LEVEL OF AND FACTORS ASSOCIATED WITH BIRTH PREPAREDNESS AND EMERGENCY PLANNING AMONG PRENATAL WOMEN IN BUGIRI HOSPITAL

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RS19M07/034

A DISSERTATION SUBMITTED TO THE FACULTY OF PUBLIC HEALTH, NURSING AND MIDWIFERY AND IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A DEGREE OF MASTER OF PUBLIC HEALTH AND LEADERSHIP OF UGANDA CHRISTIAN UNIVERSITY

February, 2024

UGANDA CHRISTIAN UNIVERSITY

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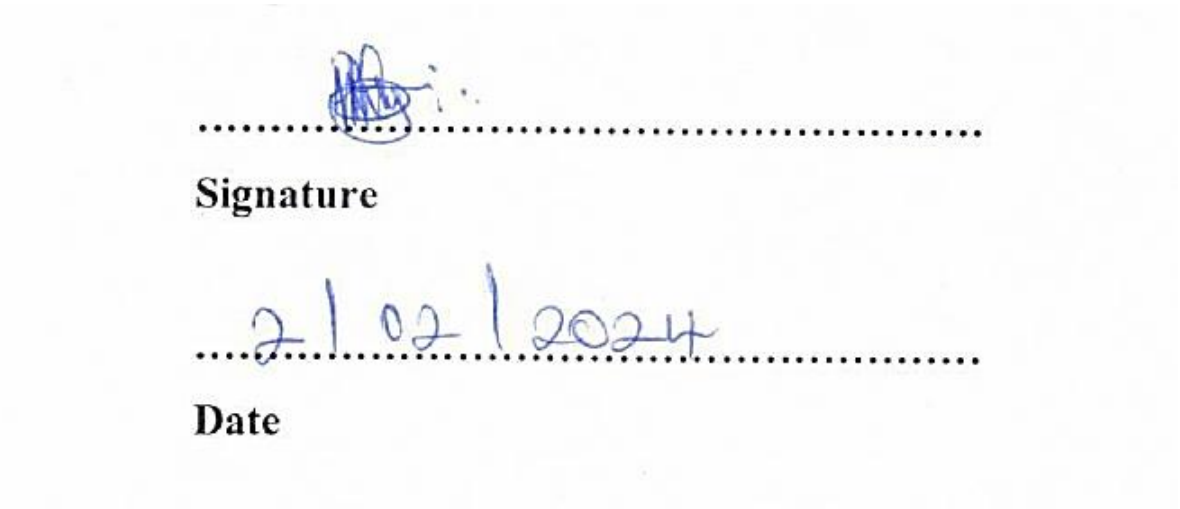
DECLARATION

I **Namumbya Beatrice do** affirm that I am the sole author of this paper and that any support I received in its preparation has been fully acknowledged and disclosed within the document. Additionally, I have appropriately cited all sources from which I obtained data, ideas, or language, whether directly quoted or paraphrased. Furthermore, I confirm that this paper was created by me expressly for the completion of the master's program in public health leadership at Uganda Christian University.

Name

NAMUMBYA BEATRICE



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Date

APPROVAL

As the assigned supervisor for the research project titled "Level and Factors Associated with Birth Preparedness and Emergency Planning Among Prenatal Women in Bugiri Hospital," I have thoroughly reviewed the final research report submitted by Namumbya Beatrice. I confirm that it comprehensively presents the research objectives, methods, findings, and conclusions. The analysis is sound, and the interpretations are supported by the data collected during the study.

Based on my evaluation, I hereby grant my approval for the submission of the completed research report for assessment and dissemination.

Supervisor's Signature: _____

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Date: 29/01/2024

ACKNOWLEDGEMENT

Thanks be to God for the gift of life and wisdom, sincere gratitude to my supervisors namely Prof. Pius Okong for his dedication towards this research and thank you for your guidance towards my research work.

Also special thanks to the administration of Bugiri Hospital and antenatal clinic clients who provided the required information to make this study a success.

May the Almighty God reward you abundantly.

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OPERATIONAL DEFINITIONS

Birth preparedness: According to the study birth preparedness is a state when a pre-natal woman is able to tell the danger signs during labor and after, being able to plan on which health worker to attend to her during birth, choosing a health facility and saving some money to help meet the requirements during and after delivery. based on the assumptions that preparing for childbirth and being ready for complications reduce delay in obtaining care.

Emergency planning: anticipating what may not occur according to what is expected and preparing for actions to address the emergency should it occur.

Maternal Mortality: death of a woman during pregnancy or within 42 days after delivery.

Antenatal care: refers to the care provided to pregnant women during pregnancy to monitor and promote the well-being of both the mother and the developing fetus, detect and manage potential complications, teaching her how to prepare for delivery and after delivery and provide education and support to pregnant women.

Reproductive age; according to the study reproductive age referred to mothers between 18 years to 49 years of age.

ABSTRACT

Introduction; Birth preparedness refers to the readiness of pregnant women to give birth safely. It involves a series of actions and plans to ensure both the mother and baby receive proper care and support before and during childbirth. This study therefore sought to determine the level and factors of birth preparedness and emergency planning in the pre-natal women of Bugiri Hospital. Specifically, the study intended to find out the socio-demographic, obstetrics, and gynecology factors and intervening factors that affect the level of birth preparedness.

Methods; The study employed a purely quantitative study design to collect primary data from the 288 selected respondents targeting prenatal women in Bugiri Hospital. Analysis was done at three distinct levels using SPSS software. These included univariate (frequencies and percentages), bivariate (chi-square tests), and multivariate (binary logistic regression). Significant factors were identified through chi-square tests and logistic regression analysis.

Results; A significant association was observed between education level and birth preparedness (Odds Ratio = 2.597, p = 0.004). Higher education increased the likelihood of optimal birth preparedness among participants. Women with a history of stillbirths exhibited a substantial association with childbirth preparedness (Odds Ratio = 4.771, p = 0.039). The experience of stillbirth heightened the sense of need for preparedness to prevent future complications. Male partner involvement demonstrated a robust association with birth preparedness (Odds Ratio = 1.904, p = 0.004). Active engagement of male partners was transformative, positively influencing overall childbirth experiences.

Conclusion; The study concluded that birth preparedness is not solely the responsibility of pregnant women but also the healthcare system, healthcare providers, and the community. It was recommended that the inclusion of childbirth plans in ANC packages is vital alongside other interventions like educational programs, community outreach, and improved access to antenatal care services.

CHAPTER ONE

1.1 Introduction

This chapter encompasses the study's background, problem statement, study purpose, research objectives, research inquiries, and rationale, importance, and study scope.

1.2 Background to the Study

Birth preparedness is an important element of antenatal care (ANC), to ensure timely access to emergencies and neonatal care to avert adverse maternal and fetal outcomes, especially at the time of childbirth. This process entails crafting a birth plan that encompasses the identification of danger signs, arrangements for birth attendants, selection of delivery location, establishment of transportation options, and financial preparations to cover potential expenses, including transportation costs and other unforeseen expenses. WHO (2023) recommends that all women receive assistance from skilled birth attendants during childbirth. Based on the mother's health and other considerations, a health worker caring for a woman in pregnancy/ANC will advise and recommend the level of health care/facility for safe delivery for example in a hospital or Health Center (III or IV). For the safe delivery of a child under the care of a skilled attendant, it is imperative for the woman and her family to carefully consider and plan various aspects. This requirement remains pertinent even in the event of an emergency.

Worldwide, on average, a woman loses her life every minute due to pregnancy- or childbirth-related complications. The severity of this issue is particularly pronounced among women in Sub-Saharan Africa, encompassing countries like Uganda, Kenya, and Ethiopia, among others (Markos D, Bogale D. 2014). According to Odimegwu C, Adewuyi (2015), insufficient understanding of birth planning, limited utilization of skilled birth attendants during delivery, and inadequate preparation for promptly addressing obstetric complications are widely recognized as risk factors contributing to delays in accessing skilled care.

WHO (2010) states that high maternal mortality rates (MMR), particularly in developing nations, continue to be a global public health concern. Pregnancy and its consequences resulted in around 275,288 maternal deaths worldwide. Aiming to reduce MMR by 75%, member countries of the World Health Organization were the focus of the 2000 Millennium Development Goal (MDG). However, the maternal mortality rate (MMR), which is 920 per 100,000 live births in poor

nations, especially in sub-Saharan Africa, is still too high. The lifetime risk of maternal death is 1 in 16, as opposed to 1 in 2400 in Europe. Ethiopia is a nation where the MMR rate is high. It is the most accurate measure of overall growth and the differences in health between richer and poorer countries. Children and other families are not the only family affected by MM's impacts. The nutritional status of children and other critical child health care practices that involve the mother have a substantial impact on the survival status of all children under five. The MDGs were not met by several developing nations, also known as Low- and Middle-Income Countries (LMICs). At present, these nations have embraced the UN Sustainable Development Goals (SDGs) and the WHO's Universal Health Coverage philosophy. The goal of SDG 3 is to lower the maternal death rate to 70 per 100,000 live births by 2030. This tactical change places an emphasis on a comprehensive approach to the health of mothers and children, realizing the connections between various health outcomes and the critical role that mothers' well-being plays in accomplishing more general developmental objectives. (Nabulo et al., 2023).

The World Health Organization (2015) estimates that problems related to pregnancy and delivery claim the lives of roughly 580,000 women annually. At least one woman passes away from pregnancy- or childbirth-related problems every minute. In Sub-Saharan Africa, where one in every sixteen women dies from pregnancy-related reasons, the situation is far worse for women. 98% of maternal fatalities occur in Sub-Saharan Africa. Out of the 4 million neonates that die worldwide, 75% pass away in their first week of life, and the mortality rate is 32 per 1000 deliveries, with 24–37% of those stillbirths occurring during the intrapartum period.

These variables are responsible for a high percentage of maternal deaths in Sub-Saharan Africa. Universal elementary and secondary education programs must be encouraged in order to increase the impact that knowledge of important danger signs has on birth readiness practices. Finding a qualified provider and arranging the required arrangements to receive skilled care for every birth are components of birth readiness in a skilled care approach. On the other hand, in order to significantly improve maternal health care, infant and child health, and lower the associated mortality rates, birth preparedness and emergency planning are essential. In Ethiopia, there is a dearth of understanding regarding emergency preparation and birth readiness, particularly in the remote southern regions. Maternal mortality rates are high in some parts of the world, which highlights the disparity between the rich and the poor and reflects access to high-quality

healthcare. In 2020, the maternal mortality ratio (MMR) in low-income nations stood at 430 per 100,000 live births, while in high-income countries, it was 12 per 100,000 live births. (WHO, 2023).

Being ready for childbirth is seen as a beneficial and doable action that offers several benefits. It may result in a rise in the need for professional services to prevent difficulties and deal with unforeseen occurrences that arise during pregnancy and labor. Uganda had a maternal mortality ratio of 284 deaths per 100,000 live births in 2020. According to World Data Atlas Uganda, Uganda's maternal mortality ratio decreased with time, from 453 deaths per 100,000 live births in 2001 to 284 deaths per 100,000 live births in 2020. The main tenet of both preparing for a typical delivery and seeking emergency interventions is birth readiness. It improves expectant mothers' and family members' preparedness and decision-making for delivery. This considers the possibility of unforeseen problems for both the mother and the fetus, making every pregnancy dangerous.

According to the available data, Uganda has very little emergency planning and readiness for births (Barber et al., 2017). The world health organization laid a simple and smart outline of a birth plan, this is supposed to be included in the ANC package that is given to expecting mothers but you find that even the midwives who take through the mother have no idea of how the recommended birth plan looks like. the goal of this study is to fill in the knowledge gap about birth preparedness and complications readiness in the Bugiri district hospital, as there are only anecdotal reports and no studies done in the study area.

Kabakyenga et al,2011 states that 35% of the mothers interviewed in Mbarara district were birth prepared and the rest were not prepared.in the study the prevalence of knowledge of at least three key danger signs during the three phases of pregnancy was very low at (19%).the lack of a birth preparedness plan in the Health Care Package provided during ANC is one of the factors to low levels of preparedness hence the study.

1.3 Statement of the Problem

Study Objectives

Globally, every minute at least one woman dies from complications related to pregnancy or child birth, the situation is worse for women in sub Saharan Africa (Ayelech Kidanemariam et al, 2020), sub Saharan Africa incurs 98% of maternal deaths, three quarters of the four million global neonatal deaths occur in the first week of life and still birth rate is 32 per 1000 deliveries of which 24-37 occur during the intrapartum period (Mulugeta et al. reproductive health 2020). Reducing the frequency of maternal deaths in Uganda has progressed significantly. The health facility-based maternal mortality rate for 2019–20 was 99 deaths per 100,000 live births, according to the UBOS report 2021. The promotion of birth readiness during prenatal treatment by means of counseling and raising awareness of Danger Signs has received a lot of attention. This is included in the Minimum Health Care Package, which has been offered since 2000 through ANC (Antenatal Care) programs. Mothers and their families are found to be less prepared for crises in the Bugiri district, particularly at Bugiri General Hospital, which acts as the district's referral center for all medical institutions. An increasing number of women giving birth in hospitals without being ready for labor or an emergency gave rise to this concern. When issues emerge, access to hospital care is delayed for many pregnant women who give birth in hospitals, even though they anticipate a typical delivery. This is demonstrated by the inability to make decisions quickly, the lack of funds to deal with emergencies, and the inability to get necessities for a safe delivery or necessary tools and resources like emergency transportation. According to the 2020–2021 Health Sector Report, 25% of women had neither a birth plan nor any indication that they were ready for parenthood. Hence, the objective of this study is to evaluate the degree and associated aspects of emergency planning and birth preparation among pregnant women attending antenatal care (ANC) at Bugiri Hospital.

1.4

1.4.1 General Objective

To assess the extent and factors influencing birth preparedness and emergency planning among pregnant women attending antenatal clinics at Bugiri Hospital.

1.4.2 Specific Objectives

i. To determine the level of birth preparedness and emergency planning among women in the Antenatal Clinic in Bugiri Hospital.

ii. To identify the factors associated with birth preparedness and emergency planning among women in antenatal clinics in Bugiri Hospital.

1.5 Research Questions

i. What is the level of birth preparedness and emergency planning among women in the antenatal clinic in Bugiri Hospital?

ii. What are the factors associated with birth preparedness and emergency planning among women in antenatal clinics in Bugiri Hospital?

1.6 Justification

The trends for maternal mortality have been fluctuating since 2016 despite interventions such as mentorship and counseling in facilities. In 2019 we saw a reduction in mortality in both hospital and lower-level facilities (Report from Maternal and Newborn Scale-Up (MANeSCALE) this was a project conducted in Eastern Uganda in 2019 to strengthen care to both mothers and children. This project reflected that though there was a reduction in maternal deaths in their annual health sector performance report by districts in the financial year 2019/2020, Bugiri district was between 119-200 maternal deaths (Ministry of Health), one of the reasons is the low level of preparedness. This study will establish why this problem is prevalent at a high degree and explore measures that may help to avert this problem. This study will also examine whether women and their families think about birth emergency preparedness plans.

1.7 Significance

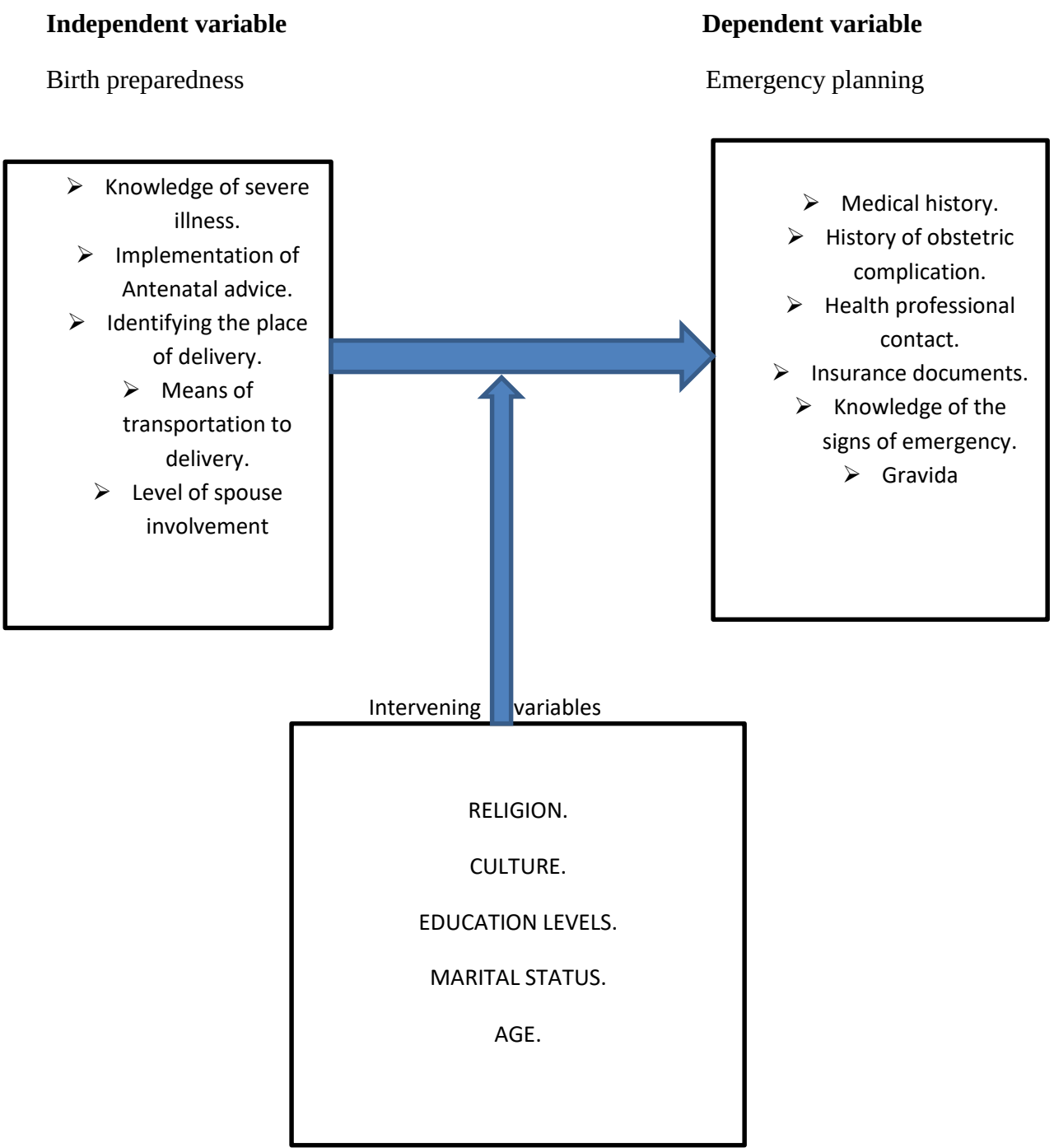
This study aims to offer foundational data on the subject, which could assist health administrators, professionals, researchers, policymakers, and politicians in developing and expanding safe motherhood initiatives. By addressing the highest maternal and neonatal mortality rates in Bugiri, the Busoga region, and Uganda as a whole, this research endeavors to contribute to the implementation and scaling up of effective interventions.

Furthermore, this research paper will entail to unveil demographic statistics level of birth preparedness, complication due to birth unpreparedness and the rate of pregnancy emergence planning in Bugiri district because of the district high prevalence of deaths during child labor.

In Bugiri district, the research will derive strategies to promote the timely use of skilled maternal and neonatal care especially during childbirth, with a view that mothers that have attained child birth education will improve their awareness and utilization of suitable medical facilities to ensure safe delivery and minimize maternal and neonatal mortality.

The study will further add onto the existing literature from the study findings which will be of help as reference for future researcher in the same field of public health.

1.8 Conceptual Framework.



Designed by the researcher 2024

Figure 0.1: Conceptual Framework

The conceptual framework shows factors at the individual level, family, and environmental/community levels. The independent variables birth preparedness with indicators such as knowledge of severe illness, sustainable implementation of antenatal advice, identification of place of delivery will influence the dependent variable significantly with indicators such as medical history, professional contact at the time of delivery. However, it must be understood that intervening variable for example culture, education level, marital status will influence both the independent and the dependent variables.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presented a review of existing literature relevant to the study objectives. The literature review was thematically undertaken in terms of the specific objectives which included: To establish the factors associated with birth preparedness and emergency planning; To establish if pregnant women and their spouses prepare for birth and emergencies.

2.2 Level of birth preparedness and emergency planning among prenatal women

Decreasing maternal mortality is a fundamental component of the Sustainable Development Goals (SDGs). Preparing for childbirth early and increasing the availability of experienced health attendants during pregnancy and child delivery are the keys to lowering the maternal mortality ratio and enhancing the health of mothers and newborns. The procedure of preparing in advance for a safe and well-organized delivery, along with the requisite actions to take in the event of an emergency during childbirth, is referred to as Birth Preparedness and Complication Readiness (BPCR) (Van Bavel et al., 2022). BPCR makes safe delivery easier by organizing ahead of time. Care decision-making delays are decreased using the BPEP approach. First, it advises expectant mothers to schedule skilled medical professionals for each delivery. Women and their families will arrive at the medical institution before any serious complications arise if they make plans to seek care prior to the commencement of labor and successfully follow them through childbirth. Second, having an emergency plan helps women, families, and communities recognize serious warning signs, which improves problem recognition and shortens the time it takes to decide to seek care (Noor et al., 2022). Research with a low BPEP status was conducted among women in the Thatta area of Sindh who were of reproductive age. The overall response rate was 94.6%. Just 163 (21.2%) of the 770 participants were well prepared, and 607 (72.8%) were not, for both childbirth and potential problems (Noor et al., 2022).

The issue of maternal mortality persists on a global scale, particularly in sub-Saharan Africa, where the rate of maternal deaths per 100,000 live births is still high at 533, despite a decline (Barber et al., 2017). One of the causes is the absence of emergency planning and birth

preparedness, which is acknowledged as a crucial element of safe motherhood initiatives worldwide (Taal et al., 2011). Birth Preparedness and Emergency Planning (BPEP) is a holistic approach aimed at facilitating prompt access to skilled maternal and neonatal health services. Additionally, it encourages proactive preparation and decision-making regarding childbirth among pregnant women and their families. (JHPIEGO, 2004). A birth plan should include the following: locating the closest appropriate care facility and a skilled birth attendant; setting aside money for emergency and birth-related costs; coordinating transportation to a medical facility for obstetric and birth-related emergencies; and identifying suitable blood donors in case blood transfusions are required (JHPIEGO, 2001). In Rwanda, where there are centralized blood banks that draw blood from willing donors, the latter requirement is not applicable. Birth readiness is regarded by UNICEF (2016) as a realistic and helpful strategy that offers several benefits. It can enhance the utilization of skilled services, mitigating the risk of unforeseen complications during pregnancy and enabling women to plan for necessary contingency measures. Ethiopia has historically experienced elevated levels of maternal morbidity and mortality (Sharma et al., 2019).

According to WHO (2015), ANC attendance at least four times, an initial ANC visit in the first or second trimester, receiving prenatal illness counseling, and male engagement are all good ways to encourage birth readiness. When ANC is sought later in pregnancy, there is a time constraint for taking measures. (*UNICEF Strategy for Health 2016-2030,* n.d.). Research on Maternal Health in Africa by Bustreo et al. (2013) asserts that the situation in Sub-Saharan Africa is particularly dire. During the mother's lifetime, one in sixteen women in the region pass away from pregnancy-related causes, compared to one in two,800 in developed regions.

Donati et al. (2021) in research on birth preparedness reported that most Ethiopian pregnant women planned for their recent baby to be born. The World Health Organization (2015) stated that families should be the ones who support expectant mothers. Helping the mother with home tasks like cooking, gathering firewood, and collecting water could be one way to support her. These tasks are frequently completed by the aunts or mother-in-law. It was stated that the mother's rest is crucial to the child's healthy development. In the study in Ethiopia (Aklil et al., 2022), More work needs to be done to educate and empower women on how to prepare for birth and emergencies during and after pregnancy, both in urban and rural settings, with a focus

primarily on the former. The report revealed that over half (56.02%) of women had knowledge of birth preparation and emergency planning. The partner should begin saving money for the pregnancy as soon as the pregnancy is confirmed. The expectant woman ought to talk to her husbands about where they would store the money safely. The males are required to strive toward earning money since they are viewed as the source of funding and are responsible for securing the items needed for the delivery. These consist of clean cloths, cord ties, basins, surgical blades, surgical gloves, and sewing threads. Pregnant women are frequently asked to make sure they have these supplies with them for the birth. If males were unable to accumulate money and offer this kind of support, they were viewed as reckless.

Theuring et al. (2009) suggested that when a wife informs her husband that she is expecting, he should begin arranging for the baby's birth. Wear clothes, gloves, razor blades, and make sure your spouse delivers the baby in a safe location. Additionally, the money saved ought to go toward hiring a vehicle. Victora et al. (n.d.) noted that family members work very hard to save up enough money to get the expectant woman closer to the referral hospital as part of birth preparation. WHO (2014) states that being ready for delivery at the hospital is crucial. It was believed delivering in a hospital offered greater safety compared to delivering at home, and that any issues were handled promptly and expertly. There was also expressed confidence in the skill of the highly qualified healthcare professionals. It was also mentioned that not many women in this community give birth at home. Unlike in the past, when the preceding generation tended to deliver at home, things are different now. Many midwives should be trained by the government. and ought to reside in the neighborhood; this will enable them to deal with issues and make references to the more challenging ones. After these individuals are appointed, they must receive training. Additionally, they typically have all the required tools, including plastic gloves and other items (Koblinsky et al., n.d.). Paxton A., et al (2015) deposited that Families should receive financial help from the government to act in accordance with their wishes and intentions and to facilitate prompt transportation in case of emergency. Health professionals must acknowledge that it is crucial to teach expecting families BP/CR, so they are aware of what to do in childbirth-related scenarios in order to help them become more self-assured.

2.3 Factors associated with Birth Preparedness and Emergency Planning.

A comprehensive component of improving the practice of providing skilled healthcare during childbirth, birth preparedness and emergency planning (BPEP) is one of the main strategies to reduce the number of mothers and newborns who die during childbirth. Pregnancy and childbirth are still considered exclusively a woman's problem in sub-Saharan Africa. It is uncommon to locate a male companion during prenatal treatment, and in many areas, it is unimaginable for a man to accompany a woman to the labor room during childbirth. Nonetheless, men dominate society and the economy, particularly in Africa, and they have great influence over their spouses. They determine the size of the family, the timing and terms of sexual encounters, and whether or not their spouse will make use of the healthcare system (Barber et al., 2017). Therefore, if maternal health is to improve and maternal morbidity and mortality are to be reduced, male partner involvement is crucial. Men should be included in birth preparation and emergency planning, as well as having their knowledge of emergency obstetric situations increased through strategies for involving men in maternal health services. (Prativa & Mangala, 2016). When men are involved, they can help their spouses seek emergency obstetric services early, which will help the pair prepare for birth and potential difficulties. This might have a beneficial effect on delivery outcomes by reducing all three phases of delay.

Cultural attitudes and ignorance impede prenatal care and the birth of the expected child in many countries around the world. The family tries to take action after labor starts, as no activity is performed before the delivery. The majority of expectant mothers and their families are unaware of the warning indicators of problems. When issues arise, the unprepared family will lose a lot of time diagnosing the issue, organizing, obtaining funding, arranging for transportation, and arriving at the proper referral facility (Sabita et al., n.d.). Understanding warning signs, selecting the desired birthplace and attendant, identifying the nearest suitable healthcare facility, setting aside finances for birth-related and emergency costs, arranging for a birth companion, arranging support for household and childcare responsibilities during the woman's absence, organizing transportation to the medical facility for delivery, arranging emergency transportation in case of obstetric complications, and identifying potential blood donors in case of emergencies are all integral components of a birth plan or emergency preparedness plan. According to Redshaw and Henderson (2013), Birth preparedness and emergency planning (BP/CR) is a comprehensive package intended to address delays by empowering women, their families, and the community to improve birth planning and take emergency action. BP/CR is the process of anticipating the

actions needed in case of an emergency and planning for a normal birth. A birth preparedness and emergency planning plan should include things like choosing a delivery location, budgeting, gathering necessary supplies for the birth, finding a qualified provider, choosing a means of transportation, organizing blood donors, setting up a communication system, appointing decision-makers on her behalf, locating emergency funds, and being aware of the warning signs of pregnancy and the need to act quickly.

Idowu A, OM, (2015) asserts that Since these people will be struggling to meet their fundamental necessities and may not be able to meet additional demands, like preparing for delivery, low salaries are linked to high levels of poverty and economic instability. The partner's awareness of birth readiness was not correlated with their occupation in this study. Cultural taboos and beliefs made it difficult to prepare for childbirth. For example, society thought that the baby had to be born before clothes could be purchased. These results are associated with a study conducted in western Kenya at Lurambi, Kakamega. This could be attributed to the proximity of the study area to the western region, suggesting that these communities may share certain cultural taboos and beliefs (Cheptum et al., 2017). Berhe et al. (2018) noted that there are several well-documented factors that contribute to the growing challenges to maternal care, not only in Nigeria but also in other developing countries. These include inadequate human resources for health, inadequate and poor political commitment, poor financial support, particularly in meeting transportation challenges, the cost of prenatal, delivery, and postnatal care, problems with coordination and partnerships, low male, and community involvement, rising rates of poverty among the populace compounded by women's low socioeconomic status, the adoption of ineffective strategies to curb the escalating rates of maternal mortality, etc.

According to the UDHS (2016), Uganda has a high maternal mortality rate of 336 fatalities per 100,000 live births, or 16 women dying every day. The majority of these deaths are the result of inadequate birth preparation. Uganda is one of the countries still working toward achieving the SDGs. Nabulo and associates, 2023 Mothers don't always prepare for birth and potential problems, as evidenced by a study conducted at Mbarara Regional Referral Hospital that found delays in care delivery, delays in transportation, and poor treatment from medical staff. The majority of mother deaths happen during childbirth and the postpartum phase. According to the UDHS (2016), Uganda has a high maternal mortality rate of 336 fatalities per 100,000 live

births, or 16 women dying every day. The majority of these deaths are the result of inadequate birth preparation. Uganda is one of the countries still working toward achieving the SDGs. Nabulo and associates, 2023 Mothers don't always prepare for birth and potential problems, as evidenced by a study conducted at Mbarara Regional Referral Hospital that found delays in care delivery, delays in transportation, and poor treatment from medical staff. The majority of mother deaths happen during childbirth and the postpartum phase.

Lucy et al., n.d stated that some religious beliefs place a person's health in danger because they forbid obtaining official medical attention or support certain medical procedures like blood transfusions. Health care services are promoted because other religions encourage their followers to use them. One of the excuses for not preparing for childbirth is the thought that if plans were made beforehand, the baby might not survive. No mother would want to lose her child after birth; instead, she would rather follow social mores and cultural taboos. Tanzanian communities stigmatize young girls who become pregnant before getting married. Health facility delivery is hampered by cultural and traditional customs, such as the usage of herbs during birth. Due to cultural customs and traditional beliefs, many women in Nepal give birth outside of medical facilities. (Gudeta & Regassa, 2019).

2.4 Summary of the Literature Review

As the literature demonstrates, numerous researchers have discussed birth preparedness and its components. Studies concerning birth preparedness and emergency planning among pregnant women have been conducted. Nonetheless, little research has been done on the state of pregnant women's readiness, particularly in eastern Uganda and the Bugiri district. Although not much has been done to increase preparedness, you find that even with government initiatives around ANC, mothers still go to the hospital without the necessities for delivery. In Uganda, the Ministry of Health has taken steps to improve BPEP by improving the services offered to the mothers during ANC. This is the case at Bugiri Hospital.

CHAPTER THREE:

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology and procedures employed in the study. It includes descriptions of the research design, study area, sources of information, population and sampling techniques, variable definition, measurement of variables, data collection procedures and protocols, data collection instruments and equipment, quality control measures, data processing and analysis strategy, ethical considerations, anticipated methodological constraints, work plan/timeline, and budget.

3.2 Research Design

This was an analytical cross-sectional design, employing quantitative data collection and analysis

3.3 Area of Study

The study was conducted in Bugiri Hospital. Bugiri Hospital, established in 1967, is a district hospital with a capacity of 100 beds. It is located along the Iganga–Tororo Highway, providing healthcare services to a population of 325,000 residents in Bugiri district, Namayingo district, and the neighboring areas of Busia, Mayuge, and Iganga districts (MOH, 2016). The hospital offers both inpatient and outpatient services, including specialized clinics.

3.5 Population

3.5.1 Study Population

The study population was all women aged 18-49 (reproductive age) attending an antenatal clinic in Bugiri Hospital. They were women who lived in the Bugiri district.

3.5.2 Target population

Mothers aged 18-49 who attend the antenatal clinic of Bugiri Hospital.

3.6 Sample Size Calculation

The sample size was determined using the Kish-Leslie formula of 1965 for calculating sample sizes in descriptive studies.

N denotes the number of respondents needed for the study

Z is the value corresponding to a 95% confidence interval or risk level (1.96)

P = percentage of mothers who come to the facility unprepared for the birth (25%) i.e. The pregnant woman has not taken the necessary steps or made the required arrangements to ensure a safe and well-managed childbirth experience. These aspects included Lack of Antenatal Care, Absence of a Birth Plan, Limited Knowledge About Childbirth, Inadequate Preparation for Transportation, Failure to Recognize Warning Signs, Limited Access to Resources, Absence of Emotional Support, and Failure to Plan for Postnatal Care (Bugiri hospital quarterly report, April 2017). q =1-0.25

e is a 5% margin of error that the study accommodates

N= 288 study participants.

3.7 Selection criteria

3.7.1 Inclusion criteria

Women aged 18 to 49 years, resident in Bugiri district for the last year, attended ANC in Bugiri Hospital at least twice and of gestational age, for example, birth planning with a 16-week pregnancy.

3.7.2 Exclusion criteria

Women attending ANC but were sick and needed urgent care, deaf and blind, and under age 15–17-year-old girls.

3.8 Sampling technique

The study employed a random sampling method, every pregnant mother who reported to the antenatal clinic during regular ANC clinic days was eligible to be sampled. On average ANC receives 70 to 80 mothers and monthly is 700-800 mothers (integrated antenatal register) so 30 pieces of paper with a “YES” written on plus 30 pieces of paper with a “NO” written on, were

mixed in one container by the researcher and used every clinic day to pick the women to be recruited into the study. Every clinic day, women registering at the ANC were approached and asked to pick a piece of paper from the box. Women who picked a "YES" paper were explained about the study and further engaged in screening and recruitment into the study and those who further declined were excluded. This was done for 3 weeks of 5 working days. The sampling procedure is summarized in the table below.

Table 0.1: Sampling Procedure

Day	**ANC Attendance**	**Picked Yes**	**Picked Yes and Declined**	**Total Recruited**
1	25	16	4	12
2	42	26	5	21
3	64	30	11	19
4	59	30	6	24
5	85	30	0	30
6	31	20	7	13
7	65	30	6	24
8	78	30	10	20
9	50	28	8	20
10	92	30	11	19
11	32	15	0	15
12	36	10	0	10
13	48	25	5	20
14	67	30	11	19
15	89	30	8	22
TOTAL	**591**	**380**	**92**	**288**

3.9 Procedure of Data Collection

Ethical approval was sought from UCU, followed by an introductory letter from the Department of Public Health. These were presented to the medical pretendant who handed me over to the senior assistant nursing officer of Bugiri Hospital. On obtaining permission from the senior nursing officer, the mothers attending the antenatal clinic were engaged. On obtaining consent from potential pregnant women, the questionnaire was administered to each woman in a secure room at ANC ensuring privacy.

3.9.1 Data Collection

The study employed structured questionnaires as the research instrument with close-ended questions in the English language and administered in English. For participants who did not understand and speak English, the questionnaires were administered in Lusoga. The questionnaires were pre-tested in Naluwerere Health Centre III in Bugiri for two days. Areas and questions that lacked clarity were adjusted and the questionnaire was finalized. Questions were formulated to gather information on the factors influencing birth preparedness among pregnant women attending antenatal care. The questionnaire consisted of four parts: Socio-demographic characteristics, Obstetrics and gynecology factors, other factors, and the level of childbirth preparedness and emergency planning.

The researcher recruited and trained 2 midwives as research assistants. The training included orientation in research; ethical handling of research participants and work in the ANC clinic; administering questionnaires and submitting them to the researcher. The questionnaires were administered by the researcher and research assistants to pregnant women who fulfilled the inclusion criteria and consented to participate in the study.

1.8.2 Data Management

The questionnaires were checked by the researcher after each clinic day to ensure adherence to inclusion criteria, for completeness, and to note the number of participants recruited. The questionnaires were stored by the researcher under key and lock.

3.10 Data Analysis

Data was cleaned in MS Excel and Analysis was done using SPSS version 27 under the guidance of the researcher. Analysis was done at three levels; Univariate, Bivariate, and Multivariate levels.

Univariate analysis was done using summary statistics like mean, frequencies, and percentages. Bivariate analysis was done using the Chi-square statistic to establish the association that predetermined factors have with the level of birth preparedness among prenatal women. A p-value less than 0.05 indicated a significant association. The significant factors were then included at the multivariate level using a binary logistic regression to find out the extent and magnitude of their effect on the dependent variable.

3.10.1 Criteria for Measuring Birth Planning and Emergency Preparedness

A woman was deemed prepared for childbirth and potential complications if she implemented or adhered to a minimum of six elements of birth preparedness and emergency planning.

A woman was regarded as knowledgeable about birth preparedness and emergency planning if she articulated at least six aspects related to birth preparedness and complications readiness.

A woman was regarded as knowledgeable about obstetric danger signs during pregnancy, labor, and delivery and in the postpartum period if she articulated at least 3 of the predetermined signs in the questionnaire.

A male partner was considered involved in childbirth preparedness and emergency planning if the woman said "YES" to at least 7 aspects of male involvement in the questionnaire.

1.11 Quality/ Error Control

3.11.1 Validity

Validity pertains to the extent to which a tool accurately measures its intended constructs, allowing for appropriate interpretation of results. To ensure content validity, data collection instruments were developed with a sufficient number of items, ensuring that each item or question was relevant to the study objectives and covered a comprehensive range of variables. Additionally, the researcher consulted with the supervisor for guidance and conducted pre-testing of the instruments. During interviews, clear instructions were provided in simple language to ensure participant understanding. Questions were carefully crafted to promote consistency in participant responses. Participants were informed and educated about the study to enhance the reliability of the findings.

3.11.2 Reliability

The reliability of a research instrument refers to its consistency in producing similar results across repeated trials (Carmines & Zeller, 1979). While some degree of unreliability may always exist, a quality instrument should generally produce consistent results across different time points. The consistency observed in repeated measurements is commonly known as reliability (Carmines & Zeller, 1979). The Reliability of the two scales of the level and factors that affect birth preparedness and emergency planning among prenatal women was determined by

Cronbach Alpha coefficients as generated by SPSS. I made sure that the alpha is 70 as suggested by Nunnally (1978).

3.12 Ethical issues

The Uganda Christian The research proposal was initially approved by the university. Subsequently, permission to conduct the research was obtained from the Research Ethical Committee (REC) of UCU, and participants associated with Bugiri Hospital were provided with a written consent form prior to the interviews. Emphasis was placed on voluntary participation, and participants were encouraged to ask questions. Confidentiality was assured, and informed consent was obtained from all participants. To maintain anonymity, no names appeared on the questionnaires; only codes were used. Participants were given the right to withdraw from the study or retract any statement before analysis. As no clinical samples were required, no physical harm was anticipated. All information gathered was strictly for academic purposes and would not be used for any other purpose without the respondents' consent. Participants were informed of their freedom to withdraw from the study at any time. Consent from participants was obtained by the researcher or research assistants in a secure room ensuring privacy and no inducements were offered to them

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents the study findings, first frequency tables, and results of univariate, bivariate, and multivariate analysis in the form of tables. This chapter is condensed into three sections comprising the response rate, demographic characteristics, and results of multivariate analysis as presented below:

4.2 Response Rate

Out of the 300 recruited women who met the inclusion criteria, 288 answered the structured questions in the questionnaire as guided by the researcher and research assistants.

4.3 Univariate Analysis

This section contains the analysis of categorical variables in the form of frequencies and percentages while continuous variables were summarized using summary statistics as presented in table 4.2.1 and 4.3.1 below.

4.3.1 Socio-demographic Characteristics of the Respondents

Table 0.1: Categorical Socio-demographic Characteristics of Respondents

Characteristic	Category	Frequency	Percent (%)
Residence/Location	Urban	204	70.8
	Rural	84	29.2
Religion	Catholic	50	17.4
	Muslim	130	45.1
	Protestant	47	16.3
	Born Again	61	21.2
Age Group	18 to 25 years	155	53.8
	26 to 30 years	52	18.1
	31 to 40 years	77	26.7
	Above 40 years	4	1.4
Marital Status	Single	45	15.6
	Married	240	83.3

	Divorced	3	1.0
Highest Education Level	None	9	3.1
	Primary	154	53.5
	Secondary	105	36.5
	Tertiary	20	6.9
Partner's Education Level	None	4	1.4
	Primary	127	44.1
	Secondary	117	40.6
	Tertiary	40	13.9
Occupation	Housewife	65	22.6
	Merchant	17	5.9
	Employee	25	8.7
	Daily laborer	86	29.9
	Farming	60	20.8
	Jobless	35	12.2
Partner's Occupation	Farming	42	14.6
	Governmental Employee	35	12.2
	Non-Governmental Employee	40	13.9
	Merchant	39	13.5
	Daily Laborer	130	45.1
	Jobless	2	0.7

From Table 4.2.1 above, the majority (70.8%) of prenatal women who sought care at Bugiri Hospital resided in urban areas and the rest were rural residents. The highest number (53.8%) of the women were aged between 18 to 25 years, 18.1% were aged between 26 to 30 years, 26.7% of the respondents were aged 31 to 40 years and only 1.4% were above 40 years of age. As regards religion, most (45.1%) of the respondents were Muslims, 21.2% were Born-again Christians, 17.4% were Catholics and the rest (16.3%) were Protestants. The largest proportion (83.3%) of the women were married, 15.6% were single and only 1% were divorced. As regards education levels, the majority (53.5%) of the women had attained up to primary level, 36.5% had secondary level education, 6.9% had attained tertiary education while only 3.1% never had any education. The results showed that the majority of women have education levels at the primary and secondary levels and targeted health education programs can be designed to address the specific educational levels of the population, focusing on enhancing maternal health literacy. The education levels of partners were also similarly diverse because most (44.1%) of them had attained primary education. As regards occupation, daily laborers and housewives constitute a

significant portion of prenatal women (22.6% and 29.9% respectively). Daily laborers and farmers are prominent among the partners of prenatal women (14.6% and 45.1% respectively).

Table 0.2: Numerical Socio-demographic Characteristics of Respondents

Characteristic	**Summary Statistics**			
	Range	**Minimum**	**Maximum**	**Mean**
Currently age in years	24	18	42	25.99
Distance traveled to the nearby health facility	19.8	.2	20.0	3.039
Family monthly income	4995000	5000	5000000	259184.03
Family size	9	1	10	4.27

From Table 4.2.2 above, the age of the surveyed prenatal women ranged from 18 to 42 years since the youngest participant was 18 years while the oldest participant was 42 years old with an average of approximately 26 years. The reported distance traveled to the nearby health facility ranged from 0.2 to 20km with the average reported distance is approximately 3.04km. A significant proportion of individuals traveled relatively short distances to the nearby health facility. The lowest reported monthly income was 5,000 Uganda Shillings while the highest reported monthly income is 5,000,000 Shillings with the average reported monthly income as approximately 259,184.03 Ugandan Shillings. As regards family size, the average family size was approximately 4 members.

4.3.2 Obstetrics and Gynecology Characteristics

Table 0.3: Obstetrics and Gynecology Characteristics

Characteristic	**Category**	**Frequency**	**Percent**
Gravida (Number of pregnancies)	1	88	30.6
	2	65	22.6
	3	52	18.1
	4	35	12.2
	5	22	7.6
	6	10	3.5
	7	13	4.5
	8	3	1.0
Parity	1	251	87.2
	2	28	9.7
	3	4	1.4
	4	2	.7
	5	3	1.0

Miscarriage or Abortion History	No	205	71.2
	Yes	83	28.8
Obstetric complication History	No	218	75.7
	Yes	70	24.3
Received Advice on birth preparation	No	83	28.8
	Yes	205	71.2

From Table 4.3.2.1 above, the highest number of women were in their first pregnancy (30.6%), followed by those in their second (22.6%) and third pregnancies (18.1%). The frequency decreases as the number of pregnancies increases. The majority of the respondents had a parity of 1 (87.2%), indicating that they had one child who was born alive, and the number decreases as parity increases, with only a small percentage having a parity greater than 1. As regards the history of abortion or miscarriage, most respondents (71.2%) reported no history of miscarriage or abortion, while 28.8% reported having such a history. Understanding the history of miscarriage or abortion is crucial for providing appropriate emotional and medical support. The majority of respondents (75.7%) reported no history of obstetric complications, while 24.3% reported having a history of such complications. Lastly, the biggest percentage of respondents (71.2%) had received advice on birth preparation, while 28.8% had not received such advice. While a substantial number have received advice, there is a portion of the population that has not.

4.3.3 Intervening Factors

Table 0.4: Intervening Factors

Factor	**Category**	**Frequency**	**Percent**
Components of the Childbirth Preparedness	Not Knowledgeable	273	94.8
	Knowledgeable	15	5.2
Danger Signs During Pregnancy	Not Knowledgeable	242	84.0
	Knowledgeable	45	15.6
Danger in Labor and Delivery	Not Knowledgeable	276	95.8
	Knowledgeable	12	4.2
Danger signs in the postpartum period	Not Knowledgeable	277	96.2
	Knowledgeable	11	3.8
Male Involvement in Childbirth Preparation	Low involvement	186	64.6
	Moderate Involvement	43	14.9
	High Involvement	59	20.5

From Table 4.3.3.1 above, the majority of respondents (94.8%) were not knowledgeable about the components of the childbirth preparation plan, while only a small percentage (5.2%) demonstrated knowledge. This implies that only 5.2% could articulate at least six aspects related to birth preparedness and complications readiness. There is a significant gap in knowledge regarding the components of the childbirth preparedness plan. A substantial proportion of respondents (84.0%) were not knowledgeable about danger signs during pregnancy. 15.6% exhibited knowledge by articulating at least 3 of the predetermined signs. The majority of respondents (95.8%) were not knowledgeable about the dangers of labor and delivery, with only 4.2% demonstrating knowledge of at least 3 predetermined signs. Furthermore, a significant percentage of respondents (96.2%) lacked knowledge regarding danger signs during the postpartum period, while only 3.8% knew by identifying at least 3 of the predetermined signs. As regards male involvement in childbirth preparation, a notable proportion of the studied prenatal women (64.6%) reported low partner involvement in childbirth preparation, while 14.9% indicated moderate involvement and 20.5% reported high involvement. The varying levels of male involvement reflected opportunities for promoting and encouraging greater participation.

4.3.4 Level of Childbirth Preparedness and Emergency planning among Prenatal women in Bugiri Hospital

During the study, 12 indicators of Childbirth preparedness and emergency planning were predetermined, and a woman was deemed prepared for childbirth and potential complications if she implemented or adhered to a minimum of six elements of birth preparedness and emergency planning (See Appendix 2)

Table 4.3.5 below shows the 6 most frequently answered indicators about childbirth preparedness.

Table 0.5: Indicators for Childbirth Preparedness among women

Indicator	**Response**	**Frequency**	**Percent**
Identified appropriate health facility with skilled provider for delivery	Yes	270	93.8
	No	18	6.2
Saved money to be used during childbirth	Yes	194	67.4
	No	94	32.6
Prepared essential items for clean and save delivery	Yes	211	73.3
	No	77	26.7
Know the location of the nearest health facility	Yes	277	96.2

where emergency service is provided	No	11	3.8
Have planned for transport means	Yes	75	26.0
	No	213	74.0
Have people ready to support you	Yes	160	55.6
	No	128	44.4

A significant majority (94%) of women have identified an appropriate health facility with a skilled provider for delivery, and an even higher percentage (96%) know the location of the nearest health facility that provides emergency services. This suggests a high level of awareness about the importance of accessing skilled care during childbirth. However, while 67% of women have saved money for childbirth expenses and 73% have prepared essential items for a clean and safe delivery, there remains a notable minority who have not, which could lead to financial and logistical challenges during labor. Furthermore, a substantial 74% of women have not arranged for transportation to the health facility, indicating a critical gap in birth preparedness that could result in delays during emergencies. Additionally, while 56% have people ready to support them, 44% do not, highlighting potential issues in obtaining immediate help when needed. These findings imply that while there is good awareness and preparation in some areas, significant gaps remain, particularly in transport planning and support systems, which could adversely affect timely access to skilled care and emergency services during childbirth. Addressing these gaps through targeted interventions could improve maternal health outcomes in the region.

Table 0.6: Level of Childbirth Preparedness and Emergency planning among Prenatal women in Bugiri Hospital

Level of Preparedness	**Frequency**	**Percent**
Unprepared	98	34.0
Prepared	190	66.0

The majority of prenatal women (66.0%) in Bugiri Hospital were classified as "Prepared" for childbirth and emergency planning whereas 34.0% of prenatal women were categorized as "Unprepared."

4.4 Bivariate Analysis

This section contains cross-tabulations of the different factors to establish their association with the level of childbirth preparedness among prenatal women in Bugiri Hospital.

4.4.1 Relationship between socio-demographic Factors and Childbirth Preparedness Levels among Prenatal Women in Bugiri Hospital

Table 0.1: Chi-Square Cross tabulation for Socio-demographic Factors and Childbirth Preparedness Levels among Prenatal Women in Bugiri Hospital

Socio-Demographic Factors		**Level of Preparedness**		**Chi-square**	**p-value**
		Unprepared	Prepared		
Age group	18 to 25	55.5%	44.5%	25.296	0.001
	26 to 30	30.8%	69.2%		
	31 to 40	16.9%	83.1%		
	Above 40	_-	100.0%		
	Rural	39.3%	60.7%		
Residence/Location	Urban	31.9%	68.1%	1.460	0.625
	Catholic	28.0%	72.0%		
Religion	Protestant	21.3%	78.7%	7.522	0.057
	Muslim	41.5%	58.5%		
	Born Again	32.8%	67.2%		
	Single	66.7%	33.3%		
Marital Status	Married	27.1%	72.9%	9.821	0.022
	Divorced	100.0%	_		
	None	77.8%	22.2%		
Education Level	Primary	44.8%	55.2%	11.698	0.041
	Secondary	22.9%	77.1%		
	Tertiary	15.0%	85.0%		
	Housewife	36.9%	63.1%		
Occupation	Merchant	47.1%	52.9%	2.111	0.867
	Employee	12.0%	88.0%		
	Daily Laborer	23.3%	76.7%		
	Farming	31.7%	68.3%		
	Jobless	68.6%	31.4%		
	None	50.0%	50.0%		
Partner's education Level	Primary	40.2%	59.8%	7.573	0.045
	Secondary	32.5%	67.5%		
	Tertiary	17.5%	82.5%		
	Farming	26.2%	73.8%		
Partner's Occupation	Governmental Employee	25.7%	74.3%	9.683	0.085
	Non-Governmental Employee	25.0%	75.0%		
	Merchant	35.9%	64.1%		
	Daily Laborer	40.0%	60.0%		

	Jobless	100.0%	_		
	Low income	43.8%	56.2%		
Family Monthly income	Medium income	21.9%	78.1%	17.997	0.001
	High Income	13.0%	87.0%		

From Table 4.4.1.1 above, the majority (55.5%) of the prenatal women under study aged between 18 to 25 years were deemed unprepared for childbirth while the majority (83.1%) of those aged between 31 to 40 years were prepared for childbirth. All the prenatal women aged above 40 years were prepared for childbirth. There was a significant association between age group and childbirth preparedness (Chi-square = 25.296, p = 0.001). Preparedness varied significantly across different age groups, with older age groups showing higher preparedness percentages. As regards marital status, the majority (66.7%) of the single women were unprepared for childbirth, unlike the married women where the majority (72.9%) were prepared for childbirth. Marital status was significantly associated with childbirth preparedness (Chi-square = 9.821, p = 0.022) as single women exhibited a higher percentage of unpreparedness compared to married ones. The majority (77.8%) of the women who had no education were unprepared whereas the largest number (85%) of those who attained tertiary education were prepared for childbirth. The level of preparedness increased with higher education levels. Education level was significantly associated with childbirth preparedness (Chi-square = 11.698, p = 0.041). This finding was similar for the respective partners of the respondents where the majority (82.5%) of male partners having tertiary education were prepared for childbirth. There was a significant association between the partner's education level and childbirth preparedness (Chi-square = 7.573, p = 0.045). Higher education levels of partners were associated with preparedness for childbirth. As regards household monthly income, the majority (56.2%) of the women from low-income families were unprepared for childbirth whereas the highest number (87%) of women from high-income families were prepared for childbirth. Family monthly income was significantly associated with childbirth preparedness (Chi-square = 17.997, p = 0.001).

4.4.2 Relationship between Obstetrics and Gynecology factors and Childbirth Preparedness Levels among Prenatal women in Bugiri Hospital

Table 0.2: Chi-square Cross tabulation for Obstetrics and Gynecology factors with Childbirth Preparedness Levels among Prenatal Women in Bugiri Hospital

Intervening Factors		**Level of Preparedness**		**Chi-square**	**p-value**
		Unprepared	Prepared		
Gravida (Number of pregnancies)	1	56.8%	43.2%	21.128	0.002
	2	32.3%	67.7%		
	3	28.8%	71.2%		

	4	22.9%	77.1%		
	5	-	100.0%		
	6	-	100.0%		
	7	30.8%	69.2%		
	8		100.0%		
Parity	0	38.2%	61.8%	15.648	0.004
	1	7.1%	92.9%		
	2	-	100.0%		
	4	-	100.0%		
	5	-	100.0%		
Miscarriage or Abortion History	No	36.6%	63.4%	2.073	0.150
	Yes	27.7%	72.3%		
Received Advice on birth preparation	No	47.0%	53.0%	8.725	0.003
	Yes	28.8%	71.2%		
Obstetric Complication History	No	39.0%	61.0%	9.841	0.002
	Yes	18.6%	81.4%		

Table 4.4.2.1 above presents a chi-square analysis assessing the association between intervening factors and the level of childbirth preparedness among prenatal women in Bugiri Hospital. The majority (56.8%) of the women who had experienced only one pregnancy were unprepared for childbirth whereas the majority of those with more than one pregnancy were prepared. There was a significant association between the number of pregnancies (gravida) and childbirth preparedness (Chi-square = 21.128, p = 0.002). Higher levels of preparedness were observed with lower gravida, suggesting that women with fewer previous pregnancies are more likely to be prepared for childbirth. As regards parity, all (100%) of the prenatal women with parity more than one were prepared for childbirth. There was a significant association between parity and childbirth preparedness (Chi-square = 15.648, p = 0.004). The majority (63.4%) of the women who had no miscarriage or abortion history were prepared for childbirth. Additionally, this percentage increases to 72.3% for women with a miscarriage or abortion history. There was no significant association between miscarriage or abortion history and childbirth preparedness (Chi-square = 2.073, p = 0.150). While not statistically significant, there is a trend suggesting that women with no history of miscarriage or abortion are more prepared. This could imply that women without a history of pregnancy loss may feel more confident and prepared for childbirth. As regards receiving advice on birth preparation, the highest number (81.4%) of those who had received expert advice on childbirth were prepared. The level of preparedness was increasing as women were receiving more expert advice on childbirth. There was a significant association between receiving advice on birth preparation and childbirth preparedness (Chi-square = 8.725, p = 0.003). The significant association indicates the importance of providing advice on birth preparation. Women who receive advice are more likely to be prepared for childbirth. Women without any history of obstetric complications were mostly (61%) prepared for childbirth. However, the ones with a history of obstetric complications were more prepared for childbirth

(81.4%). There was a significant association between obstetric complication history and childbirth preparedness (Chi-square = 9.841, p = 0.002).

4.4.3 Relationship between Intervening Factors and Childbirth Preparedness Levels among Prenatal Women in Bugiri Hospital

Table 0.3: Chi-square Crosstabulation of Intervening Factors with Childbirth Preparedness levels among Prenatal women in Bugiri Hospital

Intervening Factors		**Level of Preparedness**		**Chi-square**	**p-value**
		Unprepared	Prepared		
Components of childbirth plan	Not Knowledgeable	35.9%	64.1%	8.162	0.004
	Knowledgeable	_	100.0%		
Danger signs during pregnancy	Not Knowledgeable	34.7%	65.3%	0.575	0.448
	Knowledgeable	28.9%	71.1%		
Knowledge of danger in labor and delivery	Not Knowledgeable	35.5%	64.5%	6.459	0.011
	Knowledgeable	_	100.0%		
Knowledge of danger signs in the postpartum period	Not Knowledgeable	35.4%	64.6%	5.899	0.015
	Knowledgeable	_	100.0%		
Male Partner Involvement	Low involvement	45.2%	54.8%	29.646	0.000
	Moderate Involvement	9.3%	90.7%		
	High Involvement	16.9%	83.1%		

From Table 4.4.3.1 above, all (100%) of the prenatal women who were knowledgeable about the components of a childbirth plan were prepared for childbirth. There was a significant association between knowledge of the components of the childbirth plan and childbirth preparedness (Chi-square = 8.162, p = 0.004): Women who were knowledgeable about the components of the childbirth plan were significantly more prepared for childbirth. As regards the danger signs during pregnancy, the majority (71.1%) of the women who could identify at least 3 signs of danger signs were prepared for childbirth. The level of preparedness increased with more knowledge about the danger signs during pregnancy but there was no significant association between knowledge of danger signs during pregnancy and childbirth preparedness (Chi-square = 0.575, p = 0.448). All (100%) of the women who could identify at least 3 danger signs during labor and delivery were prepared for childbirth. There was a significant association between knowledge of danger in labor and delivery and childbirth preparedness (Chi-square = 6.459, p = 0.011). As regards the postpartum period, all (100%) of the women who could identify at least 3 danger signs (knowledgeable) in the postpartum period were prepared for childbirth. There was a significant association between knowledge of danger signs in the postpartum period and childbirth preparedness (Chi-square = 5.899, p = 0.015). Similar to labor and delivery,

knowledge about danger signs in the postpartum period is associated with higher preparedness. As regards male partner involvement in childbirth preparation, the highest number (83.1%) of the women whose partners were highly involved in supporting them with childbirth preparedness were prepared for childbirth. A relatively lower percentage (54.8%) of those whose male partners were lowly involved were unprepared for childbirth. There was a highly significant association between male partner involvement and childbirth preparedness (Chi-square = 29.646, p = 0.000). Higher involvement correlates with higher preparedness which implies engaging and educating male partners can positively impact women's preparedness for childbirth.

4.5 Multivariate Analysis

This section presents a binary logistic regression for the significantly associated factors with the level of childbirth preparedness to find out their magnitude of significance.

Table 0.1: Binary Logistic Regression

$R^2 = 0.2098$ **P=0.0000**				
Childbirth Preparedness Level *Reference category (unprepared)*	**Odds Ratio**	**p-value**	**[95% Confidence Interval]**	
Age group *Reference category (18 to 25 years)*	1.0167	0.947	0.6253	1.6534
Marital status *Reference category (Single)*	1.3904	0.398	0.6474	2.9862
Education Level *Reference category (None)*	2.5974	0.004	1.3558	4.9671
Partner's Education Level *Reference category (None)*	0.9803	0.946	0.2342	1.0654
Family Monthly Income *Reference category (Low income)*	1.4536	0.263	0.9871	1.9292
Gravida (Number of Pregnancies) *Reference category (1)*	1.3542	0.064	2.8263	3.9002
Parity *Reference category (1)*	4.7713	0.039	1.0833	21.0135

Advice on birth preparation *Reference category (No)*	0.7833	0.506	0.3815	1.6079
Obstetric complication History *Reference category (No)*	1.3390	0.476	0.6001	2.9881
Male Partner Involvement *Reference category (Low involvement)*	1.9044	0.004	1.2294	2.9498

From Table 4.5.1 above, women aged between 18 to 25 years of age had higher odds (1.0167) of being unprepared for childbirth as compared to other age groups. The odds of being prepared for childbirth did not significantly change with age and the p-value (0.947) indicates that age is not a significant predictor of childbirth. The single prenatal women had higher odds (1.3904) of being unprepared for childbirth as compared to the married and divorced. However, the result is not statistically significant (p = 0.398). As regards education level, uneducated women had higher odds (2.5974) of being unprepared for childbirth than the educated ones at all other levels and there is a 95% confidence level that these odds lie between 1.3558 and 4.9671. This effect was statistically significant with a p-value of 0.004. On the contrary, women whose partners never attained any education had lower odds (0.9803) of being unprepared for childbirth as compared to those with educated partners. This effect was not statistically significant at a 95% confidence level (p-value = 0.946). Prenatal women from low-income families had higher odds (1.4536) of being unprepared for childbirth than those from higher-income families. The effect of income on childbirth preparedness levels was not statistically significant (p=0.263). Women who had experienced only one pregnancy (gravida 1) had higher odds (1.3542) of being unprepared for childbirth as compared to those with gravida 2 and above. However, this effect was not significant on childbirth preparedness (p=0.064). As regards the parity among the studied prenatal women, those who had only one parity (live birth) were more likely (odds = 4.7713) to be unprepared for childbirth as compared to those with a higher parity number. The parity of a woman had a statistically significant effect on their level of childbirth preparedness (p = 0.039). Women with an obstetric complication history had higher chances (1.3390) of being unprepared for childbirth as compared to those who never had an obstetric complication history. There was no significant effect of obstetric complication history on a woman's level of preparedness for childbirth (p = 0.476). As regards male partner involvement, low involvement was associated with a higher chance (1.9044) of being unprepared for birth among prenatal women. Higher levels of male involvement significantly increase the odds of being prepared for childbirth (p = 0.004). The Pseudo R-squared was 0.2098, which means that the logistic regression model explains about 20.98% of the variance in the childbirth preparedness variable. The model's effectiveness was statistically significant (p = 0.0000). The logistic regression model for the significant factors on childbirth preparedness is stated below.

$$\log\left(\frac{p}{1-p}\right) = 4.450 + 2.5974Education\ level + 4.7713Parity + 1.904Male\ partner\ involvement$$

Where p is the probability of the dependent variable is 1 (prepared for childbirth), $\frac{p}{1-p}$ is the odds of the event occurring and the function log (·) is the natural logarithm

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a comprehensive exploration of the study's findings and their potential significance in the context of maternal and neonatal health in Bugiri Hospital. It is therefore expected that the insights shared in this chapter will serve as a valuable resource for healthcare practitioners, policymakers, and researchers seeking to improve birth preparedness and emergency planning among prenatal women, ultimately leading to enhanced maternal and neonatal health outcomes.

1.2 Discussion of Findings

5.2.1 The Level of Birth Preparedness among Prenatal Women in Bugiri

The majority of prenatal women in Bugiri Hospital being prepared for childbirth and emergency planning is a positive indicator, suggesting that a significant portion of the population had taken steps to prepare for childbirth and potential complications and reflects a proactive approach among the population and well on the hospital's efforts in promoting preparedness. To a high level, this was similar to a cross-sectional study by Ohenhen et al. (2023) among women receiving antenatal care in Benin City, Nigeria which found that about 77% of the respondents were well-prepared for birth. To a lower level, this finding was also similar to a descriptive study by Das et al. (2019) that measured birth preparedness among antenatal primigravida mothers in a selected hospital in Guwahati, Assam found that 63.3% had adequate practice of birth preparedness. These similarities suggest that there are commonalities in factors influencing preparedness in different settings, especially among developing economies/countries.

5.2.2 The effect of socio-demographic factors

In this study, higher education was found to be significantly associated with birth preparedness (table 4.5.1, p=0.004) and this is consistent with the study by Hailu in Southern Ethiopia and a systematic review and meta-analysis by Ketema et al. (2020) that evaluated the effects of maternal education among Ethiopian pregnant women. It is believed that several mechanisms have been suggested to explain how higher education impacts health behavior and the health of pregnant women. Some of these are; women with a higher level of education tend to have better access to information and resources. Therefore, they are more likely to be aware of the importance of birth preparedness and emergency planning. Additionally, Education often empowers women to make informed decisions about their health and the health of their baby. They may be more likely to understand the potential risks and complications associated with pregnancy and childbirth, which can motivate them to engage in birth preparedness activities as

suggested by Nabulo et al in a study of referred women in Mbarara Regional Referral Hospital. Education can also lead to better employment opportunities and increased income, which can provide women with the financial means to afford essential components of birth preparedness, such as transportation to the hospital, purchasing necessary supplies, and paying for healthcare services. Therefore, educated women are more likely to have regular antenatal care visits and access to healthcare facilities.

In this study, it was found that older women's level of preparedness was 83.1% similar to a study by Hailu et al., (2011) in Malaysia where 72% of prepared women were prepared for birth. Older pregnant women may have greater access to resources and more life experience and may be better equipped to engage in birth preparedness activities and make informed decisions about their childbirth plans. Secondly, age is also linked to educational attainment. Younger women may still be in school or have completed fewer years of education, which can impact their knowledge about maternal and child health and their understanding of the importance of birth preparedness. Thirdly, the age at which a woman becomes pregnant can influence the level of social support she receives. Older women may have stronger social networks and more experience in seeking support, which can aid in birth preparedness. This is consistent with the study by Theuring et al., (2009).

5.2.3 Obstetrics and Gynecology Factors

It was found that all (100%) of women with a parity of 3 and above were prepared for childbirth and this relationship was found statistically significant (table 4.5.1, p=0.039). This percentage increases as parity increases. This finding on a high level is similar to a descriptive study by Oshomoh et al. (2021) where 82% of the respondents with high parity were prepared for birth. Women with higher parity may have gained more experience and knowledge about childbirth over time and with each birth, women often become more familiar with the childbirth process, including what to expect and how to prepare. This familiarity may lead to a proactive approach to childbirth preparedness. Furthermore, cultural, or social factors may also play a role. In some communities, there might be a tradition of increased attention to childbirth preparedness with each subsequent pregnancy. Social networks and shared experiences among women in the community could influence preparedness behaviors. Therefore, acknowledging this positive trend by Bugiri Hospital is crucial in understanding the population's behaviors and needs.

5.3.4 Intervening factors

The significant effect male involvement had on the level of preparedness for both among women was found in the study (table 4.5.1, p=0.004) with women having highly supportive partners well prepared for childbirth (83.1%). To a smaller extent, this is similar to a review by Lucy et al about institutional factors influencing male partner involvement in antenatal care in Kenya where 75% of the males who were involved had well-prepared pregnant partners. The idea of shared responsibility between partners during pregnancy and childbirth implies that when both partners actively engage in preparing for childbirth, it can lead to a more comprehensive and collaborative approach to addressing the needs of the expectant mother. When fathers or male partners actively participate in the birth preparation process, it can have several positive effects. For example, male involvement can provide emotional and psychological support to pregnant women. This support can help reduce stress and anxiety, leading to a more positive birth experience as (Theuring et al., 2009) concluded. Secondly, male partners can contribute to the financial aspect of birth preparedness, ensuring that the necessary resources are available for a safe and comfortable childbirth. They can also assist with practical preparations, such as arranging transportation to the healthcare facility. It is also important to note that couples who engage in birth preparation together tend to have better communication about their expectations, preferences, and any concerns they may have. This improved communication can lead to a more coordinated and informed approach to childbirth.

In some societies, male involvement can help overcome cultural or societal barriers that might limit women's autonomy in decision-making about childbirth. When men are supportive, women may feel more empowered to make choices aligned with their preferences as recognized by Exner et al., (2009). This is because women may face societal pressures or gender norms that limit their autonomy in decision-making about pregnancy and childbirth. Male partners who challenge and resist these norms can empower women to assert their preferences without fear of judgment or backlash.

5.3 Conclusions

Bugiri Hospital's maternity care services appear to be effective in providing education, support, and resources to pregnant women, resulting in a high level of preparedness for childbirth. Adequate and quality antenatal care services may be in place, ensuring that expectant mothers receive the necessary information, guidance, and support to prepare for childbirth.

High levels of education among prenatal women have a strong effect on their likelihood of being prepared for birth. Education plays a crucial role in increasing awareness about the importance of childbirth preparedness.

Higher parity among prenatal women has a significant effect on the level of childbirth preparedness. Experience from previous pregnancies contributes to increased knowledge and readiness and may serve as learning opportunities, allowing women to better understand the childbirth process, anticipate potential challenges, and make informed decisions for subsequent pregnancies.

The involvement of male partners in supporting prenatal women is very pertinent when preparing for childbirth. This is not only pertinent but also transformative. It contributes to a more holistic and positive childbirth experience, fostering a supportive environment for both the pregnant woman and her partner.

5.4 Recommendations

Bugiri Hospital should share the successful practices and experiences with other health centers in the region (III and IV) or other healthcare organizations working in maternal and child health. This can contribute to collaborative learning and improvement in childbirth preparedness strategies across different settings. For unprepared women, the hospital should provide individualized counseling sessions for each woman to understand her specific circumstances, concerns, and reasons for being unprepared. This can help tailor interventions to address their unique needs.

Education is a key determinant, so the government should consider integrating maternal health education into school curricula. Working towards incorporating relevant aspects of maternal health, family planning, and childbirth preparedness into school education ensures that young girls receive information that may positively influence their future decisions.

The government and other Civil Society Organizations should recognize the importance of male involvement and promote gender-inclusive programs. They should design and implement programs that actively involve and engage both men and women in maternal health initiatives to acknowledge the role of male partners as key influencers and contributors to a positive childbirth experience.

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APPENDICES

Appendix I: Questionnaire

THIS QUESTIONNAIRE IS FOR THE RESPONDENTS

This questionnaire is purely for an academic project and the information you will give shall be treated with utmost confidentiality. The study title of the project is, "**The Level and Factors that Affect Birth Preparedness and Emergency Planning among Prenatal Women in Bugiri Hospital, Bugiri District" The** study seeks to establish the level and factors associated with birth preparedness and emergency planning; of pregnant mothers and their spouses prepare for birth and emergencies and the essential strategies for safe motherhood to ensure birth preparedness and emergency planning for pregnant mothers.

You are kindly requested to respond to the questionnaire to the best of your knowledge regarding the issues or questions posed. I will be grateful if you do not leave any questions unanswered.

Part one: Maternal characteristics

Table one: Socio-demographic and economic characteristics of the respondents in Bugiri Hospital

S. No	Question	Response	Code
101	Currently age in years?	----------in year	
102	What is your place of residence?	1. Urban 2. Rural	
103	What is your religion?	1. Catholic 2. Muslim 3. Protestant 4. Born Again 5. If others specify……..	
104	What is your current marital	1. Single	

	status?	2. Married 3. Divorced 4. Widowed	
105	What is your highest attained level of education?	1. None 2. Primary 3. Secondary 4. Tertiary	
106	What is your Occupation?	1. Housewife 2. Merchant 3. Employee 4. Daily labourer 5. Farming 6. If others specify……..	
107	What is your partner's level of education?	1. None 2. Primary 3. Secondary 4. Tertiary	
108	What is your partner's Occupation?	1. Farming 2. Governmental Employee 3. Non-Governmental Employee 4. Merchant 5. Daily labourer 6. if other Specify----------	
109	How much distance do you travel to the nearby health facility?	1. In kilometres by car/motorbike…… 2. In hours by foot…….	

110	How much is your family's monthly income?	……in Ugandan Shillings	
111	What is the size of your family?	----------members (both children and adults)	

3. **Section 2: Obstetrics and Gynaecology factors influencing birth preparedness and emergency planning plan.**

201	Gravida (Number of pregnancies)	……...in number	
202	Parity (stillbirths)	……...in number	
203	Have you ever experienced miscarriage/abortion?	1. yes 2. no	
204	Are you advised to prepare for birth and its complications during your ANC follow-up time?	1. yes 2. no	
205	Have you experienced any obstetric complications?	1. Yes 2. No	

4. **Section 3: - Knowledge of respondents about birth preparedness**

301	What do you know about components of preparation for birth and its emergency planning?	1. Identify an appropriate health facility with a skilled provider for delivery. 2. Choose a skilled provider. 3. Make a plan for transportation means and a person to accompany to identify health facility	

	(possible to select more than one answer)	at the start of labor 4. Make a plan for communication means. 5. Save money to be used during an emergency. 6. Prepare essential items for clean and safe delivery. 7. Identify support people to help 8. Be able to identify signs of obstetric emergency. 9. Know the importance of seeking care without delay when complications occur 10. Have a plan to be able to respond immediately in the event of an emergency to avoid delays 11. Know the location of the nearest health facility where emergency service is provided. 12. Arranging blood donors in case of an emergency	
302	When do you think obstetric danger signs occur? **(possible to select more than one answer)**	1. During pregnancy 2. During labor and delivery 3. During post-partum period 4. unaware	
303	What types of obstetric danger signs occur during pregnancy?	1. Vaginal bleeding 2. Swollen hands and face 3. Blurred vision 4. High fever 5. Severe lower abdominal pain 6. Fits or loss of consciousness	
304	What types of Obstetric danger signs can occur during labor and	1. Severe vaginal bleeding 2. Prolonged labour > 12 hours	

	delivery? **(possible to select more than one answer)**	3. Hand, feet, cord, or face appears first. 4. Retained placenta. 5. Fits or loss of consciousness 6. Severe headache	
305	What types of danger signs can occur during a post-partum period? **(possible to select more than one answer)**	1. Vaginal bleeding 2. Offensive Vaginal discharge 3. Severe Headache 4. Blurred vision 5. Fever 6. Fits or loss of consciousness	

5. Section 4: -Level of respondents' birth preparedness and emergency planning plan

401	Identify appropriate health facilities with skilled providers for delivery	1. Yes 2. No	
402	Choose a skilled provider	1. Yes 2. No	
403	Make a plan for transportation means and a person to accompany you to identify health facility at the start of labor	1. Yes 2. No	
404	Make a plan for communication means	1. Yes 2. No	
405	Save money to be used during an emergency	1. Yes 2. No	

406	Prepare essential items for cleaning and save delivery	1. Yes 2. No	
407	Identify support people to help	1. Yes 2. No	
408	Be able to identify signs of obstetric emergency	1. Yes 2. No	
409	Know the importance of seeking care without delay when complications occur	1. Yes 2. No	
410	Have a plan to be able to respond immediately in the event of an emergency to avoid delays	1. Yes 2. No	
411	Know the location of the nearest health facility where emergency service is provided.	1. Yes 2. No	
412	Arranging blood donors in case of an emergency	1. Yes 2. No	

6. Section 5: -Male Involvement in birth preparedness and emergency planning plan

501	Has your male partner attended any antenatal classes with you?	1. Yes 2. No	
502	Has your male partner actively participated in discussions about your birth plan?	1. Yes 2. No	
503	Has your male partner accompanied you to any antenatal care appointments?	1. Yes 2. No	

504	Has your male partner been involved in making decisions about the place of delivery?	1. Yes 2. No	
505	Has your male partner participated in any childbirth education sessions?	1. Yes 2. No	
506	Is your male partner aware of the potential complications during childbirth?	1. Yes 2. No	
507	Has your male partner made arrangements for transportation to the healthcare facility for the delivery?	1. Yes 2. No	
508	Is your male partner familiar with the contents of your birth plan?	1. Yes 2. No	
509	Has your male partner received information about supporting you emotionally during labor?	1. Yes 2. No	
510	Will your male partner be present during the childbirth process?	1. Yes 2. No	

Appendix II: Informed Consent Form

Title of the Study: "Level and Factors Associated with Birth Preparedness and Emergency Planning Among Prenatal Women in Bugiri Hospital"

Principal Investigator: Namumbya Beatrice

Introduction: You are invited to participate in a research study that aims to explore the level of birth preparedness and emergency planning among prenatal women in Bugiri Hospital, with a focus on identifying associated factors. Before deciding to participate, you need to understand the purpose of the study, the procedures involved, and the potential risks and benefits. Please take the time to read the following information carefully. Feel free to ask any questions before deciding whether or not to participate.

Study Procedures: If you agree to participate in this study, you will be asked to:

1. Participate in an interview or complete a questionnaire related to your experiences, education, and factors influencing birth preparedness.
2. Share information about your pregnancy, childbirth experiences, and any birth plans you may have.

Potential Risks: There are minimal risks associated with participating in this study. However, discussing personal experiences may bring up emotions or discomfort. If you experience any distress, support services will be provided.

Benefits: The information obtained from this study will contribute to a better understanding of factors influencing birth preparedness. The findings may inform healthcare practices and interventions to improve maternal and child health.

Confidentiality: Your privacy is of utmost importance. All information collected during this study will be kept confidential. Your name and any identifying information will be replaced with a code to ensure anonymity. Only the research team will have access to the data.

Voluntary Participation: Participation in this study is entirely voluntary. You have the right to withdraw at any time without penalty. Your decision to participate or not will not affect your current or future medical care.

Contact Information: If you have any questions or concerns about the study, please contact +256 703967423. If you have any concerns about your rights as a research participant, you may contact the Institutional Review Board at Uganda Christian University (UCU).

Consent: I have read and understood the information provided in this consent form. I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily agree to participate in the study.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

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DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: ……23rd May 2024……

Name of Candidate: ……Namumbya Beatrice……

Reg. No: ……Rs19/M07/034……

Title of Dissertation …Level and Factors Associated with Birth Preparedness and Emergency Planning of Prenatal Women in Bugiri Hospital

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	The candidate should revise typos and grammatical errors	I updated the whole work	All through the work
2	The candidate should look at the conceptual frame work again,	I redesigned the conceptual framework	Page 6
3	The candidate should change the Study was	I restated it as advised	Page 14

	analytical not descriptive		
4	The background information should include a paragraph on Uganda's birth preparedness plan and its effects on maternal mortality and morbidity	It is restated in the background	Page 1
5	How many women attend ANC per day	I stated the average number of women attending ANC	Page 15

SN	COMMENTS BY INTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	The candidate should revise the methods section and revise the setting, quality control and data analysis	I edited all the three areas as advised	Page 14, 15, 1nd 16
2	Correct topographical and grammatical errors	I revised the whole book	All pages
3	The candidate should give operational definition of birth preparedness	I operationalized the definition	Roman index ten
4			
5			

SN	COMMENTS BY VIVA VOCE PANNEL	ACTION TAKEN	INDICATOR
1	Title page	I corrected the title page	Page 1
2	What new thing does your research add to the body of knowledge, this research has been done by many people what new thing does yours add	I added it under significance of the study	Page 5

3	Conceptual frame work, breakdown the birth preparedness and emergency planning what components are there	I expanded conceptual frame work	Page 6
4	How did you measure birth preparedness	I stated it	Page 17
5	You never put the factors under birth preparedness under one composite indicator to be able to measure	I developed a table	Page 23 table 4.3.5

Namumbya Beatrice…… …… **Prof. pius Okong**…… ……

Candidate's Name Signature Supervisor's Name Signature