WOMEN’S PERCEPTIONS OF ANC AND DELIVERY CARE SERVICES, A COMMUNITY PERSPECTIVE.
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The aim of the Future Health Systems (FHS) Research Programme Consortium is to find ways to translate political and financial commitments to meet the health needs of the poor. The consortium addresses fundamental questions about the design of future health systems, and works closely with actors who are leading the transformation of health systems in their new realities. Our research themes are:

— Protecting the poor against the impact of health-related shocks
— Developing innovations in health provision
— Understanding health policy processes and the role of research

Working papers are intended to make available initial findings and ideas from the research of members of the consortium. They are not intended to be polished academic papers, but are scholarly inquiries aimed at provoking further discussion and investigation. Comments and suggestions on these papers are welcome, and can be directed to the authors.

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# Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS:</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC:</td>
<td>Antenatal Care</td>
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<tr>
<td>FGD:</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FGD’s:</td>
<td>Focus Group Discussions</td>
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<tr>
<td>HIV:</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>MMR:</td>
<td>Maternal Mortality Rate</td>
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<tr>
<td>MOH:</td>
<td>Ministry of Health</td>
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<tr>
<td>MOH-MCH/FP:</td>
<td>Ministry of Health-Maternal Child Health/Family Planning</td>
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<tr>
<td>TBA:</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UDHS:</td>
<td>Uganda Demographic and Health Survey</td>
</tr>
<tr>
<td>UNICEF:</td>
<td>United Nations Children’s Fund</td>
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<td>WHO:</td>
<td>World Health Organization</td>
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Abstract

Introduction: To reduce maternal morbidity, mortality and improve neonatal health, government has focused on improving access and supply of maternal health services. Despite these efforts, maternal morbidity and mortality remain a major public health problem in Uganda. This study explores the factors and challenges experienced in utilizing ANC and choosing a delivery place in order to inform the implementation of a proposed intervention aimed at improving access to maternal delivery services.

Methodology: This was a qualitative study that employed Focus Group Discussion (FGD’s). Participants were purposively sampled. Six FGD’s were conducted among women aged 15-49 years who had ever had a child and were residing in eastern Uganda in the districts of Kamuli, Soroti, Tororo and Pallisa. All data was tape recorded with consent from participants and transcribed thereafter. Typed data was analyzed manually using qualitative thematic analysis techniques.

Results: The majority of respondents attended ANC at least once. The major limitations to accessing ANC services were long distance and high transport costs to health care facilities. All FGD’s reported that health centres, traditional birth attendant (TBA’s), homes and private clinics were the usual delivery sites. Despite the noted benefits of health facility deliveries many barriers deterred utilization of formal delivery services. These included; user fees charged, hospital requirements, long distance to health facilities and rude service providers. TBA’s were appreciated because of the hospital training they had acquired and the flexibility of their services in terms of payment and the site of provision. Home deliveries were viewed as potentially risky but due to high transport costs were at times the only affordable option. Participants expressed excitement over the upcoming project and believed it would improve accessibility to maternal health services.

Conclusion and implications: The findings of this study indicate that demand side barriers such as transport and cost of maternal health services are a major challenge affecting utilization. Services offered by TBA’s were more accessible in terms of distance and cost. Interventions to improve the attitude of health workers and ensure abolition of informal fees may be helpful in improving utilization of formal services. It was believed that a project to provide free transport for accessing maternal health services would greatly improve the health of women in the region.
1.0 Introduction and Background

Half a million women die annually due to pregnancy and childbirth related events. In addition, three hundred million women in the world currently suffer from long-term or short-term illness brought about by pregnancy or childbirth (WHO 2005b). According to maternal mortality estimates, Africa has the highest maternal mortality rate (MMR) estimated at 900 deaths per 100,000 (WHO 2005a). Various social, economic and political factors influence health care delivery and contribute to this high maternal mortality rate (MMR). Such a scenario makes improving maternal health care and deliveries a major priority of many African countries. Uganda is one of the thirteen countries accounting for 67 percent of global maternal deaths. The 2007 Uganda Demographic and Health Survey Report estimates the MMR at 435 deaths per 100,000. The main causes of maternal morbidity and mortality in Uganda include preventable/treatable causes such as abortion, haemorrhage, obstructed labour, sepsis, eclampsia and anaemia (Mbonye 2007).

It is every woman’s right to access high quality maternal health services that in turn must be accessible, affordable, effective, appropriate and acceptable to them in order to avoid preventable morbidity and mortality (WHO 2005b). Many complications of pregnancy and childbirth that lead to mortality can be prevented by providing quality care that involves early detection of problems and appropriate timely interventions (Campbell et al. 2006; MOH 2008).

Coverage and access to maternal health services.

According to the 2007 Uganda health services provision survey the majority of deliveries (58 percent) took place at home. Deliveries in health facilities were 41 percent, 29 percent occurred in public health facilities, and 12 percent took place in private health facilities. According to the same survey, 7 in 10 facilities offer antenatal care services in the country, although some essential equipment and supplies for antenatal care were noted to be missing. Facilities in central Uganda are more likely to offer ANC compared to facilities in other regions. Only 3 of 10 facilities offering ANC offer the full essential safe motherhood antenatal package.

Maternal delivery services are only offered in 50 percent of facilities. Normal delivery services are mainly available in hospitals, HC-IVs and HC-llls. All hospitals and health center fours are supposed to offer caesarean section services; however, 84 percent of hospitals and 24 percent of HC-IVs offer these services. Maternal emergency referral remains available at less than 50 percent of the facilities. Services supporting home deliveries hardly exist in health facilities (Ministry of health and Macro International, 2008). Low coverage and poor utilization of maternal health services predisposes mothers and infants to the risk of dying from pregnancy related causes (United Nations Population Fund 1999)
Most of the interventions in Uganda have focused on addressing the supply side barriers, with very few attempts at addressing the demand side. The Future Health Systems study intends to pilot an intervention that will attempt to reduce demand side barriers such as access to transport, and the cost of seeking services as well as supply side factors such as lack of adequate supplies and equipment and poor attitudes of health workers. The findings of this exploratory study will inform the implementation of this intervention.

1.1 Objectives

**Overall Objective**

To explore the utilization of ANC and choice of delivery place in order to inform a proposed intervention that is aimed at improving access to maternal care services.

**Specific Objectives**

— To explore the use of ANC services among women of reproductive age.
— To explore the choice of delivery places.
— To document women’s suggestions for promotion and improvement of institutional deliveries.
— To establish the attitude of women of reproductive age towards a project that aims at reducing the cost of seeking maternal health services.
2.0 Methods

Study area and population: This study was conducted in Eastern Uganda in the districts of Tororo, Pallisa, Soroti and Kamuli. The study population comprised of women of reproductive age who had children aged less than two years.

Study Design: The study was qualitative in nature and it employed Focus Group Discussions for data generation.

Sample size: Six FGD’s were conducted; a decision to stop at six was based on the fact that there was a repetition of emerging views.

Sampling Procedures: Study participants were purposively selected. Study participants were selected from Tororo, Pallisa, Soroti and Kamuli districts in Eastern Uganda. The study team contacted community health workers and briefed them on the study objectives and requested their cooperation in identifying study subjects. Eligible participants were identified by the community health workers in each district. A total of six FGD’s compromising of 8-12 participants were conducted. Two FGD’s were conducted in two of the districts visited first and one FGD each in the other two districts visited last. Discussions were held at a venue suggested and convenient to the participants—tree sheds were mostly chosen.

Quality Control: Research assistants (RA’s) were recruited on the basis of previous experience in collecting qualitative data and knowledge of the local languages. The RA’s were informed of the study objectives, trained on the use of the FGD guide and note taking. All FGD’s were recorded after consent was sought from study participants. The tape recorded versions were transcribed into English. Participants were guaranteed of anonymity.

Data management and analysis: The data was analysed manually using thematic content analysis techniques. Categories and themes were developed in line with the research questions, which were; utilization of antenatal services, choice of delivery place, recommendations for increasing institutional deliveries and attitude towards proposed project.

Ethical considerations: The research was approved by the Makerere University School of Public Health Higher Degrees, Research and Ethics Committee and Uganda National Council for Science and Technology. Permission was sought from the District Health Department of the respective districts to allow the study to be conducted. Informed consent was obtained from the study participants after explaining the goal and objective of the study, confidentiality measures and potential risks and benefits of the study. The informed consent document was translated to the local language (Lusoga, Iteso and Japadhola); consent was obtained in the language that the participants best understood.
3.0 Results

3.1 Socio-demographic Information

The FGD’s were conducted among women of reproductive age from the districts of Tororo, Pallisa, Soroti and Kamuli districts in Eastern Uganda. The participants were from the rural, peri-urban and urban settings. The participants comprised of women who had given birth at least two years prior to the data collection exercise.

3.2 Utilization of Antenatal Care Services

The majority of women reported going to a health unit for Antenatal Care (ANC) at least once during pregnancy. In the event that a woman had complications they reported that the facility staff referred them to higher level health units.

In some rare cases some women would not attend ANC at all. Failure to attend any ANC visit was thought to be a result of reluctance and lack of knowledge of ANC importance.

“Some come to deliver only, when they have not even come for ANC. Some women, when they don’t get any complication during pregnancy they don’t come for ANC.” (FGD, Kamuli District)

The participants reported to have gone for their first ANC visit at varying times during pregnancy. The gestational age at the first ANC visit ranged from as soon as one knew she was pregnant to eight months. However, the mothers were full of mixed feelings with regard to when to start ANC. Mothers who felt pain or had concerns about the baby’s development tended to attend ANC early. Generally the mothers felt if there were no complications it was needless to attend ANC early in pregnancy.

“I start ANC immediately I get pregnant because when you delay you can produce lame children because you have not checked to see what is in the womb.” (FGD, Kamuli District)

“Some begin at one month old to visit a health centre for antenatal periodically until the time of delivery.” (FGD, Pallisa District)

“Because I begun going for ANC late, if there is no problem or pain in the womb, I do not have to frequently go to a health facility.” (FGD, Soroti District)
“The poor pregnant mothers that I have at least interacted with, visit the health centres when their pregnancies are around eight months old.” (FGD, Pallisa)

According to the mothers, the number of ANC visits attended was dependent on the gestational age at first visit and the maternal health condition. It is believed an early gestational age at the first visit gave the mother ample opportunity to attend up to five follow-up visits. However, mothers who were poor often attended fewer visits. Long distances to the health centre coupled with the cost of transport contributed to poor adherence to the ANC schedule.

“For me all my 8 pregnancies I went 5 times each but the ninth one I only went once because I was weak and I was unable to walk so I went only once” (FGD, Tororo)

For me I am from Agwara so when it’s the day to go for ANC I try to borrow the bicycle and if I fail to get it and I have no money for transport then I delay to go for ANC.” (FGD, Soroti)

ANC was deemed beneficial to a number of mothers. It was considered a reliable method of assessing the unborn baby and detecting any complications. HIV testing that was part of the ANC package provided sero-positive mothers an opportunity to prevent the transmission of HIV to the unborn baby through the prevention of the mother to child transmission programs at the health facilities.

“They check and see whether the baby is well positioned in the womb.” (FGD, Namwendwa Health Centre)

“If they find that you are HIV positive, they will advise you to take drugs which will prevent the child from getting HIV from the mother” (FGD, Serere, Soroti)

Long distances coupled with high transport costs were some of the limitations to accessing ANC and contributed to delays in attending ANC. Conditions associated with pregnancy such as tiredness and feeling lazy, were implicated in compromising the mothers’ ability to walk to the health center.

“I am from far and transport rates are high so I postpone coming until when I am about to deliver.” (FGD Soroti District)
“For me I normally find a problem during pregnancy. The legs become paralyzed and I cannot move and if I have no bicycle then I cannot go to the hospital in time.” (FGD, Soroti District)

Material demands made on the mother by the health care providers during ANC also discouraged some mothers from seeking ANC services.

“If you go to hospital without lesus handbooks they send you back home without treatment – she lamented.” (FGD, Soroti District)

Another reason that was given for low attendance of ANC was lack of knowledge about the benefits of attending ANC.

“Most of these poor mothers are ignorant of the antenatal visits because they are not informed; so most of them visit when the pregnancies have reached advanced stages - but a few of them who are atleast informed usually go for antenatal when the pregnancies are at four months”. (FGD, Pallisa District)

It was communicated that some health care policies inhibited antenatal care attendance. One such policy was the provision of antenatal care only if the woman attended with her husband. Although couple counselling is important, it should not inhibit mothers from attending ANC.

“These days we have a policy here that each pregnant mother must go together with the husband for ANC. But some men go on drinking waragi so when you tell him to go with you, he is already drunk and tells you that we shall go tomorrow and then this delays you for ANC”. FGD Soroti

“Even if you go alone without the husband the nurses will not attend to you. Another thing is most men fear going to the hospital, because when you reach hospital you are supposed to be tested, most men fear testing.” (FGD, Soroti)

If the husband refuses to come with you to hospital for ANC you don’t go because we have a policy here which requires a man and a woman to come together to health facility for ANC”. FGD Soroti
3.3 Choice of Delivery Place

The most frequently mentioned delivery site in all six FGD’s was homes of either TBA’s or of the clients themselves. This was followed by the health facilities and lastly private clinics. The table below attempts to summarise the delivery sites used in eastern Uganda.

**Table 1: Choice of delivery Place**

<table>
<thead>
<tr>
<th>SITE</th>
<th>FGD 1</th>
<th>FGD 2</th>
<th>FGD 3</th>
<th>FGD 4</th>
<th>FGD 5</th>
<th>FGD 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Unit</td>
<td>***</td>
<td>*</td>
<td>*</td>
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<tr>
<td>TBA’s home</td>
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<td>***</td>
<td>*</td>
</tr>
<tr>
<td>Respondents home</td>
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<td>***</td>
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<tr>
<td>Clinic</td>
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</tr>
</tbody>
</table>

**Key**

*** Very frequently mentioned

** Frequently mentioned

* Mentioned a few times

**Key**

FGD 1 – Soroti Serere FGD  
FGD 2 – Pallisa FGD  
FGD 3 – Namwendwa FGD  
FGD 4 – Kidera FGD  
FGD 5 – Atiiriri FGD  
FGD 6 – Tororo FGD

**Benefits of Health Care Deliveries**

Health units were viewed as safe delivery sites. Availability of immunization services was viewed as an important benefit of delivering in hospitals. Other benefits mentioned were provision of some free services and proper management of complications with an effective referral system.

“Others deliver from Soroti if the mother completely fails from the small health centers then she is referred to Soroti referral Hospital.” (FGD, Soroti District)
“In a government hospital when you fail to deliver they can operate you.” (FGD, Pallisa District)

“When you deliver from here they immunize your child.” (FGD, Kamuli District)

“For me I delivered all my 8 children at home only the ninth child I delivered at the hospital, but delivering at home I lose a lot of blood but in hospital I don’t lose a lot of blood and I gain strength very fast.” (FGD, Tororo)

Another benefit cited was the provision of prevention of mother to child transmission (PMTCT) of HIV services. The participants acknowledged the importance of saving the newly born child from HIV infection. PMTCT interventions were available in health care settings.

“If you deliver from a health facility when you are HIV positive they can save your child from getting HIV virus.” (FGD, Kamuli District)

“If you are HIV/AIDS positive and you decide to deliver at home the people at home do not know how to cut the umbilical cord well that is why some of us prefer to come to the hospital so that the nurses will be able to cut the umbilical cord so the baby will be safe from getting infection.” (FGD, Soroti District)

Challenges to Health Care Deliveries

Despite the benefits cited, respondents reported that there were some difficulties experienced in the use of government health facilities. Challenges mentioned included unfriendly services, distance to the health units and high transport costs. In addition, hospital requirements needed and the fee charged for delivery services made it difficult to access health unit delivery services.

Health care delivery services were viewed as unfriendly because of the way some midwives handled expectant mothers. It was reported that the rudeness and negligence exhibited by some health providers was deterring mothers from using health facility delivery services. Some women after a bad experience did not want to deliver in a health unit ever again.

“They foot slowly to the health centre; If a mother has come for delivery, she is first of all neglected by the midwives; then if they turn to help, they disguisedly slap her because she has not paid them some money. I remember I was one time harrased also in the same way.” (FGD, Pallisa District)
“At mukuju hospital, one woman was about to deliver but the nurse left the woman alone. When she began pushing she was alone, in the process the child hit the ground and died instantly since the woman had no attendant and the nurse also not being around” (FGD, Tororo District)

Even if officially user fees were abolished, mothers usually still have to pay informal fees and they also have to buy some requirements such as gloves, washing detergent, soap, polythene sheets and a razor blade. These requirements are usually available for sell at the health unit and during antenatal care. Participants reported that the cost of delivering in a health center was too high; consequently many mothers sought alternative delivery sites.

“Others think if they go to deliver in hospital where will they get the money for paying hospital bills for example if the child is a boy you pay 4000 and if it is girl 5000. Even those who will pour the placenta will need 1000 and a glove a pair is 1000. So, if you are checked five times you pay 5000 and that is why the majority of women prefer to deliver at home.” (FGD, Pallisa District)

“The first thing before you climb the bed you have to produce gloves and two polythene papers if you don’t have they will not accept to help you.” (FGD, Soroti District)

“The child am carrying right now (7 months old), they told me to pay something in order to be given a polythene paper, I did not have and I was told to go away, what have you come to do from here, they beat me on my shoulder” (FGD Tororo District).

A few participants viewed the charges as a payment for service. They thought it was only fair that if someone offered a service they should be paid. A few participants expressed indifference, whether they paid or did not pay, it did not seem to matter much to them.

It is further reported that when women go through such experiences, they don’t stop at keeping it to themselves; they go back home and discuss with their fellow mothers their experiences. Such information about the health workers’ conduct tends to discourage mothers from delivering from the health facilities.

“If one happens to have met rude midwives who will slap a woman, then such a woman meets another pregnant woman and tells her experience, that discourages other mothers from going to health, facilities.” (FGD, Soroti District)
However, a few participants expressed a different opinion. They noted that not all health workers were rude, and defined each as having a different behavioural trait. In some settings, they have been defined as good.

Another challenge that was mentioned was the availability of transport. At the time of labour, access to health facilities especially at night seemed rather difficult. Transport at night seemed more difficult to secure and some mothers delivered on the way or at home because of this. “Most of the time, they foot because they can not afford using any means of transport to reach the health centres. Because of the long distance, they are really exposed to many dangers such as diziness, hunger, thirst or even death because of failure to access a health centre on time for deliveries using transport like a taxi or motorcycle.” (FGD, Pallisa district)

The Use of Traditional Birth Attendants

The commonly cited reason for use of TBA’s was the difficulty in transport that left mothers with no alternative but to use TBA’s. These TBA’s were more accessible than health units and TBA’s were flexible enough to carry out a delivery in one’s home.

“If you fail to get transport you just deliver at home especially with help of the old women.” (FGD, Soroti District)

“Even me I delivered at home alone because the man was not there so my co-wife helped me to cut the child.” (FGD, Soroti District)

Those who can not manage to pay the traditional birth attendants are helped to deliver in the banana plantations or the bush by a family member who is usually an elderly mother who has experience in conducting deliveries. They usually administer herbs. (FGD, Pallisa District).

TBA’s were perceived to be competent since they were trained at the health facilities. In some areas, TBA’s were known to refer clients who failed to deliver and therefore mothers were not afraid of going to them.

“Those people are trained here so people think they are competent.” (FGD, Kamuli District)

“We deliver at the village because even the TBA’s were trained to help mothers so most men prefer calling TBA’s instead of going to hospital because after delivering the mother, the TBA reports the case to the hospital.” (FGD, Soroti District)
“When you go to them and they fail to work on you they refer you to the health centre.” (FGD, Kamuli District)

“The way of going to hospital become difficult because our bicycle was spoilt and when we tried to borrow the bicycle from the neighbour we still failed to get so there was no way out, so we picked TBA.” (FGD, Serere, Soroti)

In addition, TBA’s were also noted not to be as demanding as health workers. Mothers who could not afford the hospital requirements opted to deliver with the TBA’s. Besides TBA’s requested payment after conducting the deliveries unlike midwives who demanded the requirements before conducting the delivery.

In spite of the continued occurrences of home deliveries, some mothers do acknowledge the dangers associated. They noted that labour complications could not be adequately managed at home and the mother would be at risk of getting tetanus and over bleeding.

“Another thing which makes us go to deliver in hospital is if any complications occur which need caesarean section and you are at home you just die.” (FGD, Soroti District)

“It is bad to deliver from the village because you can easily get tetanus.” (FGD, Kamuli District)

Private Health Care Providers

Clinics and private hospitals were not reported to be a major delivery site. Clinics were used when they were the nearest health facility or as an alternative to government facilities. Service providers in clinics were described as, “not rude.” However, the services were described as being expensive but most convenient.

“It may be the nearest facility where you can get the services.” (FGD, Kamuli District)

In some situations, mothers (especially those aware of the importance of supervised deliveries) have had no option but to go to private facilities.
“Sometimes when you come here these health workers abuse you, calling you a fool such things so you find yourself fearing to come here for the services and when you go to the clinic since these people want money they will give you enough care.” (FGD, Kamuli District)

“If you deliver from Kamuli Lubaga hospital it is like you are buying a plot of land because they charge a lot of money.” (FGD, Kamuli District)

### 3.4 Recommendations for Increasing Institutional Deliveries

To improve access to health centres, the participants recommended that health units should be built closer to the people. This would reduce on the walking distance and improve health centre utilization.

“To take the services near them like setting up more maternity centres near them.” (FGD, Kamuli District)

If health facilities are to charge, a fixed amount should be charged. The amounts suggested ranged from three thousand shillings to five thousand shillings. The participants suggested that government should assist in ensuring that these extra charges are either completely abolished or standardised.

“It is very bad. Let the government now give us the knowledge because it is also bad for us to say we don’t pay any money to the hospital because we do not know anything. But since government is our mother, let it inform us of what to do? Whether to continue paying or not?” (FGD, Pallisa District)

### 3.5 Attitude towards Voucher Project

When informed about the project that was planning to provide transport to the health facility and fees for formal charges, the respondents expressed gratitude. They stated that they were positive the project would facilitate mother’s access to delivery services, although they were still worried about informal payments for health workers.

“We shall be very grateful, except the money for paying the nurses, but we thank the government for that help.” (FGD, Pallisa District)
They acknowledged that they usually walk all the way to the health units. They reported that only a few mothers whose husbands owned bicycles used them to travel to the health facilities. Motorcycles and bicycles were available at a cost but the majority of the women could not afford it.

“To talk the truth, since I began producing, and right now I have 10 children I have never used a bicycle for coming for ANC. I walk on foot to and from the health facility.” (FGD, Soroti District)

“Now most of the time, the majority of mothers foot because they are too poor to hire any means of transport to go to a health centre. So those who came to the health centre footing go back footing.” (FGD, Pallisa District)

The mothers seemed excited about the project and they recommended that the health workers and local leaders be involved in planning the project.
4.0 Discussion

4.1 Utilization of ANC Services

According to the participants, most mothers of reproductive age seek ANC services at some point during pregnancy. This is in line with the national estimate that 94% of expectant mothers attend at least one ANC visit (UBoS et al. 2007). The timing of the first ANC visit varied from soon after one knew they were pregnant to eight months. The majority of the mothers attended their first ANC visit after the first trimester. This was also in agreement with the UDHS finding that 83 percent of women attend their first ANC visit after the first trimester. However, WHO recommends that the first ANC visit should be within the first trimester (UBoS et al. 2007).

The timing of the first ANC visit was one of the major factors that influenced the number of visits attended. Generally women who went late- (after five months) for the first visit attended one or two antenatal visits. Women who presented for the first visit fairly early usually attended three or more ANC visits. Another factor was the mother’s state of health. Mothers who felt unwell or had symptoms like headache and pain, tended to attend ANC early. While those who had no complaints tended to attend ANC late. These findings indicate that the majority of mothers attend at least one ANC visit. The majority of the respondents did not express strong opinions on the frequency of the visits and the importance of attending three or more visits as recommended by WHO. Nationally there is a drop from the first ANC visit to the fourth; this may be due to late presentation at the first visit as seen in this study or lack of awareness of the importance of attending the recommended four ANC visits.

Distance and high transport costs were mentioned in all FGD’s as a limitation to accessing ANC and were reported to contribute to late attendance of ANC. Material demands of the health facility also made it difficult for some women to attend ANC. From these findings it is evident that improving access to maternal health care services would require removal of such barriers at the supply side to enable mothers build a free relationship with the system. Furthermore, policies that seem to deter utilization need to be relaxed. Of particular concern were the local ANC policies that required mothers to come along with their spouses for ANC.

4.2 Choice of Delivery Site

It was reported that more deliveries took place at home, either assisted by TBA’s relatives or friends. This is in agreement with the current situation in the country where 62 percent of deliveries either take place at home or with TBAs (UBoS et al. 2007). Such a practice poses severe risks of mortality and morbidity to both the mother and the child.

Even though a significant proportion of mothers reported to be delivering at their homes or with TBA’s, they all seemed to acknowledge the benefits associated with health facility based deliveries. The benefits of health facility deliveries mentioned included; proper management during labour and timely referrals when necessary, availability of HIV/AIDS prevention of mother to child transmission and provision of immunization for the baby. The mothers themselves thought that there was a need to increase community awareness on the benefits of hospital deliveries.
Similar barriers as mentioned for ANC access and utilization seemed to affect health facility based deliveries. It was mentioned that the costs involved in meeting hospital requirements and paying user fees and informal fees as well as meeting personal requirements, was too high, the cost of transportation, the attitude and conduct of service providers (rude and disrespectful to their clients), also deterred service utilization. A study done in Mukono to assess the effect of midwifery practices and behaviour towards utilization of maternal health services found that 35.3 percent of respondents thought that the disrespectful behaviour of midwives affected the utilization of maternal health services (Mwebaza 2007).

Some of the recommendations to improve health facility deliveries included building of more health centres to reduce the distance travelled to seek services, and abolition of user fees (mainly informal) for maternal services. These fees were reported to range from three thousand to five thousand shillings. In addition to these fees, mothers were expected to buy polythene sheets for delivery, gloves and soap that they had to present before they could receive any care. Participants reported that this was a great barrier and advocated that government intervenes to abolish these fees. Although user fees were officially abolished by the Ugandan government in 2001, it still prevails as under the table payments. In addition, mothers are asked to buy requirements such as gloves because the facilities are not stocked with adequate supplies.

The use of traditional birth attendants (TBA's) as alternative maternal health service providers is a strong norm in the community. They are more accessible, and are perceived to be competent because they received training from the formal health sector. In addition, their payments are flexible, and they are willing to deliver mothers at home.

The use of private health care providers was mentioned by a minority in all FGD’s. Private providers were used if it was the nearest health facility or if labour started when one was at the clinic for treatment. Providers in private health facilities were described as polite. However, services were rated as very expensive, although considered a safety net for those mothers who clearly understood the importance of institutional deliveries.

4.3 Attitude Towards the Project

FGD participants expressed excitement over the project. They thought it was a good project that would increase access to maternal health services. In addition to availing transport they hoped the project could provide hospital requirements and pay delivery user fees.
5.0 Emerging Issues

- The main factors that affected utilization of ANC included distance and lack of knowledge about the importance of ANC. Most women tended to start attending ANC late.
- All FGD’s reported that homes (TBA’s homes and respondents homes) were the most common places of delivery followed by the health facilities.
- The main factors that affected utilization of delivery care included the cost of transport, informal fees, demands for requirements such as gloves, and the poor attitudes of the providers.
- The attitude towards the project was generally positive.
- The main suggestion for improving access to delivery care was the construction of more facilities.
6.0 Implications for the Implementation of the Intervention

- By addressing demand side barriers such as transport, cost of treatment, the project will decrease barriers to accessing maternal health services.

- Informal fees might interfere with provision of services especially in the public facilities. The project needs to identify mechanisms for trying to reduce this practise. In addition carefully documentation of this occurrence and responses to attempts to deal with it will be required.

- The project should also identify mechanisms of helping the midwives improve their attitude towards patients.

- If essential supplies are not provided adequately, it will be very difficult, to ensure that the patients are not required buying extra supplies. The project needs to track the availability of supplies.

- Careful documentation of events during the project implementation will be required, since this may explain the effectiveness of the scheme in increasing institutional deliveries.
References


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