

PREVALENCE OF HOME BIRTHS, ASSOCIATED FACTORS, AND OUTCOMES: A
CROSS-SECTIONAL STUDY IN PAICHO SUB-COUNTY, GULU DISTRICT, NORTHERN
UGANDA

BY

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DECLARATION

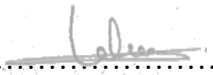
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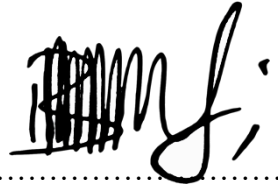
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APPROVAL

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DEDICATION

This dissertation is dedicated to my Husband, Mr Komakech Vincent and children Lagum Shalom, Gum King Joseph, Bedmot Morgan Ezriel and Elijah Gabriel. My Parents Mr. John Muto Onoo P'Lajur and Mrs. Cecilia Muto. My classmates Dr. Lapat Jolly Joe, Dr. Jimmy Opee, Apio Monica Clara. Faith in Action groups members for the support, patience, love and encouragement during this journey.

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TABLE OF CONTENTS

DECLARATION	i
APPROVAL	ii
DEDICATION	iii
ACKNOWLEDGEMENT	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES	x
LIST OF FIGURES	xi
ABBREVIATIONS AND ACRONYMS ABBREVIATION.....	xii
OPERATIONAL DEFINITIONS.....	xiii
ABSTRACT.....	xiv
CHAPTER ONE: INTRODUCTION.....	1
1.0 Background	1
1.1 Problem statement	3
1.2. Significance of the study	5
1.3. Scope of the study.	5
1.4. Broad objectives	6
1.5. Specific objectives.....	6
1.6. Research question.....	6
1.7. Conceptual framework	7

1.8 Narrative of the conceptual framework.....	7
CHAPTER TWO: LITERATURE REVIEW	9
2.0. Introduction.	9
2.1. Prevalence of Home Births	9
2.2. Factors Associated with Home Births.....	10
2.3. Sociodemographic factors.....	10
2.4. Educational Level	10
2.5. Knowledge about Birth Risks	10
2.6. Financial Constraints.....	10
2.7. Cultural Beliefs and Cultural Beliefs	11
2.8. Geographical Barriers	12
2.8. Long Distance to Health Facility	12
2.9. Road Conditions.....	12
2.10. Availability of Transport.....	12
2.11. Health facility factors	13
2.12. Lack of Health Facilities.....	13
2.13. Antenatal Care (ANC) Visits	13
2.14. Shortage of Skilled Health Workers	14
2.15. Lack of Equipment and Supplies	14
2.16. Health Worker Attitude.....	14

2.17. Previous home birth Experiences	15
2.18. Outcomes of home birth.....	15
CHATPER THREE: METHODS	17
3.0. Study Design	17
3.1. Study area.....	17
3.2. Study population	18
3.3. Inclusion Criteria.....	18
3.4. Exclusion Criteria.....	18
3.5. Sampling methods.....	18
3.6. Sample Size Estimation.....	18
3.7. Data collection tool	19
3.8. Data Collection procedures	19
3.9. Data Management and analysis.....	20
3.10 Ethical Consideration	21
3.11. Study Limitations and mitigation strategies.....	22
3.12 Research Dissemination Plan.....	22
CHARPER FOUR: RESULTS	23
4.0. Demographic characteristics	23
4.1. Prevalence of home birth.....	24
4.2. Factors associated with homebirth	24

4.3. Outcome of home birth.	27
CHARPER FIVE: DISCCUSSION	28
5.0. Summary of key Findings	28
5.1. Prevalence of home birth.....	28
5.2. Factors associated to home birth	29
5.3. Outcome of Home Birth.....	30
CHARPTER SIX: CONCLUSION AND RECOMENNDATION	33
6.1 Conclusion.	33
6.2. Recommendation.....	33
6.3. Research Gaps	33
6.4. Recommendations for Future Research	34
6.5. Strength and limitation of the study	34
REFERENCES	35
Appendix 1: Data Collection Tools	51
A.3.1 Questionnaire – English Version	51
A.3.2 Questionnaire - Acholi Version	57
Appendix 2: Approval letter from GUREC	62
Appendix 3: Clearance Letter from the District	64
Appendix 4: Consent Forms	65
A.4.1. Informed Consent Document for Adults – English Version.....	65

Appendix.4.1. Informed Consent Document for Adults – Acholi Version	68
Appendix 5. Consent Forms for Emancipated Minors	72
A.5.1 Informed Consent Form for Emancipated Minors – English Version	72
A.5.2. Informed Consent Form for Emancipated Minors – Acholi Version	75
Appendix Four: Plagiarism Certificate	79

LIST OF TABLES

TABLE 1: DEMOGRAPHIC CHARACTERISTICS.....	23
TABLE 2: BIVARIATE AND MULTIVARIATE ANALYSIS OF FACTORS ASSOCIATED TO HOME BIRTH....	25
TABLE 3: OUTCOME OF HOME BIRTH.....	27

LIST OF FIGURES

FIGURE 1: CONCEPTUAL FRAMEWORK	7
FIGURE 2: PREVALENCE OF HOME BIRTH.....	24

ABBREVIATIONS AND ACRONYMS ABBREVIATION

ANC	Antenatal Care
DHO	District Health Officer
MMR	Maternal Mortality Rates
SDG	Sustainable Development Goals
SMLG	Saving Mothers Giving Life
TBA	Traditional Birth Attendant
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
WHO	World Health Organization

OPERATIONAL DEFINITIONS

Home birth: Any birth that took place outside the health facility and assisted by unskilled attendant

Skilled birth attendant: These are birth attendants who are professionally trained health workers who went through formal training school on gynecology and midwifery.

ABSTRACT

Background

Home births, prevalent globally at 28% pose significant risks, especially in countries that are under developed. The study focused on prevalence, associated factors, and outcomes of home births in Paicho Sub- County, Gulu District, Uganda.

Methods

Between March and May 2024, a cross-sectional study was conducted among women who gave birth in the last 36 months. Data was collected using interview-guided questionnaires and analyzed using multivariable logistic regression in Stata version 14. Snowball sampling, non-probability sampling technique was used to recruit participants in the study.

Results

A total of 394 women with a mean age of 28 ± 6.5 years were recruited. The prevalence of home births approximately 15%, (59/394), with 64% (38/59) attended to by traditional birth attendants 75% (296/394) attended ANC at least 4 or more times. Factors associated with home birth includes ANC attendance > 4 times (aOR-0.02, 95% CI: 0.007-0.029), $p=0.002$), previous home birth experience (aOR-2.67 (95% CI: 1.40-5.09), $p=0.003$), and availability of transport means, (aOR=4.87, (95% CI: 1.42-16.65), $p=0.003$), risks of complications among home birth vs. risk of complication among facility birth (33/59 vs. 40/335), including prolonged labor (31.8% vs. 5.6%), obstructed delivery (4.1% vs. 0.7%), there is higher number of referral among home birth compared to facilities birth (52.5% vs. 7.8%).

Conclusion

Study result show prevalence of home delivery is associated to high risk of complication with high rates of referrals. Promoting group ANC with comprehensive healthcare packages will equip mothers to reduce home births.

Key Words: Home birth, skilled birth attendant.

CHAPTER ONE: INTRODUCTION

1.0 Background

Home birth refers to delivering a baby in one's own home or a non-clinical setting, typically without skilled medical assistant and often relying on natural child birth practices techniques (Atuhaire, 2019a), (Appiah et al., 2021b). Globally, about 28% of births take place at home, though this rate varies significantly by region. While European and Central Asian countries report a low prevalence of 5%, rates are significantly higher in East Asia and the Pacific at 38% (Hernández-Vásquez et al., 2021a). The risks associated with home births, particularly in less developed nations, are significant. For example, a 2009 study highlighted that maternal deaths accounted for a large portion of the 2.6 million deaths among young people (ages 10–24) in sub-Saharan Africa, with 97% of these occurring in developing countries (Patton et al., 2009). Perspectives on home birth differ widely across the world (Brunton et al., 2021). Institutional deliveries are the norm in developed nations while a large number of mothers in less developed countries prefer home birth (Maximore et al., 2022).

A multilevel analysis in sub-Saharan Africa reported that 31% of mothers who attended ANC visits still birth from home (Zegeye et al., 2023). Across Africa, the prevalence of home birth has been reported to be more than 50% (Hernández-Vásquez et al., 2021b). With East Africa seeing a prevalence of 24% prevalence. In Uganda the UDHS (2016) reported a prevalence of home birth of 23.4% with variation across the districts (Sserwanja et al., 2021). For instance, south western Uganda, found that 30% of women gave birth at home assisted by unskilled birth attendant (Atukunda, Mugenyi, Obua, Musiimenta, Najjuma, et al., 2020). In Lira district, study results shows that only 6.9% of pregnant mother who are HIV positive delivered from home (Kasede et

al., 2021). In Northern Uganda in a community based study of post conflict war found that 33% of the mothers gave birth from home (Mukunya et al., 2021). The experiences of people about home birth vary from one country to another (Brunton et al., 2021). Factors associated to home birth include limited ANC visits and follow-up (OR-2.57,95%CI 1.32,5.01), (Adewuyi et al., 2019; Feyisa et al., 2023; Khanal et al., 2024). Education level attained (Regassa et al., 2022) poor access to timely transportation (aOR-0.797 at 95%CI=0.674-0.9943,p<0.001]) (Vincent Moshi et al., 2020) access to safe and timely transport to nearby hospital (Wax & Barth, 2017). How far the residence is from health facilities (aOR 1.48, 95%CI 1.15 to 3.81,), (Adewuyi et al., 2019) among others.

Skilled birth attendant are the professionally trained midwives, obstetric nurses and general physician to manage pregnancy and labour complications (S. M. Id et al., 2022). In contrast, Unskilled birth attendants, TBAs or relatives lack professional training, with many acquiring informal skills during community deliveries and does not know how to manage risk during pregnancy and complications related to labor (Agboyoye et al., 2024). Further to note is that unskilled birth attendants unlike professionally trained midwives or doctors, lack formal training to manage labor and its complications, relying instead on informal experience (Shimpuku et al., 2021). In south western Uganda, majority of women like to give birth from home (Atukunda, Mugenyi, Obua, Musiimenta, Najjuma, et al., 2020). Home birth is not recommended by health authority (Birthweight & Group, 2023)

Some of the underlying drivers of home birth in these areas include includes distance to health facility, fear of health facility delivery procedures, influence of mother in law, or husbands decision, and lack of transport (Lalthapersad-Pillay, 2021), (Kawungezi et al., 2015). In addition health facility constrain such as inadequate number of health worker, limited supply further

contribute to home birth (Tetui et al., 2012). Given the limited research on home birth in northern Uganda, this study seek to survey the prevalence, factors associated and outcomes of home birth among women in Paicho Sub county.

1.1 Problem statement

Home birth continues to be common, particularly in under developed countries, with serious risks to both maternal and newborn health (Hernández-Vásquez et al., 2021a; Wax & Barth, 2017). According to World Health Organization, (WHO) 2016 guidelines, any mother who is should attend a minimum of eight antenatal care visits (ANC), (Jiwani et al., 2020). However, despite this recommendation, many pregnant women do not adhere to the full schedule of ANC visits (Odusina et al., 2021). Though woman have right to quality maternal care including ANC checkups, medical examinations, and counseling, by skilled, by skilled (Dunn et al., 2017). Many continue to deliver from home.

In many regions, considerable number of pregnant women still give from home. For instance, Nigeria, reported that 62% of women gave birth outside health facilities (Adedokun & Uthman, 2019). Home births increase the likelihood of complications and mortality among mothers and newborn children, underscoring the need for effective interventions. Research in Ethiopia's Borena Zone, (Oromia Region) found that home birth was two times higher than facility birth with higher risk of death compared health facilities birth (Sara et al., 2019). Similarly, Home delivery is also a known risk factor for stillbirth, early neonatal death, and perinatal mortality, especially among the urban poor population (Lawn et al., 2016). In Uganda's urban slums, most maternal and neonatal deaths occurred during home births, attended by TBAs or family members (Atusiimire et al., 2019).

Similarly, Rwanda reported that 16% neonatal deaths were linked to home births (Gupta et al., 2018). In rural eastern Uganda, neonatal mortality remains higher compared to urban areas (Kananura et al., 2016).

Despite government efforts to strengthen Uganda's health system, by training professional skilled birth attendant, improving technology example caesarean section, ensuring availability of supplies and equipment, good referral pathways, several factors still contribute to home births. These include poor perceptions of healthcare quality, fear or past experiences of mistreatment by health workers, limited access to timely care, poverty, lack of delivery supplies, and inadequate birth preparedness (Anastasi et al., 2015). Additional barriers include challenges related to transport, emergency care, and financial constraints (Dantas et al., 2020b).

All pregnant women are recommended to deliver from health facilities with qualified skilled birth attendants, the facility also has equipment, and resources to manage childbirth process and handle complications that may come during the process (Kassie et al., 2022). This approach aligns with Sustainable Development Goal (SDG) 3, which aims to reduce maternal and neonatal death (Dowou et al., 2023). Achieving this goal requires increasing facility-based deliveries with skilled birth attendance (Addo et al., 2023). Any factor that prevents access to such care may hinder the achievement of SDG 3 (Addo et al., 2023). Overcoming these obstacles is essential for improving health of mothers and new born children (René et al., 2025).

There is limited evidence on existence of studies on prevalence, associated factors, and outcomes of home birth in Paicho sub-county. Therefore this study was conducted to address this contextual knowledge gap.

1.2. Significance of the study

All pregnant women are strongly recommended to deliver at health facility with trained healthcare professionals who can monitor the labor process, manage complications, provide essential care, or initiate referrals when necessary (René et al., 2025). Facility-based delivery serves as a critical indicator of a well-functioning health system. This study's findings on the prevalence of home births will assist policymakers and healthcare providers in better allocating resources and developing targeted strategies to promote institutional deliveries, thereby improving maternal and neonatal outcomes. Furthermore, identifying the factors contributing to home births and their outcomes will help guide future interventions and shape health policies aimed at reducing such practices. These study findings will also serve as a valuable reference for researchers conducting further studies on home birth and its associated determinants.

1.3. Scope of the study.

Cross sectional study design mainly quantitative approach to determine the prevalence, factors associated and outcome of home birth among women who have given birth within 36 months from the date of data collection. The independent variables include socio-demographic, geographical, and health facility factors that leads to home birth. And dependent variable being home birth that is determined by the factors above. The study was conducted in Paicho sub county of Gulu District, Northern Uganda between March and May 2024. Any person living in the household where there is a mother who had given birth in the last 36 month from the date of this data collection was included in the study. And any eligible person who refused to participate in the study was excluded.

1.4. Broad objectives

- To determine prevalence, factors associated and outcomes with, and outcome of homebirth in Paicho Sub County, Gulu District, and Northern Uganda

1.5. Specific objectives

1. To determine, the prevalence of home births among women in Paicho Sub County, Gulu District.
2. To identify factors associated with home birth among women in Paicho Sub County
3. To determine the outcomes of home birth among women in Paicho Sub County, Gulu District

1.6. Research question

1. What is the prevalence of home births among women in Paicho Sub County, Gulu District, Northern Uganda?
2. What factors are associated with home births among women in Paicho Sub County Gulu District, Northern Uganda?
3. What are the outcomes of home births among women in Paicho sub-county, Gulu District, Uganda?

1.7. Conceptual framework

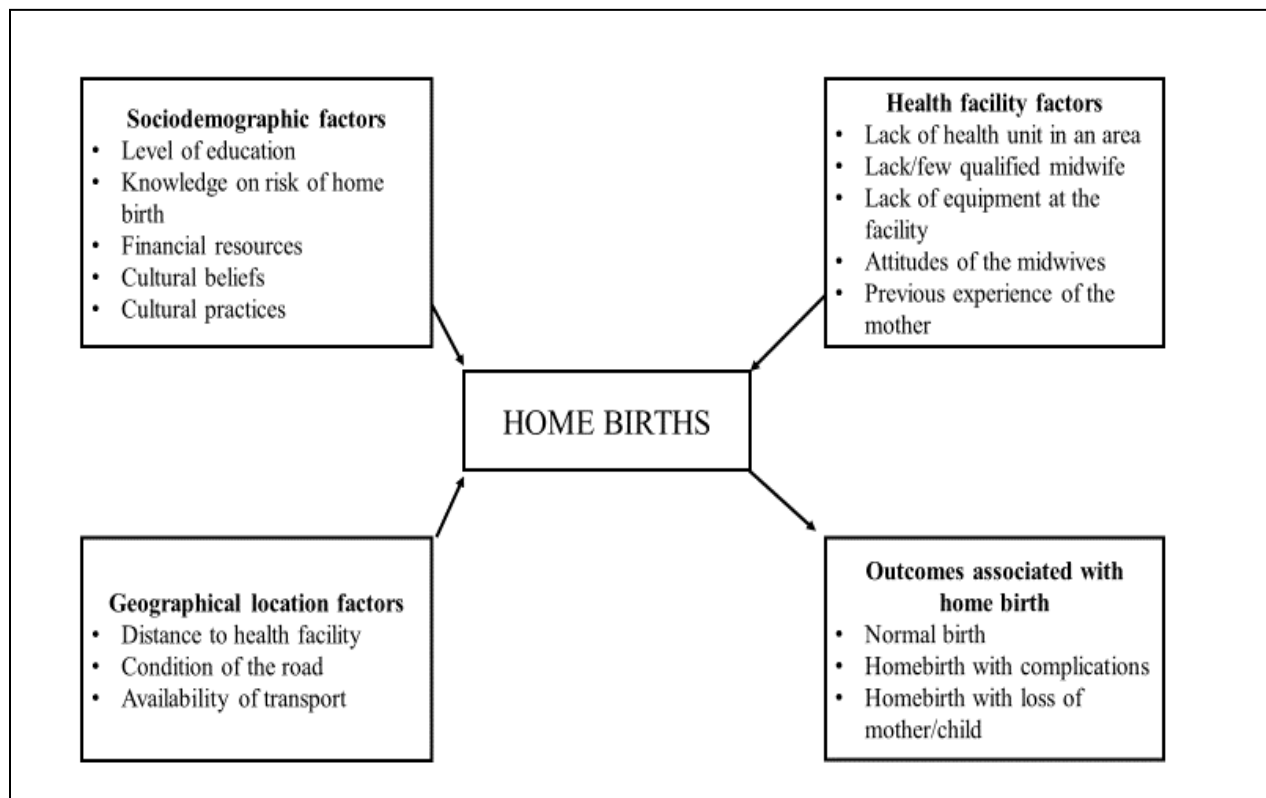


Figure 1: Conceptual framework

1.8 Narrative of the conceptual framework

This conceptual frame work shows a wide range of factors that influence home birth. Using the independent-dependent variable model, in this study the independent variables that cause changes in the number of homebirth includes: First Socio demographic which are the individual and community factors education levels, knowledge on risk of home birth, financial constrain, cultural practices and beliefs, number of ANC visits. Secondly, geographical factors such as long distance to facility. Condition of the road. Lastly, Health facility factors focusing on lack of health unit in the area, few staffs, lack of equipment and supplies, previous birth experience. The independent variables are factors which can be modified, and changes in of the independent variable will cause

changes in the dependent variable (home birth.) causing either increase in number or decrease in number of home birth.

The dependent variable is home birth. Occurrence of home birth depends the factors above, example availability of transport to take the mother to deliver from health facility. In the absence of transport means, mother will not be taken to health facility hence deliver from home.

Outcome of home birth is normal delivery without any complications where there was no risk. But home birth is as associated to a lots of complications including over bleeding, prolonged labour, difficulties in delivering. These risk comes as result of unqualified attendances assisting in the birth process. When there is complication, the mother has to be referred to health facility. Home birth puts the mother and child at risk of dying.

In our study outcome of home birth can be complications that has not been manage properly and can result in death of child or mother. The conceptual frame work summaries that home birth is determined by factors that are interconnected, Socio economic status, health facility factors and geographical factors which determines place of delivery.

CHAPTER TWO: LITERATURE REVIEW

2.0. Introduction.

The study focused on determining the prevalence, associated factors and outcome of home birth in Paicho Sub-County, Gulu District, and explored the various factors contributing to this practice. Existing literature highlights a range of determinants of home birth, the determinant includes socio-demographic factors, geographical challenges, health facility factors, as well as the associated outcomes of home births.

2.1. Prevalence of Home Births

Multiple studies have assessed the prevalence of home births across different regions. Much as there is about 94% of women in Sub-Saharan Africa who attend ANC at least once, approximately 38% of child birth occur at home, often assisted by unskilled attendant (Atuhaire & Mugisha, 2020). In rural Zambia, 15.3% (Beck et al., 2021)). Tanzania 35% gave birth from home (Moshi & Mbotwa, 2020). Ishaka Municipality, Western Uganda reported 6.7% child birth conducted at TBA home (Muhongya et al., 2020). Study found 308 (33%), out of 930 mothers in post conflict northern Uganda gave birth from home (Mukunya et al., 2021). A lot of strategies has to be put in place that needs to be done in order to reduces home birth (Adedokun & Uthman, 2019).

Reported prevalence rates vary widely: Southern Ethiopia (73.6%), (Delibo et al., 2020), Margibi County, Liberia (90.6%) (Maximore et al., 2022), and rural Zambia (15.3%), (Beck et al., 2021)) In Tanzania, 35% of women gave birth at home (Moshi & Mbotwa, 2020). while in Ishaka Municipality, Western Uganda, 6.7% delivered at TBA homes and 9.5% at their own homes out of 195 participants (Muhongya et al., 2020).

In post-conflict Northern Uganda, 33% of mothers reported giving birth at home (Mukunya et al., 2021). There is still a lot of strategies that needs to be done in order to reduces home birth in Sub-Saharan Africa (Adedokun & Uthman, 2019).

2.2. Factors Associated with Home Births

2.3. Sociodemographic factors

2.4. Educational Level

Educational attainment significantly influences place of delivery. An analysis across 39 Sub-Saharan countries found higher number of home birth among mothers with low level of education (Benova et al., 2017). Similarly, evidence from Benin showed that women whose husbands had higher level of education less likely opt for home birth (Appiah et al., 2021a).

2.5. Knowledge about Birth Risks

Home birth continues to occur even among women aware of labor complications (Sinkamba, 2019). In Ethiopia, women lacking knowledge of risk during pregnancy were four folds more to have home birth (Siyoun et al., 2018). Study in Southern Ethiopia found that number women who are unaware about the benefits of institutional delivery gave birth at home 5 times more than women who are aware of benefits of institutional delivery (S. S. Alemu et al., 2022).

2.6. Financial Constraints

Finance is an important need in the preparation for childbirth, financial limitations are a major barrier to facility-based deliveries. Mothers unable to afford hospital bills or transport often deliver at home. In Zimbabwe's Mberegwa District, women who could not meet hospital costs delivered at home (Nunu et al., 2019). Similarly, study in Dodoma found that 21.4% of mothers gave birth

at home or on route to hospitals due to sudden labor, long distances, lack of money, or negative experiences with health workers, in Tanzania (Ngowi et al., 2017). In Uganda, women living around poverty-concentrated places were less likely to deliver in facilities, (Micah & Hotchkiss, 2020), Women prefer to give birth from home because of financial dependency on others for provision like their husbands affecting their ability to take decision to seek care, hence too poor to get transport or prepare for hospital birth (Atukunda, Mugenyi, Obua, Musiimenta, Agaba, et al., 2020). Studies in Rukungiri and Kanungu districts reported that 12.5% cited high delivery costs and 18.2% cited lack of transport funds as reasons for home birth (Mugambe et al., 2021). Furthermore, women dependent on others for financial support, particularly their husbands, were less able to prepare for hospital deliveries (Atukunda, Mugenyi, Obua, Musiimenta, Agaba, et al., 2020).

2.7. Cultural Beliefs and Cultural Beliefs

Cultural beliefs strongly influence childbirth choices. In Laos, pregnancy perceived as an easy and natural state reduces the perceived need for hospital delivery (Sato et al., 2019). Among the Afar in Ethiopia, childbirth is seen as a natural process meant to occur at home, with reliance on TBAs and traditional practices (Ahmed et al., 2019). In rural Northwest Tanzania, cultural norms related to delivery positions and placenta handling discourage facility births, (Konje et al., 2020). In southwestern Uganda, 60% of women preferred home delivery, they believe on childbirth as normal process which does not require medical intervention (Atukunda, Mugenyi, Obua, Musiimenta, Agaba, et al., 2020). Similar findings were reported among the Sabinu people in Eastern Uganda, where cultural practices strongly influenced homebirth decisions (Betty, 2024).

2.8. Geographical Barriers

2.8. Long Distance to Health Facility

Long distances from residence to health facilities are well-documented barrier. Ethiopian pastoralist communities cited distance and inadequate transport as major reasons for homebirth (Ibrahim et al., 2018). In Zambia, TBAs were trusted due to proximity and perceived competence (Sialubanje et al., 2015). In Uganda, studies from Rukungiri and Kanungu reported that 25% cited long distance and 31.8% (Mugambe et al., 2021). lack of transport as reasons for home delivery, (Anastasi et al., 2015).

2.9. Road Conditions

Poor road infrastructure further hinders access to facilities. In Bangladesh, impassable roads year round led many women to deliver at home (Sarker et al., 2016). Similarly, the same challenges were found in Ghana (K. A. A. Id et al., 2021), Sierra Leone (Treacy et al., 2018), Ethiopia (Y. F. Alemu et al., 2022). West Java (., 2019), and Gomba District, Uganda (Sserwanja et al., 2021)

2.10. Availability of Transport

Transport availability makes movement easy from one place to another. In the rural areas transport is a problem. Many people use Boda Boda to transport them or walk to the health centre, where transport is not available, a mother in labor may not be able to walk to the facility hence decides to give birth from home. The following studies done shows that when transport is not available, there will be high home birth. Studies done in rural Ghana bad roads and lack of transport forced women to deliver at home and that brings complications (Atuoye et al., 2015). In rural Tanzania lack of transport was reported as public transport can also be irregular in all villages as a contributing factor for home birth (Mrisho et al., 2007).

2.11. Health facility factors

2.12. Lack of Health Facilities

The absence of nearby health units often results in home births. In Karamoja, Uganda, poor infrastructure, lack of drugs and supplies, and reliance on TBAs were major barriers (Wilunda et al., 2014). A study done in Kibbis village in rural Uganda found out that lack of transport and money prevents pregnant others from reaching the nearest health facility, the only available transport means is motorcycle taxi which they have to use on condition that they have the money to pay (Dantas et al., 2020a)

2.13. Antenatal Care (ANC) Visits

The number of antenatal care (ANC) visits significantly influences a mother's choice of delivery location. Women who attend ANC are better informed about safe delivery practices. Similarly, a meta-analysis by Md. Ashfikur Rahman found that women who had ANC visits <4 times are more likely to give birth from home, in South-Asian countries (aOR = 5.64, 95% CI: 4.34–7.32), $P < 0.001$). Home birth is less among women who visited ANC three times or more. compared to women with less or no ANC Visits (Rahman et al., 2021). Child home birth was higher among women who had no ANC visit compared to ANC-booked women Yitayish, Damtie in Ethiopia Yitayish Damtie (Damtie et al., 2022). Increase in number of ANC visits contributed to increase in number of Facility deliveries in Mara and Kagera regions in Tanzania. Study done by Dunstan R. Bishanga. Antenatal care is a key intervention that link women to health facility to delivery with skilled attendant and post-natal care services Moke Magoma in rural Tanzanian districts (Magoma et al., 2010). Uganda demographic health survey 2016, reported that health facility birth was approximately 4 times higher among women who attended ANC compared to women who

did not attend ANC by Quraish Sserwanja (Sserwanja et al., 2021.). Home birth was fewer among mothers who attended the recommended number of ANC visits compared to mothers who did not meet the recommended number of ANC visits (AOR = 0.33, CI = 0.18–0.63). In Benin Demographic and health survey (Appiah et al., 2021b). A similar findings was got meta-analysis of 67 low and middle income countries (AOR = 0.33, 95%CI = 0.18–0.63)., (Hernández-Vásquez et al., 2021a).

2.14. Shortage of Skilled Health Workers

A shortage of qualified staff discourages mothers from seeking facility-based delivery. In Addis Ababa, women perceived health workers as incompetent, which drove them toward home births (Sendo & Chauke, 2020). Uganda faces similar challenges due to low staff recruitment and retention, particularly in rural areas (Dantas et al., 2020a).

2.15. Lack of Equipment and Supplies

Inadequate equipment, such as beds and supplies, lowers confidence in facilities (Andrino et al., 2016). In Torit County, South Sudan, women cited low quality of services being offered to mothers and few staff as reasons for avoiding facilities (Bayo et al., 2021). Similar issues were noted in southeastern Uganda (Dantas et al., 2020a).

2.16. Health Worker Attitude

Negative attitudes among midwives discourage facility utilization. In Sindh, women avoided facilities due to fear of operations and poor treatment (Sadia et al., 2022). Southern Ethiopia studies highlighted verbal abuse and negligence (Delibo et al., 2020). In Northern Ghana, women reported neglect by qualified staff (Adatara et al., 2020).

2.17. Previous home birth Experiences

Mothers experience about home birth environment is that home provides greater comfort and safety and good environment for giving birth (Descieux et al., 2017). Additionally, study findings in rural Tanzania, states mothers with successful history of home birth develop trust in TBA and does not consider home birth as risk, this perception makes women choose home birth (Moshi & Nyamhanga, 2017). Majority of mothers 102(76.6%) out of 133 mothers who have had at least one or two home birth are more than grand multiparous meaning. In Uganda, fewer young mothers gave birth from home compared to grand multiparous women, among rural mothers in Gomba district (Atuhaire, 2019b).

2.18. Outcomes of home birth

Majority of women who give birth at home experience some complications (Worku et al., 2023). Systemic review and meta-analysis revealed that history of home birth is associated to adverse birth outcome among grand multiparous African women (Zelege et al., 2025). A retrospective cohort study in Ethiopia revealed that women who had obstructed labour developed obstructed complications such as uterine rupture, post-natal anemia, post-partum hemorrhage, and sepsis (Desta & Ferede, 2023). Retrospective Cohort study in Hungary also revealed that Women who had home birth were 1.28% times the risk of complications compared to women who had health facility birth (Wami et al., 2022). A systematic review and meta- analytic pooling revealed 16% of negative childbirth experience (Bagherinia et al., 2025). World Health recommendations have a supported active management of third stage labour as a critical interventions for PPH prevention by administration of uterotonic, preferably oxytocin immediately after baby is born, controlled cord contraction to deliver the placenta and massage of the uterine fundus after the placenta is delivered (New, 2013). Delays in detecting malpresentation may lead to neonatal distress and birth

trauma (Birabwa Catherine, 2025). Out of 70% pregnant women who had planned for home birth, 20% were referred to hospital with fetal distress, 14% had cesarean section and 6% normal and delivery (Obwegeser et al., 1996). Additionally, women who encountered excessive bleeding were referred to health facility by the TBAs among rural women in Uganda (Ononge et al., 2016). Births built trust in TBAs (Moshi & Nyamhanga, 2017). In Uganda Gomba district, homebirth was more common among grand multiparous women than young women with few children (Atuhaire, 2019b). Study done in Mbarara regional referral hospital also revealed that women referred during labour from home were always in critical conditions (Nabulo et al., 2023)

Most studies in the literature review focused on prevalence or factors associated with home birth separately or determine both prevalence and factors associated home birth. There is limited existence of study on the prevalence, factors associated and outcome of home birth in Paicho sub county, Gulu District. Therefore this study was conducted to address this contextual gap in Paicho Sub County.

CHAPTER THREE: METHODS

3.0. Study Design

The study used cross-sectional study design and was conducted between March and May 2024. A community based cross sectional study design was appropriate because it enabled the collection of data at a single point in time. The study purposed to determine prevalence, factors associated and outcome of home among women who had given birth within the 36 months from the date of data collection. To estimate the prevalence of home births, determine factors associated (dependent variable) and outcomes of home birth. Data collected using structured guided questionnaires aligned with the study objectives, translated in Acholi language, to facilitate understanding and interpretation by participants. Prevalence of home birth was calculated as a proportion and percentage compared to health facility births.

3.1. Study area

The study took place in Paicho sub-county Gulu, district, Northern Ugandan. The Sub County had been divided into two administrative units at the time of data collection. First, Paicho sub county having 7 parishes, and 27 Villages , 4 government health facilities, (Cwero III) and Two Health Centre II at level II, (kal ali health center II and Tegot health center II). Secondly, Omel sub county having 6 parishes and 24 villages, and only one health facility at level III, (Omel HC III) and lastly, two private for profits facilities. (Paicho Medical Center and Gracious Clinic). Each village had got 2 village health team (VHTs) trained on ICCM, they help link pregnant mothers to health facility on any matter of health concern including referrals to health facility and follow up of mothers.

3.2. Study population

Study population were mothers who gave birth in the last 36 months from the date of the data collection. Any member age 18 years and above living in eligible household and accepted to participate in the study, consented by signing the consent form, these were selected and excluded based on the following criteria.

3.3. Inclusion Criteria

To participate in this study, any person aged 18 years and above who was able to answer the questionnaires that was living in the household where a woman who gave birth within the in the last 36 months. This participants, must, however, have signed written informed consent

3.4. Exclusion Criteria

All eligible household member who refused to consent to participate in the study and all those that did not meet the above inclusion criteria were excluded from this study.

3.5. Sampling methods

Linear snowball sampling (non-probability sampling technique) was used to recruit eligible household's member into the study. The method involved identifying initial participants, each participants refer the research assistant to another eligible households, creating a chain of referrals. This method allowed us to access eligible mothers to the required number of 394.

3.6. Sample Size Estimation

The methods used to estimation sample size was Kish Leslie 1965 formula.

$$n = \frac{Z^2 xp(1 - p)}{d^2}$$

The formula was defined as:

N= stands for sample size.

Z = stands for confidence interval's standard error (1.96).

P = stands for proportion of home birth (0.5% was used because the proportion was not yet known)

d = stands for Marginal error divide by Sampling error. (0.05) substituting into the formula

After substituting into the formula, N = 384.

Considering 10% of non-response, the sample size is 427 participants. However, 394 women successfully participated in this study. There was no challenge of non-respondent.

3.7. Data collection tool

Given that the study purposed to determine prevalence, factors associated and outcome of home birth among women who had given birth within 36 months from the date of data collection, data was collected using structured guided questionnaire designed in alignment with the study objectives. These were translated in Acholi language, to facilitate understanding and interpretation by participants.

3.8. Data Collection procedures

After getting approval letter from GUREC Administration and permission from CAO Gulu, made a courtesy visits to Sub county leaders and the health facilities level III Village, then Village Health Team (VHT) members were identified to participate in the position of research assistants.

Data was collected from respondents who voluntarily consented to participate using a questionnaire that captured variables on home birth frequency, socio-demographics characteristics, and geographical factors. Data was collected daily, reviewed for completeness, and

respondents were encouraged to complete any missing information. Supervision of data collection process was monitored closely, ensuring data quality and adhering to COVID-19 precautions, including mask-wearing and physical distancing.

A convenient place considering confidentiality was agreed upon to administer the questionnaire. Private 60-90 minutes, and were conducted in Acholi, the native language. The questionnaire were translated into Acholi for ease of understanding.

3.9. Data Management and analysis

Variables was given codes, entered into excel spread sheet, imported to statistical software Stata version 14. In Stata, variables was uncoded, cleaned and that made it easier to understand the data during analysis, normality of the using Shapiro Wilk test. Results showed that data was normal. Variables was analyzed using logistics regression to determine the factors .associated to homebirth.

Descriptive analysis: For descriptive analysis univariate logistics regression was used to determine frequency and percentages of each variable.

Objective 1: For Prevalence of homebirth, Proportion of home birth, the result presented as frequency and percentages of home birth.

Objective 2: Factors associated to home birth, bivariate analysis was used to determine statistically significant independent variable associated to home birth, the result was given in crude odds ratio, 95% confidence interval and P-Value. Correlations between the variables was tested using variance inflation factor, (vif) where vif >10 are considered to have high multicollinearity. The result indicted vif of 2.7 this shows that there is no correlations between the independent variables.

Objective 3: Outcome was describe using univariate analysis, results given by frequency and Percentages.

All the variables that were statistically and marginally significant was taken for multivariate analysis, using stepwise backward elimination method to determine the model of best fit.

Akaike's information criteria, (AIC) and Bayesian information Criteria were used to estimate the best fitting model. The model with lowest Bayesian information criteria, (BIC) were considered to determine the best-fitting model. Six different models were used to reach the best fitting model. The results presented as Adjusted Odds Ratio (aOR), and 95% confidence interval, and p-value with significance level of 0.05.

Objective: 3 Outcome of home birth was describe using the univariate analysis and results given in frequencies and percentages

3.10 Ethical Consideration

Approval letter was obtained from Gulu University Research Ethics Committee (GUREC) Number GUREC-2023-750. Got Permission from Chief Administrative Officer, Gulu through District Health Officer, and a courtesy visits to Sub County stakeholders, in charges and LC 1 of the villages before data collection.

Eligible Participants in consent by signing the consent form, and the data collected from them was kept confidential. Each participant was given unique number for identification and confidentiality. Data collected was kept in safe place with password. The information was to be only accessible to those authorized by principle investigator.

3.11. Study Limitations and mitigation strategies

Mothers who had given birth at home may give false information that they gave birth from health facility. A good and comprehensive information was given to the mothers to reassure them that the purpose of this basically academics, not to criminalized anybody, Secondly check their ANC cards and discharge from the health facility.

Some participants who were unable to read and write, the research assistant read the informed consent form for them to understand, and they put a thumb print for signing.

3.12 Research Dissemination Plan

Dissemination plan are as follows:

Submitted copies of this book to the following office the office directorate of institute research, CAOs office, Office of the District Health Officer, office of Paicho Sub County.

CHARPER FOUR: RESULTS

4.0. Demographic characteristics

A total of 394 women with mean age 28 ± 6.5 years, participated in this study, and the most of the women had primary education 291(73.86%), Majority of participants were married 281(71.32%), with a diverse religious background, Catholic 204 (51.78%), Anglican 113(28.68 %), and Born Again 75(19.04%), Employment was predominantly non formal 383(97.21%), with working as farmers 377 (95.69 %).

Table 1: Demographic Characteristics

Variable	Frequency	Percentages
Age(mean and SD)	28	6.5
Education Level		
Primary level	291	74
Secondary level	69	18
Tertiary	34	8
Marital Status		
Single	76	19
Married	281	71
Separated	30	8
Widow	7	2
Religion		
Catholic	204	51.78
Moslem	2	0.51
Anglican	113	28.9
Born Again	75	19
Employment		
Formal	11	3
Non Formal	383	97
Occupation		
Farmer	377	95.69
Teacher	8	2.03
Business	9	2.28

Source: Primary data

4.1. Prevalence of home birth

The study result revealed the prevalence of home birth to be 15% (59/394), most of those who delivered at home 64% (38/59) were assisted by TBA. Majority of participants 75% (296/394) attended ANC Visits 4 or more times.

Source: Primary data

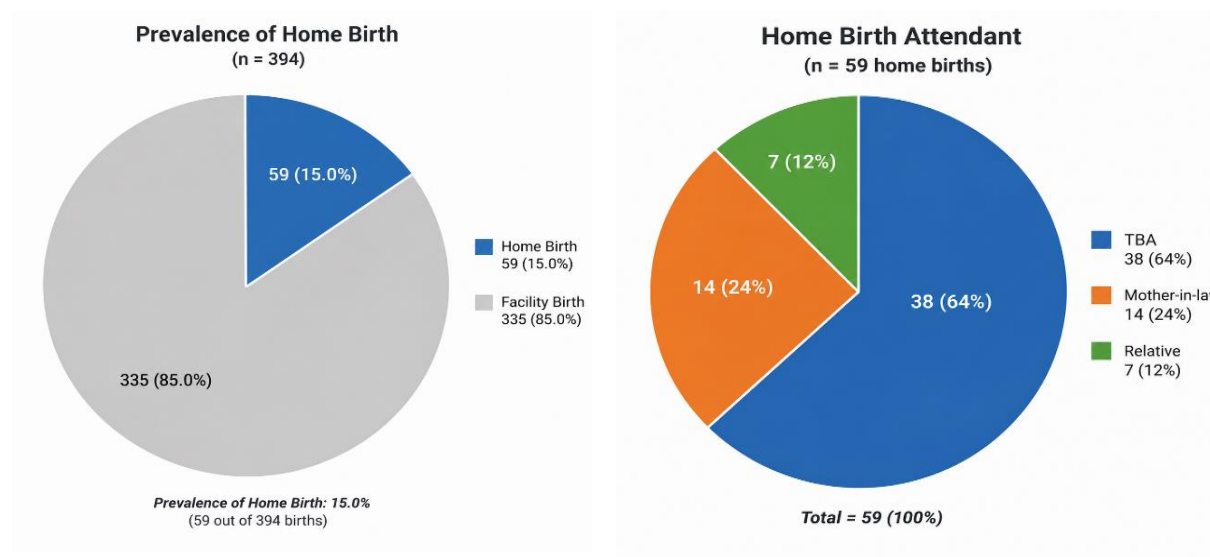


Figure 2: Prevalence of home birth

4.2. Factors associated with homebirth

At the bivariate level, several factors showed significant associations with home birth. Women with only primary education and those engaged in farming significantly opted more for home birth compared to their counterparts with higher education or formal occupations ($p < 0.001$). Marital status also showed some influence, with single women having less number of homebirth compared to other categories ($p < 0.001$). Similarly, home birth was more common among women with previous home birth experience ($p < 0.001$). The number of times of ANC visits demonstrated clear

protective effect, where increasing visits, particularly three or more, was associated with reduced odds of home delivery ($p<0.05$). Distance and mode of transport were also important: walking more than two hours ($p<0.001$) and reliance on boda boda transport ($p=0.004$) significantly increased number of home birth.

After adjusting for the confounders in the multivariate model, three independent predictors of home birth remained significant. First, ANC visits 4 or more times has reduced the odds of home delivery by 98% compared to attending fewer visits (aOR = 0.02; 95% CI: 0.007–0.23; $p=0.002$). Second, mothers who relied on available means of transport boda boda for transport were approximately five times more likely to deliver at home compared to mothers who walked to the facility, (aOR = 4.87; 95% CI: 1.42–16.65; $p=0.012$), while those using taxis had significantly reduced odds (aOR = 0.18; 95% CI: 1.40–5.09; $p=0.003$). Third, women with prior birth experience were about three times more likely to deliver at home compared to those without such experience (aOR = 2.67; 95% CI: 1.40–5.09; $p=0.003$)

Table 2: Bivariate and Multivariate analysis of factors associated to home birth

Variable	Bivariate cOR (95% CI),	P- Value	Multivariate aOR (95%)	P- Value
Education Level				
Primary Level	0.17(0.125-0.239)	0.000		
Secondary Level	0.65(0.279-1.517)	0.320		
Tertiary level	2.08(0.907-4.751)	0.084		
Marital Status				
Single	0.288(0.167-0.494)	0.000		
Married	0.542(0.286-1.028)	0.061		
Separated	0.385(0.104-1.427)	0.154		
Widow	0.578(0.651-5.141)	0.623		
Occupation				
Farmer	0.171(0.128-0.227)	0.000		
Teacher	1.952(0.384-9.917)	0.420		
Business	1.672(0.339-8.263)	0.528		
No. of ANC Visits				
Once	1.250(0.336-4.655)	0.739	1	
Twice	0.720(0.146-3.544)	0.686	0.16 (0.01-2.02)	0.155
Three times	0.200(0.146-3.543)	0.028	0.30 (0.002-0.360)	0.005
4 or more times	0.094(0.239-0.366)	0.001	0.02 (0.007-0.23)	0.002
Knowledge on risk				
No	1.002(2.84-3.532)	0.997		
Yes(cons)	0.176(0.132-2.34)	0.000		
Financial constrain				
No	1.012(0.543-1.889)	0.968		
Yes(cons)	0.176(0.127-0.243)	0.000		
Distance				
Walking > 1 hour	1.572(0.865-2.856)	0.137		
Walking < 1 hour	0.275(0.638-1.186)	0.083		
Walking>2 hours	0.169(0.118-0.241)	0.000		
Transport				
Boda Boda	5.872(1.772-19.455)	0.004	4.87 (1.42-16.65)	0.012
Taxi	0.049(0.015-0.156)	0.413	0.18 (1.40-5.09)	0.003
Walking(cons)	0.049(0.015-0.156)	0.000	1	Ref
Birth experience				
Yes	3.803(2.129-6.794)	0.000	2.67 (1.40-5.09)	0.003
No (cons)	0.925(0.592-0.144)	0.000	1	

Source: Primary Data

4.3. Outcome of home birth.

The findings in table 3 below show that majority of women who gave birth from home significantly had complications (55.9%). The most frequently reported complications during home births were prolonged labour (37.3%), excessive bleeding (11.9%), and difficult delivery (10.2%). In addition, referrals were more frequent among women who delivered at home (30.5%)

Table 3: Outcome of home birth

Variable	Home Birth n=59(%)	Facility Birth n=335 (%)	P-value
Complications			
Yes	33(55.9)	40 (11.94)	<0.001
No	26(44.07)	295(88.06)	
Which Complication			
Over bleeding	7(11.86)	5(1.49)	<0.001
Difficult in delivery	6(10.17)	12(3.58)	<0.001
Prolonged Labour	22(37.29)	25(7.46)	<0.001
Referred to higher facility			
Yes	18(30.51)	31(9.25)	<0.001
No	41(69.49)	304(90.75)	

Source: Primary Data

CHARPER FIVE: DISCUSSION

5.0. Summary of key Findings

This study involved 394 women, with mean age of 28 ± 6.5 years. The prevalence of home births was 15% ($n = 59/394$), with 64% ($n = 38$) of home births assisted by traditional birth attendants (TBAs), number of times of (ANC) visits more than four significantly reduced the likelihood of home births. Other factors associated with home births included availability of transport means, specifically boda boda, and previous birth experience.

5.1. Prevalence of home birth

The study found the prevalence of home birth at 15 %, ($n=59$), out of 59 women who had home child birth. Home birth prevalence is low because of improved health care services such as availability of qualified health workers at the facility and also supplies. The level of awareness creation about risk involved in home delivery have also increased through the different platforms such as social media (Radio talk shows), community dialogue and meetings. Enhanced community awareness through health education and media campaigns on the importance of skilled birth attendance has likely contributed to the decline in home deliveries. This finding is almost the same with a study in rural Zambia, which reported a prevalence of 15%, (Beck et al., 2021)) under literature review under sub heading prevalence. However, it is lower than the prevalence reported in Sub-Saharan Africa (38%), (Atuhaire & Mugisha, 2020), Southern Ethiopia (73.6%), (73.6 (Delibo et al., 2020), Margibi County in Liberia (90.6%), (Maximore et al., 2022), and Tanzania 35%, (Moshi & Mbotwa, 2020). It is also lower than the 33% prevalence reported in post-conflict Northern Uganda study, (Mukunya et al., 2021). Conversely, the prevalence found here is higher than that reported in Ishaka Municipality, Western Uganda, where 6.7% of births were conducted by TBAs and 9.5% occurred at home, (Muhongya et al., 2020). The relatively lower prevalence

observed in this study may reflect improvements in Uganda's health care delivery system, community sensitization about the dangers of home birth, and increased awareness among TBAs regarding the importance of referring mothers to facilities. WHO recommends at least eight ANC visits during pregnancy (WHO, 2016), and evidence shows that women who attend ANC four or more times are less likely to deliver at home. Enhanced community awareness through health education and media campaigns on the importance of skilled birth attendance has likely contributed to the decline in home deliveries. However, continued efforts are needed to reduce the practice further and promote safe facility-based deliveries.

5.2. Factors associated to home birth

Multivariate analysis revealed that number of times of ANC visits, available transport means, and previous home birth experience were significantly associated with home birth. Home birth were less common among mothers who attended ANC ≥ 4 times, more among mothers who attended less than 4 times (aOR = 0.02; 95% CI: 0.007–0.23; $p=0.002$). This is consistent with findings from South Asia, where women with more ANC visits were less likely to deliver home (Rahman et al., 2021). Similar results were reported in Ethiopia, where lack of ANC visits was strongly associated with home delivery, (Damtie et al., 2022), (Yoseph et al., 2020). The Uganda Demographic and Health Survey (UDHS) also reported that attending ANC increased the odds of facility delivery nearly four-fold, (Sserwanja et al., 2021).

The odds of Women with previous home delivery experience were almost three folds higher than odd of women who did not experience home again, (aOR = 2.67; 95% CI: 1.40–5.09; $p=0.003$). This aligns with studies from Tanzania showing that women who successfully delivered at home developed trust in TBAs and perceived home birth as safe (Moshi & Nyamhanga, 2017). Other studies highlight that familiarity, comfort, and family support during home births encourage repeat

home deliveries (Atuhaire, 2019b). (Descieux et al., 2017), (Andrino et al., 2016). Conversely, more women with negative home birth experiences were referred to seek facility-based care in subsequent pregnancies (Bohren et al., 2017).

In relation to transport availability, home birth among mothers who relying on boda boda were nearly five times higher among women who walk to health facility (aOR = 4.87; 95% CI: 1.42–16.65; p=0.003). This may be due to delays in accessing transport, high costs, insecurity, and the risks of using motorcycles during advanced labour. Similar challenges have been reported in Ghana and Tanzania, where poor roads, lack of reliable means transport contributed to home deliveries (Atuoye et al., 2015). Improving rural road infrastructure, communication networks, and affordable transport options may therefore reduce the incidence of home births.

5.3. Outcome of Home Birth

The observation in the current study shows complication were more common among women who delivered at home than those who delivered from health facilities. Complication rates among women delivering at home (55.9%), complications among women delivering in health facilities was (11.9%). This is in line with findings by Worku et al 2023 in the literature review that revealed that majority of women who give birth at home experience some complication, Prolonged labour, excessive bleeding, and difficult delivery were the most common complications mentioned by participants. These findings explain the increased risks associated with home births, which are also reported in other studies across Sub-Saharan Africa, where lack of skilled attendance and delayed referrals contribute to maternal morbidity and mortality (Sserwanja & Gatasi, 2022) also noted that safer child birth outcomes were prevalent among mothers who sought help from health facilities that those who depended on local birth attendants. Whereas these findings provide a bad

outlook on the state of child births in this area, they are a reminder that increasing facility based deliveries could reduce preventable maternal and neonatal complications in rural areas.

The results that prolonged labour was more frequent among home births than facility births can be attributed to the lack of skilled monitoring facilities such as partographs, and the lack of access to interventions such as oxytocin drips and assisted delivery equipped across home environments. As a result, the lack of professional supervision in these home based settings increase the likelihood of most labour abnormalities escalating to emergencies due to limited capacity of home birth attendants to promptly detect them. These results corroborate those by (Desta & Ferede, 2023) who reported that unmanaged obstructed labour contributed most to maternal morbidity and mortality in out-of-facility births. Therefore, the observed prolonged labour in this study area poses serious risk to both neonates and their mothers.

In addition, the findings that excessive bleeding, which is sometimes called postpartum hemorrhage was frequent among women who delivered their children at home could be due to the lack of active management of the third stage of labour in these settings. These management strategies could be inform of uterine massage, and access to blood transfusion. Thus, given that hemorrhage is one of the leading causes of maternal mortality, it is important that all deliveries are considered in health facilities where utero-tonics and emergencies care services can easily be accessible.

In the same vein, the results that difficult deliveries, which could be inform of malpresentation and shoulder dystocia were common among mothers who underwent home births could be due to the fact that delivering outside health facilities limits access to trained personnel are capable of performing maneuvers like McRoberts positioning and institutional delivery. Moreover study by Birabwa revealed that delays in recognizing malpresentation may lead to neonatal distress and

birth trauma (Birabwa Catherine, 2025) These risks are even more pronounced in home births attended to by unskilled birth attendant.

Closely related to the above, the observation in this study that referrals were frequent among women who began labour at home can be linked to the fact that home births reach crisis points before care is sought. These always triggers emergency transfers under unstable conditions. This assertion is in alignment with findings by who showed in their study that women referred during labour from home were always in critical conditions (Nabulo et al., 2023). This was associated with delays in decision making and failure to get reliable means of transport. This implies that continued reliance on emergency referrals as a compensatory strategy for home births is not only insufficient but also increases the risks to both the mother and unborn child.

CHAPTER SIX: CONCLUSION AND RECOMENNDATION

6.1 Conclusion.

This study demonstrates that home births remain prevalent in the study area, with a significant proportion of deliveries assisted by traditional birth attendants. Home deliveries were associated with substantially higher maternal complications and increased need for referral compared to facility births. Key factors influencing home birth included inadequate antenatal care attendance, reliance on boda boda transport, and previous birth experience. While progress has been made in reducing home deliveries through improved ANC services and community awareness, persistent socio-cultural and transport-related barriers continue to influence women's choices. Addressing these barriers is essential to further reduce home births and improve maternal and neonatal health in the communities.

6.2. Recommendation

Health authorities should strengthen health education and promotion in the community about safe delivery from health facilities to help reduce home birth.

Local government and implementing partners should develop more strategies to address the factors associated to home birth such as increasing ANC coverage.

I would recommend an ambulance to be placed at every health centre III that can help to pick mothers in labour who have challenges from getting transport to health facilities

6.3. Research Gaps

Despite the findings, the researcher identified two important gaps. First, the influence of socio-cultural beliefs and decision-making dynamics, such as the role of husbands, elders, or TBAs in

choosing home births, was not fully explored. Second, the study did not investigate geographical and transport-related barriers in detail, including poor road networks, seasonal accessibility, and availability of emergency transport, which may affect timely access to health facilities.

6.4. Recommendations for Future Research

Despite the findings, the researcher identified two important gaps. First, the influence of sociocultural beliefs and decision making dynamics, such as the role of husbands, elders, or TBAs in choosing home births, was not fully explored. Second, the study did not investigate geographical and transport related barriers in detail, including poor road networks, seasonal accessibility, and availability of emergency transport, which may affect timely access to health facilities. Therefore, future studies should focus on socio cultural factors influencing home delivery decision to guide targeted interventions. Additionally, targeted studies could also be conducted to assess geographic and transport related barriers using spatial or mapping approaches to identify solutions for improving access to health facilities in the rural areas.

6.5. Strength and limitation of the study

First, data collection tool was translated to the local language Acholi, enabling participants to clearly understand and respond accurately. However, the study did not consider number of deliveries a mother had experienced, nor the frequency of home versus facility births. This limited the ability to fully assess patterns of delivery choices across multiple pregnancies. Secondly the sampling approach relies on participant referrals rather than probability selection making the sample unrepresentative and limiting the ability to generalize prevalence findings to the wider population.

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Appendix 1: Data Collection Tools

A.3.1 Questionnaire – English Version

QUESTIONNAIRE FOR THE HOUSEHOLD SURVEY SUB-COUNTY

Dear respondent I am **LALWENY DORAH, Reg No. 22/U/1977/MPH/PS**, a student of Gulu University carrying out research on a topic, *“Prevalence factors and outcome of home birth, household survey in Paicho sub county”* and am requesting you to spare for me some time and respond to my questionnaire. All the response given to me shall be treated with utmost confidentiality and only be used for academic purposes.

SECTION A. DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS. (Tick appropriately).

STUDY NUMBER.....

1. Age

_____/Years

2. Gender

A) Male []

B) Female []

3. What is your education Level?

A) Primary Level []

B) Secondary Level []

C) Tertiary []

4. What is your marital status?

A) Single []

B) Married []

C) Divorced []

D) Widowed []

E) Other (specified).....

5. Religion

A) Catholic []

B) Protestant []

C) Born again []

6 What is your employment status

A) Employment []

B) Unemployed []

7. What is your occupation?

A) Farmer []

B) Teacher []

C) Business []

Prevalence of homebirth in Paicho sub county

1. How many times did the mother of this child attend ANC?

A). once

B). Twice

C). Three times

D). Four times

2. Where was this child born

A). Facility []

B). Home []

3. If birth took place from health facility, from which health facility?

A) Omel HC III []

B) Cwero HC III []

C) Kal Ali HC []

D) Te-got HC II []

E) Others Specify.....

4. If birth took place from home or along the way, who assisted you during labour process till birth.

A) Traditional birth attendant []

B) Mother in law []

C) Relative []

D) Others Specify.....

Factors associated to home birth

Socio-demographic factors

1. Do you have any Knowledge on risk of home birth?

Yes []

No []

2. What risk do you know (Mention all that applies)

- A) There may be complication at birth []
- B) Non-medical workers are not skilled to conduct delivery []
- C) There may be asphyxia in the new born baby []
- D) There may be over bleeding []
- E) Others Specify.....

3. Was there any financial challenges in attempt to go and deliver from the facility?

- A). No []
- B). Yes []

4. What cultural belief do you have that supports home birth Cultural beliefs? (Write down the belief)

.....

5. What Cultural practices do you have in this community that makes it difficult or fear to give birth from the health facility? (Write down the practices)

.....

Geographical location factors

1. How long do you take walking to reach the facility? (Give the hours)

- A) Less than 30 minutes' walk []
- B) At least one hours walking []
- C) More than two hours to reach the facility []
- D) Need for a boda to reach the facility []

2. Do you have a stream across access road that is near to the facility?

- A). No []

B). Yes []

3. What is the Condition of the road?

A) Has a lot of potholes, rough []

B) Foot path covered with grass []

C) Small streams across the path []

D) Others Specify.....

4. What kind of transport means is available in this community that you can use to reach the facility?

A) Boda []

B) Taxi for higher []

C) Walking []

D) Others (Specify).....

Health facility factors

1. Do you have qualified Lack midwife available at the health facility

A). No []

B). Yes []

2. Are the midwife always available at the facility?

A). No. []

B). Yes []

3. Do you have medical supplies and medical equipment at the facility?

A). No []

B).Yes []

5. Have you encountered negative Attitudes of the midwife previously?

A). No []

B). Yes []

6. Have you had a successful home birth previously?

A). No []

B). Yes []

Outcomes associated with home birth

7. Was there any complication during this child's birth?

A) Yes []

B) No []

8. What complication did you encountered?

A) The baby got stuck on the way []

B) Over bleeding []

9. Was the mother taken to the higher facility after the developing the complication?

A) No

B) Yes

10. What was the results of the complication?

A) Mother died

B) The baby died

A.3.2 Questionnaire - Acholi Version

Lapeny me kwed I kom lok me nyawal kang

An nynga Lalweny Dorah, Reg No. 22/U/1977/MPH/PS, akwano I Gulu University. Atye ka kwed lok ma Waco kuman ni nywal kang, tyen lok ma weko dano nywal gang, ki adwoki me nywal gang I paicho subcounty. Dong alegi me miya cawa ni mank me dok I lapeny magi. Lagam ducu ma I miya kombedi wabi gwoko maber I mung.

Section A. Demographic characteristics of respondents. (Tick appropriate)

1. Number me kwed.....
2. Mwaka pa lagam lapeny.....
3. Dako onyo Laco
A Male []
B Female []
4. Lok me nyom ma meggi tye nining pa mim latin ma ginywaol ni?
 - a) Single []
 - b) Married []
 - c) Divorced []
 - d) [Widowed []
 - e) Others (speiify).....

5. **Kang Lega**

- a) Katoli []
- b) Silum []
- c) Anglican []
- d) Others []

6. **Tic ango ma kelo Cente.**

- a). Tic me Mucara []
- b) Pe tiyo tic ma kelo Mucara []

7. **Kit tic makelo boti cente**

- a) Farmer []
- b) Bussiness []
- c) Tic pa Gamente []
- d) Tic pa NGO []

Mukene (Specify).....

Prevalence of home birth

1. **Wat ango ma tye o kin in ki latin man**

- A). Min latin []
- B) Won latin []

C) Daa latin []

D) Nero latin []

E) Wayo latin []

2. Latin eni kinywalo I kinne me dwe 36 anged?

A) Eyo [] B) Pe []

3. Latin eni kinywalo ki kwene

A) Ot yat []

B).Gang []

C), I yo me ceto o ot yat []

4. Ka ki nywalo ki I ot yat, oy yat ma mene,

A). Omel []

B). Cwero []

C) Tegot []

D). Kal ali []

E) GRRH []

F) Lacor []

5. Ka kinywalo ki gang, Anga ma okonyo coo min latin man I cwawa men nywal.

A). Mego ma dit []

B). Anwal kena []

C). Waya []

6. Nwyal oyelo min latin eni I cawa me nywal

A). Nywal Oyelo []

B) Nywal pe oyelo []

Gin ango ma oweko in inwal gang onyo I wanga yoo.

7. Socio demographic factors

A). Kamma min latin onwal ogik iye []

B). Ngec ni nyawl gang rac []

C). Cente peke me ceto I oy yat []

D). Niye me tekwaro []

E). Kwe me tekwaro []

8. Kit ma kabledowa tye kwede

A). Ot yat boo tutwal []

B). Yoo rac ma Bod ape twero ngwec iye []

C). Boda Boda onyo mutaka pe nonge kany []

D). Kulu ma mol ogengo yo ma cok weko ot uat dugo boo. []

9. Peko ma lubu Ot yat

- A). Ot yat pe kany []
- B). Daktari me colo mon pe kany []
- C). Jami me tic pe I ot yat []
- D) pe gamo mon maber []
- E) Agiyo dong ki nwal gang []

10. Adwogi me nywal gang []

- A). Nywal maber
- B). Nywal oyeo
- C). Min latin oto
- D). Latin oto

Apwoyo Matek pigamo lapeny Magi.

Rwot Omedi gum

Appendix 2: Approval letter from GUREC



11/03/2024

To: Lalweny Dorah

GuluUniv
ersity
07826486
02

Type: Initial Review

**Re: GUREC-2023-750: PREVALENCE, FACTORS, AND OUTCOMES ASSOCIATED WITH
HOMEBIRTH; A HOUSEHOLD SURVEY IN PAICHO SUB-COUNTY, GULU
DISTRICT, NORTHERN UGANDA**

I am pleased to inform you that at the **109th** convened meeting on **16/11/2023**, the Gulu University REC meeting voted to approve the above referenced application.

Approval of the research is for the period of **11/03/2024** to **11/03/2025**.

As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.

5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **11/03/2025** in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by Gulu University REC:

No.	Document Title	Language	Version Number	Version Date
1	Informed Consent form	Acholi	Version 2	2024-03-05
2	Informed consent form	ENGLISH	Version 2	2024-03-05
3	ICF Emancipated minor	Acholi	VERSION 1	2024-03-05
4	ICF for Emancipated minor	ENGLISH	VERSION 1	2024--05
5	Protocol without tracked changes	ENGLISH	Version 3	2024-03-05
6	Data Collection Tool Version 1	Acholi	VERSION 1	2024-02-21
7	Data Collection Tool Version 2	ENGLISH	Version 2	2024-02-21

Yours Sincerely



Julaina A. Obika (PhD)

For: Gulu University

Appendix 3: Clearance Letter from the District



GULU DISTRICT LOCAL GOVERNMENT OFFICE OF THE CHIEF ADMINISTRATIVE OFFICER



Tel: 772551353 (Direct)
772361490 (DCAO)

P.O Box 2
GULU – Uganda

In correspondence to this
Please quote: CR/220/1

Date: 30th April, 2024

Ms. Lalweny Dorah
CEH, BPH, MPH

RE: LETTER OF NO OBJECTION.

Please refer to your letter dated 22nd April, 2024 for permission to collect data on research topic "Prevalence, Factors and Outcomes associated to home, a household survey in Paicho" Sub County.

This is to formally grant you permission to conduct your study research on the above subject in Gulu District.

You should however note that, no financial support shall be provided by the District.

Hoping for your cooperation.

Ochengel Ismael
CHIEF ADMINISTRATIVE OFFICER/GULU



The District Chairperson Gulu
The Resident District Commissioner/Gulu
The Principal Human Resource Officer/Gulu

Appendix 4: Consent Forms

A.4.1. Informed Consent Document for Adults – English Version

Title of the study

Prevalence, factors outcome associated with homebirth, a household survey in Paicho sub county,
Gulu District Northern Uganda

Investigator(s): Lalweny Dorah, Student No; 22/U/1977/MPH/PS

Institution(s) Gulu University, Faculty of medicine, Department of Public Health.

Introduction

My name is Lalweny Dorah, student at Gulu University doing a study on prevalence, factors associated with home birth in Paicho Sub County.

A brief description of the sponsors of the research project

The study will be self-sponsored.

Purpose:

The study seeks to determine the prevalence, factors and outcome associated to homebirth to home birth. The findings of this study will help to improve maternal and child indicator.

Procedures:

Your participation in this study will involve answering questionnaire that will be administered to you.

Who will participate in the study?

You have been chosen to participate in this study because you have a child who is eligible in the study. The interview will last for approximately 20 minutes and 427 people will be involved

Risks/discomforts:

There is no foreseeable risk of harm or discomfort that will arise from your participation in this study. The only risk or discomfort will be the inconvenience in terms of time spent during the interview.

Benefits:

There is no direct benefit, but May benefit as a community when there is improved service delivery for pregnant mothers in your area

Confidentiality:

Your identity will not be revealed to any one as we shall only use codes to identify participants. Information obtained will only be accessible by the research team. Soft copies of the data will be protected by password and hard copy files will be kept under lock and key. Confidential information will only be accessed by the principal investigator.

Alternatives:

You do not have to participate in this study if you are not interested. You will not lose any benefit in case of no participation.

Cost:

There will not be any additional cost incurred as a result of participating in this study.

Questions:

If you have any questions related to the study as a research participant, you can contact the principal investigator, Lalweny Dorah on telephone number 0782648602 or via email on

Statement of voluntariness:

Participation in the research study is voluntary and you may join on your own free will. You have a right to withdraw from the study at any time without penalty.

If you have any issues pertaining to your rights and participation in the study, please contact the Chairperson, Gulu University Research Ethics Committee, Dr. Juliana A.Obika Tel: No; 0772964491; email: j.obika@gu.ac.ug or the Uganda National Council for Science and Technology, on plot 6 Kimera road, Ntinda, Kampala on Tel 0414705500.

Statement of consent

..... has described to me what is going to be done, the risks, the benefits involved and my rights as a participant in this study. I understand that my decision to participate in this study will not affect me in any way. In the use of this information, my identity will be concealed. I am aware that I may withdraw at any time. I understand that by signing this form, I do not waive any of my legal rights but merely indicate that I have been informed about the research study in which I am voluntarily agreeing to participate. A copy of this form will be provided to me.

Name Participants Signature Date

Name of interviewer.....Signature.....Date.....

Appendix.4.1. Informed Consent Document for Adults – Acholi Version

Waraga ma nyutu yeyo I kom Kwed Wii lok me kwed:

Dano mono nywal gang, gin ango ma weko dano nywal gang, adwogi me nywal mono tye ango, kwed I dog ot ma tye I Paicho sub county, I Gulu district, kumalo me Uganda

Ngat ma tye ka kwedo tyen lok magi:

Lalweny Dorah latin kwan me MPH

Gang me kwan:

Gulu University

Wii lok

Ngat ma tye ka kwed man en aye Lalweny Dorah, latin kwan me Gulu University. Waraga man tito bot in tyen lok matut I kom kwed man dok gamo lapeny mogo ma in itwer bedo kwede I kom kwed man, ka ce iye me bedo ngat ma gamo lapeny man ci ibi keto cinge me nuytu yeyo ma meggi, ci in bene I ibi dong ki wararga meno ace..

Lok ma nyutu kama cente me timo kwed man oa ki iye.

An atye ka tic ki cente ma mega me timo kwed man, pe ngat tmoo tye ka culu pire. Ngat mo pud peya anongo ma obimiyo kony me cente me konyo ked man.

Tyen lok me kwed man

Kwed man yenyo me ngeyo ka mon ma oyac pud nywal gang, pingo kon ginywal gang ki dong adwogi me nyawl gang tye ni ngo in Paicho subcounty I Gulu kumalo me Uganda.

Adwogi me kwed man obikonyo miyo ngec I kit me yubu tic malube ki yaco, nywalo lutino I yo ma pen cik me youkom mito.

Kit ma kwed man bi bedo kwede.

Wa tye ki lapeny mogo ma cego cego ma wabi penyo ne kwede I dog ot ka ma latin ma ki nwalo I kinne me dwe 36 angec ki nino me timo kwed man

Anga ma bi bedo ngat ma gamo lapeny man.

In ibedo nagt acel ma ki yero me gamo lapeny man pien I ot megii tye latin ma nywalo I kinne me dwe dwe 36 ma okato angec ki nino me kwed man. Gamu lapeny man twero tero dekika pyera aryo keken dok dano ma romo 427 obibedo ki gum me gamo lapeny magi.

Adwogi marac me gamo lapeny man.

Gamo lapeny magi pe ki kit adwogi mo marac I kom in ki dano ma I paconi, ento kwanyo cawa ni manok keken.

Ber pa gamo lapeny magi

Ka I gamo lapeny magi, adwogi me lagam mamegi ni bi bedo me kony me weko wangayo kit peko ma lube mon nywal o ot yat tye kwede ki kit yo ango ma omyero watii kwede me yubu ne wek mon weng ma oyac onywal maber.

Gwoko Mung.

I gamo lapeny magi, pe wabi coyo nyingi ka mo keken. Ngec ma in imiyowa ni obibedo me mung. Wacoko wacoyo I computer ka ma wabigwoko ne iye kama ngat mo mapat pe obi bedo ki kare me nongo ne. Ma I karac tac eni bene wabi gwoko ne kama ber.

Gin mukene

Itye ki kare me kwero gamo lapeny magi k ace pe imito, pe wadiyp dano adiya me gamo lapeny magi.

Well cull

Gamo lapeny magi pe mito cull mo keken, tye me nono, ento nongo iweko wangeyo gin ma diyo kwo pa mege.

Lapeny

Ka itye ki lapeny mo malube ki lok kom kwed mab ma atito bot in ni, ci ipenya kom bedi.

Lok ma lubu jale pi kom kwed man

Bedo ngat ma konyo gamo lapeny magi obedo miti pa ngat ace acel me yer gamo lapeny. I twero kwero mede ki gamo lapeny magi k ace imito labongo ngolo kop mo keken.

Ka I tye ki lok mo keken ma lube ki kwed man, I tweri goyo cim I number 0772964491 bot Dr. Juliana A

Obika won kom ma loyo jang Gulu University ma loyo lok me kwed; email; j.obika@gu.ac.ug onyo the Uganda national Council for Science and technology I plot 6 kimera road, kampala I number cim 0414705500.

Lok ma lubu yeyo me gamo lapeny pi kwed man.

..... Otito bot an lok me kwed man.

Lok ma kubu peko mo marac macalo adwogi me gamo lapeny magi, onyo be pa ngamo lapeny magi, an aniang bene ni moko tam me gamo lapeny magi pe bikelo lok mo marac i koma. Ngec

ma abi miyo ne ni kibikano ne I mung. An angeyo bene ni abibedo ki kare kwero gamo lapeny
magi cawa mo keken ka a mito. An pe a kwero, an ayer me gamo lapeny magi pira kena..

Nying Lagam lapeny.....Cing.....Nino
dwe.....

Nying research assistant.....Cing.....Nino
dwe.....

Appendix 5. Consent Forms for Emancipated Minors

A.5.1 Informed Consent Form for Emancipated Minors – English Version

My Name is Lalweny Dorah a student at Gulu University, Faculty of Medicine, and Department of Public Health doing Master's degree in Public Health

I am conducting a study on the topic Prevalence, factors and outcome associated with homebirth, a household survey in Paicho Sub County.

Objectives of the study

This study seeks to determine the Prevalence of home birth in Paicho Sub County, and factors that leads to home but including its possible outcome this study results will help design strategy that improves maternal health and child health services.

You have been identified as a participant for this study because you have a child born within the last 36 month from the date of this study, and I kindly request you to take part.

Study procedure

I will ask you some questions which is predesigned in line with the objectives that will guide data collection. I request you to answer the question freely with the correct information so that we get the factors that leads to home birth.

Benefits

There is no direct benefits, but benefit as a community when there is improved service delivery for pregnant mothers in your area.

Compensation

I will compensate your time by giving you half a bar of soap.

Risks

There is no foreseeable risk of harm or discomfort that will arise from your participation in this study. It will only take some of your few minutes

Confidentiality

Any information obtained from you will be kept private and secure in a locked place and will be accessed only by the principle investigator, the research team. We will not identify you by your name. The soft copy of the information obtained from you will be kept in a password- protected computer that is only accessible by the research team.

Participants' rights

Your participation in this study is entirely voluntary and refusal to participate will not in any way make you be discriminated against. You are free to withdraw from the study at any stage in case you feel that your rights are not being respected or if you are not comfortable with the study procedure. If you choose to withdraw, all your information previously collected will be destroyed and not used as part of the data analysis or dissemination. In case you still have more questions regarding this study, you may call Lalweny Dorah Tel;No 0782648602, contact her on email komagumdorah@gmail.com.

In case of any questions regarding confidentiality or your rights as a study participant please contact the Chairperson of Gulu University Research and Ethics Committee, Dr. Julaina A. Obika Tel: No., 0772964491; email: j.obika@gu.ac.ug ; or the Uganda National Council for Science and Technology, on plot 6 Kimera road, Ntinda, Kampala on Tel 0414705500.

Consent statement

I have been informed of this study on prevalence, factors and outcome associated to homebirth, a household survey in Paicho sub county, Gulu District northern study participants are mothers who have given birth in the last 36month.

I have been given enough explanation about the study procedures, benefits, risks, and my rights as a participant in this study. I am aware that participation in this study is entirely voluntary and that I can withdraw, without prejudice, from the study at any stage in case I do not feel comfortable with the procedure or study. I understand that it will not affect my access to the healthcare/service that I will receive from this health facility or any other social services/facilities that I intend to access/visit. I therefore accept to take part in this study as a study participant.

Name of participant**Signature****Date**

.....

.....

.....

Investigator's/ research assistant's name**Signature****Date**

.....

.....

.....

Name of Witness**Signature****Date**

.....

.....

.....

A.5.2. Informed Consent Form for Emancipated Minors – Acholi Version

Waraga ma nyutu yeyo I kom Kwed

Wii lok me kwed:

Dano mono nywal gang, gin ang'o ma weko dano nywal gang, adwogi me nywal mono tye ang'o, kwed I dog ot ma tye I Paicho sub county, I Gulu district, kumalo me Uganda

Ngat ma tye ka kwedo tyen lok magi:

Lalweny Dorah latin kwan me MPH

Gang me kwan:

Gulu University

Wii lok

Ngat ma tye ka kwed man en aye Lalweny Dorah, latin kwan me Gulu University. Waraga man tito bot in tyen lok matut I kom kwed man dok gamo lapeny mogo ma in itwer bedo kwede I kom kwed man, ka ce iye me bedo ngat ma gamo lapeny man ci ibi keto cinge me nyutu yeyo ma meg'i, ci in bene I ibi dong ki waraga meno ace..

Lok ma nyutu kama cente me timo kwed man oa ki iye.

An atye ka tic ki cente ma mega me timo kwed man, pe ngat tmoo tye ka culu pire. Ngat mo pud peya anongo ma obimiyo kony me cente me konyo ked man.

Tyen lok me kwed man

Kwed man yenyo me ngeyo ka mon ma oyac pud nywal gang, pingo kon ginywal gang ki dong adwogi me nyawl gang tye ni ngo in Paicho subcounty I Gulu kumalo me Uganda.

Adwogi me kwed man obikonyo miyo ngec I kit me yubu tic malube ki yaco, nywalo lutino I yo ma pen cik me youkom mito.

Kit ma kwed man bi bedo kwede.

Wa tye ki lapeny mogo ma cego cego ma wabi penyo ne kwede I dog ot ka ma latin ma ki nwalo I kinne me dwe 36 anged ki nino me timo kwed man

Anga ma bi bedo ngat ma gamo lapeny man.

In ibedo nagt acel ma ki yero me gamo lapeny man pien I ot megiti tye latin ma nywalo I kinne me dwe dwe 36 ma okato anged ki nino me kwed man. Gamu lapeny man twero tero dekika pyera aryo keken dok dano ma romo 427 obibedo ki gum me gamo lapeny magi.

Adwogi marac me gamo lapeny man.

Gamo lapeny magi pe ki kit adwogi mo marac I kom in ki dano ma I paconi, ento kwanyo cawa ni manok keken.

Ber pa gamo lapeny magi

Ka I gamo lapeny magi, adwogi me lagam mamegi ni bi bedo me kony me weko wangelyo kit peko ma lube mon nywal o ot yat tye kwede ki kit yo ango ma omyero watii kwede me yubu ne wek mon weng ma oyac onywal maber.

Gwoko Mung.

I gamo lapeny magi, pe wabi coyo nyingi ka mo keken. Ngec ma in imiyowa ni obibedo me mung. Wacoko wacoyo I computer ka ma wabigwoko ne iye kama ngat mo mapat pe obi bedo ki kare me nongo ne. Ma I karac tac eni bene wabi gwoko ne kama ber.

Gin mukene

Itye ki kare me kwero gamo lapeny magi k ace pe imito, pe wadiyp dano adiya me gamo lapeny magi.

Well cull

Gamo lapeny magi pe mito cull mo keken, tye me nono, ento nongo iweko wangeyo gin ma diyo kwo pa mege.

Lapeny

Ka itye ki lapeny mo malube ki lok kom kwed mab ma atito bot in ni, ci ipenya kom bedi.

Lok ma lubu jale pi kom kwed man

Bedo ngat ma konyo gamo lapeny magi obedo miti pa ngat ace acel me yer gamo lapeny. I twero kwero mede ki gamo lapeny magi k ace imito labongo ngolo kop mo keken.

Ka I tye ki lok mo keken ma lube ki kwed man, I tweri goyo cim I number 0772964491 bot Dr. Juliana A

Obika won kom ma loyo jang Gulu University ma loyo lok me kwed; email; j.obika@gu.ac.ug onyo the Uganda national Council for Science and technology I plot 6 kimera road, kampala I number cim 0414705500.

Lok ma lubu yeyo me gamo lapeny pi kwed man.

..... Otito bot an lok me kwed man.

Lok ma kubu peko mo marac macalo adwogi me gamo lapeny magi, onyo be pa ngamo lapeny magi, an aniang bene ni moko tam me gamo lapeny magi pe bikelo lok mo marac i koma. Ngec ma abi miyo ne ni kibikano ne I mung. An angeyo bene ni abibedo ki kare kwero gamo lapeny magi cawa mo keken ka a mito. An pe a kwero, an ayer me gamo lapeny magi pira kena.

Nying Lagam lapeny.....Cing.....Nino
dwe.....

Nying research assistant.....Cing.....Nino
dwe.....

Appendix Four: Plagiarism Certificate

GULU
P.O. Box 166
Gulu, Uganda



UNIVERSITY

Tel: +256-471-32924
Fax: +256 471343095
Emails: ul@gu.ac.ug
URL: www.gu.ac.ug

OFFICE OF THE UNIVERSITY LIBRARIAN

PLAGIARISM CHECK

Declaration for Originality Form

This form must be completed and signed for all scholarly work produced.

Name: LALWENY DORAH (MS.)

Personal File No.(staff) Reg. (student). **REG. NO. 22/U/1977/MPH/PS**

Faculty/Institute: **FACULTY OF MEDICINE, GULU UNIVERSITY**

Department: **PUBLIC HEALTH**

Title and bibliographic description of the work

PREVALENCE OF HOME BIRTHS, ASSOCIATED FACTORS, AND OUTCOMES: A HOUSEHOLD SURVEY IN PAICHO SUB-COUNTY, GULU DISTRICT, NORTHERN UGANDA.

Declaration.

1. I understand what plagiarism is and I am aware of the University policy on this regard,
2. I declare that this ... **Dissertation** ... (Proposal, thesis, essay, assignment, paper, report etc.) is my original work and has not been submitted elsewhere for examination, award of a degree or publication. Where other people's work or my work has been used, this has been properly acknowledged and referenced in accordance with Gulu University requirements,
3. I have not sought or used the services of any professional agency to produce this work,
4. I have not allowed, and shall not allow anyone to copy my work with the intention of passing it off as his/her own,
5. I understand that any false claim of this work shall result in disciplinary action in accordance with University Policy on Plagiarism.

Signature [Signature]

Date 1/10/2025

Originality Report

The article/thesis/document titled above have been subjected to plagiarism check and the level was found to be.....**18%** (percent) this is classified as:

- ☒ Minor
☐ Moderate
☐ Serious

Yours sincerely, 29 SEP 2025

[Signature]
Clement Lutaaya Nabutto Claire (PhD)
University Librarian