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Influence of pregnancy perceptions on patterns of seeking antenatal care among women in reproductive age of Masaka District, Uganda

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Abstract: Maternal mortality remains a challenge in Sub-Saharan Africa including Uganda. Antenatal Care (ANC) is one of the recommended measures to improve maternal and child health. However, the influence of pregnancy definition and perception on patterns of seeking regular and timely antenatal care among women in the reproductive age group (15-49 years) is not known. The objectives of this study were to: (i) understand the women's social definitions and perceptions on their pregnancy; (ii) understand the socio-cultural beliefs related to pregnancy among women of the reproductive age group; and, (iii) examine the influence of social definitions, perceptions and beliefs about pregnancy on women's antenatal care seeking behaviour patterns to inform the decentralised health care delivery system in Uganda. A total of 45 women, mothers and expectant women who were purposively selected from Kimanya sub county of Masaka district in Uganda participated in the study. Ten key informant interviews and four Focus Group Discussions (FGDs) were also conducted. Key findings indicate that the women's socio-definitions and perceptions of pregnancy influence their seeking behaviour on antenatal health care. To the women with a positive orientation towards antenatal care, pregnancy provides joy, happiness, pride, promotes their social status and safe-guards their marriage. Pregnancy is rewarding with care, love, support and gifts. Women who shun antenatal care perceive pregnancy to be a source of misery, sadness, pain and suffering. It is an uncomfortable and regrettable experience. Women also hold socio-cultural beliefs on pregnancy, which are culturally constructed and rooted in taboos, rituals and practices of their communities. It is therefore important to sensitise women and those who attend to them when they are pregnant to understand these perceptions and definitions to motivate them to seek antenatal and postnatal care for better maternal and child health.

Keywords: women, pregnancy, perception, socio-cultural beliefs, seeking, antenatal care, Uganda

Introduction

The experience of being pregnant encompasses physiological, psychological, spiritual and socio-cultural dimensions (WHO, 2003). Antenatal care (ANC) services are essential for a healthy pregnancy and child delivery though some workers argue that this is still an on-going debate (Adjiwanou & LeGrand, 2013). Conrad *et al.* (2012) argue that experience from countries which have achieved low maternal mortality suggests that access to good-quality maternity services is critical to the improvement of maternal health. ANC is an interactive process between the pregnant woman and the medical personnel such as doctors, nurses and midwives. Like any other social interaction, it is influenced by socio-cultural definitions and perceptions particularly on pregnancy itself in this case. These definitions, perceptions and beliefs depend on the cultural and value systems.

In 2007, the World Health Organisation reported that 1,500 women die every day from pregnancy and childbirth related complications the world over. In 2005 it was estimated that 536,000 maternal deaths occurred worldwide due to pregnancy related complications (WHO, 2007). Though in 2012 a 47% decline in annual maternal deaths was reported (UNFPA/UNICEF/WHO/ World Bank, 2012), it was still noted that many countries, particularly in sub-Saharan Africa will fail to reach the Millennium Development Goal target of reducing maternal death by 75% from 1990 to 2015. Developing countries account for 99% of all the deaths and most of these deaths are due to direct causes of pregnancy complications (WHO, 2014). In developing countries, complications of pregnancy and child birth are the leading causes of death and disability among women within the reproductive age group (http://www.who.int/healthinfo/statistics/indmaternalmortality/en/).

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Whereas millions of women lack access to maternal health care including antenatal care that would save their lives during pregnancy and mitigate disability during child birth, tens of thousands of women, who have access to the care turn up late, make fewer medical contacts and a bigger number of expectant women do not seek the service for various reasons (Simkhada *et al*., 2008; Kisuule *et al.,* 2013). When a mother dies, her family and community also suffer and the surviving children face higher risks of poverty, neglect and or even death (Otsui, 1997; World Bank, 2006). According to WHO (2003), expectant women should visit health care facility at least four times depending on the risks identified with the pregnancy on the first contact. The four visits have different maternal and child health goals. These goals revolve around confirmation of the pregnancy and expected date of delivery; classification of women for basic antenatal care (four visits) or more specialized care (Lincetto *et al*., 2006). It is also intended to screen, treat and give preventive measures for certain diseases; and to develop a birth and emergency plan with the expectant mother. The subsequent three visits aim at assessing maternal and foetal well-being, excluding pregnancy-induced hypertension and anaemia, giving preventive measures, reviewing and modifying birth and emergency plan. The last fourth visit, in addition, is intended to exclude or give preventive measures for multiple pregnancy and mal-presentation (Lincetto *et al*., 2006:54). During these contacts, pregnant women are immunized against tetanus to protect the foetus, diagnosed and treated against diseases such as anaemia, malaria and sexually transmitted infections. During child birth, delivery should be supervised by a medical personnel in a safe health facility equipped to handle high-risk deliveries and to provide post natal care. It is these and other risk factors as well as birth preparedness that need to be improved for better ANC results and outcomes (Tetui *et. al.,* 2012).

Available statistics show that in Uganda there was little improvement in the utilisation of ANC between 1990 and 1996 and further improvements were recorded between 2000 and 2006 (PRB, 1997; WHO, 2006; UBOS, 2012). However, the WHO (2006) indicated that there was stagnation at 44% in the seeking of antenatal care in the African region. In 2006 only 60% of the mothers in developing countries attended antenatal care from a qualified medical worker (WHS, 2008). Furthermore, according to World Health Statistics (WHS, 2008), about 50 million of would-be antenatal seekers did not seek assistance from medical personnel during pregnancy and child birth. In Uganda, the Ministry of Health (MOH) implemented a 'Safe Motherhood' programme to improve health status of women in the reproductive age group with special emphasis on antenatal care provision and treatment of sexually transmitted infections (MOH, 2006). The Ministry recommended at least four visits during pregnancy to a health worker by an expectant mother. It further recommended that a woman attends antenatal care monthly during the first seven months, every two weeks in the eighth month and weekly in the ninth month until birth. By the end of 2006, 47% of the women attended at least four times as recommended and only 17% of the women visited the medical personnel within the first three months of the pregnancy (UBOS, 2006). In 2011, almost 95% of women who gave birth in the five years preceding the survey received antenatal care at least once from a skilled provider (UBOS, 2012).

Though economic, structural and service quality have been advanced as key barriers, the situation calls for more concerted efforts to identify all the possible variables responsible for low level attendance of antenatal clinics. A number of barriers to meaningful utilisation of health care services and antenatal care services in particular have been documented. The barriers include factors that influence antenatal care seeking among women of the reproductive age (Watuulo, 2000; Kisembo, 2001; Kyomuhendo, 2003; Neema *et. al*., 2004). However, none of these studies has specifically focused on how pregnant women and mothers perceive or define their pregnancy and related beliefs and the influence of such perceptions on antenatal care seeking behaviour. In addition, though Jagwe-Wadda (2007) argues that the causes of maternal mortality are culturally interlinked, women's perception of pregnancy has not received sufficient research attention. The objectives of the study were, therefore, to: (i) understand the women's social definitions and perceptions on their pregnancy; (ii) understand the socio-cultural beliefs related to pregnancy among women of the reproductive age group; and, (iii) examine the influence of

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social definitions, perceptions and beliefs about pregnancy on women's antenatal care seeking behaviour patterns to inform the decentralised health care delivery system in Uganda.

Materials and Methods

Study area

The study was conducted in the sub county of Kimanya-Kyabakuza of Masaka district in Uganda. Masaka is located in central Uganda and is one of the districts with the highest number of health facilities yet with the lowest deliveries supervised by medical professionals (MFPED, 2002). Though predominantly inhabited by ethnic Baganda, Masaka is a multi-cultural district due to high level immigration.

Study design and data collection

A case study design was adopted to allow for more in-depth explanation and understanding of the qualitative nature the variables in the study and how they influence women's decisions on seeking antenatal care. The case study was deemed to be appropriate and relevant to collect the required information on the study objectives.

The study was qualitative and the required information was collected using in-depth interviews and focus group discussions with women and key informant interviews. Qualitative methods aimed at capturing the needed data from people with knowledge and experience on antenatal care. A qualitative sample of 45 women within the reproductive age group (15-49 years) was therefore purposively selected from eight villages in two parishes of Kimanya and Kyabakuza. A total of 15 mothers, 15 pregnant women attending ANC at the hospital and 15 women clients to Traditional Birth Attendants (TBAs) were involved in the study. In-depth interviews focusing on women's demographic characteristics, perceptions, definitions and beliefs related to pregnancy and how they influence women's antennal care seeking behaviours were done using an unstructured questionnaire.

Exit interviews were conducted with every 5^{th} expectant woman as they left the antenatal clinic of Masaka Government Regional Referral Hospital. The 15 clients of TBAs were obtained through snowball sampling and with help from TBAs in the villages. The remaining 15 mothers (who had parity of at least one birth) were reached with the aid of the Local Councils officials at their residences with a systematic sampling interval of five houses. Key informant interviews were held with the district medical officer, two midwives at the antenatal care department of the hospital, two local opinion leaders, two TBAs, one elderly lady who has ever helped a woman deliver, a medical staff at Marie Stopes Reproductive Health Centre and two women representatives at Local Council One (LC1) from the two parishes. A question guide was used during key informant interviews. Lastly, four focus group discussions (with 9-11 participants) were conducted with clients to TBAs, middle aged women between 20-30 years, teenage expectant girls between 15-19 years and elderly women aged 40-45 years. A question guide was used to elicit and capture their responses.

The tools used during the interviews and discussions were designed in English and questions, where necessary, were translated into Luganda (the local indigenous language of the study area) which is the mother tongue of the researchers. The information was captured with use of both note taking and tape recording. The tape recordings were afterwards transcribed into English.

Data analysis

After transcription, the qualitative information derived from note taking and tape recordings was analysed using thematic and content analysis. The analysis was done at three levels. Level one captured all the information and experiences of women and other persons on the understanding of pregnancy and antenatal care as well as the demographic characteristics of the women. Level two focused on categorising the information generated by level 1 into perceptions, definitions and beliefs on pregnancy and antenatal seeking behaviour. Level 3 focused on analysing how

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perceptions, definitions and beliefs influenced the patterns of antenatal seeking behaviour. The analysis aimed at identifying commonalities, variations and divergences in the perceptions, definition and beliefs in terms of how they influenced different women on seeking antenatal care.

Ethical considerations

The study was approved through internal research review committees for higher degrees and research grants at School of Social Sciences, Makerere University. Necessary ethical precautions were taken to protect the confidentiality of the respondents and the information they gave. Only respondents who consented were interviewed and were informed of their rights to withdraw from the interview at any time they wished.

Results

Socio-demographic characteristics of respondents

Most of the respondents had attained basic primary education, were married, dominantly catholic compared to other religions and Baganda by ethnicity. Most women were either housewives or small scale farmers with very few of them employed in public service sector. Teenage respondents (15-19 years) were reported to be poor seekers of ANC yet most of them were having their first pregnancy and belonged to the risky age group that needs extra antenatal and postnatal care. Few of the women in this age group sought assistance from medical professionals. A FGD of expecting teenagers, for example, reported: "*…as a young girl, I often find it hard to pay a visit to the antenatal clinic due to lack of money to facilitate my movement to the health centre. This is sometimes the case with other fellow teenage expectant women who find themselves missing attending antenatal care clinics because they have no money or they lack the required information to enable them attend antenatal care clinics*". Whereas women at the beginning and end of the reproductive ages were poor seekers of ANC middle aged women had a more positive attitude towards antenatal care compared to the teenage mothers. There were few older women who sought ANC from the trained medical health workers usually for fear of being attended to by comparatively younger female health workers.

Occupations of women tended to affect utilisation of antenatal care services and seeking patterns in terms of affordability and time. In this study, most women were housewives who are not engaged in financially gainful employment and hence depended on other decision makers for their choice to go for antenatal care. One respondent who was a housewife, for example, said *"I solely rely on my husband's financial support or a free ride to hospital whenever I am to attend antenatal care. If he is away, then I miss or wait until he comes back"*. In relation to this, the place of residence also appeared to influence the patterns of ANC seeking behaviour among expecting women. Women and mothers whose residences were in rural areas or far from a government health unit found it more difficult to travel long distances to attend antenatal care compared to those who stayed in semi-urban areas with comparatively easier access to health units. This was mainly caused by transport costs and health status of the women. In one FGD, for example, it was reported *"the distance to the only government hospital in this sub county is too long for me to travel on foot. Travelling to the health centre is only possible by use of public transport that is uncomfortable and expensive for me. This often discourages me and other women from going for antenatal care at the hospital and instead go to the traditional birth attendants in our village for assistance"* (FGD of Clients for Traditional Birth Attendants). More urban or semi-urban women compared to rural women sought ANC from trained medical personnel within the sub-county.

Women who had attained tertiary education reported seeking antenatal care from trained medical personnel compared to their counterparts who had never been to school. Some of the women who have never been to school did not visit antenatal care health clinics at all. This was corroborated by the response from a medical staff of Marie Stopes Reproductive Health Care Project who said *"women who have been to school and completed the secondary level of education have been found to have basic information related to the benefits of attending antenatal*

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care clinics. This provides us with background information against which we support them when it comes to maternal issues including antenatal care". However, some educated women used both local herbs and modern medicine from trained medical personnel.

Social perceptions and definitions of pregnancy

Women had different perceptions and experiences of pregnancy. Some women perceived pregnancy to be a valuable and unique encounter. It was described as an experience that requires special care. Such care includes attending antenatal clinics for the four or more recommended times to avoid any complications that may lead to the loss of the pregnancy. In this study, most women who were happy to get pregnant felt excited and talked about pregnancy as a wonderful experience through which they saw their childhood dreams of being mothers fulfilled. A traditional herbalist aged 41 years old, for example, said *"I was happy and full of joy and could not help it but tell my mother because she always offered me a listening ear".* Another Primary five drop-out aged 30 years also said, *"I was happily married during my first pregnancy. It was the right time because I and my husband were ready to have a child. When I realised I was pregnant I informed him because he was responsible for the pregnancy and he happily supported me".* To such women pregnancy was socially acceptable and a source of joy and excitement. These values, in turn, motivated the expectant women to go for antenatal care to avoid jeopardising their dreams. Most women who sought antenatal care to the full gestation period reported that it was a way of promoting happiness and excitement they had got when they became expectant. Others said that the motivation came from the important traditional cultural value of extending the family line as well as what they termed 'eliminating genetic decay'.

On the other hand, some women defined pregnancy as a painful and regrettable experience especially if they conceived accidentally or outside their own volition. Such a perception of pregnancy was more likely to make women report late for antenatal care or not turn up at all. Some women looked at their pregnancy as an accident and/or a surprise over which they had no option but to cope with. This category included women, such as students, who did not want or were not supposed to get pregnant but found that they were pregnant. Such women found themselves in a situation of fear, shock and hate and hence did not want to go for ANC mainly because they had not psychologically and socially accepted their pregnancy. One Catholic hairdresser respondent from Kimanya B, said, *"I felt bad since I was a student and did not tell anyone due to the fear I had but afterwards my boy friend got to know and supported me*". In addition to self stigma, society and health service providers often add more insults to such young mothers leading to some women perceiving pregnancy as painful and full of suffering, sadness, misery, fear and discomfort. The findings further showed that majority of the interviewed women had experienced nausea, dizziness, headache, loss of appetite, general physical weakness, vomiting and having cravings for peculiar foods or even soil.

Yet other women defined pregnancy from their socio-cultural or values system perspective. Such women believed in cultural facts about pregnancy. These were taboos, customs and rituals supposed to be practiced by the expectant women in order to avert any bad omen likely to harm a mother and unborn child before, during birth and after child birth. These beliefs were reflected or manifested in the do's and don'ts reported or observed during pregnancy and child birth. The beliefs were culturally constructed and passed on from one generation to another through customs and traditions. Through the different ethnic groups, it was possible to observe the different cultural orientations among the women that are useful in understanding the general belief system as socially constructed, defined and perceived. In addition, cultural values on pregnancy in terms of definitions and perceptions influenced the decision to seek antenatal care in several ways. Some women wanted to get pregnant while others did not for various reasons. Some women became pregnant when they actually wanted while others did so when they least expected it. The study found that the main reasons women got pregnant were related to economic readiness, proof of maturity and being responsible and to safeguard marriage. Other reasons included gaining personal independence or to have a child of

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a different sex. However, a few women reported that their pregnancy was an accident and had not been planned for.

Antenatal care seeking patterns

Women's antenatal care seeking behaviour patterns did not conform to the medical recommendations. The timing of visits shows that very few women attended ANC during the first trimester. The first trimester starts at the time of conception and stops at the 3rd month of the pregnancy, the second starts at the 4th month and stops on the 6th month while the last one starts at the 7th month up to the time of delivery. This behaviour pattern started from the first pregnancy and persisted throughout the subsequent pregnancies. However, behaviour pattern among expecting mothers improved for the second trimester especially for the first pregnancy. Some women only visited the ANC clinic in the third and last trimester of their pregnancy.

An inconsistence in seeking ANC among women at different pregnancies was observed. Most women did not go for antenatal care when expectant. Some pregnant women reported late while others reported for less than the four visits recommended. Many more others sought assistance from traditional birth attendants. Most expectant women reported for their first antenatal care in the second trimester of pregnancy. This was consistently done from the first to the second and third pregnancies considered during the study. Study findings further show that most women visited antenatal clinics during their first and second pregnancies but more women reported during the third pregnancy. At no single point during any of the pregnancies did all the women seek antenatal care which is worrying for better maternal and child health.

Social perceptions of pregnancy, culture and antenatal care seeking behaviour

Women who perceived pregnancy as a source of happiness, joyous experience, especially during their first pregnancy, were excited and motivated to seek support, including antenatal care, to keep the pregnancy and deliver it normally. This first experience tended to influence the behaviour during the subsequent pregnancies. Most women who visited the ANC clinics did so to ensure that they get the needed health care to preserve the pregnancy to full gestation period as a way of promoting and sustaining the happiness and excitement they had got when they became expectant. There was, for example, a woman who viewed pregnancy as socially acceptable, pleasurable experience, a redefinition of woman's status and associated with rewards. In addition to their own joy, pregnancy was also described as a way of safeguarding marriage and attracting care, affection, and support including gifts from other community members.

In addition, other women described pregnancy as a normal development process which every woman should undergo as they grow from childhood to maturity (*Olutalo lw'Abakyala or Orugamba rw'Abakazi* literally translated as *every woman's battle*). To such women, being pregnant was a normal process of growth or expected form of experience and hence needs no special care. Women with such perceptions said that there was no need for special treatment to be accorded to pregnancy: every true woman must be pregnant and successfully deliver the child normally. Such women reported that they had had no complications during pregnancy. A 37 years old housewife of Kimanya A, for example, said, "*I felt normal during my first pregnancy and I had no complications and hence did not need to go to hospital for antenatal care*". On the contrary, the women who conceived accidentally were not prepared to face the demands and challenges of pregnancy. Their experiences were shrouded in shock or fear and subsequently negatively affected their antenatal care seeking behaviour. Most of them reported that they did not want any person, including those close to them, to know that they were pregnant and yet seeking antenatal care from a public health centres would expose their secret.

The study findings further established that these perceptions further influence the desire to be or not to be pregnant. Some women reported that they conceived because they wanted to have a child especially at that point when they felt that they were financially able. Another group of women reasoned that they became pregnant to gain personal independence and get societal approval about their maturity since it is the grown-up and mature woman that can produce

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children. Other women said they became expectant because they wanted to safeguard their marriages. It is worth noting that the reasons women presented for becoming pregnant were also in themselves definitions, perceptions and beliefs they hold about pregnancy.

In addition to cultural values on personal definition of pregnancy, there were also cultural beliefs that define what should and should not be done during pregnancy. In the Kiganda culture like most other African cultures, there is a widely held belief that use of herbs averts bad omen likely to cause harm to a mother and the unborn child before, during and after child birth. The beliefs about pregnancy become visible through the "dos and don'ts" observed during pregnancy which include the use of *emumbwa* (the preservation of herbal medicine by mixing it with clay soil). Different forms of *emumbwa* are believed to perform different roles including removing bad omen, keeping the expectant woman energetic, curing sexually and genetically transmitted diseases and also widening the pelvic bones to facilitate safe normal delivery. In the study, women reported that they had ever used herbs for different purposes while the majority reported that they had ever used at least one of the herbs during pregnancy. One Key informant who helped a woman to deliver said *"when the expectant woman is feeling well and has no pain, there is no reason to attend antenatal care as long as she has bathed in local herbs"*. This may be attributed to the fact that even the TBAs use these herbs themselves as was discovered in one FGD for TBAs *"...when I had my third pregnancy, I used to mix 'kakubamuliso' and 'ekikakala' (local herbs) in water in my basin and then took a cold bath in the morning which helped me to prevent Nabuguma (high body temperatures) and since then I have never had a miscarriage as it was the case in the early stages of my child bearing experiences"*. Furthermore, the District Medical Officer also commented on the use of herbs as follows: "*Some women strongly believe in the herbs and the rituals they perform when they are expectant. This obstructs them from attending antenatal care clinics because the people who provide them with the herbs are friendly to them and at times they pay by credit or in kind*".

Furthermore, some taboos restrict women from eating certain foods, slaughtering of animals, sharing toilets or a washing basin, crossing road or pathway junctions and seeing a burning house or bush as well as extramarital sexual intercourse. One medical key informant said "*avoidance of engagement in extramarital sex by both the mother and father of the unborn child should be observed to avoid 'amakiro' or pre-eclampsia (puerperal psychosis)*" while a TBA from Kyabakuza Local Council 1 said *"A pregnant woman should avoid attending burial ceremonies or digging the grave yards and jumping over graves because the unborn child may have a deformed head or may become insane*". The study established that avoiding slaughtering of animals is believed to avert the risk of killing the unborn child. Seeing newly born bird chicks which are still blind or seeing dead animals are believed to cause still births. The other problems which were reported to result from non-observance of the strongly held taboos include, in order of mostly reported: general body weakness and being sickly, abnormal foetus movement, miscarriages, abdominal pains, malaria and fevers, loss of weight, being pregnant beyond the gestation period of nine months, bleeding and vaginal discharge as well as sexually transmitted diseases. On the contrary, respecting the cultural taboos was believed to result in a healthy pregnancy characterised by normal and healthy position and movement of the foetus, healthy and strong expectant mother who is emotionally stable.

Discussion

Though most literature quote economic, structural constraints and quality of service as the key barriers to access and utilisation of health services including reproductive health care services (PRB, 1997; Kisembo, 2001; Kyomuhendo, 2003; MOH, 2006; UBOS, 2006, 2012; WHO, 2007), demographic and household/family as well as cultural realities have a strong influence on health outcomes. Furthermore, though UBOS (2012) reports that women who had antenatal care by a skilled provider varies very little by background characteristics, the nature and quality of demographic characteristics of age, occupation and residence may either promote or discourage the willingness, ability or need to attend the ANC clinic as this study found.

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Age of a woman influences the knowledge of and attitude towards antenatal care. The young and adolescent mothers tend to lack knowledge and support. According to Atuyambe *et al.* (2005), adolescent mothers face domestic and family violence, gender, economic and health service problems when they are pregnant. These problems traumatise and stigmatise the young girls and constrain their options to the extent of trying unsafe abortion. Older mothers tend to be chief custodians of strongly held cultural beliefs and values that may not favour using modern health care services including antenatal care (Sychareun *et. al.*, 2009) particularly amidst the socio-economic challenges that mostly affect rural women. Hence, service providers need to bear in mind the needs of women of different reproductive age groups.

Women occupations affect utilisation of antenatal care seeking patterns in terms of affordability and time. A majority tends to be housewives without independent and stable financial or other resources position which limits their independent decision making on seeking antenatal care services. As a result most mothers depend on their husbands or other relatives to access essential services beyond the households including health services. Differences in occupations influence time availability and access to vital information on ANC as well as general accessibility for health services. A woman involved in gainful employment finds it comparatively easier to meet costs for health needs and to access information needed on ANC services than a large number of women who stay at home as housewives. Similar findings have been reported from rural Ghana where economic ability of women was found to be a major factor affecting health (Yakong, 2008). Financial dependence of women on their husbands affects their decision making because health care options must be supported by their husbands. Women lack the power to spend money on health care without their husbands' permission. Similar findings have been reported elsewhere in Uganda (Okutu, 2011).

Though education influences the level of knowledge and information that a person has, there is no significant relationship that has been found to exist between education and seeking antenatal care in this study. Similarly, although Ndyomugyenyi *et al.* (1998) found that though parity significantly influenced antenatal care attendance, level of education, religion and marital status did not. Hence, the differences in the antenatal care seeking behaviour among women could be more attributed to other factors like pregnancy perceptions and experiences than educational differences.

The less influence of background characteristics on antenatal care attendance points to the importance of the individual experiences by pregnant women. Painful experience of pregnancy causes and/or is characterised by suffering, sadness, misery, fear and being uncomfortable. Many pregnant women tend experience nausea, dizziness, headache, loss of appetite, general physical weakness, vomiting and having cravings for peculiar foods (Neema *et. al.* 2004). Such experiences by expectant women may force them to hate the pregnancy subsequently resulting into failure to care for it and to shun antenatal clinics. On the other hand, a lovely and memorable experience motivates expectant women to seek all help including antenatal care to safeguard the expected child. However, all these perceptions tend to be cushioned in cultural value systems. According to Okutu (2011), socio-cultural belief systems, values, and practices also shape an individual's knowledge and perception of health and illness/disease, and health care seeking practices and behaviours. These value and belief systems are shaped by the dominant organizational philosophy. In dominant patriarchal cultures such as those found in Uganda, for example, men constitute a strong determinant factor in the definition of a health care need and how it is met given that they control almost all the resources in or for the family. Perceptions of men and women depict the agitation of men to deny their wives or daughters-in-law from seeking antenatal care to avoid exposing their genitals to other men who are not their husbands because (Kasolo & Ampairwe, 2000). Most women prefer TBAs, who are dominantly older women, to doctors/midwives/nurses (Okutu, 2011). Usually Traditional Birth Attendants do not see private parts during attendance, except they just feel by touching which is more common in the rural parts of the country. Hence, it is imperative for the health care takers of expectant women to be aware of these contextual and cultural realities as they welcome, teach, sensitize and assist women during antenatal care visits.

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Study findings revealed that antenatal care seeking behaviour patterns of expectant women do not conform to the medical recommendations. Most women do not go for antenatal care when expectant, a number of pregnant women reported late while some women reported for less than the four visits recommended (WHO, 2003). UBOS (2012) confirms that whereas 95% of women go for ANC to a health facility, it is usually once during a pregnancy. Inconsistence in attending ANC clinics needs to be understood from the way the individual mothers perceive and define their pregnancies. According to Kleinman's (1978) model, there are different reasons that may compel a patient to seek for medical attention. One of the aspects is time and mode of onset of symptoms such as the nature or type of pregnancy complications that occur. Experiences of abdominal pains or other complications and fear of caesarean section during delivery, for example, may motivate women to contact medical professional for ANC services. On the other hand, women who do not experience pregnancy complications and also have normal child delivery tend to take it for granted and may see the health professionals less for ANC. Women continuously use their cultural value systems to interpret the meaning and perceptions of their pregnancy and the need for medical attention including antenatal care.

There is a strong interaction of social perceptions and definitions of expectant women, their culture and how they seek antenatal care. A joyous experience, for example, obliges the father to the unborn baby and his family to support the expecting wife. One reason why the husband and family support the expecting wife is to eliminate genetic decay which also qualifies the husband as a man. This concurs with Safadi's (2005) findings that expectant women seek antenatal care due to the support and care they are given by their husbands and family members during pregnancy. Whereas a painful experience of pregnancy may encourage some women to seek for antenatal care, it may also discourage others especially the adolescent mothers who often meet unfriendly reactions to their pregnancy from their family and health providers. Women clearly distinguish a healthy pregnancy from one with complications. A healthy pregnancy is defined and characterised as one in which there is movement of the foetus. It is proof that both the woman and pregnancy are healthy. Other signs of a healthy pregnancy include feeling strong, freedom from malaria, fevers, vomiting, headache and anaemia. Some expectant women argue that such signs imply that one does not need to visit the medical health worker for ANC checkups, meaning that such a construction of pregnancy negatively influenced ANC health seeking behaviour.

Furthermore, strong patriarchal cultures also influence women's health seeking behaviour patterns. Such systems make expectant women take their socio-economic and physical vulnerability as normal. To believe that a true woman should go unsupported through pregnancy to safe child delivery implies that the woman takes the blame for a bad pregnancy or unsuccessful child delivery while success usually goes to the man and his family. This is part of patriarchal domination and exploitation though the perception is gradually weakening among women of the contemporary society because of western formal education and more exposure to health information.

Expectant women must observe certain taboos during the pregnancy period, in the process of preparing for birth, during child delivery and after birth. It is believed that once these taboos are observed, the health of the mother and child will be assured. The influence of cultural values and belief systems is much more qualitative than quantitative, varies from context to context and hence not standard and is more endogenous than exogenous in terms of bias (Rockers *et al.,* 2009). Cultural value systems expose women to barriers that lie beyond lack of resources in healthcare services or accessibility to such services. Cultural barriers force women to adhere to very traditional practices of child birth. They, for example, deceive women that pregnancy is a test of endurance and subsequently make maternal death just appear sad but normal reality. This cultural view also hinders the chances of women seeking professional maternal care. The socio-cultural beliefs that women hold on pregnancy are culturally constructed and reconstructed and further rooted in taboos, rituals and practices of their communities. Hence, the service providers to expectant women need to be trained to be aware

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of and understand these dynamics in order to appropriately respond the antenatal care needs of women.

Antenatal care is central to the realization of maternal and child health goals. However, there are other factors and processes that facilitate or hinder the achievement of such health indicators. These are demographic, structural, quality of services, social perceptions or definitional and cultural. However, whereas the first three have received greater attention in terms of research, publication and policy (Hulton *et al.,* 2000; Atinga & Baku, 2013), more needs to be done on the influences of social perceptions, definitions and culture. The experience of positive perceptions, definitions and beliefs encourages better antenatal care seeking behaviour and the reverse is also true. Experiences of pregnancy are socially constructed and constitute the basis for the behaviour that women exhibit when it comes to the seeking of antenatal care. This is in line with Kleinman's (1978) health model of health and illness, where the expectant women evaluate rationale for their pregnancy, causes of their pregnancy complications and make decisions on the appropriate treatment for desired outcomes. What is important is not whether a woman has a positive or negative experience but how positive experiences can be harnessed and how the causes of negative experiences can be removed or managed under a decentralised health care delivery system.

Given that such social definitions of pregnancy held by women influence their antenatal care seeking behaviour, it is important to sensitise women and those who attend to them to understand these social constructs and perceptions in order to motivate pregnant women or mothers to seek antenatal and postnatal care for better maternal and child health. The health care delivery system needs to critically and strategically determine how the custodians of traditional cultural values which are related to conception and child delivery are integrated to tap into their supplementary role while at the same time containing negative influences from such cultural values. The value of seeking timely antenatal care from competent sources and clearing of myths about pregnancy taboos should be promoted through both electronic and printed media as well as religious forums. The information should be accessible, intelligible and in a language that can easily be internalised by recipients.

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