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Determinants to grand multi parity among women of reproductive age (35-45), at Entebbe regional referral hospital, Wakiso district. A cross-sectional study.

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Abstract

Background

The study aims to identify the individual and facility-related determinants of grand multiparity among women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital in Wakiso District.

Methodology

A descriptive cross-sectional study design employing a quantitative research method was used, targeting women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital. A total of 59 respondents were considered, and a simple random sampling technique was used.

Results

22(37%) were 39-42 years, 22(37%) had 3-4 children. 58(66%) said it was not easy for them to access family planning information in their location.
32(54%) said their spouses decide on the number of children to have in the family. 48(81%) agreed that gender preferences influenced their desire to have more children. 26(44%) were not informed of the health risk of grand multiparity. 39(51%) had ever experienced unintended pregnancies due to stockouts of contraceptives at the health facility.
24(40%) said insufficient or unclear guidance was given to them on family planning by health workers. 28(47%) were living more than 10 km from the nearest health facility.

Conclusion

Individually, financial status, limited access to family planning information, lack of decision-making autonomy, and inadequate knowledge about the health risks associated with multiple pregnancies were all key contributors to grand multiparity. Health facility-related determinants, stockouts of contraceptives, geographic barriers such as long distances to health facilities, and prolonged waiting times discouraged women from seeking reproductive health services, thereby contributing to continued high parity.

Recommendation

The Ministry of Health should ensure consistent availability of contraceptives in all health facilities to prevent unintended pregnancies and support family planning efforts. Health facility administrators should reduce waiting times and improve counseling services to enhance accessibility and effectiveness of reproductive health services.

Keywords: *Determinants, Grand multi-parity, Women of reproductive age (35-45), Maternal and neonatal risks, Entebbe Regional Referral Hospital*
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Background of the study

Globally, grand multiparous women aged 35-45 years face 76% higher risks of adverse outcomes such as postpartum haemorrhage, hypertensive disorders, anaemia, and preterm delivery, leading to 66% increased maternal and neonatal morbidity and mortality (Kumar, 2019). Grand multiparity, defined as having five or more viable pregnancies, poses serious maternal and neonatal health risks, including postpartum hemorrhage, uterine rupture, low birth weight, and stillbirth. This condition is especially common in low-resource settings due to poor access to healthcare and strong cultural influences.

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Studies in Pakistan, rural women aged 38-45 years on the impact of socioeconomic status on grand multiparity found that 58% of women in the lowest wealth quintile were grand multiparas compared to 22% in the highest quintile Anwar et al., 2023).

In Ethiopia, women aged 36-42 years study on cultural norms and grand multiparity found that 70% of grand multiparas adhered to traditional beliefs that large families were a blessing. Mengie et al. (2022). Long distances to healthcare facilities were a significant determinant of grand multiparity among women aged 35-45 years. Hunie Asratie & Belay (2022). Approximately 46% of respondents reported difficulties accessing family planning services due to the location of health facilities. This challenge led to missed opportunities for contraception, contributing to high parity levels. 52% of women of reproductive age who were grand multiparas cited long waiting times in health facilities as a deterrent to seeking family planning services (Mulugeta, 2021). Overcrowded facilities often discouraged regular visits, resulting in inconsistent contraceptive use. 57% of grand multiparas reported negative attitudes from healthcare workers as a factor influencing their family planning choices Gökçe İsbir et al., 2024). Disrespectful or judgmental behavior by providers discouraged women from seeking family planning counseling or returning for follow-up services.

In Eastern Ethiopia, 61% of grand multiparas indicated that health facilities lacked outreach programs to educate communities on the importance of family planning (Raru et al. 2022). This gap in community engagement resulted in low awareness and misconceptions about contraceptives. In Rwanda, inadequate postpartum family planning services were highlighted as a key contributor to grand multiparity (Nsabimana et al. 2023). Approximately 59% of women reported that they were not offered contraceptive counseling immediately after delivery, leading to unplanned pregnancies. In Uganda, 41% of women over 35 years are grand multiparous, with the highest rates. At Entebbe Regional Referral Hospital, a notable number (69%) of women of reproductive age (35-45 years) are grand multiparous, exposing them to potential health risks during pregnancy and childbirth (HMIS 105 Health Unit Register, 2024). The study aimed at identifying the individual and health facility-related determinants of grand multiparity among women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital, Wakiso District.

Methodology

Study Design and Rationale

A descriptive cross-sectional study design employing a quantitative research method was used to obtain data. The study was descriptive because the researcher assessed the factors of the research topic and analyzed the data using descriptive statistics. The study was cross-sectional because it was carried out at one point in time without further follow-up. Quantitative methods involved the use of structured tools such as questionnaires to gather numerical data. The design was chosen because it was cost-saving, easier to carry out, and conducted in a shorter time.

Study Setting and Rationale

The study was conducted at Entebbe Regional Referral Hospital, a government-owned public health facility located in Wakiso District, Central Uganda. The hospital is situated approximately 35 kilometers southwest of Kampala, the capital city of Uganda, along the Kampala–Entebbe highway. It offers services including maternal and child health, general outpatient and inpatient care, family planning, and specialized obstetric and gynecological services. The hospital has a bed capacity of 200 and employs approximately 120 healthcare workers, including medical officers, midwives, nurses, and support staff, ensuring a multidisciplinary approach to patient care. It serves a large population from neighboring districts such as Mpigi, Mukono, and Kalangala, in addition to the residents of Entebbe Municipality and surrounding areas. The facility is a critical provider of maternal healthcare services, registering an average of 350 antenatal visits monthly and about 120 deliveries, of which a significant proportion involves women of reproductive age (35–45 years). Reports indicate that 43% of women aged 35–45 years who deliver at the hospital are grand multiparas facing complications such as uterine rupture, postpartum hemorrhage, and prolonged labor. The hospital's geographical coordinates are 0°03'30.0"N, 32°28'00.0"E (Latitude: 0.058333; Longitude: 32.466667).

Study Population and Rationale

The study targeted women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital, Wakiso District during the time of data collection. This population was considered for deep exploration of the determinants of grand multiparity among women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital.

Sample Size Determination

The sample size determination followed the guidelines provided by Krejcie and Morgan's 1970 table.

According to the Entebbe Regional Referral Hospital Postnatal Clinic Register 2024, there were over 100

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pregnant women receiving Postnatal Clinic care services. Given this large population at the study site, Krejcie and Morgan's 1970 table provided an appropriate and statistically suitable sample size to ensure that the findings were representative of the entire population. Therefore, the researcher considered the population size (N) to be 70, based on efficiency, resource limitations, and the appropriateness of the study area, with a sample size (S) of 59, as determined by Krejcie and Morgan's 1970 table, as drawn in Appendix VII in the appendix section.
Therefore, the 59 respondents were considered for the success of this study.

Sampling Procedure

The study used a simple random sampling technique. This technique was chosen because it ensured that the sample was representative of the study population and helped reduce bias. To obtain the participants, the researcher made pieces of paper of similar size labeled with P and Q. Respondents were requested to pick papers from an enclosed box on each day of data collection, and those who picked papers labeled with P were considered to participate. The process ran for six days, sampling 10 respondents each day until a total of 59 respondents was obtained for the success of the study.

Selection Criteria

Inclusion Criteria

Women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital who, upon informed consent, agreed to participate in the study.
Those who had time to respond to the questions were included in the study.
Those who picked papers with P were included

Exclusion Criteria

Women of reproductive age (35-45 years) who, upon informed consent, failed to participate in the study for some reasons.
Those who had no time to respond to the questions were included in the study.
Those who picked papers with P but are not willing to continue giving a response

Study Variables

The study focused on determinants to grand multiparity among Women of reproductive age women of reproductive age (35-45 years).

Dependent Variables

Grand multiparity Women of reproductive age (35-45 years), and this meant the variable that was being predicted and did not change, for example, birth grand multiparity.

Independent Variables

Individual-related determinant of grand multiparity among women of reproductive age due to individual-related causes.
Health facility-related determinant of grand multiparity among women of reproductive age due to health facility-related causes.

Research Instruments

The researcher used a structured questionnaire. It was written in English and contained closed-ended questions related to the study objectives. However, illiterate respondents were also considered, as the questions were verbally read to them while the researcher filled in their responses with the assistance of research assistants. The questionnaire consisted of three sections: socio-demographic data, individual-related determinants, and health facility-related determinants.

Data Collection Procedure

Upon the proposal approval, an introductory letter from the Dean, School of Nursing, Mildmay Uganda School of Nursing and Midwifery was granted to the researcher, which helped the researcher seek permission from the administration of Entebbe Regional Referral Hospital. The purpose of the study was explained, and the researcher was introduced to the person in charge of the Postnatal Clinic to interact with women of reproductive age and continue to collect data. Data collection took 6 days, sampling 10 respondents every day until the required sample of 60 respondents was reached. Data collection also involved training research assistants who helped translate English questions to the local language for illiterate respondents during the administration of the self-administered questionnaires at the hospital. Verbal permission and informed consent were sought from respondents with a clear explanation of the research purpose. Respondents were assured of confidentiality and requested to cooperate in the researcher-administered questionnaire.

Data Management and Analysis

Data Management

After collecting data, each questionnaire was checked for completeness and accuracy. The data collected was coded and cleaned before analysis. Accurate and filled questionnaires were kept in a lockable cabinet, and a password for the computer was created for the

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management of electronic data to ensure maximum safety and confidentiality.

Data Analysis

Data was analyzed manually, and findings were entered into a computer using Microsoft Excel (version 2013). The data was then presented in the form of frequency tables, graphs, and pie charts using descriptive statistics.

Quality Control

Validity

This was done by setting questions according to the research objectives and ensuring they aligned with the intentions of the research study, with guidance from the research supervisor. Validity helped in measuring the accuracy of results within the study, facilitating the formulation of proper interventions to address the research problem.

Reliability

The questionnaires were pre-tested at Kajjansi Health Centre IV on 10 women of reproductive age before being used at the study site to ensure consistency and dependability of the research instruments. The questions were then re-tested on 5 respondents to make further edits and ensure that no mistakes remained before commencing the formal study.

Bias.

The assessment of determinants was based primarily on self-reported data, which was subject to recall and social desirability bias, potentially affecting the accuracy of the findings.

Ethical Considerations

After the approval of the research proposal by the research supervisor and the institution's research committee, an introductory letter was obtained from the Dean, School of Nursing, Mildmay Uganda School of Nursing and Midwifery, which was presented to the administration of Entebbe Regional Referral Hospital. The director then directed the researcher to the person in charge of the postnatal clinic, who granted permission to carry out the research among multiparous women. The in-charge introduced the researcher to women of reproductive age (25-35 years) and staff, who, in turn, supported the researcher in accessing respondents. All respondents were provided with written informed consent after receiving a detailed description of the study. Eligible participants consented in privacy, and no incentives were given. Anonymity of the respondents was ensured at all stages of data collection and analysis.

Results

Social demographic characteristics

Table 1: Social demographic characteristics of the respondents. n=59

Variable	Category	Frequency(f)	Percentage (%)
Age	35-38 years	19	32
	39-42 years	22	37
	43-45 years	18	31
Level of education	No formal education	10	17
	Primary school	14	24
	Secondary education	16	27
	Diploma	19	32
Religion	Protestant	15	25
	Catholic	18	31
	Muslim	9	15
	Born Again	17	29
Number of children	1-2	13	22
	3-4	22	37
	5-7	18	31
	8 and above	6	10

Table 1, 22(37%) were 39-42 years, 19(35-38 years while the minority 18(31%) were 43-45 years. 19(32%) were diploma holders, 16(27%) had secondary education 14(24%) had primary education, and above while the

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least, 10(17%) had no formal education. 18(31%) were Catholic, 17(29%) were Born Again, 15(25%) were Protestant and the least, 9(15%) were Muslim. 22(37%) had 3-4 children, 18(31%) had 5-7 children, 13(22%) had 1-2 children while minority 6(10%) had 8 children and above.

Table 1 showing the respondents' current financial situation's effect on their ability to plan family size

Variable	*Frequency (n=59)*	Percentage (%)
The current financial situation's effect on the ability to plan family size		
Significantly affects decisions	30	51
Has minimal effect	17	29
Does not affect at all	12	20
Level of ease to access family planning information		
Very easy	17	29
Un easy	10	17
Not easy	32	54

From table 2, 30(51%) said their current family status significantly affects their decisions to plan a family, 17(29%) said their financial status has minimal effect, while the minority, 12(20%), said it does not affect them at all. 58(66%) said that it was not easy for them to access family planning information in their location, 17(29%) very easily accessed family planning information, while the minority 10(17%) said it was uneasy.

Table 2 showing the decision maker the number of children for the family and gender preferences

Variable	Frequency (n=59)	Percentage (%)
I make the decision myself	9	15
My spouse makes the decision	32	54
We decide together	18	31
Whether gender preferences influenced respondents' desire to have more children		
Yes	48	81
No	11	19

Table 3 shows, 32(54%) said their spouses decide on the number of children to have in the family, 18(31%) said they make the decision together, while the minority 9(15%) mentioned that they make decisions themselves. The majority of respondents, 48(81%), agreed that gender preferences influenced their desire to have more children, while a minority, 11(19%), disagreed.

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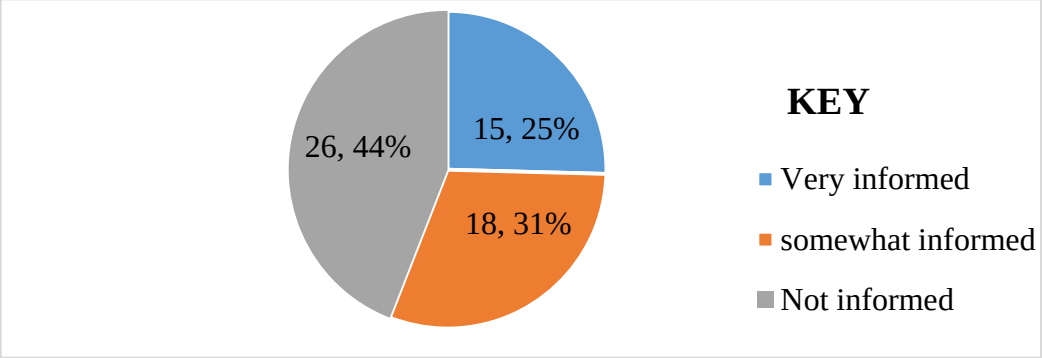
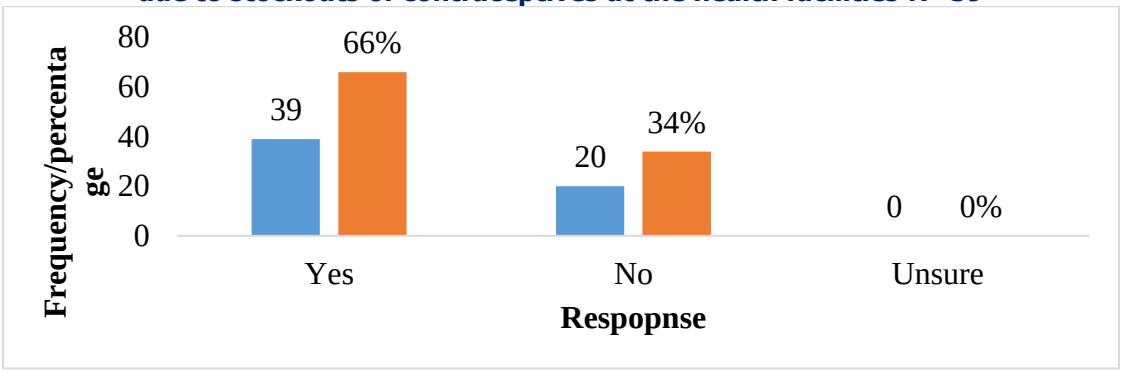
Figure 1 showing awareness of the health risk associated with multiple pregnancies n=59



In Figure 1, 26(44%) were not informed of the health risk of grand multiparity, 18(31%) were somewhat informed, while a minority, 15(25%), were very informed.

Health facility-related determinants to grand multiparity among women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital, Wakiso District.

Figure 2 showing whether respondents had ever experienced unintended pregnancies due to stockouts of contraceptives at the health facilities N=59



From figure 2, 39(51%) had ever experienced unintended pregnancies due to stockouts of contraceptives at the health facility, while a minority, 20(34%) disagreed.

Table 3 Showing how respondents rate the counselling they receive on family planning from health workers, distance to the nearest health facility, and description of the healthcare workers' behavior

Variable	Frequency(n=59)	Percentage (%)
Clear and comprehensive	12	20
Helpful but not detailed	23	39
Insufficient or unclear guidance	24	40
No counselling provided	0	0
distance to the nearest health facility		
More than 10 km	28	47
5-10 km	24	41

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Less than 5 km	7	12
Description of the healthcare workers' behavior during family planning consultations		
Respectful and supportive	15	25
Neutral	8	14
Disrespectful or judgmental	36	61
Total	59	100

From table 4, 24(40%) said insufficient or unclear guidance was given to them on family planning by health workers, 23(39%) said the information was helpful but not detailed, while a minority, 12(20%), said they received clear and comprehensive information from the health workers. 28(47%) were living more than 10 km from the nearest health facility, 24(41%) mentioned 5-10 km, while a minority of 7(12%) mentioned less than 5 km. 36(61%) reported that healthcare workers were disrespectful and judgmental during family planning consultations, 15(25%) mentioned that they were respectful and supportive, while a minority of 8(14%) mentioned that they were neutral.

Figure 3 showing the average duration of waiting for family planning services N=59

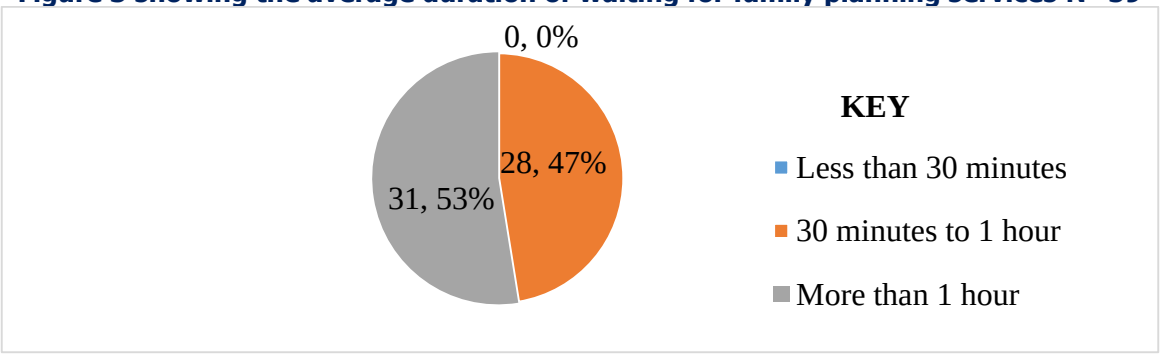

Figure 3, 31(53%) waited more than 1 hour for the family planning services, while the least 28(47%) waited for 30 minutes to 1 hour.

Discussion

Individual-related determinants to grand multiparity among women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital, Wakiso District.

Regarding financial status, the majority of the respondents (51%) said their current family status significantly affects their decisions to plan a family. This could be because respondents could take care of a growing number of children, which might have influenced multiparity. The findings of the study are supported by the study done in Pakistan by Anwar et al. (2023), where findings showed that women in the lowest wealth quintile were grand multiparas compared to those in the highest quintile.

Concerning family planning, the majority of the respondents (66%) said that it was not easy for them to access family planning information in their location. This might have contributed to respondents' practice of having many children since they could have lacked the information on how to plan for their families. The findings of the study align with the study done in sub-Saharan Africa by Ahinkorah et al. (2020), where findings revealed that grand multiparas reported inconsistent access to health information.

Pertaining to decision making, over half of the respondents (54%) said their spouses decide on the number of children to have in the family. The respondents' spouses who could have believed in having many children might have influenced multiparity amongst the respondents. The findings of the study are in agreement with the study done in Nigeria by Sandström et al. (2023), where findings showed that grand multiparas reported that their partners made decisions about family size.

Furthermore, more than half of the respondents (44%) were not informed of the health risk of multiple pregnancies. This might have led respondents to give birth to many children without fear of any implications. The findings of the study concur with the study done in Ethiopia by Tesfay et al. (2022), where findings revealed that grand multiparas were unaware of complications such as uterine rupture and anemia.

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Furthermore, most respondents (81%) agreed that gender preferences influenced their desire to have more children. This could be because respondents aimed at getting a certain gender and changing sex amongst children, and eventually, it could have contributed to them having a large number of children. The findings of the study agree with the study done in Uganda by Noor (2020), where findings showed that grand multiparas pursued additional pregnancies to achieve a preferred gender balance among children.

Health facility-related determinants to grand multiparity among women of reproductive age (35-45 years) attending Entebbe Regional Referral Hospital, Wakiso District.

Regarding unintended pregnancies, over half of the respondents (51%) had experienced unintended pregnancies due to stockouts of contraceptives at the health facility. This could be because they lacked means of birth control, which could have increased the chances of unintended pregnancy, contributing to multiparity. The findings of the study agreed with the study done in Mozambique by Hobday et al. (2020), where findings revealed that grand multiparas reported limited access to family planning services in health facilities due to persistent stockouts of contraceptives.

Nearly half of the respondents (40%) said insufficient or unclear guidance was given to them on family planning by health workers. This could have led to improper usage of the family planning services provided to respondents, which might have eventually led to multiparity. The findings of the study are in agreement with the study done in Indonesia by Pakaya et al. (2022), where findings showed that grand multiparas cited poor health worker counseling as a major barrier to effective family planning utilization.

Pertaining to distance, close to half of the respondents (47%) were living more than 10km from the nearest health facility. Long distances might have acted as a barrier preventing respondents from easily accessing family planning services, leading to multiparity. The findings of the study concur with the study done in sub-Saharan Africa by Hunie Asratie & Belay (2022). Findings revealed that respondents reported difficulties accessing family planning services due to the location of health facilities.

Concerning waiting time, most of the respondents (53%) waited more than 1 hour for the family planning services. Long waiting times might have discouraged respondents from seeking family planning services. The findings of the study agree with the study done in Ethiopia by Mulugeta (2021), where findings showed that women of reproductive age who were grand multiparas cited long waiting times in health facilities as a deterrent to seeking family planning services.

Lastly, the majority of the respondents (61%) reported that healthcare workers were disrespectful and judgmental during family planning consultations. This might have discouraged respondents from seeking family planning services. The findings of the study are in agreement with the study done in Turkey by Gokçe İsbir et al. (2024). Findings showed that grand multiparas reported that disrespectful or judgmental behavior by providers discouraged women from seeking family planning counseling or returning for follow-up services.

Generalizability.

The sample size was relatively small, which may limit the ability to generalize the results to the broader population of women of reproductive age in Wakiso District or Uganda at large.

Conclusion

Individually, the study revealed that financial status significantly influenced reproductive decisions, Limited access to family planning information, lack of decision-making autonomy where spouses determined family size, and inadequate knowledge about the health risks associated with multiple pregnancies were all key contributors to grand multiparity. Additionally, a strong desire for specific gender preferences among children further drove women to have more children.

Health facility-related determinants of grand multiparity; stockouts of contraceptives at health facilities led to unintended pregnancies among many respondents, insufficient or unclear guidance from health workers about family planning, geographic barriers such as long distances to health facilities and prolonged waiting times discouraged women from seeking reproductive health services, disrespectful and judgmental attitudes from healthcare providers negatively impacted women's willingness to utilize family planning services, thereby contributing to continued high parity.

Limitations to the Study

The study was conducted in a single health facility, Entebbe Regional Referral Hospital, limiting the geographic scope and, therefore, the applicability of the findings to other settings or regions.

The cross-sectional nature of the study design restricts the ability to establish causal relationships between the identified factors and grand multiparity.

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Recommendation

The Ministry of Health should ensure consistent availability of contraceptives in all health facilities to prevent unintended pregnancies and support family planning efforts.
Healthcare workers should receive training on respectful and non-judgmental care to encourage women to seek and utilize family planning services without fear or stigma.
Community leaders should promote awareness campaigns on the risks of grand multiparity and the importance of shared decision-making in family planning.
Health facility administrators should reduce waiting times and improve counseling services to enhance accessibility and effectiveness of reproductive health services.

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I really want to thank God from the bottom of my heart as I express my sincere, deepest gratitude to His endless grace for enabling me to accomplish this research and this course.
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May God richly bless them all.

List of Abbreviations

HIMS: Health Information Management System
LMICs: Low and Middle-Income Countries
MOH: Ministry of Health
UHPAB: Uganda Health Professions Assessment Board
WHO: World Health Organization

Source of funding

There is no source of funding declared.

Conflict of interest

The author stated no conflict of interest.

Data availability.

Data was available upon request.

Author Biography

Biira Janet, a diploma student Midwife at Mildmay Uganda School of Nursing and Midwifery
Immaculate Naggulu Prosperia is the Dean of Midwifery at Mildmay Uganda School of Nursing and Midwifery

Author contributions.

Biira Janet participated in the study data collection and the project.

References

1. Ahinkorah, B. O., Ameyaw, E. K., & Seidu, A.-A. (2020). Socio-economic and demographic predictors of unmet need for contraception among young women in sub-Saharan Africa: evidence from cross-sectional surveys. Reproductive Health, 17, 1-11. https://doi.org/10.1186/s12978-020-01018-2
2. Anwar, J., Torvaldsen, S., Morrell, S., & Taylor, R. (2023). Maternal Mortality in a Rural District of Pakistan and Contributing Factors. Maternal and Child Health Journal, 27(5), 902-915. https://doi.org/10.1007/s10995-022-03570-8
3. Gökçe İsbir, G., Serçekuş, P., Yenal, K., Okumuş, H., Durgun Ozan, Y., Karabulut, Ö., Abbasoğlu, D., Gönenç, İ. M., Sarı, E., & Aktaş, S. (2024). The prevalence and associated factors of fear of childbirth among Turkish pregnant women. Journal of Reproductive and Infant Psychology, 42(1), 62-77. https://doi.org/10.1080/02646838.2022.2057938
4. Hobday, K., Zwi, A. B., Homer, C., Kirkham, R., Hulme, J., Wate, P. Z., & Prata, N. (2020). Misoprostol for the prevention of post-partum haemorrhage in Mozambique: an analysis of the interface between human rights, maternal health and development. BMC International Health and Human Rights, 20, 1-13. https://doi.org/10.1186/s12914-020-00229-9
5. Hunie Asratie, M., & Belay, D. G. (2022). Pooled prevalence and determinants of completion of maternity continuum of care in Sub-Saharan Africa: a multi-country analysis of recent demographic and health surveys. Frontiers in Global Women's Health, 3, 869552. https://doi.org/10.3389/fgwh.2022.869552
6. Mengie, T., Dessie, Y., Egata, G., Muche, T., Habtegiorgis, S. D., & Getacher, L. (2022). Food taboos and associated factors among agro-pastoralist pregnant women: A community-based cross-sectional study in

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Original Article

Eastern Ethiopia. Heliyon, 8(10). https://doi.org/10.1016/j.heliyon.2022.e10923

7. Pakaya, N., Laksono, A. D., Masruroh, M., Sujoso, A. D. P., Ibrahim, I., Marasabessy, N. B., Rohmah, N., Seran, A. A., & Wulansari, I. (2022). Is the educational level of women related to contraceptive use? Analysis of the 2017 Indonesia demographic and health survey. International Journal of Health Sciences, 6(S2), 5561-5570. https://doi.org/10.53730/ijhs.v6nS2.6440
8. Raru, T. B., Ayana, G. M., Yuya, M., Merga, B. T., Kure, M. A., Negash, B., Birhanu, A., Alemu, A., Dessie, Y., & Dheresa, M. (2022). Magnitude, trends, and determinants of institutional delivery among reproductive age women in Kersa Health and Demographic Surveillance System Site, Eastern Ethiopia: a multilevel analysis. Frontiers in Global Women's Health, 3, 821858. https://doi.org/10.3389/fgwh.2022.821858
9. Sandström, L., Kaunonen, M., Klemetti, R., Raussi-Lehto, E., & Aho, A. L. (2023). Factors helping pregnant multiparas cope with fear of birth: A qualitative study. Midwifery, 125, 103803. https://doi.org/10.1016/j.midw.2023.103803
10. Tesfay, N., Tariku, R., Zenebe, A., Firde, H., & Woldeyohannes, F. (2022). Target areas to reduce the burden of maternal death due to obstetric hemorrhage in Ethiopia. Plos One, 17(9), e0274866. https://doi.org/10.1371/journal.pone.0274866

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