulated in the Universal Declaration of Human Rights (Article 25(1), 1948). But these merely express that despite the massive investments by government and other partners there still exists impediments to attaining maternal health that requires investigation. This study does so with the aims of coming with suggestion to reduce such impediments/challenges. This study assessed the factors that affect maternal health services in government health facilities in Uganda using Kabwohe Health Centre IV, in Sheema district as a case study. It uses a human rights approach in understanding the impeding factors to maternal health and it further looks at both the supply side (the service providers) and the demand side (consumers or those who use such services) for the following reasons. First for the fact that the attainment of right health (maternal health inclusive) is not one person's responsibilities and secondly it has a policy connotation that requires the supply side actors such as the government or state institutions to operationalize it. Thus, the need to establish these factors from both angles is crucial in order to suggest all-encompassing strategies to the problem of maternal health. Thirdly for other reasons advanced in the later sections of this chapter.

This chapter presents the background of the study, the statement of the problem, objectives of the study, Research questions, Scope, significance, justification of the study, definition of key terms and the conceptual framework.

1.1Background of the Study

The article three of Universal Declaration of Human Rights states that "Everyone has the right to life, liberty and security of person". This implies that right to health and maternal health is a fundamental right to which every pregnant mother is entitles to. However, World Health Organization (2010) estimated that "Every day around the world, 1500 women die from pregnancy- or child birth related complications" (Johnson, 2010, p.40). this is said to be the failure for many pregnant women not receiving the care they need before, during and after childbirth and up to 1 million pregnant women die every year from what are considered "largely avoidable causes" (Johnson, 2010). Further still, more than 536,000 women die annually from complications related to pregnancy or childbirth in 2011 according to the United Nations Summit (UN 2011, p.1). The reality is that pregnancy is not a disease, but maternal mortality is one of the leading causes of deaths of women globally. Out of these total deaths across the world, 95 percent of all maternal deaths occur in developing nation-states, the majority of them preventable and caused by complications that are hardly ever lethal in wealthy nation-states (UNFPA, 2009, p.3).This clearly raises the question of whether the right to health in particular maternal health or maternal health care is a mystery or reality. This is imperative to ascertaining the impediments to factors affecting maternal health. But first it's important to understand what maternal health entails and later explored in context of human rights framework. Approaching this study from this point of view will not only give an opportunity to advance women centered approach but to discern policy alternatives for both states (suppliers) and individuals (consumers).

Understanding Maternal Health and Right to Health

Maternal health or Maternal health care refers to prenatal, obstetric, and postnatal health care (World Health Organization, 2010) that, at minimum, means several things according to Johnson (2010, p.40) which include; (1) having access to a skilled health care professional when needed during pregnancy; (2) having a skilled health care professional present during delivery if desired; (3) the access and ability to utilize basic emergency obstetric care; and (4) having access to a

skilled health care professional as needed for 42 days after the birth of a child or the termination of a pregnancy (such as through miscarriage). This implies the crucial role of both the state or governments and individual beneficiaries must not be undermined. In fact it with the realm of state or governments to ensure the right to health, maternal health as defined above is embraced.

Ideally maternal health care should include more than having mere access to a skilled healthcare professional, and states should be encouraged to go beyond providing only the four minimum standards stated above. Nonetheless, because as many as 2/3 of maternal deaths in the world today are considered to be preventable, even these minimum requirements for maternal health care would make a tremendous difference in reducing maternal death globally (White Ribbon Alliance, 2010) The definition of maternal health care above draws from the maternal mortality reduction strategy outlined by Human Rights Watch:

> There is broad global consensus on three critical maternal mortality reducing strategies – skilled attendance at birth,11 access to emergency obstetric care,12 and access to referral systems ...Available research suggests that access and ability to utilize emergency obstetric care will have maximum impact on maternal mortality ... The most skilled attendant cannot save a woman experiencing life-threatening pregnancy-related complications unless she is able to reach the appropriate health facility in time. A strong referral system is not limited to ambulance services. It must at a minimum provide obstetric first aid in case of emergencies and have easily accessible and affordable around-the-clock health care and referral facilities that connect both private and public health facilities. For all three core interventions to successfully reduce and eliminate preventable maternal mortality and morbidity there has to be a functional public health system. Hence the global priority that is being given to maternal mortality reduction is increasingly hailed as an opportunity to improve public health systems (Johnson, 2010, pp.42-43)

Maternal health and maternal health care are to be distinguished. The right to maternal health (like the right to health generally) encompasses a range of divergent factors and underlying human rights that must be realized to fully realize the right to maternal health (such as food, clean water, and other socio-economic factors). While the underlying conditions that pregnant women face around the world are a critical part of their right to maternal health, as an attempt to define a set of minimum standards and to develop attainable, enforceable duties on governments to prevent maternal mortality, this study focus only on both the duty of governments to provide pregnant women with maternal health care, arguing that duty exists in international human rights

law (Hill, 2009) and the women accessibility of these services. From the above definition, the link between what maternal health is, and the right to health and especially maternal health stated in article three of the UDHR cannot be underestimated and will definitely affect maternal health of pregnant women which this study seeks to establish.

The above conceptualization also supports the world's conception of maternal mortality not only as a health issue, but also as a human rights violation. This has led to the international community to adopted several international commitments, with the goal of ensuring maternal health and women's right to life is attained. International treaties pertaining to women's rights and maternal mortality that have spelt out the need to enhance maternal health care or services of women include the Universal Declaration of Human rights (UDHR), the Convention of Elimination of All Forms of Discrimination against Women (CEDAW), and the United Nations Millennium Development Goals (MDGs). However, before the later concept was introduced, first below is a look at the cases of how maternal health has been conceptualized and operationalize across different countries and contexts.

Evolution and Trends in Maternal Health care or Services

Maternal and Child Health Program started way back in 1912 when Public Law (PL) in the United States of America, established the Children's Bureau under President William Howard Taft. The creation of the Children's Bureau on April 9, 1912, represented the culmination of over 6 years of effort on the part of determined citizens and child welfare organizations to persuade Congress to establish an agency primarily focused on the health and wellbeing of children. The creation of the Children's Bureau constituted the first public recognition that the federal government has a vested interest in and responsibility to promote maternal and child health. From the Children's Bureau "would flow knowledge of the conditions surrounding children's and mothers' lives, ideas on how to improve these conditions, and plans and programs for action." The Children's Bureau existed as a single entity responsible for the health and wellbeing of the whole child from its establishment in 1912 until a 1969 reorganization split the Bureau, separating Maternal and Child Health activities. During the roughly 60 years that the Children's Bureau existed as a unified entity, that promoted health and social wellbeing of children that other international bodies learnt to improve maternal and child health (Elliot, 1962).

Following the global challenges the policy orthodoxy that had focused on development through macroeconomic fundamentals had achieved limited results. For instance, the Asian financial crisis of 1997–98 sent shockwaves around the globe and Latin America was recovering from its own series of economic crises. Sub-Saharan Africa had suffered two "lost decades" of economic growth while a rampant HIV/AIDS pandemic infected twenty-five million people without a global treatment effort (McArthur, 2014). These experiences lead to the year 2000, the establishment of Millennium Development Goals (MDGs) aimed to respond to them.

In 2000, a crucial change offered political leaders an opportunity to revise the terms of global cooperation. As a result, a unique legitimacy to convene the global conversation, led by the then-UN Secretary-General Kofi Annan who was at the height of his influence and his perceived moral leadership was central to reframing debates around a new spirit of partnership. That spirit gave rise to the MDGs. The MDGs since became the world's central reference point for development cooperation. However, due to a range of divergent beliefs, the MDG launch process did not take place on a single date as a unified global policy effort, accompanied by explicit budgets, strategies, or operational procedures. Instead, the MDGs took shape through a complex mix of international political processes, agreements, and proposals, interwoven with real-time global debates. Perhaps inevitably, the complexity of formulating and launching these goals has led to a variety of common misunderstandings regarding their origins (McArthur, 2014).

The 2000 Millennium Summit of the United Nations established eight international development goals code-named the Millennium Development Goals (MDGs), following the adoption of the United Nations Millennium Declaration. All 189 United Nations member states at the time (there are 193 currently), and at least 23 international organizations, committed to help achieve the following Millennium Development Goals by 2015. Among the eight goals, the fifth goal is to improve maternal health. The targets sent and agreed upon in the maternal health were to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio i.e. maternal mortality ratio and Proportion of births attended by skilled health personnel. To achieve, by 2015, universal access to reproductive health that involves contraceptive prevalence rate, antenatal care coverage and unmet need for family planning (Kabeer and Naila, 2003). Globally, the maternal mortality ratio declined by 47 per cent over the past two decades, from 400 maternal deaths per

100,000 live births in 1990 to 210 in 2010. All regions made progress, but meeting the MDG target of reducing the ratio by three-quarters required accelerated interventions (Grown and Caren, 2005).

Global Scenario of Maternal Health

With 99% of maternal deaths occurring in developing countries, it should not be assumed that maternal mortality is not a problem in wealthier countries (WHO, 2011). In 2011, United Nations placed the United States 50th in the world for maternal mortality-with maternal mortality ratios higher than almost all European countries, as well as several countries in Asia and the Middle East (Coeytaux et al, 2011). Even more troubling, the United Nations data show that between 2008 to 2011, while the vast majority of countries reduced their maternal mortality ratios for a global decrease of 34%, maternal mortality nearly doubled in the United States (WHO, 2011). USA is a country that spends more than any other country on health care and more on childbirth-related care than any other area of hospitalization that amount up to US$86 billion a year. This is a shockingly poor return on investment (OECD, 2011; Andrews, 2011).

Given that at least half of maternal deaths in the United States are preventable, this is not just a matter of public health, but a human rights failure. The Universal Declaration of Human Rights states that "every human being has the right to a standard of living adequate for the health and well-being of himself and his family, including medical care and necessary social services" (Amnesty International, 2011). This means that the United States health care system must provide health care services that are available, accessible, and acceptable and of good quality. In addition, the health care system must be free from discrimination, must be accountable and must ensure the active participation of women in decision-making. Yet, instead, too many women in the United States face shortages of providers and facilities and inadequate staffing; financial, bureaucratic, transport and language barriers; care that is not culturally appropriate or respectful; a lack of opportunity for informed decision-making and the lack of a system to ensure that all women receive high-quality, evidence-based care. The comparatively high rates of maternal deaths in the United States is an indicator of the failure to ensure that women have guaranteed lifelong access to equitable, quality health care, including reproductive health services (UN, 2012).

Maternal, new-born and child health remains Canada's top international development priority and is committed to working with Canadian and international partners toward the goal of ending the preventable deaths of mothers, new-born and children under the age of five. Canada committed $3.5 billion to improve the health of mothers and children for the period of 2015-2020. This aims at targeting the most effective ways to reduce maternal and child deaths by prioritizing three programmatic areas: strengthening of health systems, improving nutrition, and reducing the burden of leading diseases. Canada looks forward to tackle emerging challenges, including greater emphasis on better reaching children in the fragile first month of life, stepping up immunization efforts and building civil registration and vital statistics systems to improve accountability for results and as a passport to a child's rights (Canadian Forward Strategy, 2014).

Canada targets its investments to ensure that mothers and children have access to the most effective life-saving vaccines and medicines, so that their lives are not cut short by preventable diseases and illnesses. These include AIDS, TB and Malaria and Polio to achieve results for women and children. Canada also considers its global leadership on nutrition, which has emerged as a far more important factor in maternal and child mortality than had been originally appreciated. Through its food security, Canada focuses on tackling under-nutrition, which contributes to 45 per cent of deaths of children below five years of age. That is why Canada will work with like-minded partners through the Scaling-Up Nutrition Movement to ensure that countries are able to deliver the package of integrated nutrition interventions that represents the best return on development investment (Canadian Forward Strategy, 2014).

According to Bhushan (2014), the sustainability of Canada's investments and the health of women and children require strengthened and improved health systems and will thus remain a core component of Canada's approach. Canada prioritizes working with partners to fill system gaps by investing in improved service delivery at the local level, training more health workers, increasing access to adequately equipped local health facilities, and expanding access to services. Accountability for results will also continue to underpin Canada's investments for mothers and children. Canada's partnership with the World Health Organization has already supported 70 countries in developing concrete plans to improve their national accountability systems. A critical next step will be supporting country partners' efforts to collect timely and relevant data

for planning and decision making. To accomplish this, Canada considers working with partners like the World Bank, UNICEF and the World Health Organization to advance a global effort in support of country partners' efforts to strengthen their civil registration and vital statistics systems. These systems are believed to provide a foundation for all aspects of its development efforts and will amplify other investments for women and children by improving the delivery of health services, providing national documentation to help secure and safeguard an individual's rights, and allowing for participation in the democratic process and the economy (Canadian Forward Strategy, 2014).

For Canada to achieve its collective objectives, it looks forward to deepen and expand existing and new partnerships. In recognition of its wealth of expertise, Canadian civil society, academic, and private sector organizations will play a critical role in shaping and delivering on her commitment. Consultations will be held with Canadian and international experts and her partner countries to inform these new investments. A call for proposals was launched in September 2014 in support of Canadian partners' work to save the lives of mothers and children in developing countries. The Government of Canada also re-commits to working hand-in-hand with the Canadian Network for Maternal New-born and Child Health, who represents the country's best and brightest in saving the lives of women and children. Canada has further planned beyond 2015. Considering the Millennium Development Goals that have catalyzed significant global attention on the need to improve maternal health and reduce child mortality. While there has been remarkable progress in recent years, Canada has not yet reached her goal, but it's within arm's reach. Canada remains committed to seeing through the promise it made to the world's women and children through the Muskoka Initiative, and will push to ensure it in the post-2015 development agenda. This agenda has the potential to be the voice for the world's most vulnerable citizens and Canada will advocate for it to remain focused and measurable, to ensure that it mobilizes concrete action to reduce poverty and improve the lives of women and children (Bhushan, 2014).

Regional Scenario of Maternal Health

Maternal health has improved significantly in Asia, with maternal mortality rates reduced by more than half the 1990 levels. Four of the 33 developing economies with data have reduced

their maternal mortality rates by three-quarters. However, 24 countries are expected to meet the target only after 2015 (UNDP, 2012). This is unfortunate, as maternal deaths related to childbirth are generally preventable, as demonstrated by the early achievers. Four of the most populous economies are included here are: Bangladesh, India, Indonesia, and Pakistan. Only in Tonga is the maternal mortality rate continuing to increase. Ten of the economies, including the early achievers Bhutan, the Maldives, Nepal, and Viet Nam, had greater reductions during 1990-2000 than 2000-2010. The ratios for the high-income economies (Australia, Japan, the Republic of Korea, New Zealand, and Singapore) do not exceed 20. Five economies of Azerbaijan, the Kyrgyz Republic, Tajikistan, Thailand, and Turkmenistan experienced a rise by 2000, then a decline by 2010 (ESCAP, 2012).

Among the estimated number of more than 500 000 women that die every year in the world due to complications related to pregnancy or childbirth; half of them live in Sub-Saharan Africa (WHO, 2005). World-wide, this problem is acute in Sub-Saharan Africa which bears the lowest annual reduction rate of 0.1% (UNICEF, 2008). According to Kenya National Bureau of Statistics (2011), *i*n Kenya maternal mortality in rural areas is still very high. Rural women in Kenya need to have increased access to maternal health services. This is attributed to a number of factors that contribute to high rates of maternal mortality in rural Kenya, including lack of access to quality care and skilled birth attendants, the high burden of HIV/AIDS, and an unmet need for family planning. Though nearly 90 percent of women in rural Kenya seek antenatal care. According to the UNFPA, many wait until the second or third trimester, limiting the benefits. Additionally, a majority of women in rural Kenya give birth outside of health facilities, oftentimes without the care of a skilled birth attendant. Many rural women lack transportation to often distant health facilities which prevents them from seeking adequate maternal health care.

In Rwanda, the country needs 586 more midwives to reach 95 percent skilled birth attendance. Rural areas are still underserved: Forty percent of women live more than an hour away from a health facility. Even with the increase in family planning and decline in the total fertility rate, contraception remains unavailable to or underused by many Rwandans implying a gap in the maternal health services (Worley, 2015). South Sudan has some of the worst health outcome indicators globally, in spite of modest improvements over the last five years. Maternal mortality ratio has stagnated at 2054 per 100 000. Mortality rate for infants and children under five years

declined from 102 and 135 in 2006 to 75 and 104 in 2012 per 1000 live births respectively (WHO, 2014).

In developing regions, few pregnant women receive the minimum recommended number of antenatal visits (four). Antenatal visits provide expectant women with education, birth preparation, the opportunity to ask questions, and routine screening. These visits are crucial to ensuring a woman has a safe delivery. If there is a plan in place as to where to deliver, with whom, and what supplies will be needed for the birth women eliminate unnecessary delays that can happen in labor. Antenatal visits demonstrate to communities the importance of individual responsibility in maintaining good health. These visits also educate communities, regarding not only maternal health, but health for the entire family. When a skilled birth attendant discusses the importance of good nutrition or measuring blood pressure, a woman can then pass this knowledge along to her entire family.

Poor maternal health is harmful to household survival and function. Mothers are the forerunners to educated communities. Mothers are more likely than fathers to support their children's educational development, which can lead to sustainable change within communities. Education is a major step in changing the cycle of poverty. Maternal mortality is a 21st Century problem that can be almost eliminated, as we have seen in developed countries, through easy access to skilled attendants and health facilities. Improving maternal health not only saves mothers, but entire communities.

WHO (2010) intervention involves revitalizing Safe Motherhood Action Groups to raise awareness of the need to prepare for pregnancy complications and delivery. The main aim was to improve both understanding of maternal health and access to maternal health-care services. The approach was predicated on the assumption that women require not only knowledge about when they should seek skilled help but also their husbands' approval for care seeking, which can be encouraged by community leaders. There is growing evidence that better utilization of maternal health-care services depends on mobilizing the entire community (Mullany et al, 2007). For example, in a programme for improving birth preparedness in Nepal that focused only on women, knowledge of obstetric danger signs increased but there was little change in the proportion of deliveries involving a skilled birth attendant (Babalola and Fatusi, 2009). It was

suggested that the lack of progress occurred because education was provided only for women and not for the whole community and because other barriers to health care, such as the cost of facility, persisted (Powell, et al, 2011).

Maternal Health in Uganda

In Uganda, maternal mortality remains high at 440 maternal deaths per 100,000 live births (MOH, 2012). For every maternal death in Uganda, at least six survive with chronic and debilitating ill health. Most maternal deaths are due to causes directly related to pregnancy and childbirth unsafe abortion and obstetric complications such as severe bleeding, infection, hypertensive disorders, and obstructed labour (Countdown Uganda, 2015). Others are due to causes such as malaria, diabetes, hepatitis, and anaemia, which are aggravated by pregnancy (UDHS, 2013).

All pregnant women in Uganda face some level of maternal risk. About 40% of pregnant women experience delivery complications, while about 15% need obstetric care to manage complications which are potentially life threatening to the mother or infant. There are few reliable and accurate data on maternal deaths available countrywide in Uganda. It is estimated that the national average for the Maternal Mortality Ratio (MMR) has ranged from 700 to 505 deaths per 100,000 live births for the survey period 1988/89 to 2000/0 (Ssengooba et al, 2014).

It is conceivable, however, that institutional mortality rates would be higher than national averages due to the fact that women will tend to seek institutional care when complications arise. This situation is as a result of an environment of poor access to quality maternal and neonatal care, that have continued to expose Ugandan mothers and infants to a high risk of death from pregnancy related causes as there is an estimation of one woman in ten dying from maternal causes in Uganda that would otherwise be preventable with appropriate treatment (Ssengooba, et al, 2014).

1.2 Statement of the Problem

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity” (WHO, 1946, cited in Johnson, 2010, p.44). Maternal health care falls under the right to health as a form of health care that individuals are entitled to as part of the overarching right to health. In other words, the right to health encompasses the right to maternal

health care (Johnson, 2010). Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death (WHO, 2014). Yet maternal health is fundamental human right of women clearly stipulated in universal declaration of human rights and must be addressed.

According to Mirembe (2013), Uganda's road map for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda 2006-2015, the current maternal mortality ratio of 435 deaths per 100,000 live births translates to about 5220 women dying every year due to pregnancy related causes. Uganda is implementing innovative and complementary private sector approaches through partnerships at the community, facility and pharmacy levels in selected districts to address maternal health. This is aimed at reducing maternal mortality rates in Uganda. The government further employed the use of community change agents like Village Health Teams (VHTs) that led initiatives of seeing expectant and new mothers receive a clean safe delivery kit at a subsidized price. However, this is costly as the government will inject more money in the process and even these private health providers charge some money for the services though subsidized, majority of the rural based women cannot afford to pay for maternal services.

Studies about maternal health in Uganda point out that the maternal health of rural women constitutes 80% and there is still a gap in accessing maternal health services (Musoke, 2002). These merely express that there still exist challenges of maternal mortality despite the many interventions that have been put in place and thus the need for studies that provides context specific suggestion to reduce such challenges impeding maternal health. This study has been conducted to assess and document factors affecting maternal health services in Kabwohe Health Centre in order to overcome the impeding factors to attaining maternal health by providing relevant recommendations.

1.3 Purpose of the Study

The purpose of the study was to assess factors that affect maternal health services in government health facilities in Uganda, a case study of Kabwohe Health Centre IV, in Sheema district.

1.4 Objectives of the Study

The specific objectives of the study were:

I. To establish the maternal health services offered at maternal health facilities in Kabwohe health Centre IV
II. To examine how social, economic and cultural factors among rural women influence accessibility to maternal health services in Kabwohe health Centre IV.
III. To find out the obstacles leading to constant increase of maternal health issues in the health facilities in Kabwohe health Centre IV.
IV. To seek possible beneficiary owned strategies to overcome the problems in the accessibility to maternal health services in Kabwohe health Centre IV.

1.5 Research Questions

I. What are the maternal health services offered at maternal health facilities in Kabwohe health Centre IV?
II. How do social, economic and cultural factors among rural women influence accessibility to maternal health services in Kabwohe health Centre IV?
III. What are the obstacles leading to constant increase of maternal health issues in the health facilities?
IV. What are the possible beneficiaries' owned solutions to the problems in accessing maternal health services?

1.6 Scope of the Study

1.6.1 Content Scope

The study specifically focused on assessing factors that affect maternal health service delivery. It specifically focussed on the, social, economic and cultural factors influencing rural women accessibility to maternal health services. It also explored the obstacles leading to constant increase of maternal health issues and established possible solutions to the problems from beneficiary perspectives. In the event of looking at maternal health services, the medical services offered to pregnant women and attending to women during child birth will also be considered in the study.

1.6.2 Geographical Scope

The study was carried out at Kabwohe Health Centre IV, which is located in Kabwohe Division, Kabwohe- Itendero Municipality in Sheema District that is found in South- Western Uganda. Sheema district is bordered by Buhweju district to north, Bushenyi, to the west, Ntungamo to the south and Mbarara district to the East. Kabwohe Health Centre IV in particular is situated at Kabwohe ward in Kabwohe Itendero Municipality. The municipality is bordered by Kagango division in the east, Kashozi division to the south, Sheema central division to the west and Kitojo-Rushozi division to the north. This case was selected to represent other health units in the study of maternal health service delivery. Kabwohe health center draws patients across the aforementioned divisions and is surrounded by Ankole Western University, one of Uganda's private universities, a central market, Nganwa Secondary School - A secondary school administered by the Uganda Ministry of Education and Kabwohe Clinical Research Center (KCRC) - A research, development, and medical testing center.

1.6.3 Time Scope

The study covered the period 2011-2015. This was chosen because it is within these years that maternal health service delivery should have increased in order to deliver the fifth goal of the MDG since Kabwohe Health Centre has been serving as the district's main health centre when Sheema became an operational district in 2010 and 2011 Period. Similarly this year is the transition of MDGs to SDGs and hence a period to evaluate the outcome of MDGs, especially maternal health service provision with a context of Kabwohe Health centre IV .

1.7 Justification of the Study

Safe motherhood is one of the most important issues any community needs to address. This led the entire world to come up with the development goals under which improvement of safe motherhood was allocated a priority in the fifth position out of eight. This was projected to have been accomplished by the year 2015. According to World Bank (2015), the Ugandan maternal mortality rate stands at 360 deaths per 100,000 live births up from 310 deaths per 100,000 in 2010. However, with the target year approaching, little has been done and a need for a study becomes inevitable.

Furthermore, Despite a significant reduction in the number of maternal deaths – from an estimated 523,000 in 1990 to 289,000 in 2013 – the rate of decline is less than half of what is

needed to achieve the MDG target of a three quarters reduction in the mortality ratio between 1990 and 2015(Maternity Worldwide, 2015). Even in the MDG goals of reduction in maternal mortality failed to be achieved in Uganda by 2015 thereby giving way for sustainable goals. That is the new UN Sustainable Development Goals (SGDs). The SDGs have come in to place replace the MDGs. SDG number three- subsection one states that by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. The study therefore makes contributing recommendations on how Uganda can reach the SDG target by or before 2030.

1.8 Significance of the Study

Maternal health is a very important study because its service delivery is a big cause to worry. The study availed data on the magnitude of maternal health service delivery in Kabwohe Health Centre IV. Also, analysis was made assessing factors that affect maternal health delivery in relation to address the problem.

Problem solving and delivery of maternal health services

The study accordingly will make recommendations on the best way possible to totally transform the health sector in order to improve maternal health service delivery.

Policy formulation

The recommendations is not be limited to Kabwohe Health Centre IV, but to other stakeholders, like policy makers so that the findings could help in designing policies that can improve maternal health service delivery.

Adding to body of knowledge

To academicians, the study findings will add on the already existing knowledge about maternal health service delivery and to other researchers, new areas of study will be discovered in the similar field. This may help them make collective efforts to reduce poor maternal health service incidences in the entire country.

1.8.1 Definition of Key Terms

Community: A group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time (WHO, 2004).

Health centre: Services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health (WHO, 2004).

Health providers: A group comprising a variety of professionals (medical practitioners, nurses, physical and occupational therapists, social workers, pharmacists, and spiritual counsellors), as well as family members, who are involved in providing coordinate d and comprehensive care (WHO, 2004).

Maternal health: The health of women during pregnancy, childbirth, and the postpartum period (Concern 2015).

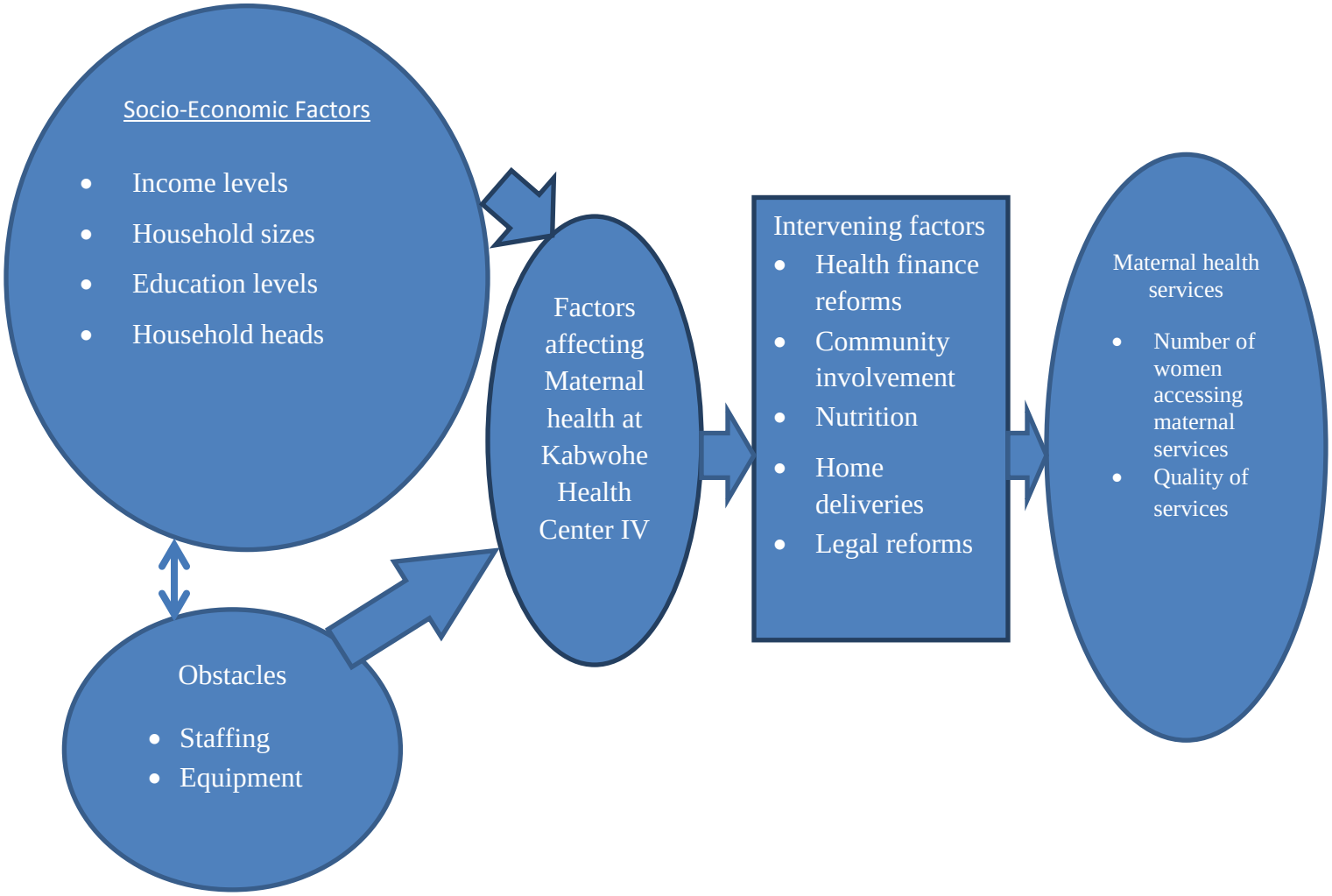
Maternal mortality: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (Pathfinder International, 2005).

Rural: A part of the country that is not a metropolitan statistical area (World Health Organisation, 2004).

Study: A systematic method of gathering facts relating to a given event or situation to generate information (Mugenda and Mugenda, 1999).

1.9 Conceptual framework

Fig.1. The Conceptual Framework



Source: Primary Data

The conceptual framework shows the relationship between concepts of this study and how they interact. The factors that involved social economic factors and obstacles are linked to or affect maternal health services at Kabwohe Health Centre IV. On the other hand the maternal health services delivered will highly depend on the how these factors interact. The higher socio-economic, and obstacles such as limited staff and working conditions for health workers the likelihood of the persistency in high maternal health issues such as death. However, the social-economic factors, obstacles such as lack of equipment and staff shortage have positive effect on maternal health delivery.

CHAPTER TWO

LITERATURE REVIEW

2. 0 Introduction

All research studies need to demonstrate familiarity with existing literature both to ensure that the research is not merely repeating something that has already been done, and to provide an opportunity to build on the existing work (Mark et al, 2008).

This chapter presents a review of literature on different factors and maternal health services delivery. The researcher will review a selection of literature as presented in the text books, journals, magazines, internet and articles on maternal health services with a focus on Kabwohe Health Centre IV. This Chapter is arranged under actual literature review on objective by objective and a summary of review.

2.1 Social, Economic and Cultural Factors among Rural Women and Accessibility to Maternal Health Services.

Many factors impede a woman from seeking care. Women in developing countries have at least one problem accessing maternal health services with concern over costs, drug availability, and distance to a health facility. A woman's likelihood of seeking antenatal care and delivering her baby with a skilled birth attendant present is closely correlated with residence (urban or rural), level of education, wealth, and level of empowerment within her household. A woman with a primary school education, for example, is almost 10times more likely than a woman with no education to seek at least one antenatal care visit and four times more likely to deliver her baby in a health facility. Access can be determined or prevented by availability, traditional medicine use, and perception of quality, affordability and socio-cultural factors (Perry and Gesler, 2010).

Availability refers to the distance the patient lives from a health care facility, transportation and total travel time, wait time and available services, (Hjortsberg and Mwikisa, 2012; Perry and Gesler, 2010). In Andean, Bolivia where travel times are greater than one hour by walking, (Perry and Gesler 2010) found limited physical access to care to be a major obstacle in improved health. Limited access is especially important in rural areas where there are fewer healthcare facilities and villages may be physically isolated. In Zambia, 56% of surveyed rural household perceived distance as an obstacle (Hjortsberg and Mwikisa, 2012) In the same study, only 17%

of individual living more than 40 kilometres from a facility sought care when sick compared to 50% of individuals living less than five kilometres away. Another barrier in the rural areas is that travel time takes longer per kilometre than in urban areas due to poor quality of roads and the burden of having to use several modes of transportation. Climate is also a factor especially during the rainy season when heavy rains and flooding create even worse road conditions. Advanced transportation is often non-existent in developing nations and healthcare may be unattainable if the means of transportation are in adequate or time consuming such as walking, bicycling or using the bus (Perry and Gesler, 2010). These longer travel times deter individuals from travelling particularly to access advanced technology that may only be available in large health facility located in the cities. These sometimes overwhelming obstacles may also encourage women in developing countries to turn to traditional medical practices.

The World Health Organization (2013) defines traditional medicine as health practices, approaches, and knowledge and beliefs incorporating animal and mineral based medicines, spiritual therapies, manual techniques and exercise singularly or in combination to treat diagnose and prevent illness or maintain wellbeing. Culture and society shape traditional medical beliefs and practices. Traditional Medicine is often used when the economic, social and cultural cost of using public health services are perceived as too high. In Africa up to 80% of the populations utilize traditional medicine for health care (WHO, 2013). Traditional birth attendants are also considered a part of traditional medicine. Women are often more comfortable with traditional practice and the individual performing these services, which in turn alleviates the stress of using unfamiliar western style medical services at health care facilities. Scientific evidence for the efficiency and safety and of traditional medicine is ambiguous (WHO, 2013).

The cost of health care services, prescription drugs and transportation determine the affordability of health care. Hjorstborg and Mwikisa, (2012) found cost to be a critical determinant of health care access in Zambia. They argue that this is mostly a rural concern where a large percentage of the population lives in poverty and have difficulty paying for services. People residing in the rural areas pay a large proportion of their income than their urban counterparts. As women in many developing countries are expected to conform to social and gender roles and remain at home to perform household work, they cannot develop economic independence. As a result, they

may be unable to afford services, especially since essential goods such as food and education must be purchased before health care, thus making their access to health care services limited.

Measuring patient satisfaction offers insight into possible inadequacies in the system. The importance of understanding patient perception of quality of care is importance since a higher perceived quality is positively correlated with an individual level of utilization. Factors in the quality of care influencing an individual's decision to seek health care include the perceived quality of the service including attitude of the personnel, the knowledge and abilities of the staff, availability of supplies and the level of satisfaction with the diagnosis and effectiveness of the treatment provided.

Ondimu (2000) disapproved this assumption by finding that patient's dissatisfaction in the Nana province in Kenya created a loss of community confidence in the local public health facility. This negatively affected the health of vulnerable groups such as the poor children and the pregnant women. Maternal health is highly contingent on the quality of the local primary health care system, which is a common entry point for antenatal care that helps identify problems in pregnancy early on. Consistently poor performance in primary health facilities including lack of personnel, lack of appropriate medicines, and indifferent or contemptuous treatment by facility staff not only undermines the quality of care an expectant mother receives, but over time erodes confidence in the health care system overall and deters women from seeking care (Erim et al 2012).

Socio-cultural variables also affect access to health care services. The educational level of a woman often affects her health care use. Attaining at least a primary education contributes positively to the health of women by providing women with skills training for employment and personal income. Thus enabling women to afford health care services (Wickrama and Lorenz , 2002) Education level, employment, family income and marital status shape women's use of health care services. Furthermore, income provides women with the ability to access improved nutrition and adequate housing, both of which protect and advance their health status (Buor, 2004). Skelenburg et al (2004) and Kamal (2009) found that there is a positive relationship between maternal health care services use and women's formal employment suggesting that the capacity to earn could contribute to maternal healthcare services utilization through

empowerment. It has also been found that in some regions of the world that non-working women are more likely to use some maternal health care services than earning mothers.

2.2 Obstacles and Constant increase of Maternal Health Issues in Health Facilities

Staffing is a term used in the sphere of employment. It has been applied to more than one aspect of the working environment. Staffing is the process of acquiring, deploying, and retaining a workforce of sufficient quantity and quality to create positive impacts on the organization's effectiveness (Heneman, 2005). According to Henenman, acquisition comprises the recruitment processes leading to the employment of staff. It includes human resource planning to identify what the organization requires in terms of the numbers of employees needed and their attributes (knowledge, skills and abilities) in order to effectively meet job requirements.

In addition the selection techniques and methods of assessment to identify the most suitable candidates for a particular job, deployment involves decisions about how those recruited will be allocated to specific roles according to business demands. It also concerns the subsequent appointment to more advanced jobs through internal recruitment, promotion or reorganization. Retention deals with the management of the outflow of employees from an organization. This includes both managing voluntary activities such as resignation, and controlling involuntary measures whereby employees are managed out of the organization through redundancy programs or other types of dismissal. The overriding objective is to minimize the loss from the organization of valued employees through strategic and tactical measures whilst enabling the organization to reduce employment costs where circumstances dictate (Heneman, 2005).

The challenges facing England's maternity services were identified in similar areas in need of improvement, including staffing, training and communication. There is much debate at present about staffing levels in maternity. The numbers of midwives has raised concerns about shortages. There is a need to increase staffing numbers, particularly midwives and consultants. There is recognition that midwives, particularly, are under pressure due to the rising birth rate, the increasing complexity of many births and high levels of retirement from the profession. However, staff feedback obtained from the Safer Births events suggested that, while staffing levels are important, changes in staff deployment could address at least some of the challenges to delivering safe care (Birthrate Plus, 2013). The King's Fund (2008) suggested that, while

numbers of staff are important, it is the effective deployment of the right staff doing the right thing at the right time in the right place that is the key to improvement. The deployment and skill mix in maternity services in terms of their impact on safety during labour and birth raised this fundamental question: Can the safety of maternity services be improved by more effectively deploying existing staffing resources? Despite recent initiatives to make use of maternity support workers (MSWs), dedicated operating theatre assistants, nurses, models of team/caseload midwifery and changes to obstetric roistering, there remains a widespread perception that having more qualified staff is the key to improving safety in maternity services (Bragg et al, 2013).. Although gaps in staffing levels do exist, the current economic outlook for the National Health Service (NHS) suggests that significant staff increases are unrealistic and that the NHS as a whole, including maternity services, will need to focus on enhanced productivity as a route to improved safety. Of course, focusing on staffing is not the only route to improved productivity and it should be acknowledged that productivity gains could be looked for in other areas, for example, risk and litigation and inappropriate or unnecessary use of caesarean section. The King's Fund (2008) defined productivity as 'the right person, doing the right thing, at the right time, at the right place'. It concluded: 'Applying the same approach to maternity should free up staff time, with a positive knock-on effect on safety as well as on the experience of professionals'. The right person includes having obstetric consultants on labour wards at times of greatest risk and pressure, and easily accessible to junior staff at other times. It might also mean having the appropriate skill mix to support midwives on maternity units and in the community. Doing the right thing might include actively aiming to reduce unnecessary interventions, releasing staff time spent in operating theatres and on extended postnatal care. Doing the right thing at the right time involves early detection of problems and their referral to the right people. This involves early involvement of medical consultants in the care of women with pre-existing medical conditions (Smith et al, 2013). Delivering care in the right place might involve using triage midwives to keep elective cases and women who are not in labour away from labour wards and theatres, while ensuring the availability of home births and community-based care for suitable women. It can be concluded that, although staffing levels are important, the more crucial issue is how available staff are deployed. More effective deployment, it is suggested that some way to addressing the safety issues facing maternity services should be sought.

Medical instruments are familiar among people who work in medical department. This equipment helps medical workers to diagnose and monitor and seek the best remedies for the specific medical conditions. In other words, medical instruments have saved millions of life in each year, both at the hospital or their homes. Medical instruments are varied from stethoscopes, x-ray machine, ultrasound, CT scanners and many others. The ultimate purpose of instruments is to sustain the life of a patient who currently in vital condition, their life is depending on the machine; it keeps them breath and pump their heart automatically (Cancino, 2007). Technology in medical instrument has saved the lives of many people and gives significant impact at the people health improvement. People who gone through big surgery and needed a long-term medical care from their recoveries need to be supported with medical equipment such as air purifiers, wheelchairs and respiratory machine. Medical instruments are important equipment for hospital, because they are important for individual care (Cancino, 2007).

WHO (2013)has identified the shortage of functional medical equipment in low-income countries as a critical barrier to meeting the health-related MDGs. Hospitals in low-income countries frequently report the poor state of medical equipment as being a key challenge they face in delivering services (WHO,2013). It has been a requirement for countries to appoint medical equipment specialists (typically medical engineers) within the Ministry of Health to advice on medical equipment procurement and budgeting. This leads to guidelines for good procurement and donation practices. Maintenance teams have been established in many large hospitals and over wider referral networks and many new innovative technologies have been designed that are more appropriate for use in developing countries. However, much remains unattended to. Very few training programs exist to produce medical equipment technologists and engineers in Africa. Equipment maintenance personnel need more training prior to and while in post; they need better tools, equipment and reference materials in their workshops and need to be more effectively engaged in equipment decision-making in their hospitals (Mullally, 2015). Equipment donations should meet guidelines to ensure they are more sustainable and contribute positively to service delivery. Procurement should always include budgeting and training for maintenance activities. Regulatory mechanisms should be in place to oversee the quality and safety of medical equipment, and there should be equipment management committees in hospitals and wider health systems to oversee medical equipment over its entire

lifespan (Mullally, 2015). WHO estimates that between 50 and 80% of medical equipment is out of service in low-income countries, economic loss of 15% of medical equipment in the developing world being out of service is $12.8 billion USD annually, or 22% of the total health spending in the WHO's AFRO region, eighty percent of the medical equipment in some sub-Saharan African countries is donated equipment; the majority of which is out of use, eighty five percent of African hospitals reported difficulty finding qualified medical engineers locally (77% in Latin America and 60% in Asia)- (Mullally, 2015).

2.3 Possible Solutions to the Problems of Maternal Health Services

Improving nutrition for pregnant and lactating women is an important goal, but such nutritional interventions must occur within the optimal window from early pregnancy through the first 1,000 days of a child's life. Nutrition and health programs should also combat misconceptions about vitamins, alter harmful diets through behaviour change, and increase production and availability of high-value food sources (Bathala, 2013).

Male champions- husbands, religious leaders, policymakers, and community leaders-are needed to support women's health and galvanize additional male support for maternal health. Educating men about danger signs and pregnancy complications increases the likelihood that future births will take place in health care facilities (Bathala, 2013). In addition, raising men's awareness of the benefits of family planning will reduce maternal mortality by increasing intervals between births. Increasing men's support for family planning may also require directly addressing their worries and the misinformation about potential side effects of family planning methods, particularly those side effects that are rumoured to affect sexuality. Maternal health programs should incorporate a thorough understanding of local culture and social norms and should work with religious groups to ensure successful program implementation (Bathala, 2013).

Reducing maternal mortality requires a strong health system with well-distributed, high-quality facilities that can provide emergency obstetric care. Women with obstetric complications should be encouraged and able to use these facilities rather than give birth at home or in clinics without emergency services. Overall, better financing and accountability in the health system will improve maternal health. Health finance reforms are key to increasing accountability to the needs of citizens. Institutions and governments need to do more research on how best to integrate

maternal health more fully into the health care system. In many remote places of the world, better transportation and access to enhanced health services through referrals would significantly improve maternal health outcomes (Greene and Ostrowski, 2013).

Four major commodities- oxytocin, misoprostol, magnesium sulphate, and manual vacuum aspirators address the three leading causes of maternal mortality. The distribution of these commodities must be scaled up significantly to improve maternal health outcomes across a wider area. If oxytocin and misoprostol were available to all women giving birth, they could prevent 41 million postpartum haemorrhage cases and save 1.4 million lives (Greene and Ostrowski, 2013). For home deliveries, safe birthing kits are a critical part of the continuum of care. According to PATH (2013), most safe home-birthing kits contain a small bar of soap for washing hands, a plastic sheet to serve as the delivery surface, clean string for tying the umbilical cord, a new razor blade for cutting the cord, and pictorial instructions that illustrate the sequence of delivery events and hand-washing.

Mobile health (mHealth) interventions hold much promise, but more research is needed to determine how mobile phones might strengthen and enhance health systems and to ensure that evidence would guide programming. For example, access to phones must be considered when evaluating the effect or success of these efforts. Over the long term, public-private partnerships are critical to the sustainability of mHealth programs (Bathala, 2013). The evolving realities of the HIV epidemic require donors and policymakers to shift their responses to new areas, including fulfilling the unmet need for contraception and family planning as a means of combating transmission and increasing treatment. Increasing the links between HIV/AIDS centres and maternal health clinics and implementing the United Nations–WHO model framework for preventing mother-to-child transmission would reduce rates of transmission to children and increase the number of women receiving care (Greene and Ostrowski, 2013).

2.4 Summary of Literature Review

Among the articles and publications reviewed in relation to factors that affect the delivery of maternal health services, the documents presented abstract information about the approaches used in the general health service delivery. Furthermore, in the Ugandan context, the literature doesn't present the overall service delivery in the entire country and little information is availed

on health since it tackles all public services delivery. This has generated a gap whereby the information given about maternal health service delivery in Uganda particularly Kabwohe Health Centre IV. This gap that has been created regarding the factors that affect maternal health service delivery needs to be filled since it has been proved to be a virgin area hence this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Research methodology is an approach through which the study was conducted. It provides a guide to which data collection is to be done and analysed in order to come up with the findings (Amin, 2005). This chapter provides information concerning the methodology that was used in this study. It presents among others the research design, study population, area of study, sample size determination and sampling techniques, data collection methods and instruments, data collection procedures, data analysis and measurement of variables.

3.1 Research Design

This study employed predominantly a qualitative approach this was simple because the study sought to establish the experiences of people as they occurred in their daily encounter of maternal health issues. Qualitative research is a "means of exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2014). This study therefore involved asking for the experiences of the people and emerging questions pertaining the factors affecting maternal health of rural women in Kabwohe Health Centre. Given the nature of data required and ensuring reliability for an accurate picture of the findings the study employed triangulation of methods of data collection. As Denscombe (1998) notes a triangulation of methods of data collection enhance the reliability of the data for investigation of research problem thus triangulation of methods including questionnaires, interviews was inevitable.

This study adopted a case study deign which according to Bryman (2012) entails the detailed and intensive analysis of a single case. The choice of single case of Kabwohe Health Centre IV maternal health service provision ensured that the researcher explored in depth the program and the individuals' engaged in its consumption within the specified time using appropriate data collection methods. Since case study is predominately used in qualitative studies, the research engaged in the data collection process through semi structured questionnaire and interviews later explained in detailed in the next sections of this chapter.

3.2 Area of study

The study was carried out at Kabwohe Health Centre IV, located in Kabwohe division, Kabwohe- Itendero Municipality in Sheema District that entirely holds a population of 20,300 people as per Uganda National Bureau of Statistics (2014). Majority of the people are farmers with large sums of banana plantations, an element of cattle keeping and some in business center. Majority of the women who access the health facility are rural women, who mostly depend on their husbands for survival. Women are largely farmers (housewives) do not participate in decision making both at family and community level. There is also a noticeable high rate of early marriages since the majority of the expectant women were young. Kabwohe Health Center IV is supposed to admit patients both women, men and children, however due to the overwhelming numbers of patients, it does not fulfil the requirement.

3.3 Study Population

Kumar (2011) define study population as people who you want to find out about or from whom you want to obtain information on a phenomenon that they are engaged with. Jensen and Rogers (2001) adds that accessible population is the number of potential respondents that the researcher is able to reach in a specified period of time using available resources without the intended outcome of the research being affected. The study population included the District Medical Officer, Medical officer, Senior nursing officer, clinical officers, nursing officers, enrolled nurses, enrolled midwives, nursing assistants, lab assistants and clients(women that access maternal health services. This study population was selected because of the different roles and responsibilities required by the medical team at Kabwohe Health center IV and maternal services provided to expectant mothers at the health facility.

3.4 Sampling Procedure

A sample refers to segment of the population that is selected for research. It is a sub set of population (Bryman, 2012) while sampling in the process of selecting the sample from the sampling frame (which in this study is defined by the study population) to become the basis for estimating the prevalence of information of interest to the study (Kumar 2011). Most sampling techniques fall under two broad categories namely probability and non-probability sampling categories. The sample used for the study was derived from both categories and the techniques used are Purposive and Simple random sampling.

3.4 Sample Size

Sample size refers to the number of respondents selected from the respondents categories defined by a study population (Kumar 2011). In this study a total of 80 respondents were sampled as indicated in the table below.

Table 1: Showing Research Respondents by category and sample

Category	Sample Size	Sampling Technique	Data Collection Methods
District Medical Officer	1	Purposive	Interview
Medical officer	1	Purposive	Interview
Clinical officers	2	Purposive	Interview
Senior nursing officer	1	Purposive	Interview
Nursing officers	4	Simple random sampling	Questionnaire
Enrolled nurses	9	Simple random sampling	Questionnaire
Enrolled midwives	4	Simple random sampling	Questionnaire
Nursing assistants	4	Simple random sampling	Questionnaire
Lab assistants	2	Simple random sampling	Questionnaire
Clients (Women accessing maternal services)	52	Simple random sampling	Questionnaire
Total	**80**		

Source: Primary Source

In table 1 above, the Kabwohe Health Centre IV structure provided the staffing of the health facility alongside the average number of daily clients that access maternal health services.

3.4.1 Sampling Techniques

Purposive Sampling

Purposive sampling is a sampling technique in which researcher relies on his or her own judgment when choosing members of population to participate in the study (Black, 2010). The purposive sampling is usually preferred because it is cost effective, saves time, and mainly focuses on key informants who are knowledgeable about the subject matter. Purposive sampling was used for the selection of the district medical officer, the medical officer, senior nursing

officer and the clinical officers. These were key respondents who are knowledgeable and believed to have authority to provide any relevant information needed in this study.

Simple Random Sampling

Simple random sampling involves taking a representative selection of the population and using the data collected as research information (Latham, 2007). Sampling is more efficient (Cochran, 1953; Latham, 2007), Cochran further stipulates that using correct sampling methods allows researchers the ability to reduce research costs, conduct research more efficiently (speed), have greater flexibility, and provides for greater accuracy.

Simple random sampling was used to select the rest of the respondents from middle staff and women accessing maternal health services at the health center. This was due to the larger size of the respondents and this helped the researcher to avoid possible biases in selecting the respondents.

3.5 Data Collection Methods and Instruments

The researcher used multiple data collection methods so that validity of findings was assured. Primary data was collected using the semi structured questionnaire and interview methods and secondary data through documentary review method.

3.5.1 Questionnaire

According to Mathers, Fox and Hunn (2007), Questionnaire refers to a set of questions used to collect data. This method was used to collect primary data from 75 respondents comprising of nursing officers, midwives, nursing assistants and clients (although 66 of 75 were obtained). This method was selected because it allowed the researcher to collect data systematically and address the research issues in a standardized and economical way. The method was also used because it was easy to administer to such a large number of respondents in a short period of time. It was also flexible and was used to collect data within a short time (Sekaran, 2003). Questions were also helpful in collecting sensitive information from respondents. There was also an assurance of achieving honesty and confidentiality using this method. Because of the fact that many of the partaking maternal services are affected by varied factors comprising those who come from the rural areas, the questionnaire was mainly unstructure in a way to capture the views of people

within streamlined themes developed and to gather other information that may not be captured in a highly structure questions.

Section A include the background information of respondents, followed by sections B, C and D that relates to the first, second and third objectives respectively were unstructured.

3.5.2 Interviews

Face to face interviews were used to supplement the questionnaire method. An interview is any planed conversation with a specific purpose involving two or more people, it involves presentation of oral-verbal stimuli and reply in terms of oral responses (Kothari, 2004) .This method was used on the following respondents; the District Medical Officer, Medical Officer, Clinical officers, and Senior Nursing Officer. These were key respondents in this study because they were more knowledgeable and provide insight. Mugenda and Mugenda (1999) states that interviews provide in depth data which is not possible to get using questions and the beauty about it is that interviews can take advantage of the interactive situation to get further information or clarification on responses given thereby enriching the findings. This method allowed for an in-depth assessment and critical analysis of the subject. Interviews were carried out by the researcher herself to save on time and costs, but also to allow for an in-depth study and clarification on issues hence enriching the findings.

3.5.3 Documentary Review

This method involved the researcher looking at written sources of data such as books, reports, plans, journals and other official company records like statistics (Denscombe, 2000). The researcher reviewed documents and extracted data to supplement questions and interviews hence enriching the findings. As other academicians have found out, the advantage with documentary review is that data can be verified by other scholars; saves time and costs of acquiring information(Sekaran, 2003) and is flexible since data can be accessed at any suitable times (Oso and Onen, 2009)

3.6 Quality Control Methods

3.6.1 Validity

Validity refers to the appropriateness of the research instruments (Amin 2005). In this study, validity tests were carried out prior to the administration of these instruments. This was done to

find out whether the questions will be capable of capturing the intended responses and table 2 below presents the outcomes.

Table 2: The Validity Statistics

Validity Statistics

CVI	N of Items
.756	7

After running the validity statistics, the content validity index (CVI) for the instrument was discovered standing at 0.756 that is above the recommended 0.7 by Amin (2005), hence the tool used was valid for the study.

3.6.2 Reliability

Sekaran (2003) defines reliability as the measure of the degree to which a research instrument yields consistent results. It is an indicator of the suitability, repeatability and consistency with which the instrument measures concepts. The tools were tested for reliability and table 3 reflects the results.

Table 3: Reliability Statistics

Reliability Statistics

Cronbach's Alpha	N of Items
.891	29

After conducting a pre-test, the computed Alpha coefficient and the tools were found to have it at 0.891 that is over and above the recommended 0.7 by Amin (2005) hence the tool used was applicable for the study.

3.7 Data Management and Processing

Upon approval of the proposal by Uganda Martyrs University, the researcher obtained a letter of introduction. This was used to get permission to carry out research in Kabwohe Health Centre

IV. The researcher proceeded to fine tune the instruments and test run them before administering them to the respondents.

The researcher went to the field to collect data on the study subject with the help of research assistants. Questionnaires were administered to respondents who were given a timeframe within which to complete and return them. The data was collected, sorted, coded for analysis using both thematic analysis. The researcher held face to face interviews herself with senior management of Kabwohe Health Centre IV based on their conveniences. Appointment dates were set before proceeding to hold the interviews as agreed. After collecting data, the researcher then edited, analysed and interpreted it for the findings.

3.8 Data Analysis

Upon completion of the data collection from the field the researcher proceeded to data analysis. All data was checked, edited, coded and entered into the computer for processing and analysis in order to make meaning out of it.

Qualitative data was analysed systematically and thematically based on the objectives of the study. The researcher categorized and summarized all the data collected for ease of analysis. During and after, the researcher recorded observations, made general summaries, coded the data where applicable and summarize data. Analysis involved identifying patterns, inconsistencies and relationships and reasons for their occurrences with the aim of explaining factors affecting maternal health services in Kabwohe Health Centre IV. Using content analysis, data was critically studied, analysed and interpreted to generate meaning and conclusions made thereafter in line with the objectives of the study.

3.9 Ethical Considerations

Carrying out a study on health services delivery is a sensitive issue. This required privacy and confidentiality of the information given by the respondents. To ensure privacy, the respondents were informed that their names were not required and it was optional for them to answer the asked questions or not. The respondents were not forced to give responses to the questions that were asked in the study as recommended by Mugenda and Mugenda (2003). To ensure more confidentiality, the respondents were informed that the information sought was for academic purposes and the data obtained was to be treated in confidence as recommended by Amin (2005).

3.10 Limitations and Delimitations of the Study

In the process of data collection, a lot of challenges were encountered by the researcher and these included the following:

Some respondents feared to answer because they thought that they would be quoted. This was due to sensitivity of the subject and thinking that the researcher would publish their names and responses.

Some respondents never had ample time to attend to the researcher because of their daily duties. Sparing time for an interview or answering the questionnaire was generally a challenge.
Furthermore, some respondents especially among women that were sampled among service seeker were not able to interpret some of the questions as their education levels were low and this made it a bit difficult for them to answer.

However, these were overcome in a sense that appointments had to be made with the respondents, obtaining an introductory letter from Uganda Martyrs University helped introduce the researcher who went ahead and sought another written authority from the District Health Officer which eased work through accessing different offices and the respondents were assured that the information thought was strictly confidential and were not bound to mention their names. This helped them to feel free in giving the required information.

In some instances, some translations to the local language was done to enable some of the respondents effectively respond to the questions. This eased the data collection process.

One would expect that a study about health related issues should be conducted by health experts, yes this may be true to certain aspects health issues one wishes to investigate. However, in this study the researcher delimits the study to the understanding social aspects of people that affects their participation in maternal health services. It particularly focused on the issues provided for in the objectives of this study.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents the analyses and it interprets the study findings arising from the field information collected from respondents on the assessment of the factors affecting maternal health services in Uganda, using Kabwohe Health Centre IV as the case study. This chapter brings in the key issues that have been established by the research questions and this has been presented thematically. The themes have been provided and categorised under the objectives of the study as discussed below.

4.1 Response Rate

A total of 75 interviews were set to be obtained from the following categories of respondents. Nursing officers, Enrolled nurses, Enrolled midwives, Nursing assistants, Lab assistants, and 52 Clients (Women accessing maternal services), and 66 were returned giving a response rate of 88% suggesting that the results contain substantial information and the survey results were representative of the population. The higher response rates also suggested more accurate results (Weller and Romney, 1988).

Response rate was determined, Response rate = $\frac{\text{No of tools returned x 100}}{\text{No of tools distributed}}$

= 66/75x100=88%

4.2 Background Characteristics of Respondents

This section presents the characteristics of the respondents in relation to gender, education level, duration of service with the health services, and positions of the respondents.

4.2.1 Gender of the Respondents

Table 4: Showing the Gender of the Respondents

Gender		Frequency	Percent
	Male	2	3.0
	Female	61	92.4
	Total	63	95.5
	Non-response	3	4.5
Total		**66**	**100.0**

Source: Primary Data

From the above table, the researcher was interested in the gender of the respondents. 2 (3.0%) of the respondents were males and 63(95.5%) were females. This implies that the study was basically focusing on maternal health services which are sought by females. This is an indicator that the information got from these majority females is relevant to the study. However, males also had some representation hence their views were also considered in the study.

4.2.2 Age of the Respondents

Table 5: Showing the Age of the Respondents

Age groups		Frequency	Percent
	Below 20 years	4	6.1
	20 - 29 years	33	50.0
	30 - 39 years	21	31.8
	40 - 49 years	3	4.5
	50 - 59 years	2	3.0
	Total	63	95.5
	Non-response	3	4.5
Total		**66**	**100.0**

Source: Primary Data

The researcher was interested in the age of the respondents. This was to enable the researcher get persons above 18 that were thought to have experience with maternal health services. From the above table, it was discovered that 4 (6.1%) of the respondents were below 20 years, 33 (50%) of the respondents were between 20-29 years, 21(31.8%) of the respondents were between 30-39 years, 3(4.5%) of the respondents were between 40-49 years and 2 (3.0%) of the respondents were above 50 years of age. The majority of the respondents; 54(81.8%) of the respondents were between 20-39 years of age. This is the most reproductive age implying that the right people who seek maternal health services were consulted in the study increasing on the quality of the information that was sought.

4.2.3 Education Level of the Respondents

Table 6: Showing the Education level of the Respondents

Educational Level		**Frequency**	**Percent**
	Primary level	13	19.7
	Secondary level	13	19.7
	Tertiary level	23	34.8
	Bachelor's degree	10	15.2
	Postgraduate degree	2	3.0
	Total	61	92.4
	Non-response	5	7.6
Total		**66**	**100.0**

Source: Primary Data

The researcher was interested in the education levels of the respondents in order to establish their literacy levels. From the above table, 13 (19.7%) of the respondents had a primary level of education, 13 (19.7%) of the respondents had a secondary level, 23(34.8%) of the respondents had tertiary level, 10(15.2%) had a bachelors level, 2 (3.0%) had a post-graduate level. Majority of the respondents 35(53%) of the respondents had a post-secondary level of education and nevertheless, all respondents at least were literate as none reported to be without an education

level. This implies that the respondents could give information based on facts as they were all literate and could reason basing on their own assessment of the situation being studied.

4.2.4 Time Spent in Health services

Table 7: Showing the Time spent at the Health Center

Time spent at the Health center		**Frequency**	**Percent**
	Less than one year	12	18.2
	1 - 4 years	20	30.3
	5 - 9 years	10	15.2
	Over 9 years	7	10.6
	Total	49	74.2
	Non-response	17	25.8
Total		**66**	**100.0**

Source: Primary Data

The researcher was interested in knowing the time the respondents had so far spent in health services at the side of the health worker and the time respondents had taken seeking maternal health services at the side of the mothers. 12 (18.2%) had so far taken less than one year, 20(30.3%) had spent 1-4 years and 7(10.6%) had spent over nine years. Majority of the respondents of 37(56.1) had spent between 1 year to over 9 years. This implies that the respondents had taken some time interacting with maternal health services and were therefore in position to give accurate information on the matter the researcher was seeking.

5.0 The Maternal Health Services Offered at Kabwohe Health Center IV

According WHO (2016), maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. It further states that the major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. This means

that the services outlined by the medical officer below become paramount to ensure maternal deaths are reduced.

Health centres are meant to provide certain basic services depending on the level of the health center. In Uganda these health centres range from health centres II's III's and IV. In this study the focus was on the health center IV and the following maternal health services were found to be offered at Kabwohe Health Center IV as summarised by the medical Officer in an interview on 6th August 2015:

> As a health center IV the following services are offered, Antenatal care services (pre and post natal care), delivery, prevention of mother to child transmission (PMCT), counselling and guidance, Antenatal check-ups.

These are the services offered to the rural women at Kabwohe Health Center however it is important to note the current maternal status and service delivery at Kabwohe as discussed below. These are crucial in determining how social, economic and cultural factors among rural women influence accessibility to maternal health services

The Increase of Women seeking Maternal Health Services

The respondents stated that women seeking maternal services have increased in number. This implies that generally, there has been a tremendous increase of the women visiting the health facility to seek maternal health services. This is therefore justified by the number of expectant women seeking antenatal services on a daily. The health facility receives an average number of 60 expectant mothers on a daily basis.

In an interview with the District medical officer on 4th August 2015, further confirmed this,

> There is generally an improvement in the number of women seeking maternal health services. This is because of the mobilization strategies in place employed to woo more women to seek antenatal services and encouraging them to deliver from the health centres. The only challenge is that the medical workers are overwhelmed by the number of women that visit the facility seeking services. In a day, one midwife is supposed to handle at least 4 women. But due to the number of women coming to seek maternal services, one may find that one midwife handling more than 10 women. All these women expect to be given attention and this leads to exhaustion of the midwives. Sometimes they take time off forcefully in order to relax. So this makes services inadequate due to less staffing.

The number of Women delivering in Health centres

While responding about the number of women delivering in health centres, the respondents agreed that there is a relatively high number of women delivering in health centres. This implies that there are a high number of women who deliver in health centres basing on the response of the majority respondents. Taking into consideration that there is less staffing at the health centre, expectant women wait to be attended to for longer hours.

The preference of women to deliver from health centres

Some of the respondents agreed that women prefer delivering in health centres than any other place. This indicated that women prefer delivering from the health centres as they realised how safe it is to deliver from the health centres. At the time of the visit at the health centre, a close number of 30 women had been delivered at the health centre, although there were inadequate delivery beds for the mothers. Some were being delivered at the floor in the maternity ward.

The reduction in complications that result from delivery among women

Complications that result from delivery were a concern in the study to have reduced among women, and the respondents agreed upon their existence. This implies that complications that result from delivery among women have reduced. However, these complications are still a challenge basing on the representation of the majority. The percentage of the majority cannot convince the study that the reduction is big enough to rule out the existence of the challenge. This was further confirmed by two respondents in the interview below,

> We still have a challenge of complications resulting from women giving birth. Sometimes you find that the health workers are present in the facility, willing to attend to women but the facility is not well stocked with the necessary equipment. One cannot touch a woman giving birth with bare hands and to the worse of it, getting in contact with blood. A medical worker with his/her meagre earnings, one cannot spend one's salary to buy gloves for example; to serve the overwhelming number of women coming to give birth. Sometimes expecting women are either told to buy their own equipment or referred where necessary. However, even those that are told to bring their own equipment are financially challenge hence puzzling both the health workers and the clients seeking services. (Interview with senior nursing officer and Medical officer on 5th August 2015)

The deaths of women resulting from giving birth

The respondents confirmed that few women die while giving birth; this does not give adequate representation effectively. This implies that there has been a relative reduction of women dying while giving birth. However, the challenge of women dying while giving birth is still in place as the gap in delivery of maternal services. This therefore cannot inform and convince the study that the challenge of women dying while giving birth has tremendously reduced.

Women continue to die while giving birth due to poor health conditions in the entire health centre, some die because of ignorance while others die to unconducive environment such as lack of delivery equipment like the Kits, poor infrastructure and excessive blooding during birth.

In an interview with the senior nursing officer on 3rd August 2015 confirmed that;

> On average at least 3 women die on a monthly basis at the health centre due to various delivery complications for instance majority of the women giving birth come to this health facility late, some are HIV positive therefore lack knowledge on the diet of the HIV patient. Majority die due to ignorance.

There is need for vigorous sensitisation of communities both women and men on the importance of antenatal care services, as it is during this period that women get to be check their status regarding their life whether positive or negative.

Mobilization of women to seek maternal services

The study found out that women are being mobilized to seek maternal services. This is so as stated by the majority of the respondents that agreed. This implies that there are efforts made to mobilise women to seek maternal services basing on the majority of the respondents that agreed with the statement. For instance the introduction of Village Health teams (VHT) in each village has to a certain extent increased the number of women seeking for maternal services and safe delivery at the health centre.

The responses from women seeking maternal services

It was suggested that there is a good response from women through seeking maternal services. This was so as stated by the respondents that agreed. This implies that there is a generally good response from women through seeking maternal health services at Kabwohe Health Centre IV.

While reviewing the documents, Kyomuhendo (2013) reported that 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 in utilization of these services by women or a reduction in the high ratio of maternal deaths. There is adherence to traditional birthing practices and beliefs that pregnancy is a test of endurance and maternal death a sad but normal event, are important factors. The use of primary health units and the referral hospital, including when complications occur, was considered only as a last resort. Lack of skilled staff at primary health care level, complaints of abuse, neglect and poor treatment in hospital and poorly understood reasons for procedures, plus health workers' views that women were ignorant, also explain the unwillingness of women to deliver in health facilities and seek care for complications. Appropriate interventions are needed to address the barriers between rural mothers and the formal health care system, including community education on all aspects of essential obstetric care and sensitization of service providers to the situation of rural mothers.

5.1 The Social, Economic and Cultural Factors Influencing Accessibility to Maternal Health Services among Rural Women.

This theme presents the social, economic and cultural factors influencing accessibility to Maternal Health services among rural women.

The Closeness of Health Centres to Women in their Localities

It was found out that health centres are relatively closer to the women in their localities. This enables them to visit health centres and seek for maternal health services. However, this comes with shortcomings as some of the women are located in areas where they can hardly get access to health centre. There is a small gap to fully convince the study that holistically in the study area, the health facilities are generally closer to the women that seek maternal health services.

Sensitization of Women of the Productive Age about Maternal Services

In regard to women of the productive age being sensitized about maternal services, respondents agreed. In their agreeing, it was reported that women have been sensitised about maternal health services, implying that efforts are underway to mobilise mothers to access maternal health services. However, there is still some challenges that arise from the channels being used to sensitise women as the gap between the gap that indicates that the sensitization still lacks as a relatively big percentage that remains untapped.

Ease for Expecting Mothers to Access Health Centres

Having interacted with some of the expecting mothers, it was reported that women have a challenge of accessing health centres with ease. This usually happens in terms of the distances that women have to trek from their homes to health facilities. The distances are generally long to reach health facilities that are at a level of a health centre III that have advanced services that cater for maternal health services. This implies that expecting mothers face challenges in accessing health centres since the respondents stated that expecting mothers find it hard to access health centres with ease.

The Availability of Transport Facilities to Enable Movement of Women

The study aimed at finding out the availability of transport facilities that enable movement for women. It was realised that few women are availed with efficient means of transport to the health facilities. The majority either have to trek on their feet or abandon going to the health facilities to seek maternal health services and resort to either going to traditional birth attendants or abandon any maternal attention and get exposed to maternal health related hazards. This implies that transport facilities are inadequate to enable expecting mothers to access health centres for maternal services which affect women accessing maternal services.

Location Status of Health Facilities

The study revealed that health facilities are only concentrated in urban places. However, there are also other facilities that are situated in rural areas as reported by the respondents though those that are perceived to be well equipped with equipment and staff are only concentrated in urban places. There is a relatively evenly distribution of health centres in both urban and rural areas. But majority of good and majority of the health centres are located in urban areas than in rural

areas which makes it hard for rural women to access maternal health services unlike their urban counterparts hence a factor that affects the delivery of maternal health services.

The Economic status of Women and seeking of Maternal Services

In a bid to find out whether women from rich families are the ones that seek maternal services, it was realised that there is a fair balance between the poor and the reach in accessing maternal health services. This is an implication that regardless of one's economic status, one can access maternal services as the majority generally admitted that even those that are considered to be financially challenged can seek maternal services from the government health facilities that are present in their areas of locality. Nevertheless, there are some gaps that exist in serving all women in the health centres regardless of the economic status of all women seeking maternal health services.

Traditional ways being Sought by Expecting Women

On the issue of expectant women seeking attention of the traditional birth attendants, it was revealed that that practice is less pronounced. Initiatives have been undertaken to mobilise women to seek maternal health care from established medical facilities that has seen women try as much as possible to go to health facilities to seek maternal services. This is an indicator that the majority of the women that seek maternal services from health facilities are in position to tell the quality of services offered at the health centres.

5.1.1 Discussion of Social, Economic and Cultural Factors and the Delivery of Maternal Services

In an interview with the District medical officer on 4th August 2015, He noted that;

> Due to inadequate social amenities like roads, transportation of expecting women becomes hard from their homes to the health facilities. Other women come from far places to reach the health centre and these results into complications as they take long time travelling moreover on poor roads. In addition, women take maternal health services for granted as they opt for traditional medicines which affect the delivery of maternal services.

The level of education most women have is low. This leads to little or no understanding of the messages sent to them in regard to maternal health care. As a result, they don't come to health centres and as a result, mothers affected by HIV/AIDS pass it on to their unborn children. This is

now an issue that is considered among safe motherhood in the current health sector. This was further confirmed by the senior nursing officer through a interview on 3rd August 2015;

> Women and other people have a belief that health centre III cannot handle maternal services. This makes them seek such services from the health centre IV that is far away from them.

According to the social set up, health centre IIIs are closer to communities unlike health centre IVs. Having that belief coupled with most of their financial status that is low, they meet challenges of transport costs that make it hard for them to access services from health centre IVs and hospitals whose end results is complications related to delivery.

5.1.2 The effect of social, economic and cultural factors among rural women on the delivery of maternal health services

The study found out that health centres are closer to women in their localities, there is a gap in sensitization of women to access maternal services, expecting mother face challenges in accessing health centres and transport facilities are not in place to enable movement to enable expecting mothers to access health centres for maternal services. The study further revealed that most of quality and majority of the health facilities are only concentrated in urban places which makes it hard for rural women to access maternal health services unlike their urban counterparts, and women from rich families stand a better chance while seeking maternal services.

These findings are in agreement with Hjortsberg and Mwikisa, (2002), Perry and Gesler, 2000 who stated that in developing countries, there is a challenge of drug availability, and distance to a health facility. Perry and Gesler (2000) stated that in rural areas, there are fewer healthcare facilities and villages may be physically isolated. More to that in agreement with the findings is the presence of poor quality of roads and the burden of having to use modes of walking and/or using a bicycle.

The researcher found out that women lack sensitization and transport facilities and this mix of ignorance and transport greatly affects women of Kabwohe town council to access maternal health care services. More so even the presence of the VHTs in villages has not helped much because they are not paid for the work done, no motivation, thus leading to more women losing their lives during and after birth. Lack of sensitisation coupled with ignorance among women on the importance of antenatal care increases the risk of expecting mothers to continue dying.

5.2 The Obstacles Leading to Constant Increase of Maternal Issues Among Health Workers.

Inadequate Number of Health Workers

Inadequacy of the health workers was discovered to have a contribution on maternal health issues. It was revealed that there are few health workers at Kabwohe Health Centre IV as stated by the respondents and this affects the delivery of maternal services.

It was further found that the inadequate number of health workers at Kabwohe health centre IV is responsible for poor delivery of maternal health services. Maternal health services are mainly handled by the medical officers when it comes to complex situations and midwives. But according to Kabwohe Health Centre IV structure, the facility is staffed with one Medical Officer and four Midwives yet the facility receives an average of 60 mothers that require maternal health attention. It should be born in mind that the facility doesn't only handle maternal services but also other curative services hence the few health workers getting over-burdened.

This was confirmed in an exclusive interview with a medical Officer on 4th August 2015 at Kabwohe Health IV,

> Kabwohe health centre IV lacks adequate number of health workers. The few that are there are overworked and cannot sustain the work that should be done all through the 24 Hours

The knowledge gap of available Health Workers on Maternal Health

From the interviews encountered with the respondents, it was found out that a few of the respondents reported an existence of knowledge gap among health workers on maternal health that affects effective delivery of maternal services. This creates a gap whereby the available health workers at Kabwohe Health Centre IV have issues in understanding the different trends in maternal services and handling of complicated maternal issues. And this largely affects the delivery of maternal health services.

Lack of attention given to Women seeking Maternal Services by Health Workers

The obtained interviews revealed that there is lack of attention given to women seeking maternal services by the health workers.

This implies that health workers give less attention to women seeking maternal services as stated by some of the respondents. However, there is some degree of attention given to women seeking maternal services, although there is as a gap between the perception that health workers give less attention to expectant mothers and that they do not give attention. Even though the percentage of those that agree to health workers give less attention to expectant mothers is not representative enough to convince the study that health workers don't fully give attention to women seeking maternal services. Given the two scenarios, the problem is the overwhelming numbers of expectant women seeking maternal health services and inadequate number of health workers at the facility. This can be justified by the fact that there is a limited number of health workers in the facility and this decreases on the time a health worker spends on patients.

This was further confirmed by the senior nursing officer on 3rd August 2015 at Kabwohe Health Centre.

> We are overwhelmed by the number of patients we receive on a daily basis, there is always no time for us to attend fully to all patients, even when they have a lot to share with us.

Limited availability of Drugs required for Pregnant Women

It was noted that limited availability of drugs required for pregnant women was a big concern in the study. The respondents confirmed that there is no availability of drugs required for pregnant women in the health centre even if they seek for antenatal care. Thus affecting the delivery of maternal health services at Kabwohe Health Centre IV.

In an interview with District medical officer on 4th August 2015, confirmed this,

> In instances where certain drugs become too expensive for government to purchase, mechanisms should be put in place to ensure that at least some cost-sharing is done. This will solve the challenge of drug scarcity and affordability at the side of the beneficially.

With such scarcity of drugs that are necessary for women seeking maternal health services, this affects the delivery of maternal health services as women are referred to seek unavailable drugs from other places outside the main facility.

This finding further correlates with the findings of Hjortsberg and Mwikisa, (2002), Perry and Gesler, 2000 who stated that in developing countries, there is a challenge of drug availability, and distance to a health facility.

Inadequate Space in the Health Centre for Visiting Mothers seeking Maternal Services

The space in the health centre being enough for visiting mothers was part of the study aims. This is an implication that the space accommodation within the health facility is small to handle the number of women seeking maternal health services. This becomes inconvenient for the health workers to attend to mothers hence affecting the delivery of maternal services.

This was further confirmed by a medical officer on 5th August 2015 at Kabwohe Health Centre in that:

> The health centres, the health sector and the district local government that controls the health facility are poorly financed. This makes it hard for them to operate well like recruiting and retaining good health workers, equipping the health facility and generally taking care of it. On top of financing, there are also management challenges. These basic support facilities' lacking makes the work of health workers irrelevant thus leading to non-performance that makes maternal health services wanting.

The Unattractive Environment in the Health Centre to Pregnant Women

On the issue of the attractiveness of the environment, the respondents agreed to that there is unattractiveness of the environment at Kabwohe health center IV, implying that the environment in the health facility is not conducive enough for pregnant women. This hinders some of them to come to seek maternal services which contribute to the factors that affect the delivery of maternal health services at Kabwohe health centre IV.

This was further confirmed by the senior nursing officer on 3rd August 2015 Kabwohe Health Centre

> There is lack of basic support facilities like power, water, medical equipments, and drugs that make one operate and perform quality health services. So how can a woman be allowed to sit and wait in a ward that is dirty to put her life and the expected baby into a health risk?

This question in the quote leaves one to wonder, how expectant mothers are expected to deliver in such an environment. Likewise the health workers who are expected to deliver services effectively in an unattractive environment.

This finding is in agreement with Mullally (2015) reporting that hospitals in low-income countries frequently report the poor state of medical equipment as being a key challenge they face in delivering services. Therefore, the environment in which maternal health services are offered is in a poor state.

Lack of Medical Equipment required for Maternity Services

The respondents confirmed the lack of medical equipments at Kabwohe Health centre IV. Respondents attributed this lack of medical equipment as an obstacle hindering maternal health services at Kabwohe Health center IV.

This implies that the medical equipment such as delivery kits, delivery beds for People with Disabilities (PWDs) especially expectant mothers who need a lot of attention, and operational theatre. All these medical requirements affect the delivery of maternal services at Kabwohe Health centre IV.

This finding is in concurrence with the King's Fund (2008) suggestion that the importance of medical instruments is that they save more than millions life in each year, both at the hospital or homes. With lack of such medical equipment, the lives that would rather be saved are not saved hence an effect on the delivery of maternal health services.

This was further confirmed by two respondents in the interview below,

> Kabwohe Health Centre IV lacks basic support facilities that make the work of health workers irrelevant thus leading to non-performance that makes maternal health services wanting. Some of the lacking equipment include gloves, plastic sheets, sutures and most of the theatre support equipment (Interview with Medical Officer and a Clinical Officer on 5th August 2015).

While in the study, the following challenges were discovered: There is a challenge of technical knowhow. Some of the trained health workers have limited knowledge. Take an example of using the management information systems and ICT in general. These are some of the issues that would rather support the health sector on top of health sciences themselves. More to that, not every health worker has basic knowledge of using every health equipment in the health facility. This makes it hard to effectively deliver health services in the health centre. The health centres, the health sector and the district local government that controls the health facility are poorly financed. This makes it hard for them to operate well like recruiting and retaining qualified health workers, equipping the health facility and generally taking care of it. On top of financing, there are also management challenges. The central person to act as a care taker of the facility lacks and the different managers at different levels of management of the health facilities lack genuine management knowledge and a sense of belonging that would enable them run the health facility amidst the ever existing financial challenges.

There are basic support facilities like power, water, medical equipment and drugs that make one operate and perform quality health services. But all that lack in the health centre. So how can a woman are allowed to sit and wait in a ward that is dirty to put her life and the expected baby into a health risk? These basic support facilities' lacking makes the work of health workers irrelevant thus leading to non-performance that makes maternal health services wanting.

The health facilities across the country and Kabwohe health centre IV in particular, lacks an adequate number of health workers. The few that are there are overworked and cannot sustain the work that should be done all through the 24 Hours.

The study realized that there are few health workers at Kabwohe Health Centre IV, the health workers give less attention to women seeking maternal services the challenge with the availability of drugs required for pregnant women in the health centre, a challenge with the space accommodation within the health facility being small to handle the number of women seeking maternal health services that inconveniences the health workers while attending to mothers, the environment in the health facility is not conducive enough for pregnant women, and the medical equipment required for maternal services is not available in the health facility.

These findings are in agreement with Birth-rate Plus (2013) that found out challenges facing England's maternity services that needed improvement in staffing, training and communication. Notable in the staffing was the numbers of midwives that raised concerns about shortages. There is a need to increase staffing numbers, particularly midwives and consultants. The King's Fund (2008) suggested that, while numbers of staff are important, it is the effective deployment of the right staff doing the right thing at the right time in the right place that is the key to improvement. Medical Labs and Health (2015) pointed out the importance of medical instruments as they save more than millions life in each year, both at the hospital or homes. These medical instruments were pointed out in the study as lacking in Kabwohe health centre IV which has affected the delivery of maternal health services. Mullally (2015) also concurs with the findings of the study as he pointed out that hospitals in low-income countries frequently report the poor state of medical equipment as being a key challenge they face in delivering services. This was found as a challenge in Kabwohe Health Centre IV.

5.3 The Possible Solutions to the Problems related to Maternal Health services.

The responses were sought from respondents on the possible solution to problems related to maternal health services and presented as below:

Emphasis on Education about Nutrition offered to Expecting Women

The findings indicated that nutrition for expecting women should be emphasized as confirmed by the respondents. This implies that the health of an expectant mother should be further enhanced with good balanced diet for both the mother and expecting baby.

It is therefore suggested that expecting women should continue being educated on nutrition, foods to be eaten for both body building and energy giving food as a solution towards solving maternal health service delivery.

In an interview with senior nursing officer on 3rd August 2015 at Kabwohe Health Centre,

> There is an existence of the VHTs in the health structure based in each village.. They should be used to sensitize women and the public in general to ensure effective delivery of maternal health services as they can easily reach the grassroots. There should also be a move to check on the work of the traditional

> birth attendants in the villages. Most of them are not skilled enough to handle minor cases and in case of any complications, the worst is expected.

The traditional birth attendants are said to be nearer to communities as thus expecting women find it easier to confide in them, and yet they are not trained on the basic knowledge of maternal health services.

This is an indicator that the nutrition education that is being give to the women through the Village Health Team (VHT) members is inadequate as the VHTs themselves are not trained enough or equipped, or even facilitated with necessary knowledge to manage the nutrition education.

A clinical officer at Kabwohe Health center IV on 5th August 2015 noted that,

> An emphasis should be put on sensitization. This will help to tackle maternal issues like proper balanced diet of pregnant women. Health centres, on top of offering main medical and maternal services, should be used to provide supplements on women diet

Most of the expecting women interviewed at the health facility were requested to have a balanced diet meal on a daily basis (carbohydrates and proteins)

Sensitization of Husbands and Community Leaders on Maternal Services

Majority of the respondents agreed that sensitization of husbands' and community leaders on maternal services be done thoroughly. Most of the decisions at both household and community are being taken by men and husbands. Therefore in order to strengthen the effective delivery of maternal services, vigorous community awareness should be done with husbands and community leaders such as the opinion leaders, church leaders, and clan leaders.

It is therefore called upon to have husbands and community leaders to be sensitized so that the delivery of maternal services is improved together with their support.

This finding was discussed as a negative effect on maternal health services by Bathala, (2013) who called for improvement in nutrition for pregnant and lactating women as an important goal. He stated that educating men about danger signs and pregnancy complications increases the likelihood that future births will take place in health care facilities. In addition, raising men's

awareness of the benefits of family planning will reduce maternal mortality by increasing intervals between births.

The above strategies reflect what the medical Officer opined during an interview on 04 August 2015 at the Health Centre.

> An emphasis should be put on sensitization. This will help to tackle maternal issues like proper balance diet of pregnant women. Health centres, on top of offering main medical and maternal services, should be used to provide supplements on women diet. Members of the community should be sensitized and mobilised so that they are in position to ensure that quality maternal services are offered to them through holding their leaders accountable and encouraging one another to attend/seek maternal health services.

Creation of Awareness among Husbands and Community Leaders about the Benefits of Family Planning

The respondents revealed that husbands and community leaders are aware of the benefits of family planning as stated and agreed upon by majority of the respondents agreed. This is an implication that husbands and community leaders should be aware of the benefits of family planning basing on the response of the respondents.

However, there is still a need to mobilize more husbands and community leaders about the benefits of family planning. Men who are in most cases community leaders should be sensitised on the benefits of family planning; importance of antenatal cares services for expecting women.

In an interview on 5th August 2015 at Kabwohe Health Centre, the medical officer confirmed that;

> Members of the community should be sensitized and mobilised so that they are in position to ensure that quality maternal services are offered to them through holding their leaders accountable and encouraging one another to attend/seek maternal health services and antenatal classes

Participation of Religious Leaders in Maternal Services Delivery

The participation of religious leaders in maternal services delivery was agreed upon by the respondents. This implies that religious leaders are very key in our communities since communities believe in them, and they have high chances of engaging with both women and men

in different places of worship. There is need to involve them in the effective delivery of maternal health services, equip them with basic knowledge on maternal services and need for both women and men to embrace it. This calls for effective involvement of religious leaders in mobilizing the masses in seeking maternal services.

Consideration of Maternal Services by the Local Government in its Plans and Budgets

The study found out that local government considers maternal services in their plans as stated by the respondents. This implies that there is need for the local government to consider maternal services in their plans and budgets.

However they are still challenged with effective implementation due to late disbursement of funds by the central government thus affecting implementation of services such as maternal service delivery.

Prioritization of Transport and Accessibility to Health Centres by the Local Leadership

The issue of transport and accessibility to health centres being prioritized by the local leadership, as confirmed by the respondents. This Health centre serves the whole district of Sheema, therefore becomes difficult for some expecting women to access this facility due to poor infrastructure such as roads.

This calls upon local leadership to prioritise transport and accessibility to health centres basing on the responses from this study. Without transport and accessibility to health centres by expecting mothers makes it difficult for them to seek maternal health services.

Provision of Support Kits to Expecting Mothers

From the interviews held with the respondents, they agreed that support kits be provided to expecting mothers. This indicates that expecting mothers are provided with support kits basing on the response of the majority.. In order for the kits to be utilised fully by the expecting women, training should be also conducted to support this. This will encourage women to attend antenatal care, and also contribute to the reduction of maternal deaths and mortality rates. However, there is still some gap and this calls for more support to expecting mothers by providing them with support kits.

Interventions Made to Improve Maternal Health Services

The respondents agreed that interventions have been made to equip the health centre in order to improve maternal health services. This implies that there are interventions being made to equip the health centre in order to improve maternal health services. However they are not adequate enough to serve the entire district since it is the main health centre facility. Some of the interventions such as extension of maternal ward are still underway. There is therefore need to actually equip the health facility in order to improve on the delivery of maternal health services.

This is confirmed by the District medical officer through an interview on 4th August 2015,

> Some of the interventions are actually underway such as the extension of maternal ward and renovations on the operational theatre so that it is well equipped with necessary equipment's. We have also requested for refresher training for medical personnel at the health facility to equip them with necessary information on handling on maternal complications.

There should be health workers' assessment so that those with wanting skills be identified and trained so that they are in position to handle basic maternal health cases in order to improve on the services. There is also an existence of the VHTs in the health structure. They should be used to sensitize women and the public in general to ensure effective delivery of maternal health services as they can easily reach the grassroots as they are based in each village. There should also be a move to check on the work of the traditional birth attendants in the villages. Most of them are not skilled enough to handle minor cases and in case of any complications, the worst is expected. They even lack basic support equipment like plastic sheets, gloves and cotton

In instances where certain drugs become too expensive for government to purchase, mechanisms should be put in place to ensure that at least some cost-sharing is done. This will solve the challenge of drug scarcity and affordability at the side of the beneficially. Services at the public health centres are free but people are not aware. This makes them get charged for the services sought and as a result, some people are compelled to stay in their homes or seek alternatives hence affecting maternal services. People should therefore be informed about the services being free offered at the public health facilities. The government should also organise ways of ensuring easy and affordable way of transporting expecting mothers to the health centres. Most rural women are unable to afford private means to the health facilities. People should also be

encouraged to encourage or mobilise their family members in order to go for pregnancy check-ups at the health facility. Communities are isolated and means should be thought of to have information flow so that a larger group of people can be reached.

In the study, it was suggested that expecting women should continue being educated on nutrition as a solution towards solving maternal health service delivery, husbands and community leaders to be sensitized on maternal services, there is a need to mobilize more husbands and community leaders about the benefits of family planning, religious leaders should be involved in mobilizing the masses in order to seek maternal services, local government should work towards the implementation of plans that are geared towards maternal health, transport and accessibility to health centres should be improved to make it easy for mothers to access health centres, expecting should be provided with support kits and there is need to actually equip the health facility in order to improve on the delivery of maternal health services. These findings are in agreement with Bathala, (2013) who called for improvement in nutrition for pregnant and lactating women as an important goal. He further stated that educating men about danger signs and pregnancy complications increases the likelihood that future births will take place in health care facilities. In addition, raising men's awareness of the benefits of family planning will reduce maternal mortality by increasing intervals between births. More in agreement with the study findings is Greene and Ostrowski, (2013) that argued that reducing maternal mortality requires a strong health system with well-distributed, high-quality facilities that can provide emergency obstetric care.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary of the findings generated from the study, conclusions and recommendations to factors affecting the delivery of maternal health services in Uganda. Under this chapter, the areas for further research have been highlighted.

6.1 Summary of Findings

The summary of the findings is presented with respect to the study objectives as follows:

6.1.1 The Maternal Services Offered at Kabwohe Health Centre IV

Health centres are meant to provide certain basic services depending on the level of the health center. In Uganda these health centres range from health centres II's III's and IV. In this study the focus was on the health center IV and the following maternal health services were found to be offered at Kabwohe Health Center IV; Antenatal care services (pre and post natal care), delivery, prevention of mother to child transmission (PMCT), counselling and guidance, Antenatal check-ups.

6.1.2 The effect of social, economic and cultural factors among rural women on the delivery of maternal health services

To examine how social, economic and cultural factors among rural women influence accessibility to maternal health services, questionnaires, interview guides and documentary reviews were used to gather data. It was found out that health centres are closer to women in their localities, there is a gap in sensitization of women to access maternal services, expecting mother face challenges in accessing health centres and transport facilities are not in place to enable movement to enable expecting mothers to access health centres for maternal services. The study further revealed that most of quality and majority of the health facilities are only concentrated in urban places which makes it hard for rural women to access maternal health services unlike their urban counterparts, and women from rich families stand a better chance while seeking maternal services.

6.1.3 The obstacles leading to constant increase of maternal issues among health workers and the delivery of maternal health services

To find out the obstacles leading to constant increase of maternal issues among health workers, questionnaires, interview guides and documentary reviews were used to gather data, the study realized that there are few health workers at Kabwohe Health Centre IV that affects the delivery of maternal services, the available health workers at Kabwohe Health Centre IV are knowledgeable about maternal health which doesn't affect the delivery of maternal health services, and the health workers give less attention to women seeking maternal services. More to that, there are no drugs required for pregnant women in the health centre, the space accommodation within the health facility is small to handle the number of women seeking maternal health services that inconveniences the health workers while attending to mothers, the environment in the health facility is not conducive enough for pregnant women, and the medical equipment required for maternal services is not available in the health facility.

6.1.4 The possible solutions to the problems related to maternal health services

To seek possible solutions to the problems, questionnaires, interview guides and documentary reviews were used to gather data. It was suggested that expecting women should continue being educated on nutrition as a solution towards solving maternal health service delivery, husbands and community leaders to be sensitized on maternal services, there is a need to mobilize more husbands and community leaders about the benefits of family planning, religious leaders should be involved in mobilizing the masses in order to seek maternal services, local government should work towards the implementation of plans that are geared towards maternal health, transport and accessibility to health centres should be improved to make it easy for mothers to access health centres, expecting should be provided with support kits and there is need to actually equip the health facility in order to improve on the delivery of maternal health services.

6.2 Conclusion

During the study factors such as poor transport facilities, lack of awareness and improper distribution of health facilities have an effect on the delivery of maternal health services which mainly comes from the accessibility of health facilities by the expecting mothers. These continuously featured in all the discussions during data collection.

Throughout the study, gaps such as shortage of health workers, availability of drugs required for pregnant, limited space in the health centre and availability of medical equipment were identified leading to constant increase of maternal issues among health workers and the delivery of maternal health services at Kabwohe health centre IV.

6.3 Recommendations

It is recommended that efforts to mobilise women should be increased. These efforts should target informing expecting women to seek antenatal care at least for times during pregnancy at lower health centres like health centre IIs and IIIs. This will help reduce on the congestion that takes place in health centre IVs and save women the costs of travelling to main health centres as these lower health units are relatively closer to them. This mobilization should be implemented through existing structure like the VHTs that are at the grassroots (in each village- LCIs), use of the electronic media (radios) and religious leaders as they have a more proximity to the people more than other structures.

Efforts by all stakeholders like government and development partners are called upon to ensure that more health workers are recruited to handle the number of women that come to seek maternal services. Refresher trainings are also called for so that the health workers' knowledge is enhanced to handle more complicated cases. An assessment of all health facilities should be made so that the lacking equipment is identified and where possible; improvising can be made so that alternatives support equipment can be provided to supplement the rather expensive medical equipment. For example, in case a health centre lacks an electric autoclave to sterilise the medical equipment, improvising with firewood, water and saucepans can be used to sterilize the equipment.

It is recommended that women should be trained on how they should handle and conduct themselves in case of pregnancy. Furthermore, women and the general public should be sensitised on how to demand for their rights through knowing what services they expect from government facilities. Men (Husbands) should not be left out when it comes to sensitization on maternal services as they play a role in the implementation of maternal services and they are also part and partial of the women that seek for similar services. More to that, the government should also prioritise the improvement of feeder roads as they are the ones used by the locals to access

health centres. Alternative ambulance services (motorcycles) should be placed at lower health centres to ferry women that need to access health centres to deliver. These motorcycles are relatively cheaper to buy, maintain and operate compared to vehicle ambulances in terms of fuel and mechanical breakdowns. Given the poor state of the roads and being narrow to the villages, these motorcycles can easily have access unlike vehicles.

It is further recommended that health center III and II should be upgraded to provide maternal health services such as full time medical personnel, well facilitated theatre and maternity wards. The government should put it into consideration for easy accessibility by expecting mothers.

6.4 Areas for further study

In the process of undertaking the study, some gaps were identified by the researcher. These gaps are therefore recommended by the researcher to be undertaken by other researchers/scholars in order to be filled up. The identified gaps that should work as areas for further studies include:

- Roles of general public at lower levels in the implementation of maternal health services.
- Effects of staffing on maternal services
- Factors that lead to underutilization of lower health centres by expecting women in Uganda.
- The impact of men's inclusion on the delivery of health services

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APPENDICES

APPENDIX A: QUESTIONNAIRE

Introduction

Dear respondent, my name is Happy Ainomugisha. I am a Masters student at Uganda Martyrs University-Nkozi pursuing a Masters Degree in Local Governance and Human Rights. I am gathering information about Factors Affecting Maternal Health Services in Uganda. This is to request for your contribution towards my study by participating in being a respondent. The information you will give is confidential and is not binding. Your participation is highly appreciated.

Section A. Background information

1. Gender: Male □ Female □

2. Age: Below 20 □ 20-29 □ 30-39□ 40-49□ 50-59□ Above 60 □

3. Education level: Primary level □ Secondary level□ Tertiary□ Bachelors□ Post graduate□

4. Time spent in health service so far < Year□ 1-4 Years□ 5-9 Years □ 10>□

Section B: The maternal health services in offered at maternal health facilities in Kabwohe health Centre IV

5. a) Are you aware of maternal health services offered in Kabwohe health Centre IV?

Yes No

b) If yes, what are the services offered …….

……

6. What is the current status of the maternal health services offered in Kabwohe health Centre IV? ……

…….

Section C. Factors affecting maternal health services

7. The social economic and cultural factors affecting maternal Health services

In your opinion and experience do you think the health centre is near?

Yes No

State the reason for your answer……

…….

Do you think culture has a role in ensuring access to maternal health services?

Yes No

If yes how does your culture affect maternal services…….

……..

Are health facilities in place to enable movement for women?

Yes No

If yes, give reasons for your answer……

…….

In your Opinion, are health centres concentrated in urban places?

Yes No

If yes, give reasons for your answer……

…….

Do you think traditional ways are only sought by expecting women in your area

Yes No If yes, why do you think so?

Do you think transport facilities are in place to enable movement for expecting women?

Yes No

If yes how does this contribute to maternal Health services

Section D: The Obstacles affecting maternal health services at Kabwohe Health Centre IV

8. What are the obstacles affecting maternal health services at Kabwohe Health Centre IV

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……

Section E: The Possible solutions to effective delivery of maternal health services at Kabwohe Health Centre IV

9. In your opinion what are the possible solutions to effective delivery of maternal health services at Kabwohe Health Centre IV

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……

THANK YOU FOR YOUR TIME AND PARTICIPATION

APPENDIX B: INTERVIEW GUIDE FOR KEY INFORMANTS

Introduction

Dear respondent, my name is Happy Ainomugisha. I am a Masters student at Uganda Martyrs University-Nkozi pursuing a Masters Degree in Local Governance and Human Rights. I am gathering information about Factors Affecting Maternal Health Services in Uganda. This is to request for your contribution towards my study by participating in being a respondent. The information you will give is confidential and is not binding. Your participation is highly appreciated.

Section A. Background information

1. Venue ……Date……

2. Current position in the Health Service …….

3. Time spent in health service so far < Year□ 1-4 Years□ 5-9 Years □ 10>□

Section B: The maternal health services in offered at maternal health facilities in Kabwohe health Centre IV

4. What are the maternal health services offered in Kabwohe health Centre IV? ……
……

5. What is the current status of the maternal health services offered in Kabwohe health Centre IV? ……
…….

Section C: Factors affecting maternal health services in Kabwohe health Centre IV

6. How would you comment on the effect of Social, economic and cultural factors on the delivery of maternal health services? (Please focus on: accessibility to the health facility, mobilization/sensitization and response, and beliefs
……
……

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Section D: The Obstacles affecting maternal health services at Kabwohe Health Centre IV

7. What are the obstacles affecting maternal health services at Kabwohe Health Centre IV

……

……

……

Section E: The Possible solutions to effective delivery of maternal health services at Kabwohe Health Centre IV

8. In your opinion what are the possible solutions to effective delivery of maternal health services at Kabwohe Health Centre IV

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……

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THANK YOU VERY MUCH