SOCIO- CULTURAL FACTORS AND THE UTILIZATION OF ANTENATAL CARE SERVICES IN BUDAKA HEALTH CENTRE IV, BUDAKA DISTRICT

ESTHER SABANO

S22/MUC/BSW/058

A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF BACHELOR OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF UGANDA CHRISTIAN UNIVERSITY

July, 2024

UGANDA CHRISTIAN UNIVERSITY

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DECLARATION

I, **SABANO ESTHER**, hereby declare that this is my original piece of work and an origin of my own findings and no part of this work has ever been submitted to any higher institution of learning for any award before.

Signature: ……..

SABANO ESTHER

REG. No. S22/MUC/BSW/058

Date: ……

APPROVAL

This is to certify that Reg. No. S22/MUC/BSW/058 fully participated and completed her research study titled factors affecting the utilization of antenatal care services in Budaka Health Centre IV, Budaka District under my guidance and supervision.

Signature……..

Date ……

Mr. Wabukye David

RESEARCH SUPERVISOR

DEDICATION

This work is sincerely dedicated to my family, especially my husband; sons and daughters for the moral and financial support given to me may Allah abundantly reward them for their tireless efforts towards my education. Thank you so much.

ACKNOWLEDGEMENT

Every good work is certainly impossible to accomplish single handedly. Therefore, it is with heartfelt gratitude that I convey thanks to all of you who made this search Report writing a success.

My gratitude goes to my Supervisor, **Mr. Wabukye David** who is also a lecturer at the University for the Continuous Supervision and guidance throughout the Report Writing Process.

Other special thanks are accredited to the staff of Faculty of arts and Social Sciences Uganda Christian University for the advice, guidance and support given from time to time.

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
ANC	ANTENATAL CARE
HIV	HUMAN IMMUNODEFICIENCY VIRUS
NGO	NON-GOVERNMENT ORGANIZATION
OVC	ORPHANS AND VULNERABLE CHILDREN
TASO	THE AIDS SUPPORT ORGANIZATION
TPO	TRANS-CULTURAL PSYCHOSOCIAL ORGANISATION
UAC	UGANDA AIDS COMMISSION
UNICEF	UNITED NATIONS CHILDREN'S FUND
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
VHTs	VILLAGE HEALTH TEAMS
WHO	WORLD HEALTH ORGANISATION

ABSTRACT

This Research study was conducted at Budaka Health Centre IV in District Local Government in Eastern Uganda. The study was intended to investigate the factors affecting the utilization of antenatal care services in Budaka Health Centre IV, Budaka District. In the study, Maternal health education was taken as the independent variable while utilization of antenatal care services as the dependent variable. Doctors, Clinical officer, Nurses, mothers, and other health staffs provided primary data for the study.

The research was mostly qualitative in nature, with minor mathematics used. The study adopted a cross sectional survey design. The sampling techniques included purposive sampling for Doctors and clinical officers and simple random for Nurses and mothers. In order to gather data, questionnaires were issued to clinical officers and doctors whereas mothers and other staff were interviewed. To analyze the collected data, quantitative methods were used to establish frequencies and percentages. Qualitative means were also used whereby themes and quotations were made.

The researcher carried out the study by physically interviewing Health workers, mothers and group employees etc. The data collected by research assistants and the researcher were put together for analysis and the analysis was brought out in chapter four.

Chapter five covers mostly summary discussion of finding, conclusions, and recommendations by the researcher.

Key findings of the study revealed that educated pregnant women utilise antenatal care services, they are aware and knowledgeable of the services of antenatal care services and the easily access antenatal care services.

The biggest challenge faced was the inadequate funding. This can be addressed if a fee called research emergency is introduced. This can facilitate the smooth management of the exercise.

The study recommends that Outreaches should be set in all the villages to operate on a weekly basis to allow the pregnant mothers who come from very far to access antenatal care services at a nearby place.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This study sought to examine the socio-cultural factors affecting the utilization of antenatal care services in Budaka District Local Government. The dependent variable was the utilization of antenatal care services in Budaka Health Centre IV. The chapter also covers the background to the study, the statement of the problem, the purpose or general objectives of the study, the specific objectives of the study, the research questions, the study hypotheses, the conceptual framework, the scope of the study, the significance, justification and the operational definitions of terms and concepts which were be used in the study.

1.1 Back ground to the study

According to the United Nations Millennium Development Goals, goal number five was to reduce maternal mortality by 75 % by the year 2015, (the pan African medical journal 2017).

Early entry to antenatal care (ANC) is important for early detection and treatment of adverse pregnancy-related outcomes. The World Health Organization (WHO) recommends that pregnant mothers should seek antenatal care (ANC) within the first 4 months of pregnancy Fourn, (2016). Approximately 358,000 maternal deaths occur annually, of which over 95% occur in sub-Saharan Africa and Asia. Globally 30% of women between the age group of 15-40 years do not have antenatal care, 46% of those who did not have antenatal care (ANC) are in South Asia while 34% are in sub-Saharan Africa. This low use of services leads to death and disability due to untreated hypertensive disorders or due to mal- or sub-nutrition like iron deficiency anaemia Fourn, (2016).

According to WHO (2018), antenatal care refers to the screening for health and socio-economic conditions likely to increase the possibility of specific adverse pregnancy outcomes providing therapeutic interventions known to be effective and educating pregnant women about planning for safe birth, emergencies during pregnancy and

how to handle them. Thus antenatal care is relevant for the improvement of maternal health as it enables the monitoring of the health of the mother to be and anticipation of any difficulties during pregnancy, labour and birth. According to Bhutta Z .A Chopra M. et al (2015), studies have estimated that antenatal care alone can reduce maternal mortality by 20% as long as good quality services are provided and regular attendance is guaranteed. In addition, antenatal attendance during pregnancy has been shown to have a positive impact on the use of postnatal health care services, which also play a key role in detecting key conditions after child birth consequently leading to better maternal health outcomes WHO (2018), evidence shows that four (4) antenatal visits are sufficient for uncomplicated pregnancies and more are necessary only in cases of complications. The WHO therefore recommends a minimum of four (4) visits. However in developing countries a good number of women do not attend all the minimum of the four (4) visits.

Africa has the highest burden of maternal mortality in the world and sub-Saharan Africa is largely responsible for the dismal maternal death figure for that region, contributing approximately 98% of the maternal deaths for the region. Effects of antenatal care services on birth-weight, the importance of model specification and empirical procedure were used in estimating the marginal productivity of health inputs (Bilenko, et' al., 2017).

In reference to the world health (WHO, 2018) there was an estimated 358.000 maternal death globally. The least developing countries accounted for 99 percent. And of these deaths, three fifths occurred in sub Saharan Africa where Uganda is found according to the pan African medical journal of (2017), abortion, obstetric complications such as haemorrhage , dystocia, eclampsia, sepsis and infections such as tuberculosis and HIV are major causes maternal deaths in the least developing countries , the same journal reported that much as antenatal care (ANC), is not very effective in reducing material deaths, it provides an entry for interventions which give health workers the opportunity to detect these risky conditions and therefore refer them for early management leading to better maternal outcomes.

According to Tetui in (2015) in Uganda, antenatal care (ANC) services are characterized by poor attendances, poor counselling services and poor client – provider relations, with the quality by nurse in rural areas. It must be noted that the

quality of antenatal care (ANC) is critical in enabling women and health workers identify risks and signs during pregnancy which should lead to appropriate action, (Tetui M: 2015) furthermore Ekirapa. K.E (2017), observed that whether or not women can identify danger signs during pregnancy and act appropriately aspects such as the depth of the information and counselling given during the antenatal care visits.

According to WHO regulations (2017), a reasonable antenatal care (ANC) visit in should involve history telling, clinical examination, running of essential tests including HIV tuberculosis, counselling on risk factors, danger signs and how to handle them counselling on birth preparation, administration of tetanus toxoid vaccine and other essential supplements. The provision of quality antenatal care (ANC) services requires the presence of relevant infrastructures, adequate health workers, infection control facilities, diagnostic equipment, supplies and essential drugs.

In addition, the antenatal care (ANC) process requires the use of guidelines that health providers should follow while offering care to ensure prevention, diagnosis and treatment of complications (WHO: 2016).

1.2 Problem statement

Giving quality antenatal care reduce pregnancy related diseases and deaths and thus protecting both antenatal mother and the baby Fekede, B. (2017). Global estimates indicate that only half of all pregnant women receive recommended amount of antenatal care. World Health Organization's main priority is to improve the maternal health by recognizing the importance of antenatal care. World Health Organization has recommended at least (4) antenatal visit. Antenatal care will give opportunity to identify high risk mothers, to monitor and support them Fekede, B. (2017).

Despite the importance of attending antenatal care, most of the women do not attend antenatal care in a required time (4 visits and above). It is against this background that a study was undertaken to examine the factors affecting the utilization of antenatal care services in Budaka district case study of Budaka Health Centre IV.

1.3 Objectives of the study

1.3.1 General objective

The general objective of the study was to examine the socio-cultural factors affecting the utilization of antenatal care services in Budaka Health Centre IV Budaka district.

1.3.2 Specific of objectives

i) To establish the effects of women education on antenatal care services utilization in Budaka Health Centre IV, Budaka district.
ii) To determine the effect of socio-cultural factors on antenatal care services utilization in Budaka Health Centre IV, Budaka district.
iii) To examine how household income influence the utilization of antenatal care services in Budaka Health Centre IV, Budaka district.

1.4 Research questions

i) What are the effects of women education on antenatal care utilization services in Budaka Health Centre IV, Budaka district?
ii) What is the effect of socio-cultural factors on antenatal care services utilization in Budaka Health Centre IV, Budaka district?
iii) How household income influence the utilization of antenatal care services in Budaka Health Centre IV, Budaka district.

1.5 The Significance of the study

This study is significant to the cause that it will help reveal the exact situation concerning the delivery and utilization of the antenatal care services at Budaka health Centre IV which is the biggest and main health facility in the entire Budaka district local government.

Future researchers in the field of primary health care could find his research of great value to them. They refer to these findings for their researches as a secondary source of data.

The study is significant as it may further inform the district health team about the status of antenatal care services and chart a way forward concerning the development and consolidation of attractive antenatal care services at the health facility.

Ministry of health may refer and therefore benefit from this study as the findings will further inform them about the challenges faced by mothers who seek antenatal care services. They will therefore make their decisions based on the findings of this research study.

1.6 The scope of the study

1.6.1 The Geographical scope

The study was limited to the Budaka Health Centre IV, although, some references were made to the other health centres in the district.

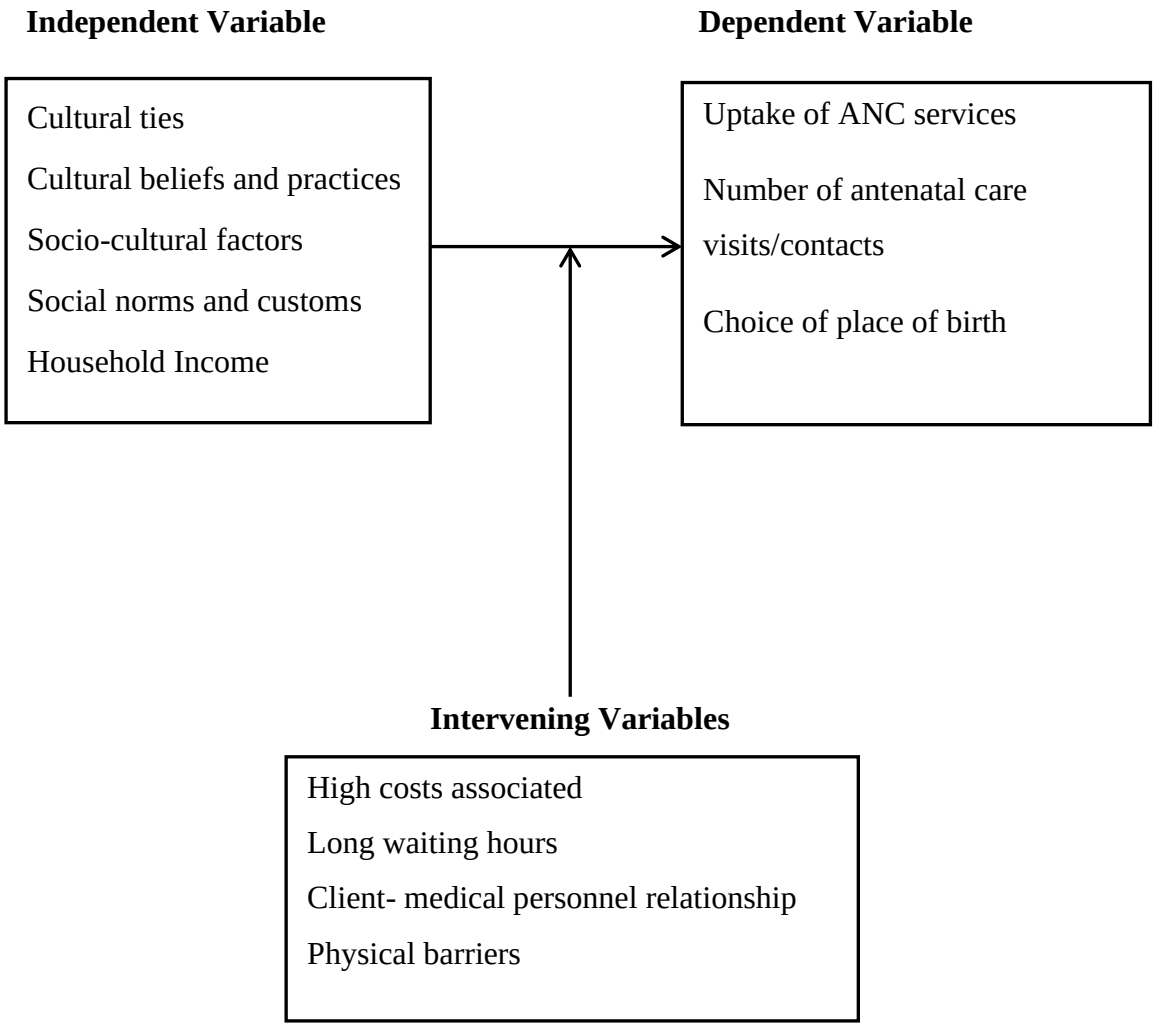
1.6.2 The time scope

The study reviewed medical and other records for a period of five years i.e. between 2017 - 2023. This extracted the records at the health centre IV regarding their addresses, physical location and the contacts of some of the mothers who were handled at the centre during that period.

1.6.3 The content scope

This study sought to establish the effects of women education on antenatal care services utilization, to determine the effect of socio-cultural factors on antenatal care services utilization, to examine how household income influence the utilization of antenatal care services in Budaka Health Centre IV, Budaka district.

1.7 Conceptual framework



Source: Researcher 2023

From the above conceptual framework, when mothers receive knowledge on health education it may lead to reduced maternal and infants mortality rates. Pregnant women being knowledgeable on antenatal care services will also help expectant mothers on deciding on the right place to deliver from.

Improved household income leads to ease access of specialised antenatal care services like having a personal gynaecologist.

As government and other partners try their best to offer antenatal care services to expectant mothers, a number of intervening factors are also at play by blocking above services, slowing them down or accelerating them. These factors include high costs associated with some antenatal services like doing obstructic scan, long waiting hours,

1.8 Definition of terms and concepts

Antenatal care

Refers to the medical care, emotional attention and nutritional awareness that you get during pregnancy from midwives, doctors and if required specialist doctors it is important that you attend appointment as they keep an eye on your health, wellbeing and that of your growing baby.

Antenatal classes

Refers to the lessons which prepares you physically and emotionally for the birth of your baby. During the classes you ask questions and explore the different ways in which you can give birth.

First visit,

Is often referred to as your booking appointment at health facility

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the reviews and related literature in line with the objectives of the study.

2.1 The Effects of Women Education on Antenatal Care Services Utilization

Educated women tend to have a greater awareness of the existence of ANC services and the advantages of using such services Ha, Bui TT, et al. (2015). It is argued that educated women were more aware of health problems, know more about the availability of health care services, and utilize the information more effectively than non-educated women Ha, Bui TT, et al. (2015)Moreover, higher levels of education tend to positively affect health-seeking behaviours, and education may increase a woman's control over her pregnancy Holtz, (2014).

Importance of socio-cultural factors

Socio-cultural factors play a critical role in individuals' development and functioning. They frequently also play a significant role in treatment outcomes because socio-cultural support, stressors, and other factors commonly have significant facilitative or debilitative effects on the course of treatment. As a result, these factors are routinely included in most approaches to behavioral health care assessment and treatment planning.

All of the topics discussed above have important influences on people's lives and so they all need to be integrated into therapists' conceptualizations of clinical practice. It is not possible to work clinically with patients without dealing with these topics, because patients routinely bring these issues with them into treatment. For example, the U.S. population is becoming increasingly demographically diverse, and knowledge and skills for dealing with the cultural influences and challenges faced by individuals who are not members of the mainstream culture need to be incorporated into the competencies required for clinical practice. Failing to do so will result in the profession becoming less relevant to increasing numbers of individuals who do not

fall within the traditional target groups for many psychotherapeutic treatments (Sue & Sue, 2012). All of the other factors previously discussed here are likewise relevant to clinical practice. Financial difficulties and employment stress are common. Relationship and family dysfunction, violence, and abuse are all too common, and large numbers of individuals experience child abuse and neglect. Religion and spirituality are important factors in people's lives as well, often as important sources of support, though sometimes as sources of stress.

Some of the above topics receive significant attention in behavioral health care education, although others receive only limited coverage in many programs. Coverage of these topics is frequently not systematic, and developing familiarity with them consequently often occurs in a haphazard manner, sometimes outside formal coursework and clinical training. Multiculturalism is one of the few topics reviewed above that normally receives significant attention in graduate curricula. Even child maltreatment, a topic widely viewed as very important in individuals' development, is often not reviewed in a comprehensive manner in many graduate programs.

Although the variables covered in this chapter are all highly influential in people's development and functioning, it is important not to overstate their influence as well. For example, in American psychology, racial and ethnic minority individuals are more likely to be viewed as members of groups that are strongly shaped by cultural processes and less by psychological processes, whereas White European Americans are frequently viewed as individuals whose behavior and characteristics are shaped by psychological processes and less by cultural influences (Causadias, Vitriol, & Atkin, 2018). This bias can result in viewing White members of society as having unique characteristics while stereotyping minority individuals as homogeneous. As a result, more attention may be given to the psychological processes involved in the development of personality and psychopathology for White individuals, while more attention is placed on cultural influences on the development of personality and psychopathology among minority individuals. There appears to be no cumulative scientific evidence to support these biases.

Taking a biopsychosocial approach can help avoid such biases by reminding us to balance psychological, socio-cultural, and biological perspectives when attempting to understand all individuals. Viewing people through lenses determined by group

membership can lessen one's ability to see their individuality and humanity, their unique personal qualities, and their universal human characteristics. Placing disproportionate emphasis on group membership i.e. whether based on race, ethnicity, gender, religion, or other variables i.e. can lead to the process of dehumanization that has caused so much violence and suffering throughout history in the first place. This of course does not imply that we have any less responsibility to fight racism, sexism, homophobia, ageism, ableism, religious intolerance, and other forms of prejudice and discrimination. Behavioral health professionals' responsibilities to promote health, well-being, and social justice are in no way lessened just because humans are complicated and have unique personal as well as group and universal characteristics.

The biopsychosocial approach to behavioral health care is complex. Individuals' development and functioning as well as the behavioral change process cannot be thoroughly understood without taking an integrative, holistic perspective that incorporates all these factors. Socio-cultural factors can be facilitative or debilitative on individuals' development, their current functioning, and the behavioral change process. In addition, building resilience and promoting optimal functioning over the long term typically involves building strengths in these areas. When the focus of health care is broadened beyond the treatment of psychopathology to the prevention of maladjustment and the promotion of health and well-being, then the importance of these factors becomes even clearer. Sociocultural factors also have significant influences on individuals' physical health, the topic considered next.

Culture

Socio-cultural factors need special attention in the assessment process as the measures that are used to identify NDDs need to be culturally and linguistically appropriate. There are some cultures where there are no words to describe ‘autism spectrum disorder’ and certain items used in the Autism Diagnostic Observation Schedule (ADOS) are not appropriate for socio-cultural norms of the society. It is thereby difficult to correlate failure in that test item to the existence a specific clinical symptom without due consideration of the cultural appropriateness of the tool (Smith, Malcolm-Smith, & de Vries, 2016). Thus there is a critical need to develop and implement at scale a universal system of early identification and stratification of children at developmental risk or showing early signs of developmental differences.

Such a system will need to incorporate elements of assessment that are culture fair and language free, thereby making care more accessible.

In this regard, our understanding of the physical, developmental, and mental health needs of children from LMIC settings is limited by a lack of data. Our research has shown that even in a high-income country such as Australia, culturally and linguistically diverse (CALD) groups are underrepresented in engagement with health services for prevention and health promotion and also they are underrepresented in research, particularly as a common exclusion criterion for research is being a non-English speaker (Eapen et al., 2014; Woolfenden et al., 2016). This is another expression of the 'inverse care law' mentioned in the introduction, whereby the ones most likely to need help are the least likely to access services. This means that we are missing essential information on outcomes and potentially modifiable risk and protective factors to inform the design of not only a more responsive identification system but of the healthcare system more broadly.

2.1.1 Socio-Cultural beliefs and practices

Despite decades of implementation of maternity healthcare programmes, including a focus on increasing the use of antenatal care (ANC) and concomitant birth preparedness and complication readiness (BPCR), the uptake of ANC continues to be below expectations in many developing countries. This has attendant implications for maternal and infant morbidity and mortality rates. Known barriers to ANC use include cost, distance to health care services and forces of various socio-cultural beliefs and practices. As part of a larger study on BPCR in rural Ghana, this paper reflects on the use of ANC in the study areas from rights-based and maternal engagement theoretical perspectives, with a focus on the barriers to ANC use.

The World Health Organisation (WHO) notes how a woman dies in every two minutes from pregnancy or related causes, the world over. Forty percent of the countries with high levels of maternal mortality are in Sub-Saharan Africa (SSA), and women in the region face 15 times the risk of dying from pregnancy and childbirth situations compared to women in developed countries. Statistics indicate that many maternal deaths occur because of preventable causes such as haemorrhagic shock, infections, obstructed labour, and hypertensive disorders in pregnancy and abortion in

rural northern Ghana. Antenatal care (ANC) has been a valuable tool in reducing maternal deaths through; 1) early identification and management of obstetric complications such as pre-eclampsia, 2) tetanus toxoid immunisation, 3) intermittent preventive treatment for malaria during pregnancy (IPTp), and 4) identification and management of infections including HIV, syphilis and other sexually transmitted diseases (STDs). Therefore, the WHO recommends up to eight ANC visits for all expectant mothers in developing countries.

Even though the strategy has proved useful in addressing many problems in pregnancies and ensuring safe births, profound barriers to ANC utilisation continue to exist in many locations due to the interactions of socioeconomic influences (such as accessibility, cost), health service-related factors (such as lack of trained staff and other resources), and a diverse array of cultural beliefs and practices.

For example, in Tigray Zone, Ethiopia, many expectant mothers had no knowledge of the benefits they would derive from utilising skilled maternity care; this lack of health literacy, combined with mockery, shame and stigmatisation from the family and community if they sought ANC, resulted in the absence of ANC uptake. In some communities of the Upper West Region (UWR) the expectant mother had to gain approval from the husband (and in some locations, permission from the community) before seeking ANC at a health facility, and a man accompanying their wife to ANC was seen as a violation of cultural norms. In these locations, expectant mothers could register for ANC but fail to follow-up or implement therapeutic interventions, and preference for home birth took precedence over ANC.

In another region of rural Ghana, it was observed that women who patronised ANC services were more likely to have the support of their husbands, and were more likely to be prepared and ready for birth and emergencies.

Even where ANC is utilised, it may not necessarily provide adequate information regarding obstetric danger signs, indicating that the quality of ANC education is also a factor shaping maternal health outcomes. In northern Ghana, for example, only 65% of women attending ANC reported receiving education on obstetric danger signs.

Overall, government efforts to significantly increase uptake of ANC continue to be problematic in rural Ghana. These challenges call for further inquiry into the issues pertaining in the utilisation of ANC from the perspectives of hard-to-reach communities in the Upper West Region, Ghana.

In addition, education may help to expose women to more health education messages and campaigns, enabling them to recognize danger signs and complications and take appropriate action. These women might have greater opportunities to receive health information and pay more attention to maternal healthcare. Studies have shown that women with lower education usually have less knowledge about ANC services and more difficulties to get access to antenatal care (ANC) services (Jallow, 2017).

A study conducted in Central Ethiopia found that women with some education were more than two times more likely to attend antenatal care (ANC) as compared with those who had no education and similar findings were found in the study conducted in North Ethiopia, Nigeria and China Health knowledge is an important factor. It enables women to be aware of their rights and health status in order to seek appropriate health services (Berglund, 2018),

The odds of utilizing antenatal care (ANC) were more than three times for those with better knowledge of danger signs of pregnancy than those with poor knowledge. The studies have revealed that sufficient knowledge of the benefits of antenatal care (ANC) and of the complications associated with pregnancy plays an important role in the utilization of antenatal care (ANC) services. In one of the studies conducted by Rosliza and Muhammad, (2016)found no significant relationship between knowledge of antenatal care (ANC) and early antenatal booking. They discovered that pregnant women's level of knowledge of the importance of antenatal care (ANC), screening tests, and complications of diabetes and hypertension during pregnancy was poor (Fekede, 2017).

Beeckman et al. (2016) found that women who were better educated, had higher incomes, or were primiparous (i.e., had only one child) made more antenatal care visits than women who were less educated, had lower incomes, or were multifarious. Friedman et al (2013) found that the primary reasons why women had not received antenatal care were substance use, denial of pregnancy, financial limitations,

concealed pregnancy, and having previously delivered. Studies in China have found that inadequate utilization of antenatal care among rural-to-urban migrants is attributable to factors such as financial difficulties, lack of knowledge concerning prenatal care, and low levels of education (Benjamins, 2015).

Ye et al (2017) found that education, marital status, family income, employment status, and duration of stay in the city were the main influencing factors on initiating antenatal care among migrant women in Shenzhou, he found that among migrant women in Beijing, Guangzhou, Chengdu and Shanghai, the education levels of women and their husbands as well as family income were the main influencing factors on antenatal care and maternal healthcare utilization.

Long et al. (2017) reported that women in western China who were less educated, from minority groups, or high parity were less likely to receive antenatal and delivery care. Higher levels of education tend to positively affect health-seeking behaviours, and education may increase a woman's control over her pregnancy. Education may help to expose women to more health education messages and campaigns, enabling them to recognize danger signs and complications and take appropriate action. Chowdhury et al. found that the odds ratios for use of services among women who had no education or only a primary education were 0.54 and 0.63, respectively, compared to those with at least a secondary education. Similarly, Hueston et al (2017) found that better educated women received antenatal care more frequently. These women might have greater opportunities to receive health information and pay more attention to maternal healthcare. We found that women who believed that antenatal care was necessary were more likely than those who did not to receive antenatal care and to do so frequently.

Hueston et al (2017) found that lower levels of education and prior pregnancy experience were associated with younger teenagers in the US receiving delayed care. Mothers' level of education influenced the use of ANC for which Mothers with primary educational level are likely to attend ANC than women who are unable to read and write. The study further revealed that availability of women's time is important as women spend more time on their multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, and trade than on their own health.

2.2 The Effect of Socio-Cultural Factors on Antenatal Care Services Utilization

Schiller and Levin (2014) noted that there is some level of religious factor in health care utilisation. Studies have consistently maintained that religion is associated with health care utilisation and improved health outcomes (Gyimah et al. 2016). Religion is thus one of the outstanding social institutions that shape individual and community health behaviour through its influence on lifestyles, worldviews and motivations (Benjamins, 2015). However, different religious groups have different views on health care and health issues. For instance, Maguranyanga (2016) found that among the ultra-conservative Apostolic groups in Zimbabwe, religious teachings, doctrine and regulations of the group stressed faith healing and total adherence to church beliefs and practices that sometimes hinder modern healthcare seeking.

The Jehovah's Witnesses, another Christian group encourages members not to accept transfusion of whole blood, red blood cells, white blood cells, platelets, and plasma based on the belief that certain Biblical passages prohibit blood transfusion (Loma Linda University, 2014). The group however does not object to the use of medical alternatives to blood transfusion. Several other Christian groups particularly the contemporary Pentecostal groups have liberal health related teachings and doctrines (Oyedepo, 2015). However most of them are of the view that seeking spiritual counsel and faith healing should precede use of medications. This is link to the belief that health problems are caused by the influence of bad diet, natural phenomenon, wrath of God as a punishment for sin, demon possession, life style and malicious spiritual manipulations by enemies (Olanisebe, 2012).

Moslems also believe in the spiritual causes of health problems and often distinguish between illness that may be treated medically and those that may be related to the will of God (Padela & Curlin, 2017). Spiritualising health situation in the process of determining when to seek medical help or when to apply formal medicine shaped utilisation of health care by adherents of different religions. This is similar to the health belief of adherents of traditional religion. For instance, Odebiyi (2018 cited in Gazali, Muktar & Gana, 2012) found that among rural residents of Ile-Ife in South western Nigeria, most illnesses are first treated traditionally before seeking modern health care services. The unacceptably high rate of child deliveries outside health

facility in most parts of Nigeria could be attributed to seeking traditional help before patronising formal health care delivery system (Ojua, Ishor & Ndom, 2013).

Given the pervasive belief in supernatural powers as explanation to individual health situations, it is surprising to observe that religion has not been extensively used to promote utilisation of maternal health care services in the country. The current National Population Policy for Sustainable Development being implemented in the country though recognised collaboration with religious organisations in the policy implementation, but rather than devise a religion-friendly programme that could be used to address the prevailing poor level of maternal health in the country, it only encouraged religious organisations to promote reproductive health services in line with their religious belief (NPopC, 2014). The theoretical framework for the study is based on the functionalist perspective. Functionalism developed by Talcott Parsons (2012-2017), examine religion from the viewpoint of societal needs. Durkheim discussed in Haralambos, Holborn and Heald (2014) categorised human society into "sacred" and "profane" worlds. The sacred involves the feeling of awe, fear and reverence that control the profane (everyday life including actions and behaviour).

Religion as an integral part of the sacred is thus a means of controlling human action and behaviour. Durkheim further asserted that for human society to recreate itself or made steady progress, certain basic conditions such as social cooperation, order and control are crucial ingredients for which religion make critical contributions to their fulfilment. Modifications to Durkheim's postulation by others such as Malinowski (2014) and Parsons (2015) buttressed the positive contributions of religion to human society.

Haralambos et al. (2014) described religious beliefs as tools of fostering class ideology and easing the pain of the oppressed for which religion serve as an instrument By soliciting veneration for the ruling class and encouraging the acceptance of the status quo, religion serve as a means of social control by removing thoughts of revolutionary overthrow of the ruling class from the minds of the oppressed and giving them false hope in their deprived conditions.

The research therefore adds that religion being part of the cultural system provides two basic things. On the one hand, it provides general rule for human behaviour. On the other hand, it provides criteria for the evaluation of human conduct. Though functionalist analysis remain useful in providing understanding of how social structure influence human behaviour, it is however weakened by its inability to account for the abnormal operations of religion.

Basing on the literature above, religion in the African continent despite its shortcomings has been fully involved in efforts to change society for good. With respect to health care, both Christianity and Islam have shown tremendous support for positive health outcomes. In Uganda, there are countless numbers of faith-based health institutions providing health services in both urban and rural areas of the country. In addition, religious bodies have often aligned themselves with public health initiatives during major health crisis. For instance, in the wake of the Ebola pandemic in Uganda, the Catholic Diocese of Wakiso, North Central Wakiso promptly banned the lying of corpses in church auditorium in the areas under its jurisdiction so as to reduce exposure to risk of infection. Some other Pentecostal churches also banned handshaking during church services to prevent the spread of the contagious disease. However, little has so far been accomplished in the use of religion to boost utilisation of antenatal care services in the country with specific interest to Budaka district in eastern Uganda.

2.2.2 Health Facility Factors

Several health facility factors impacted on a willingness to seek ANC. Some of these related to the actual facilities themselves, such as lack of running water, poor lighting, and lack of space to accommodate clients, especially during the rainy days:

We have only one bed each for ANC and delivery. Women sit on the veranda during ANC. Therefore, during rains, some are sent back home because there is no hall to contain all [FGDs, non-pregnant women, Naro/Korinyiri].

Others commented on the negative relationship between nurses and expectant mothers as a barrier to receiving ANC services. Some nurses and midwives acknowledged they both intentionally and unintentionally maltreated pregnant women when providing care. For example, Nadowli hospital is the highest referral facility for the

study area, which suggests that the hospital should welcome cases referred there. However, midwives indicated mothers were often treated poorly at the hospital (and at the clinics):

There are many challenges. Challenges from; the client and we the healthcare providers (What are the challenges on the side of the nurses?).

Communication to expectant mothers are sometimes not good and are either intentional or unintentional. It is due to pressure from the work. For some midwives, it is the pressure. There is the inadequacy of midwives, thereby putting so much pressure on the few. When we are tired, anything the expectant mother does, it irritates the midwife. Other times too we are forced to say something which is not pleasant to clients [IDIs, other nurses].

The midwife explained further that:

We shout at them sometimes when under pressure. However, their lack of resources for childbirth usually contribute to some of the poor attitudes towards them. The up and down movement to save lives makes midwives very tired that, any little thing from the expectant mother may call for insults, unintentionally…. it is not supposed to be that way but because we are stressed [because of] inadequate staff [IDIs, other nurses].

2.3 How household income influence the utilization of antenatal care services

Financial difficulties have been considered as an important barrier to antenatal care for migrant women. Most of the studies have shown a positive association between socioeconomic status and the utilization of ANC (Tim, et al, 2017). A study from Ethiopia identified that when women with higher incomes tend to start ANC early and the likelihood of utilizing ANC decreased, as the family income gets lower. Likewise, a study from China found that women who had higher household income were more likely to have adequately utilized ANC services. The positive contribution of better wealth status for all maternity service indicators and its significant contribution to postnatal care are also observed in other studies (Timothy, et al. 2014)

A study examining initiation of and barriers to antenatal care among low-income women in San Antonio, Texas found that women who were less educated or living alone, or had not planned their pregnancies were more likely to delay initiating antenatal care Malinowski (2014). A study by Odebiyi (2018) in rural Tanzania found that women cited lack of money as a reason of delaying antenatal care the study found, 20.2% of the women who had inadequate antenatal care reported they did not have enough money for antenatal care visits. Results from multivariate analysis also showed a significant association between income and timely utilization of antenatal care.

Countries with good indicators in maternal and infant mortality have pregnancy related complications identified and managed early, however according to UBOS (2016) the overall one time antenatal attendance in Uganda was found at 94% with women in rural areas being twice less likely to attend ANC than the urban women. According to the report only 8% of rural women in Uganda received ANC from a doctor. A study done by Simkhada, et al (2015) also concluded that cost, household income, women's employment, media exposure and having a history of obstetric complications.

On recognising the importance of antenatal care, WHO recommended at least 4 antenatal visits. Antenatal care will give opportunity to identify high risk mothers, to monitor and support them. Studies have showed the relationship between household income and Antenatal care Simkhada, et al (2015).

According to a report of Mexican (2016), household income and other factors are linked to differentials in maternal mortality. For instance, women with no proper financial abilities are 9 times more likely to die than those women who have good financial status and women who live in highly marginalized areas are 3 times more likely to die than those who live in the least marginalized areas

A study done in Bangladesh by (Timothy, et al. 2014) showed that the probability for use of ANC in women in the highest wealth index group is higher despite their difference in place of residence and educational level, women were found to have a higher level of use of ANC. Basing on the literature above, it depicts that household wealth is a very strong determinant of antenatal care service utilization.

Socio-cultural factors such as women being encouraged by family members and friends facilitated initial and continued uptake of ANC. However, women's inability to afford the cost of SP, social commitment and household decision making on ANC attendance hampered continued uptake of ANC services. For young unmarried women, health system and socio-cultural factors influenced their use of ANC services, which affected uptake of ANC services.

Culture

Socio-cultural factors need special attention in the assessment process as the measures that are used to identify NDDs need to be culturally and linguistically appropriate. There are some cultures where there are no words to describe 'autism spectrum disorder' and certain items used in the Autism Diagnostic Observation Schedule (ADOS) are not appropriate for sociocultural norms of the society. It is thereby difficult to correlate failure in that test item to the existence a specific clinical symptom without due consideration of the cultural appropriateness of the tool (Smith, Malcolm-Smith, & de Vries, 2016). Thus there is a critical need to develop and implement at scale a *universal system of early identification and stratification* of children at developmental risk or showing early signs of developmental differences. Such a system will need to incorporate elements of assessment that are culture fair and language free, thereby making care more accessible.

In this regard, our understanding of the physical, developmental, and mental health needs of children from LMIC settings is limited by a lack of data. Our research has shown that even in a high-income country such as Australia, culturally and linguistically diverse (CALD) groups are underrepresented in engagement with health services for prevention and health promotion and also they are underrepresented in research, particularly as a common exclusion criterion for research is being a non-English speaker (Eapen et al., 2014; Woolfenden et al., 2016). This is another expression of the 'inverse care law' mentioned in the introduction, whereby the ones most likely to need help are the least likely to access services. This means that we are missing essential information on outcomes and potentially modifiable risk and protective factors to inform the design of not only a more responsive identification system but of the healthcare system more broadly.

Lack of awareness of the benefits of ANC by some expectant mothers

Despite the general awareness of the value of ANC across all communities, some pregnant women do not use ANC due to lack of knowledge of its benefits:

In this part of the region, many pregnant women and families are not enlightened, so they do not know the importance of ANC. Some even attend ANC once and never receive care until they give birth at home. Others register and take the card but refuse to attend regularly for the medicines. Midwives are compelled to follow-up [IDIs, other nurses].

Conclusion

This literature review identified multiple socio-demographic, reproductive and access related factors which affect the utilization of antenatal care among pregnant women in different countries. Several studies conducted in different countries have shown that factors like maternal age, number of living children, education, socioeconomic status, previous bad obstetrical history, support from spouse, quality of care and distance from health care facility are significantly associated with use of antenatal care.

The writers, in the researcher's view, have not discussed ways of encouraging the multitudes of mothers and their husbands who don't attend antenatal care services as required. The efforts of governments calling upon couples to attend ANC services together, test together and attend counselling sessions together have fallen on deaf ears. This leaves a gap that researchers should undertake to establish why some pregnant women don't attend antenatal care services for the required times, irrespective of all the efforts by government and nongovernmental organisations.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the methods and tools that were used to conduct the research study. It specifies the research design, sampling procedures, research instruments and data analysis techniques that will be used to explore the underlying the factors affecting the utilization of antenatal care services in Budaka Health Centre IV Budaka District

3.1 Research Design

The researcher used a cross sectional survey design basing on the use of qualitative and quantitative approaches that will be adopted to examine the factors affecting the utilization of antenatal care services in Budaka Health Centre IV Budaka district. This design was used for profiling; defining, segmentation, estimating, predicting and examining associative relationships. A cross sectional study easily provides a quick review of what is going on with the variables for the research problem. Qualitative research is a platform for inquiry and aims to join reasoning to human behaviour to obtain an understanding of the factors that influence that behaviour (Creswell, 2006).

3.2 Population of the study.

The population of the study included doctors, nurses, Households, Single females. These respondents were chosen because they are aware of the factors affecting the utilization of antenatal care services.

3.3 Sample size

A convenient sample consisted of subjects included in the study because they happen to be in right place and time (Amin, 2005). The sample size was based on 78 respondents selected from the female councillor, single females, married, volunteer men.

According to Israel (1992) the sample size can be got on the basis of this formula

$$n = \frac{N}{1 + N(e)^2}$$

Where n = sample size, N = study population, e = level of precision which is 10% and 1 is constant

Therefore from the study population of 507 people an appropriate sample size can be got from the above formula and this illustrated below:-

$$n = \frac{507}{1 + 100(0.012)^2}$$

$$n = \frac{507}{1 + 507(0.01)}$$

$$n = \frac{507}{1 + 507}$$

$$n = 78$$

Therefore, the sample size was 78 respondents. The sample size for this study was as illustrated in table 3.1 below.

The table 3.1 below shows the population and sample of respondents

Category	**Population**	**Sample size**	**Sampling technique**
Doctors	2	2	Purposive sampling
Clinical Officers	10	3	Purposive sampling
Mid wives	5	5	Purposive sampling
Nurses	15	5	Purposive sampling
Single females	125	20	Simple random sampling
House holds	345	38	Simple random sampling
Volunteer men	5	5	Purposive sampling
Total	**507**	**78**	

Source; Primary data 2023

3.4 Sample Techniques

3.4.1 Purposive sampling

Purposive sampling was suitable to select individuals within the sample who have specialized information or experiences about the study problem by virtue of their managerial positions on project (Amin 2005). This study will use purposive sampling based on judgment on possession of specialized experiences and knowledge on factors affecting the utilization of antenatal care services. The study thus will use purposive sampling technique to select the doctors, nurses and volunteer men.

3.4.2 Simple random sampling

Is a technique where the sample group is selected randomly and in this, each member of the population is equally likely to be chosen as part of the sample. Simple random technique involves selecting a sample without being biased from the target population. Simple random sampling in this study was used to ensure that each member of the target population has an equal chance of being selected in the sample.

3.5 Data Collection techniques

The researcher will use both qualitative and quantitative methods of data collection because qualitative methods involve the use of words rather than numbers; the method involves descriptions of the study and this helps the researcher to go beyond conceptions and revise the frameworks. This approach helped the researcher to generate quality information that will give meaning to numbers. While quantitative methods involves the collection of numerical data in order to explain, predict and control phenomena of interest and the data collected to be presented as a table in numbers. The numerical data obtained is used to explain the socio economic life of the people in Budaka district in relation to factors affecting the utilization of antenatal care services. These methods include, administering questionnaire, interviewing and observation.

3.5.1 Interview guide

Patton (2002) defines key informant interviews as a qualitative research technique that involves conducting intensive individual interviews with a small number of

respondents to explore their perspectives on a particular idea, program, or situation. The researcher will adopt semi-structured interviews with questions which will be employed as one of the methods for data collection that provides qualitative data which complemented the quantitative data.

3.5.2 Questionnaires

These involved closed ended questions geared towards the research objectives. The questionnaires are preferred because they are practical that is to say large amount of information is collected from a large number of people in a short period of time and in a relatively cost effective way and information obtained can easily be analyzed more scientifically and objectively than other forms of research. The questionnaires during this research will be specifically administered to house hold, single parents and counsellors who have a vast knowledge of information about factors affecting the utilization of antenatal care services.

3.5.3 Observation

The researcher will use participant observation as a method for data generation. Sommer (2001) argues that observations help researchers to answer questions. The study involves visiting of selected respondents to assess the nature of the reasonable answers to the questionnaire. A pre-prepared observation guide to conduct systematic observation of the features, events, processes and routines that are germane to the study will be used.

3.6 Quality Control Methods

This includes the following: Validity and Reliability

3.6.1 Validity

This refers to the ability of the instruments to produce findings that are in agreement with theoretical and conceptual values, for this study purpose the instruments will be given to the supervisor to comment on ambiguity, difficulty and relevancy of questions to ensure construct content and face validity.

3.6.2 Reliability

Reliability refers to the consistency of a research study or measuring test. If findings from research are replicated consistently they are reliable. There are two types of reliability that is internal and external reliability. Where internal reliability assesses the consistency of results across items within a test and external reliability refers to the extent to which a measure varies from one use to another. Reliability will be used to measure the degree to which the questionnaires can produce consistent results under the same conditions.

3.7 Data Analysis

After data collection, the data will be edited to detect and correct possible errors and omissions that may occur to ensure consistency across respondents. The researcher intends to use the statistical package for social sciences (SPSS) as a tool to assist in data analysis. Data collected will be analyzed using descriptive statistics (frequencies and percentages) and qualitative data will be triangulated with the quantitative results to draw conclusions. This is because of the different paradigm of data collection methods (qualitative and quantitative) that will be used.

3.8 Ethical consideration

The principle underlying research ethics regarding confidentiality, honest and respect for individual and institutions will be assured from which data will be collected and informed in writing about the objectives of this study and will be requested to participate. The works of other people to be used in the study will be fully recognized through quoting and referencing.

CHAPTER FOUR

DATA PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents, analyses and interprets the data

4.2 Demographic Characteristics of Respondents

4.2.1 Gender of Respondents

A total of 75 respondents were interviewed using both the questionnaire and interview guide. 51 out the 75 respondents were female representing 68 %, while 24 respondents were male- representing 32%.

Table 2 showing the number respondents by gender

SN	GENDER OF RESPONDENTS	FREQUENCY	PERCENTAGE
1.	Male	24	32
2.	Female	51	68
	Total	**75**	**100**

Source: Raw data from the field

From the above table 24 respondents representing 32% of sample population were male while 51 respondents representing 68% were female.

It is therefore evident that more female respondents were interviewed than the male counterparts. This could be because of the nature of the research problem.

4.2.2 Age of Respondents

Table 2 showing the age group of respondents

SN	AGE GROUP (IN YEARS)	FREQUENCY	PERCENTAGE
1.	20 – 25	15	20
2.	26 – 30	19	25.3
3.	31 – 35	29	38.7
4.	36 AND ABOVE	12	16
	TOTAL	**75**	**100**

Source: Raw Data from the field

Out of the 75 respondents that were interviewed during the study, it was found out that 15 respondents were between the age group of 20 – 25 years, representing 20%, 19 respondents were between the age of 26 – 30 years, representing 25.3%; 29 respondents were in the age of 31 – 35 years, representing 38.7%, while 12 respondents were in the age group of 36 years and above. This means most of the researchers respondents were between 31 – 35 years, thus mature respondents were interviewed as can be seen in table below:-

4.2.3 Educational Background of the respondents

Table 3 showing educational background of the respondents

S/N	EDUCATIONAL LEVEL	FREQUENCY	PERCENTAGE
1.	Primary	28	37.3
2.	Secondary	22	29.3
3.	Certificate	10	13.3
4.	Diploma	8	10.7
5.	Degree	2	2.7
6.	Others (not educated)	5	6.7
	Total	**75**	**100**

Source: **Raw data from the field**

From the above table, 28 respondents were primary level representing 37.3%, 22 respondents representing 29.3% were of secondary level, 10 respondents representing 13.3% were certificate holders, 8 respondents representing 10.7% were diploma holders, 2 respondents representing 2.7% were degree holders, while 5 respondents representing 6.7% never went to school.

In summary, it is clearly noted that the biggest number of the sample population were educated while 6.7% were never went to school.

4.2.4 Marital status of Respondents

Respondents were asked to state their marital statuses and the responses are summarised in the following table.

Table 4 showing the marital status of the respondents.

SN	MARITAL STATUS	FREQUENCY	PERCENTAGE
1.	Single	14	18.7
2.	Married	40	53.3
3.	Divorced	13	17.3
4.	Widowed	08	10.7
	Total	**75**	**100**

Source: **Raw data from the field**

From the above table, 14 respondents were single, representing 18.7%; 40 respondents were married presenting 53.3% of the sample population. 17.3% of the sample population representing 13 respondents had been divorced while 10.7% of the respondents interviewed were widowed.

This means that the biggest number of respondents 53.3% were married. Given that married people are usually more stable than their unmarried counterparts; the data were collected from stable people thus high quality data.

4.3 The effects of women education on antenatal care utilization services on pregnant mothers

The study aimed at establishing the effect of women education on the utilisation of antenatal care services.

The respondents were asked to state the effects of women education on antenatal care utilization services on pregnant mothers. The responses are analysed in the following matrices: -

4.3.1 Educated women have a greater awareness of the existence of Antenatal Care services than uneducated ones

The table below summarises the findings.

Table 6 shows whether educated women have a greater awareness of the existence of antenatal Care services than uneducated one.

Variable	**Strongly agree**	**agree**	**Not sure**	**disagree**	**Strongly disagree**
Educated women have a greater awareness of the existence of antenatal Care services than uneducated one.	30	37	3	3	2
Percentage	**40%**	**49.3%**	**4%**	**4%**	**2.7%**

Source: Raw data from the field.

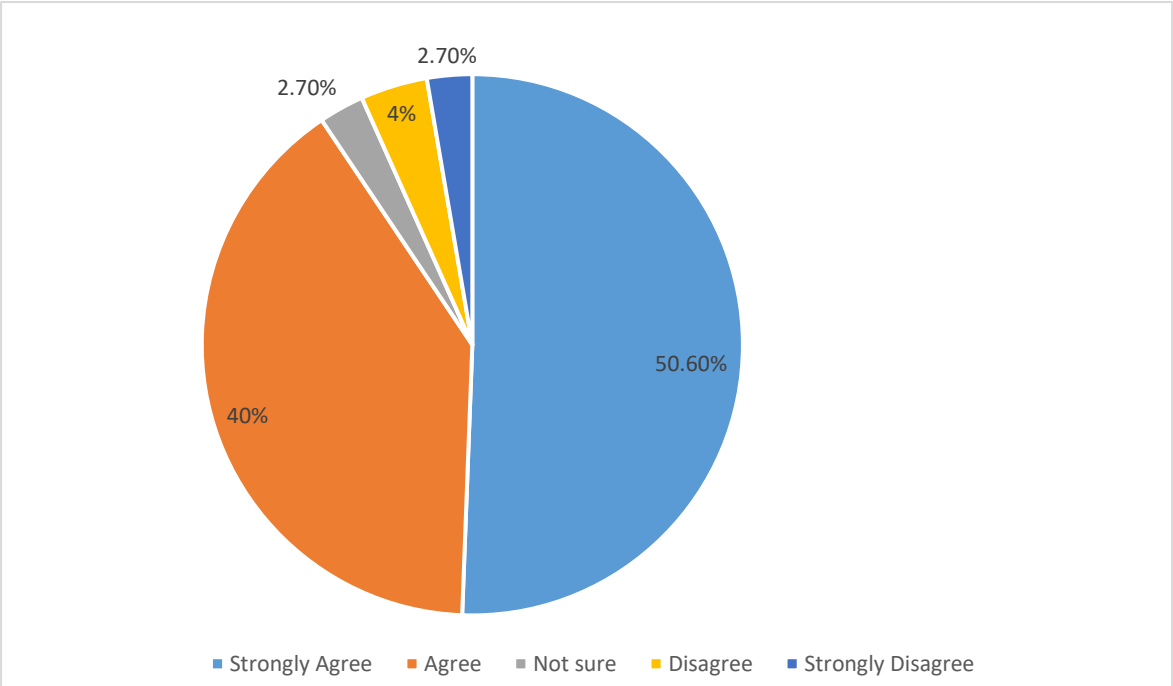
From the above table 30 respondents strongly agreed that educated women have a greater awareness of the existence of Antenatal Care services than uneducated ones. This represents 40% of the sample population. 37 respondents interviewed agreed representing 49.3%, 3 respondents were not sure, 3 of the respondents disagreed while 2 respondents strongly disagreed.

In summary, it is clear that 89.3% of respondent agreed that educated women have a greater awareness of the existence of Antenatal Care services than uneducated ones while 6.7% of the respondents disagreed.

4.3.2 Educated women know the advantages of using antenatal care services more than the uneducated

The responses are as seen the figure below.

Figure 7 shows whether educated women know the advantages of using antenatal care services more than the uneducated.



Source: Raw data from the field.

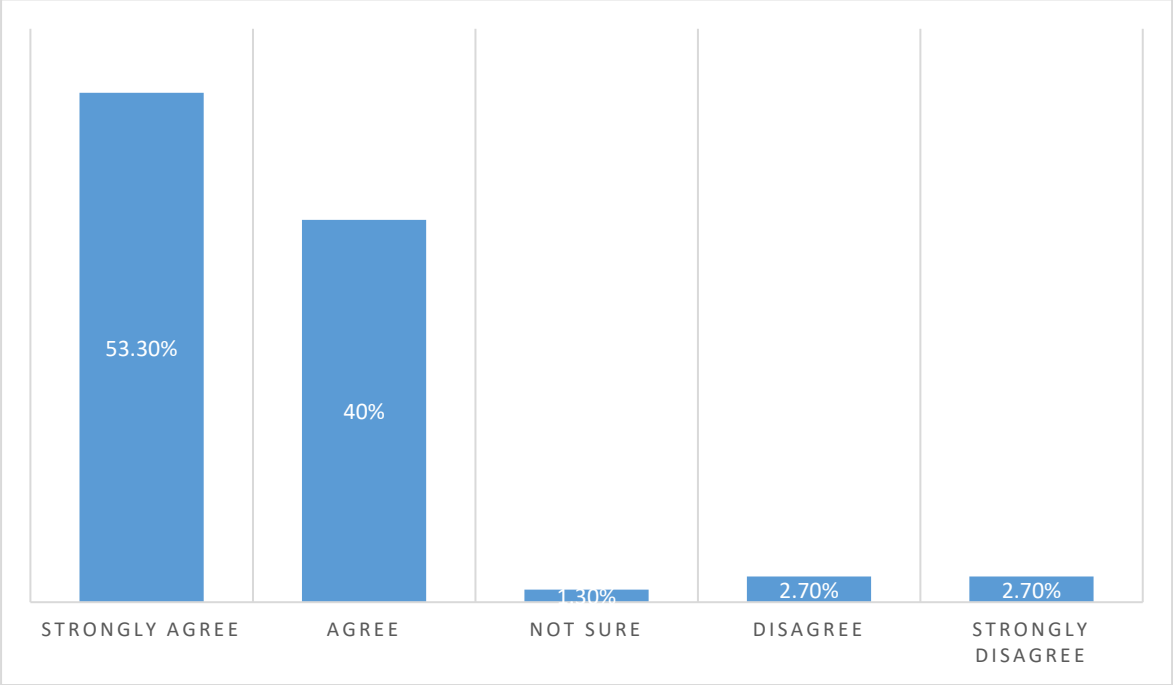
From the above figure, 90.6% of the respondents agreed that educated women know the advantages of using antenatal care services more than the uneducated, 2.7% respondents were not sure, while 6.7% disagreed.

In summary, it is clearly seen that that educated women know the advantages of using antenatal care services more than the uneducated.

4.3.3 Educated women know more about the availability of health care services than their non-educated counterparts

The figure below shows responses on whether educated women know more about the availability of health care services than the non-educated counterparts are summarised in the figure below:-

Table 8 showing whether educated women know more about the availability of health care services than the non-educated counterparts.



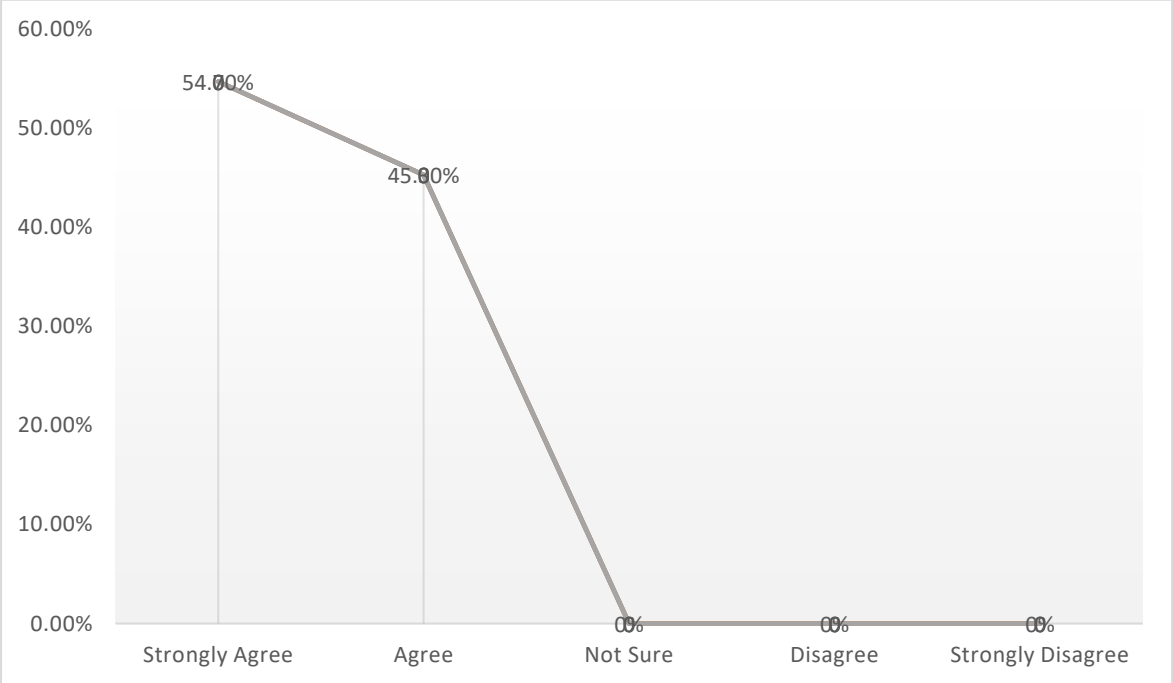
Source: Raw data from the field.

From the figure above, 93.3% of the respondents of the sample population agreed that educated women know more about the availability of health care services than the non-educated counterparts. 1.3% were not sure while 5.4% disagreed.

In short, it is clear that the biggest percentage of the sample population agreed that educated women know more about the availability of health care services than the non-educated counterparts.

3.3.4 Educated women pay more attention to maternal health care than the non-educated

Figure 9 responses whether educated women pay more attention to maternal health care than the non-educated.



Source: Raw data from the field.

From the above figure, 100% of the sample population agreed that educated women pay more attention to maternal health care than the non-educated ones. None of the respondents was not sure nor disagreed.

In short, all the respondents agreed that educated women pay more attention to maternal health care than the non-educated women because none of the respondents disagreed.

4.3.5 Whether educated women utilize the information of health problems more effectively than the non-educated.

Respondents were asked to state whether educated women utilize the information of health problems more effectively than the non-educated.

The responses can be summarised in the following figures.

Table 10 responses on whether educated women utilize the information of health problems more effectively than the non-educated.

Variable	**Strongly agree**	**Agree**	**Not sure**	**Disagree**	**Strongly disagree**	**Total**
Educated women utilize the information of health problems more effectively than the non-educated.	45	28	0	2	0	75
Percentage	60%	37.3%	0	2.7%	0	100

Source: Raw data from the field.

From the above table, 60% of the sample population strongly agreed, 37.3% agreed that educated women utilize the information of health problems more effectively than the non-educated while 2.7% disagreed and none of the respondents was not sure.

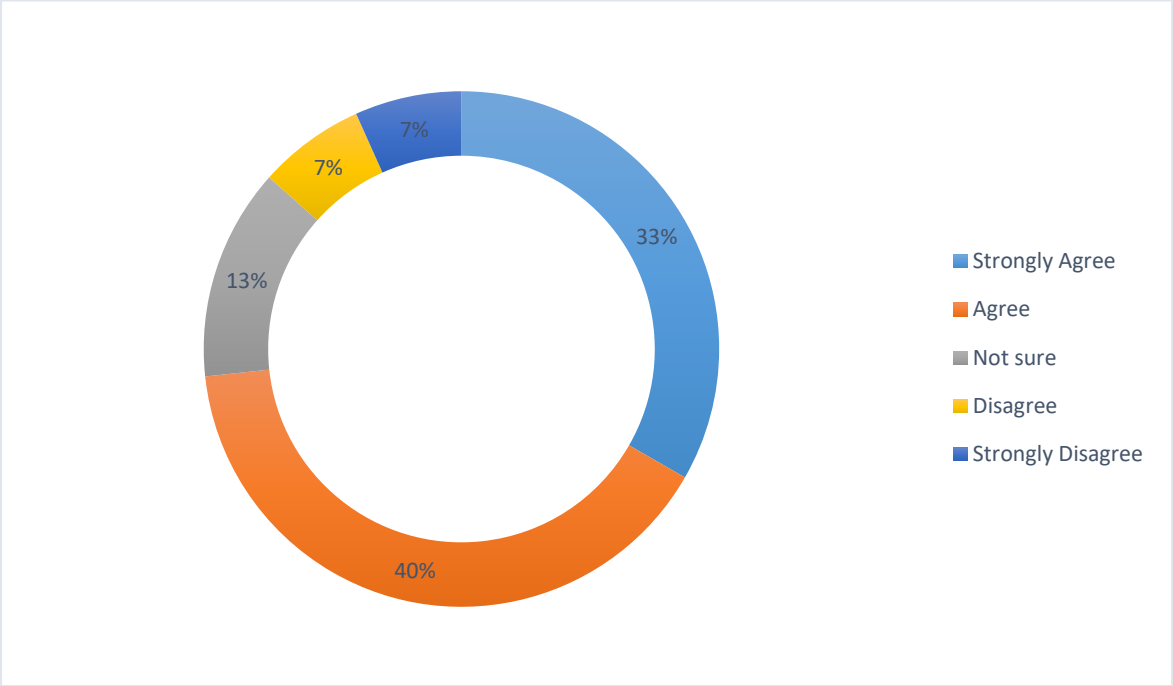
In short, greater number of respondents agreed that educated women utilize the information of health problems more effectively than the non-educated.

4.3.6 The non-educated women get more difficulties to get access to antenatal care services than the educated ones.

Respondents were asked if give their views whether the non-educated women get more difficulties to get access to antenatal care services than the educated ones.

The findings are here summarised in the table below.

Figure 11 shows responses on whether the non-educated women get more difficulties to get access antenatal care services than the educated one.



From the above figure, 33.3% of the sample population strongly agreed 40% respondents agreed that the non-educated women get more difficulties to get access to antenatal care services than the educated ones, 13.3% were not sure, and 6.7% disagreed while 6.7% strongly disagreed.

In summary, the biggest respondents agreed that the non-educated women get more difficulties to get access to antenatal care services than the educated ones, this is because the uneducated women fear to visit health facilities and their husbands fear to be tested for HIV.

4.4 The effect of religion and ethnicity on antenatal care utilization services on pregnant mothers

The study aimed at investigating on the effect of religion and ethnicity on antenatal care services on pregnant mothers.

4.4.1 Religion shapes community health behaviours through influence of lifestyle

Table 12 shows whether religion shapes community health behaviours through influence of lifestyle and the findings can be discussed as here under: -

The responses are summarised in the following matrix: -

Variable	**Strongly agree**	**Agree**	**Not sure**	**Disagree**	**Strongly disagree**	**Total**
Religion shapes community health behaviors through influence of lifestyle	30	28	2	5	10	75
Percentage	**40%**	**37.3%**	**2.6%**	**6.6%**	**13.3%**	**100**

Source: Raw data from the field

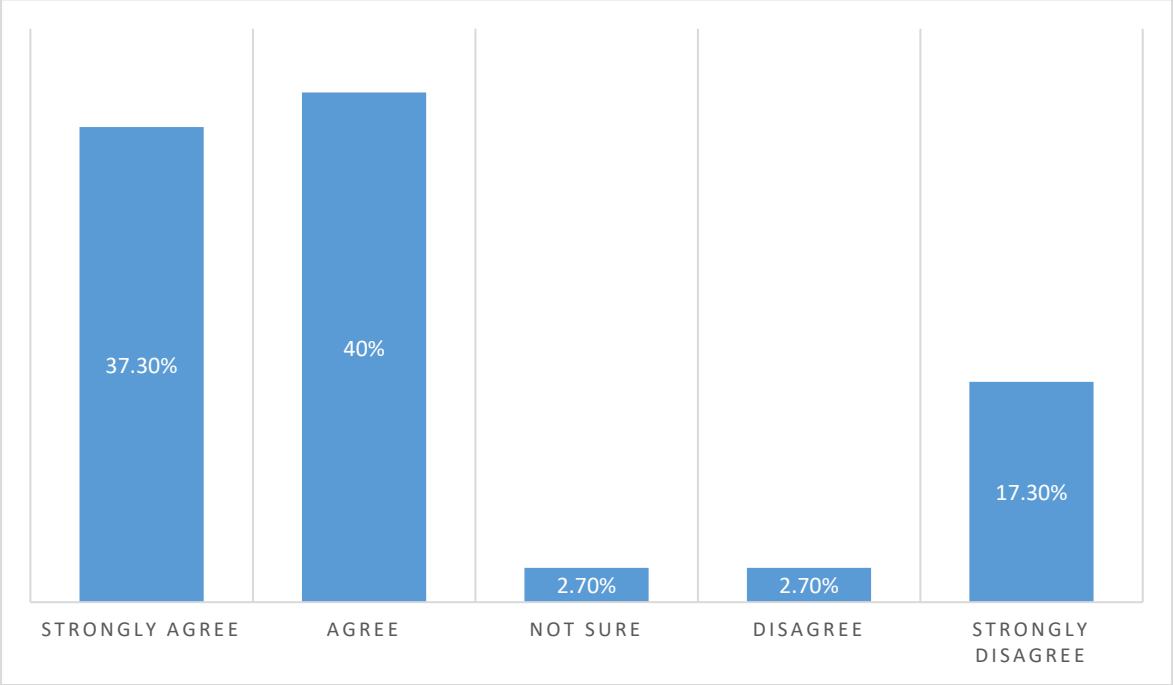
From the above matrix, 30 respondents representing40% of the sample population strongly agreed, 28 respondents representing 37.3% agreed that religion shapes community health behaviours through influence of lifestyle. 2 respondents representing 2.6% were not sure, 5 respondents representing 6.6% disagreed while 10 respondents representing 13.3% strongly disagreed.

In summary, it is clear that 77.3% of respondents agreed that religion shapes community health behaviours through influence of lifestyle while 19.9% disagreed.

4.4.2 Religious teachings, doctrines and regulations sometimes hinder modern health care seeking

Respondents were interviewed on whether religious teachings, doctrines and regulations sometimes hinder modern health care seeking. The finding was written as under: -

Table 12 responses on whether religious teachings, doctrines and regulations sometimes hinder modern health care seeking.



Source: Raw data from the field

From the above figure, 37.3% strongly agreed, 40% agreed that religious teachings, doctrines and regulations sometimes hinder modern health care seeking, 2.7% were nor sure, 2.7% disagreed and 17.3% strongly disagreed.

In short, it is clear that 77.3% agreed that religious teachings, doctrines and regulations sometimes hinder modern health care seeking while 20% disagreed.

4.4.3 Whether Faith healing and total adherence to religious beliefs and practices sometimes influence healthcare services

Table 13 shows responses on whether Faith healing and total adherence to religious beliefs and practices sometimes influence healthcare services.

Variable	Strongly agree	Agree	Not sure	Disagree	Strongly disagree	Total
Faith healing and total adherence to religious beliefs and practices sometimes influence healthcare services.	32	24	3	3	13	75
Percentage	42.7%	32%	4%	4%	17.3%	100

Source: Raw data from the field

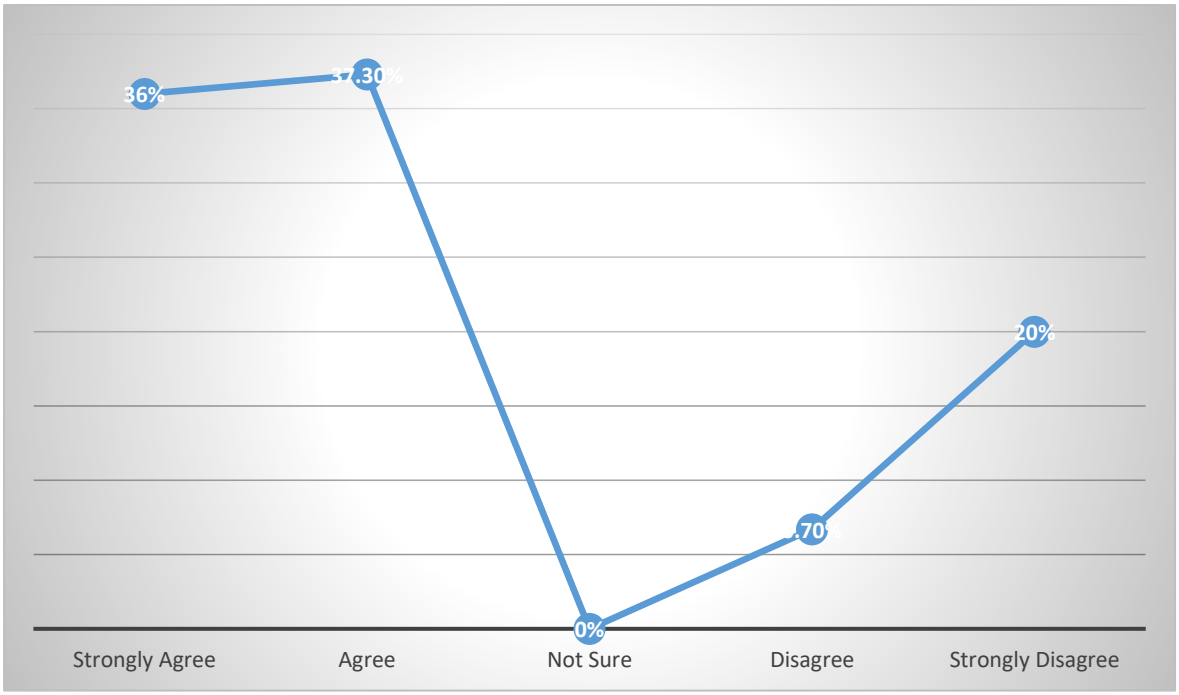
From the above matrix, 42.7% of the respondents strongly agreed, 32% of the sample population agreed that Faith healing and total adherence to religious beliefs and practices sometimes influence healthcare services, 4% were not sure, 4% disagreed while 17.3% strongly disagreed.

In summary, 74.7% of the sample population agreed, this implies that faith healing and total adherence to religious beliefs and practices sometimes influence healthcare services.

4.4.4 Whether certain religious groups have liberal health related teachings and doctrines which limits the utilization of antenatal care services

The following is the discussion of the findings.

Figure 14 shows responses if certain religious groups have liberal health related teachings and doctrines which limits the utilization of antenatal care services.



Source: Raw data from the field

From the above figure, 36% strongly agreed, 37.3% of the sample population agreed that that certain religious groups have liberal health related teachings and doctrines which limits the utilization of antenatal care services, , none of the respondent was not sure, 6.7% disagreed while 20% strongly disagreed.

In short, 73.3% of the sample population agreed while 26.7% disagreed, this implies that certain religious groups have liberal health related teachings and doctrines which limits the utilization of antenatal care services.

4.4.5 Whether the treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services

Respondents were asked for the view on whether the treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services.

Table 15 shows whether the treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services.

Variable	**Strongly agree**	**Agree**	**Not sure**	**Disagree**	**Strongly disagree**	**Total**
The treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services.	30	34	5	5	1	75
Percentage	40%	49.3%	6.7%	6.7%	1.3%	100

Source: Raw data from the field

From the above, 40% of the sample population strongly agreed, 49.3% agreed that the treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services, 6.7% were not sure, 6.7% disagreed while 1.3% strongly disagreed.

In summary, 89.3% of the sample population agreed, this means that the treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services.

4.5 Examining how household income influence the utilization of antenatal care services on pregnant mothers

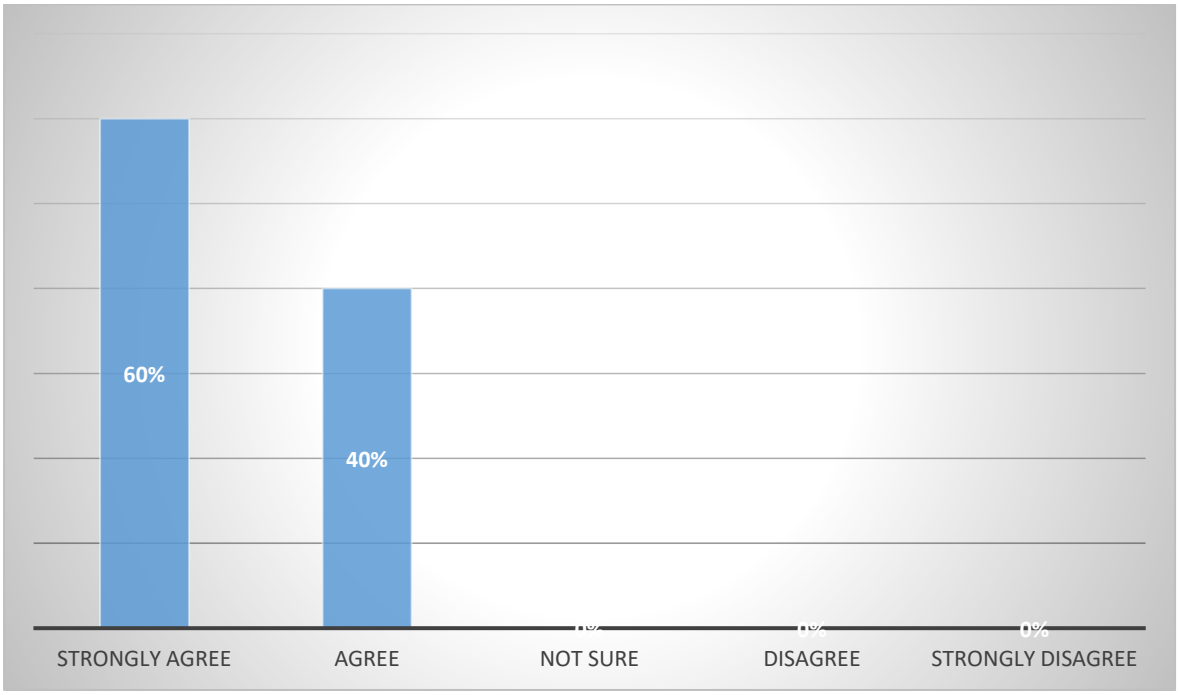
The study aimed at examining how household income influence the utilisation of antenatal care services on pregnant mothers.

Respondents were asked to show how household income influence the utilization of antenatal care services on pregnant mothers and their responses were analysed as follows:-

4.5.1 Examining how household income influence the utilization of antenatal care services on pregnant mothers

The findings are summarized in the table below.

Table 16 shows how household income influence the utilization of antenatal care services on pregnant mothers



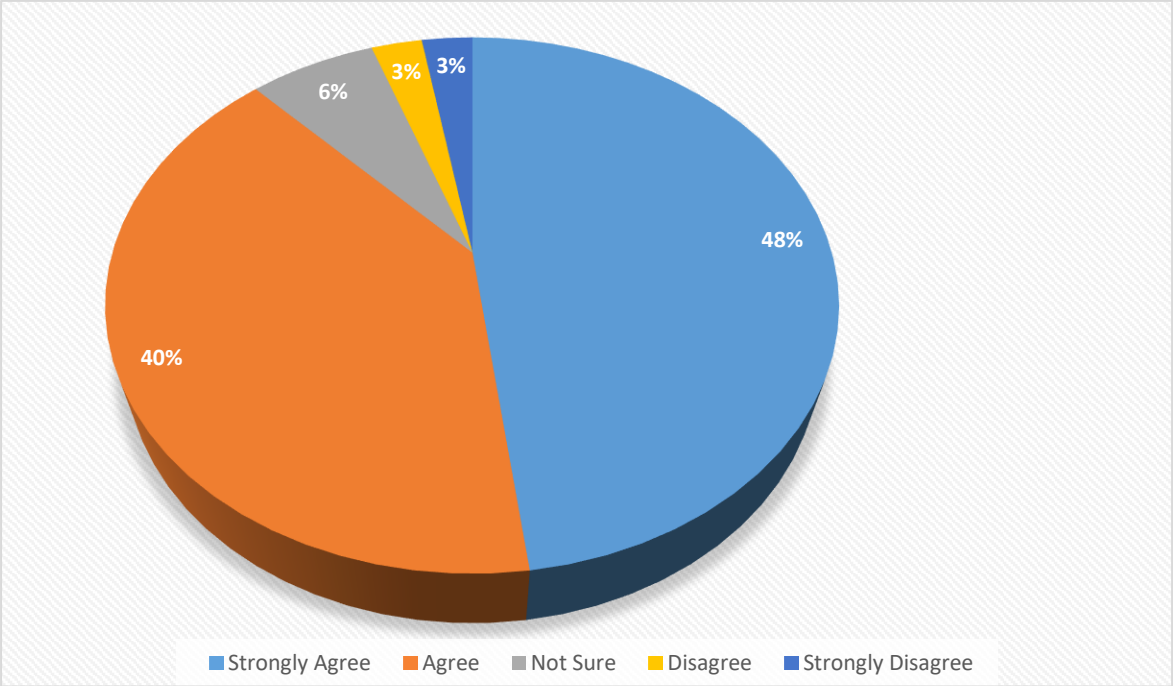
Source: Raw data from the field

From the figure, it is evident that 60% of the sample population strongly agreed, 40% agreed that financial difficulties have been considered as an important barrier to antenatal care for migrant women while none of the respondents disagreed.

In the nutshell, 100% of the sample population agreed and none of the respondents disagreed, this implies that financial difficulties have been considered as an important barrier to antenatal care for migrant women.

4.5.2 Whether Mothers of lower household income status consider visiting antenatal clinic as the mean loss of daily wages

The respondents responded to this as follows: -



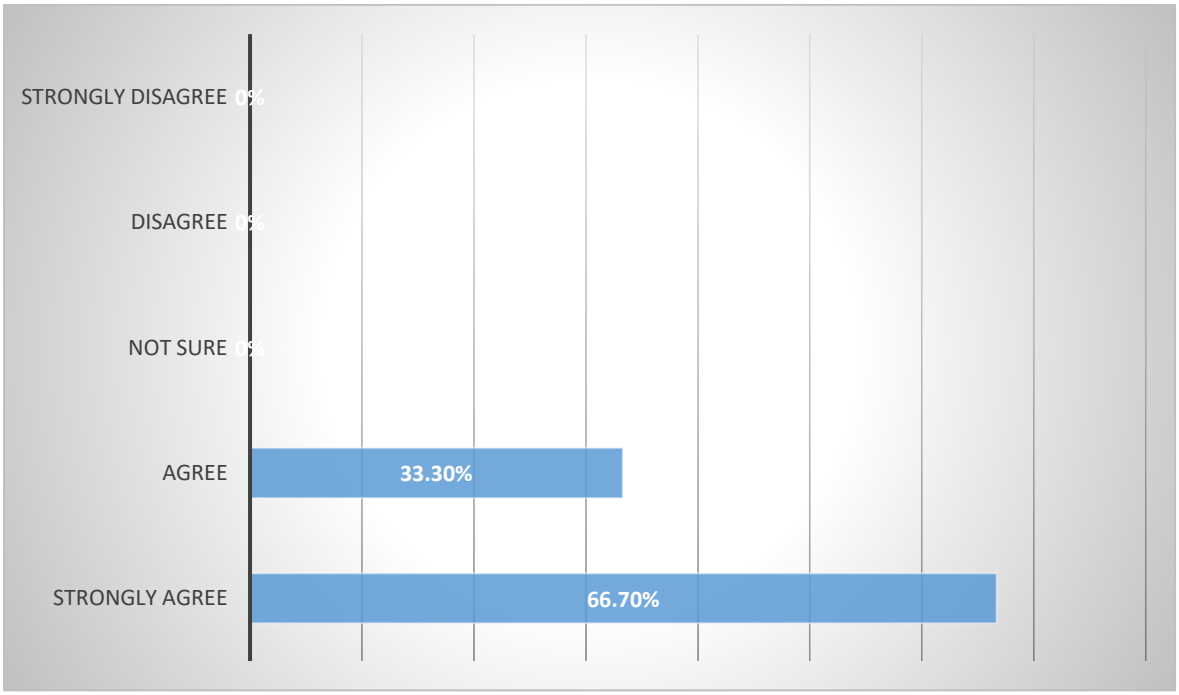
Source: Raw data from the field

From the above figure, it is evident that 48% of the sample population strongly agreed, 40% agreed, 6.7% were not sure, 2.7% disagreed while 2.7% strongly disagreed.

In short, it is clear that 88% of the sample population agreed, this implies that mothers of lower household income status consider visiting antenatal clinic as the mean loss of daily wages.

4.5.3 Whether Lack of money is a reason of delaying antenatal care utilization among women

Figure 18 shows whether lack of money is a reason of delaying antenatal care utilization among women.



Source: Raw data from the field

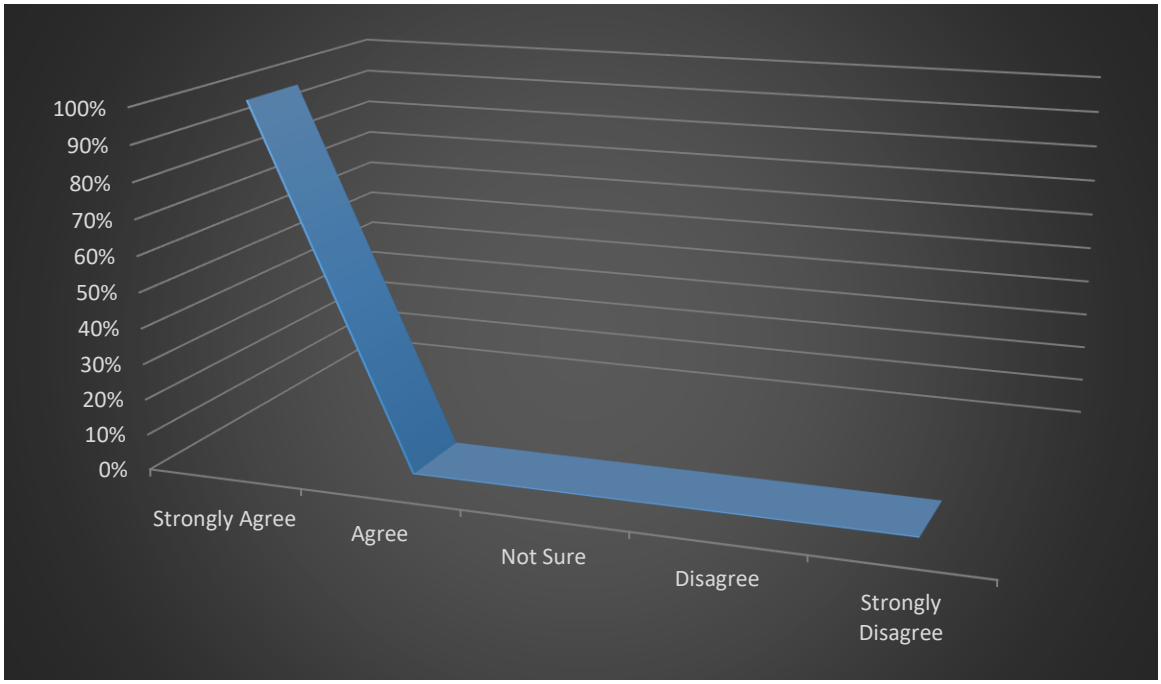
From the figure above, it is evident that 66.7% strongly agreed, 33.3% of the sample population agreed that lack of money is a reason of delaying antenatal care utilization among women while none of them disagreed nor was not sure.

In summary, it is clear that 100% of the respondents agreed that lack of money is a reason of delaying antenatal care utilization among women while none disagreed.

4.5.4 Whether higher household income women are likely to have adequately utilized antenatal care services and better wealth status for all maternity service

Respondents were asked if incomes are multidimensional socio-economic issue limiting the use of family planning. The responses are as follows: -

Table 19. Shows responses whether higher household income women are likely to have adequately utilized antenatal care services and better wealth status for all maternity service.



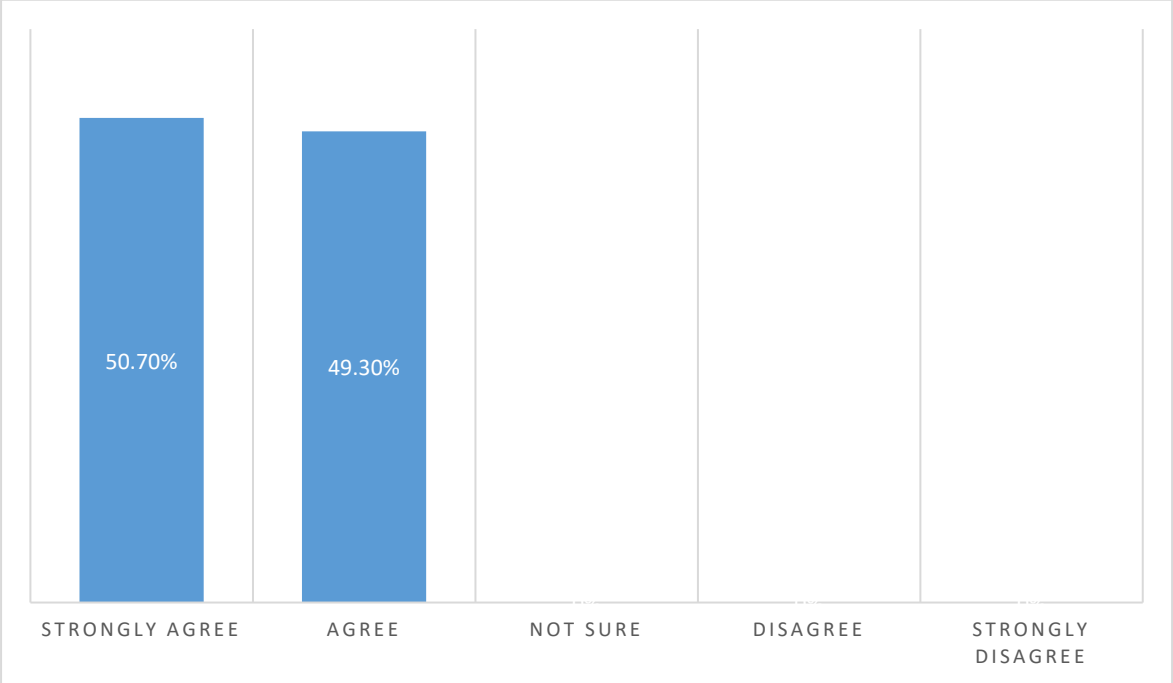
Source: Raw data from the field

From the above figure, 100% of the sample population agreed that higher household income women are likely to have adequately utilized antenatal care services and better wealth status for all maternity service and none of the respondents disagreed.

In short, all respondents agreed that higher household income women are likely to have adequately utilized antenatal care services and better wealth status for all maternity service.

4.5.5 Incomes are multidimensional socio-economic issue limiting the use of family planning

Table 20 shows responses on whether Incomes are multidimensional socio-economic issue limiting the use of family planning.



Source: Raw data from the field.

From the above figure, 50.7% of the sample population strongly agreed, 49.3% agreed that incomes are multidimensional socio-economic issue limiting the use of family planning and none of the respondents disagreed.

In summary, all the respondents agreed that 100% of the sample population agreed that incomes are multidimensional socio-economic issue limiting the use of family planning.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The discussion is based on the findings and the conclusions are drawn according to the analysed discussions in the data. The recommendations are in place to help the concerned put more attention towards urgent needs of mothers and their husbands to attend antenatal care clinics.

5.2 Discussion

The government and other stake holders should sensitize the mothers and husbands about the values of antenatal care services and teach them the negative effects of not attending antenatal care services for the recommended times.

The following discussions are in these tables below: -

Table 6 shows how educated women have a greater awareness of the existence of antenatal care services than uneducated one. Educated women are more aware of the existence of antenatal care services and seek more knowledge.

Table 7 shows how educated women know the advantages of using antenatal care services more than the uneducated ones. Educated women knows that antenatal care leads to a healthy baby.

Table 8 shows how educated women know more about the availability of health care services than the non-educated counterparts. Educated pregnant are more knowledgeable about the availability of health care services, this is because they ahead even to make consultations on the experience maternal health workers.

Table 9 shows responses how educated women pay more attention to maternal health care than the non-educated. This is because educated women know the implications of maternal health.

Table 10 shows responses how educated pregnant women utilize the information of health problems more effectively than the non-educated. This is because the educated

mother get access to health information through internet and they can utilise it efficiently.

Table 11 shows responses on how the non-educated women get more difficulties to get access antenatal care services than the educated one. This is because the uneducated pregnant mothers fear the health workers and getting health assistance becomes a big problem to them.

Table 12 shows how religion shapes community health behaviors through influence of lifestyle. Some religions say people can be cured through religious teachings.

Table 13 shows responses on how faith healing and total adherence to religious beliefs and practices sometimes influence healthcare services. This mostly born again and some Catholics who say they can pray and someone is healed.

Table 14 shows responses how certain religious groups have liberal health related teachings and doctrines which limits the utilization of antenatal care services. This is because there some religion like the born again take visiting a health as useless and only God cure.

Table 15 shows how the treatment of most illness traditionally before seeking modern healthcare has hindered the utilization of antenatal care services. This is because of the fear to be tested for HIV for both the pregnant mothers and their husbands.

Table 16 shows how mothers of lower household income status consider visiting antenatal clinic as the mean loss of daily wages. This is because the time taken when they go for antenatal is long more so in government facilities, which can be used for profitable businesses.

Table 17 clearly shows how household income influence the utilization of antenatal care services on pregnant mothers. This is because pregnant women with high household income easily accesses antenatal care services as they can even afford person doctors.

Table 18 clearly shows that lack of money delays antenatal care utilization among women. this because some women come from very far and reaching the health facility

requires some money for transport, this leads to delay in starting antenatal visits early and these end up starting antenatal visits at even seven or eight months of pregnancy.

Table 19. shows responses how higher household income women adequately utilize antenatal care services and better wealth status for all maternity service and it was noted that women of higher household income utilise antenatal care services than those of low household income.

Table 20 clearly shows responses that incomes are multidimensional socio-economic issue limiting the use of family planning.

Solutions to the problems

The government should come up with a policy of pregnant mothers attending antenatal care as early as one month of pregnancy and it should be punishable upon noncompliance of both the mother and the husband.

The communities should be sensitised about the advantages of early antenatal care visit/contact and implications of receiving late and non-attendance of antenatal care. There should be communications broadcasted over radios, televisions, celebrations and parties.

Outreaches should be set in all the villages to operate on a weekly basis to allow the pregnant mothers who come from very far to access antenatal care services at a nearby place

The government should recruit more social workers and counsellors in government health facilities so that the public is sensitised and advised on the advantages of couple HIV testing. This because most of the men fear to be tested not knowing that through testing they can know their HIV status and safeguard their lives and lives of their unborn babies.

Religious leaders should encourage the public to seek medical attention whenever they fail seek and when mothers conceive.

The government should encourage adult education in the communities, this will help the illiterates to acquire some knowledge then access and utilise it hence improve their health status.

5.3 Conclusions

From the findings, it is observed that educated pregnant women utilise antenatal care services, they are aware and knowledgeable of the services of antenatal care services and the easily access antenatal care services.

It was observed that major causes of the late and non-attendance of antenatal care is that many people fear to tested for HIV and yet is a requirement for the couple for attending antenatal care clinic.

Sensitisation should be done so that the public aware of the dangers of not attending antenatal care on time and non-attendance due cultural, religious and economic issues.

5.4 Recommendations

The researcher wishes to make the following recommendations as per the finding of the study.

The government should sensitize the public on dangers of the late and non-attendance of antenatal care.

Outreaches should be set in all the villages to operate on a weekly basis to allow the pregnant mothers who come from very far to access antenatal care services at a nearby place.

The government should recruit more social workers and counsellors in government health facilities so that the public is sensitised and advised on the advantages of couple HIV testing

The government should induct health workers on how to handle pregnant mothers and their husband.

More health workers should workers should be recruited so that quality and quick maternal health services are rendered to clients.

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