

## Prevalence and Associated Risk Factors of Ante-Partum Hemorrhage among Pregnant Women Attending Antenatal Clinic at Jinja Regional Referral Hospital Jinja City.

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### ABSTRACT

This study was carried out at Jinja Regional Referral Hospital to determine the Prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending antenatal clinics. The researcher used simple random sampling to select her Mothers to participate in the study. The mothers that participated in this study were 15 years and above and had genuine and mature answers according to the Researcher's view of the study. The questionnaires were constructed to obtain information on the prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending antenatal clinics. The researcher analyzed the quantitative data that was collected using questionnaires and analyzed using SPSS. It was expressed in terms of frequencies and percentages, which helped the researcher to show the distribution of respondents on each of the independent and dependent variables. The majority of the mothers were of the age group (26-30) years accounting for 33.3%, and the least were both (30-35) years and above 35 years accounting for 18.8%. 91.7% of the respondents were married, 4.2% were divorced and 2.1% were widows. The majority were peasants accounting for 41.7%, followed by employed ones at 31.2%, unemployed were 25.0% and lastly unspecified at 2.1%. These respondents were majorly of college/tertiary level of education accounting for 37.5%, followed by uneducated at 25.0%, secondary level at 22.9%, primary level were 10.9% and lastly post-graduate level at 2.1%. The majority of the respondents were not having PV bleeding which is 79.1% and those with PV bleeding were only 18.8% of the respondents. For those with PV bleeding it mainly lasted for 1 day with 6.2% of the respondents. It has found that APH was common in mothers in the age group of (20-30) years and factors which increased APH among women that participated in the study included the following factors smoking or chewing tobacco, number of deliverance, history of operations on the uterus, time interval to get another pregnancy, history of trauma. This made these major risk factors of APH. There the research recommended the government, sub-county, district and health workers to educate mothers on the risk factors of APH especially those above.

**Keywords:** Antepartum haemorrhage, Pregnant women, Antenatal clinic, PV bleeding, Mothers.

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### INTRODUCTION

Antepartum haemorrhage is listed as a maternal complication in 15.1% of fetal and 7.1% of early newborn deaths worldwide [1]. APH is responsible for an estimated 6.5% of maternal deaths worldwide [2]. Up to 1/5 of all very preterm

babies are born in association with APH [3]. APH complicates 2-5% of pregnancies and is defined as bleeding into or from the genital tract after the 20th week of pregnancy [4]. APH is a serious condition which accounts for a high percentage of

maternal and neonatal morbidity and mortality. Identifiable causes of APH are recognized in 50% of cases, and in the other 50% of cases, the cause for the APH is indeterminate or unknown [5]. Blood loss is often underestimated and the amount visible may only be a portion of the total volume of the hemorrhage. There were 4 deaths from APH in the more recent report [6]. In the 2005-07 report of the Confidential Enquiries into Maternal Deaths in South Africa, obstetric haemorrhage was the third most common cause of death accounting for 12.4% of all deaths; there were 108 deaths from APH and 74 of these (68.5%) were considered to be clearly avoidable. Haemorrhage emerges as the major cause of severe maternal morbidity in almost all 'near miss-audits in both developed and developing countries [7]. Between January 1 and December 31, 2013, a total of 3,854 women gave birth in JUSH Ethiopia. One hundred ninety-five of them were diagnosed to have APH showing a cumulative incidence of 5.1% in 2013. The average age of the women was 26.6 years with a standard deviation of 5.9 years. Two third of the mothers were in the age range of 21 and 34. Abruptio placentae and placenta previa were the major causes of APH established as final diagnoses in 127 (65.1%) and 52 (26.7%) APH patients, respectively. Other causes including leech infestation and unknown causes accounted for 16 (8.2%) of the cases. The incidence of abruptio placentae and placenta previa was 3.3% and 1.4% among mothers who gave birth in JUSH in 2013 [8]. In the study of patient characteristics and outcomes in antepartum haemorrhage due to placenta previa and abruption placenta at the university teaching hospital, Lusaka, Zambia, a total of 73 consecutive patients were recruited into the study from October 2013 to January 2014. One was excluded because she was recruited twice. Of the 72 participants who had APH, 55.6% were due to placenta praevia whereas 44.4% were due to abruption of the placenta. During the two-year study period involving 124 women with a diagnosis of APH, the incidence of APH was 1.311 %. Placenta

previa is 0.835% and that of abruptio placentae is 0.476%. The incidence of APH was 39% in the age group 26 - 30 years and 22% in age more than 30 years. Seventy-two per cent of cases of APH were multigravida. 38% of whom were gravida 3 & gravid 4. Fifty-seven cases (46%) had a history of previous uterine surgery. Thirty-three out of 45 cases of abruption (73%) are associated with pregnancy-induced hypertension. Out of the total number of women presenting with APH (124), 75 had preterm delivery (60.5%) Out of 124 cases who presented with APH, 112 patients (90.32%) delivered by Caesarean section and the remaining 12 (9.68%) delivered vaginally. In the present study, there were no mortalities. Thirty-six per cent were complicated by PPH. Out of the total number of women presenting with APH (124), 92 required blood and blood products transfusion (75%). For control of PPH, other operative interventions such as vessel ligation, placental bed suturing, and packing of the lower uterine segment were used.

#### **Statement of Problem**

Most maternal deaths are due to causes directly related to pregnancy and childbirth unsafe abortion and obstetric complications such as severe bleeding, infection, hypertensive disorders, and obstructed labour [9]. Severe bleeding causes the largest percentage of 35% of maternal deaths in Uganda [10]. This makes obstetric haemorrhage one of the leading causes of maternal mortality in Uganda. APH has a heterogeneous pathophysiology and cannot be predicted. In a study investigating risk factors for placental abruption, the authors concluded that abruption is usually a sudden and unexpected obstetric emergency, not predictable by means of known reproductive risk factors [11]. More to that, there is limited evidence to support interventions to prevent APH. APH is associated with complications for the mother and her fetus [12]. Complications are more likely to occur when haemorrhage is due to a placental cause (abruption or placenta praevia), when the bleeding is heavy and when the bleeding occurs at

early gestations [13]. The monitoring of the fetal heart rate in labour aims to identify hypoxia before it leads to perinatal death or impaired neurological development. There is a lack of evidence to support recommendations on intrapartum fetal monitoring after APH. Under the Millennium Development Goals, Uganda made significant progress in reducing child mortality; however, it did not achieve its goals to reduce maternal mortality [14], [15]. Moving forward, reducing maternal mortality and ensuring that women have access to safe, effective family planning services are prioritized under the United Nations Sustainable Development Goals and Uganda Vision 2040. There were no reports that were documented or described on factors associated with APH due to placenta praevia and abruptio of the placenta. This study will be aimed at better understanding the patient characteristics and outcomes in order to better the management of this problem to alleviate the associated morbidities and mortalities.

#### **Aim of the Study**

To determine the Prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital, JINJA City.

#### **Specific Objectives of the Study**

- i. To determine the Prevalence of antepartum haemorrhage among

#### **Study Design**

The researcher used a cross-sectional study to identify the Prevalence and factors of antepartum haemorrhage, risk factors associated with antepartum haemorrhage, and prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending antenatal clinic [16]. This was because it was cheap to conduct and it takes a short period of time.

#### **Area of Study**

The study was conducted at Jinja Regional Referral Hospital Jinja City in the Eastern region of Uganda.

#### **Study Population**

4,567 people were attending Jinja Regional Referral Hospital Jinja City for services

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pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital JINJA City.

- ii. To determine risk factors associated with antepartum haemorrhage among pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital, Jinja City.
- iii. To determine the Prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital Jinja City.

#### **Research Questions**

- i. What is the Prevalence of antepartum haemorrhage among pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital Jinja City?
- ii. What were the risk factors associated with antepartum haemorrhage among pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital, Jinja City?
- iii. What were the Prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital Jinja City?

#### **METHODOLOGY**

above 15 years of age according to [17], from the national census report. Pregnant women attending this health centre for services were estimated to be about 500 annually. The target population were pregnant women attending the antenatal clinic at Jinja Regional Referral Hospital Jinja City. Since the research was to determine the Prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending antenatal clinics. The study population was obtained according to selection criteria, that is inclusion and exclusion criteria.

#### **Inclusion Criteria**

One category of respondents was included in the study. These were pregnant women

attending the antenatal clinic at Jinja Regional Referral Hospital Jinja City within the study period, who had consented. These respondents were selected using random sampling based on a first come first serve basis.

**Exclusion Criteria**

All pregnant women not attending antenatal clinics at Jinja Regional Referral Hospital Jinja City were excluded.

**Sample Size Estimation**

The sample was used to predetermine the responses of the study population and the researcher selected the sample size to take part in the study using the sample size determination table formulated by Krejcie (1970). This implies that the researcher used a sample of 217 respondents in his study. This was shown in the table below.

**Table 1: Krejcie's table**

Populasi (N)	Sampel (n)	Populasi (N)	Sampel (n)	Populasi (N)	Sampel (n)
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3500	346
85	70	440	205	4000	351
90	73	460	210	4500	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367
130	97	650	242	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379
180	123	900	269	40000	380
190	127	950	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	1000000	384

**Sampling Technique**

The researcher used simple random sampling to select her respondents to

participate in the study. The respondents that participated in this study were 15 years and above to have genuine and

mature answers according to the Researcher's view of the study. Simple random sampling is a probability sampling technique which gives all respondents an equal chance of participating in the study. It was cheap and easy to apply.

**Dependent Variable**

Antepartum haemorrhage

**Independent Variables**

These included; social-economic factors, such as Age, Education, Faith, and Occupation: Health facility factors such as Personnel, Equipment, and Use of Medicine: and behaviour factors such as Alcoholism, Smoking, and hygiene.

**Intervening Variables**

Mobility, Mortality, Drug resistance.

**Data Collection Techniques**

The researcher used the following methods during data collection: Interviewing and Questionnaires as his data collection procedures. Through these, the researcher was able to collect raw data from her respondents in Jinja Regional Referral Hospital Jinja City.

**Interviewing**

In this method, there was interaction between, the researcher and her respondents in Jinja Regional Referral

Hospital, Jinja City. These interviews were held to verify the information collected using the questionnaires since there will be room to search for further information during the interview.

**Questionnaires**

The questionnaires were constructed to obtain information on the Prevalence of antepartum haemorrhage, risk factors associated with antepartum haemorrhage, and prevalence and associated risk factors of antepartum haemorrhage among pregnant women attending antenatal clinic.

**Data Analysis**

The researcher analyzed the data collected using SPSS. It was subjected to frequencies and percentages, which helped to show the distribution of respondents on each of the independent and dependent variables. The qualitative data collected through interviews were categorized, cleaned, interpreted and analyzed under their respective themes. This was used to support the findings obtained through quantitative data analysis. The analysis steps were systematically and consistently done for each one of the three objectives.

**RESULTS**

**Socio-Demographic Characteristics Findings**

**Table 2: A table showing socio-demographic finding (n=144)**

		Age of respondents	
		Frequency	Per cent
<b>Valid</b>	21-25	39	27.1
	26-30	48	33.3
	30-35	27	18.8
	above 35	27	18.8
	Total	141	97.9
<b>Missing</b>	System	3	2.1
<b>Total</b>		144	100.0

**Occupation of the respondents**

		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>	Employed	45	31.2
	un employed	36	25.0
	Peasant	60	41.7
	Total	141	97.9
<b>Missing</b>	System	3	2.1
<b>Total</b>		144	100.0

**Marital status of respondents**

		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>	Married	132	91.7
	Divorced	6	4.2
	Widow	3	2.1
	Total	141	97.9
<b>Missing</b>	System	3	2.1
<b>Total</b>		144	100.0

**Education level of the respondents**

		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>	None	36	25.0
	Primary	15	10.4
	Secondary	33	22.9
	college/tertiary	54	37.5
	postgraduate	3	2.1
	Total	141	97.9
<b>Missing</b>	System	3	2.1
<b>Total</b>		144	100.0

From the table above the majority of the respondents were of the age group (26-30) years accounting for 33.3%, followed by (21-25) years accounting for 27.1%, both (30-35) years and above 35 years accounted for 18.8%. 91.7% of the respondents were married, 4.2% were divorced and 2.1% were widows. The majority were peasants accounting for

41.7%, followed by employed ones at 31.2%, unemployed were 25.0% and lastly unspecified at 2.1%. These respondents were majorly of college/tertiary level of education accounting for 37.5%, followed by uneducated at 25.0%, secondary level at 22.9%, primary level were 10.9% and lastly post-graduate level with 2.1%.

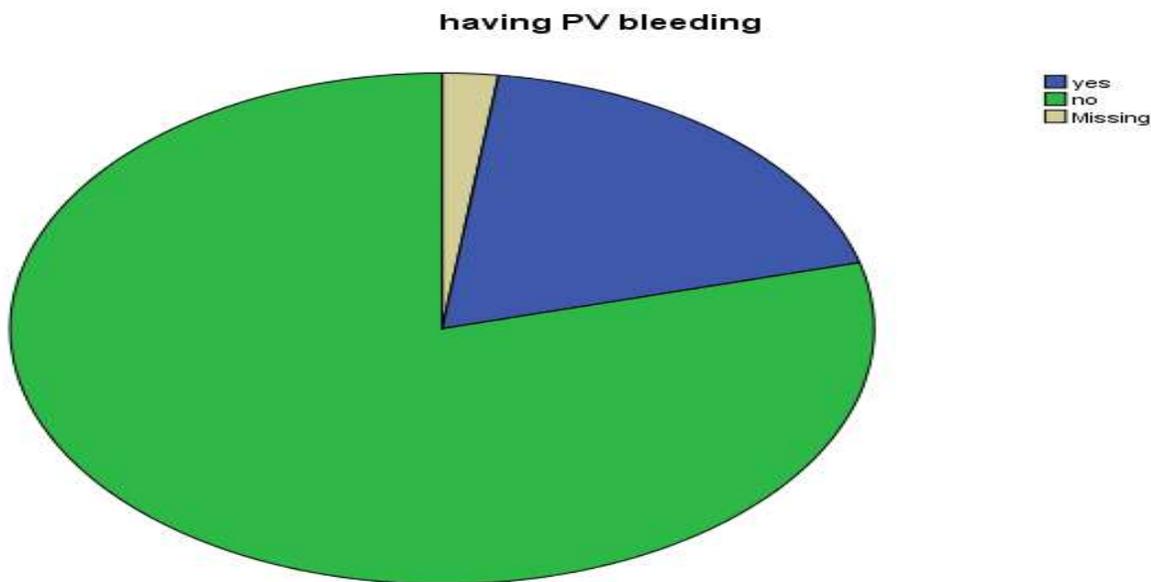
**Prevalence of APH among Mothers**  
**Table 3: A table showing PV bleeding**

**Having PV bleeding**

		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>	Yes	27	18.8
	No	114	79.2
	Total	141	97.9
<b>Missing</b>	System	3	2.1
<b>Total</b>		144	100.0

From the table above the majority of the respondents were not having PV bleeding which was 79.1% and those with PV

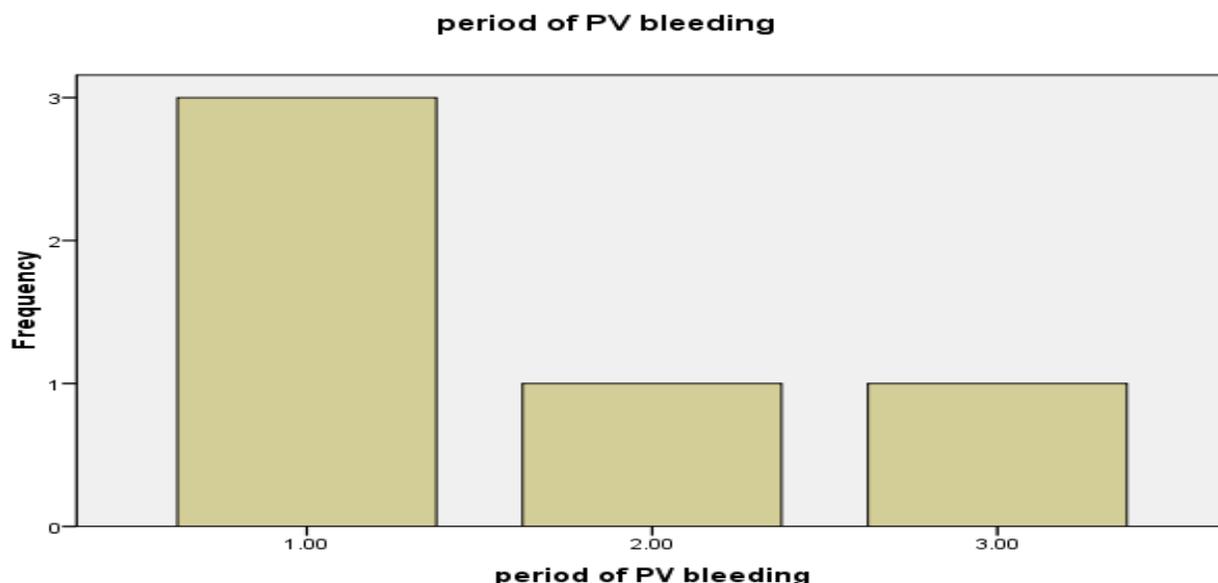
bleeding only 18.8% of the respondents. For those with PV bleeding it mainly lasted for 1 day with 6.2% of the respondents.



**Figure 1: A pie chart illustrating PV bleeding**

**Table 4: Table showing the period of PV bleeding**

		Frequency	Per cent
<b>Valid</b>	1	3	6.2
	2	1	2.1
	3	1	2.1
	Total	5	10.4
<b>Missing</b>	System	43	89.6
<b>Total</b>		48	100.0



**Figure 2: A bar graph illustrating the period of PV bleeding**  
 According to the graph above the majority of the respondents could have PV bleeding for only one day.

**Risk Factors among Pregnant Mothers**

**Table 5: A table showing risk factors among women**

<b>Conception method</b>		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>	Spontaneous	47	97.9
<b>Missing</b>	System	1	2.1
<b>Total</b>		48	100.0
<b>Number of pregnancies beyond 28 weeks</b>			
		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>		1	2.1
	1	3	6.2
	2	17	35.4
	3	11	22.9
	4	8	16.7
	5	3	6.2
	8	1	2.1
	9	1	2.1
	P.C.T	3	6.2
	<b>Total</b>	48	100.0
<b>History of serious medical condition</b>			
		<b>Frequency</b>	<b>Per cent</b>
<b>Valid</b>	Yes	3	6.2
	No	43	89.6
	<b>Total</b>	46	95.8
<b>Missing</b>	System	2	4.2
<b>Total</b>		48	100.0

		Medical condition	
		Frequency	Per cent
Valid		45	93.8
	Malaria	3	6.2
	Total	48	100.0
		Gestation period	
		Frequency	Percent
Valid	29	1	2.1
	30	11	22.9
	31	3	6.2
	32	4	8.3
	34	7	14.6
	36	6	12.5
	37	6	12.5
	38	6	12.5
	Total	44	91.7
Missing	System	4	8.3
<b>Total</b>		48	100.0
		Complications of pregnancy	
		Frequency	Per cent
Valid	No	46	95.8
Missing	System	2	4.2
<b>Total</b>		48	100.0
		History of trauma	
		Frequency	Per cent
Valid	Yes	2	4.2
	No	44	91.7
	Total	46	95.8
Missing	System	2	4.2
<b>Total</b>		48	100.0

The major conception method used was spontaneous accounting to 97.9% of the respondents. The commonest number of pregnancies were 2 and 3 accounting for 35.4% and 22.9% respectively. Many had no history of a serious medical condition accounting for 89.6% and only 6.2% of the

respondents had a history of serious medical condition which was malaria. The commonest gestation period was 30 weeks accounting for 22,9% of the respondents. 95.8% had no complications of pregnancy. The respondents with no history of trauma accounted for 95.8% of the respondents.

#### Risk Factors among Pregnant Women

**Table 6: Table showing model summary**  
Model Summary

Model	R	R Square	Adjusted R Square	Std. The error in the estimate
1	.896 <sup>a</sup>	.803	.694	.22814

- I. Predictors:(Constant), history of trauma, taking alcohol or miss using drugs, history of operations on the uterus, time interval to get another pregnancy, history of hypertension with current pregnancy, smoking or chewing tobacco, history of a serious medical condition, number of deliverance, history of passive smoking , number of pregnancies.
- II. Dependent Variable: having PV bleeding.

This table provides the R and R<sup>2</sup> values. The R-value represents the simple correlation (COR) and was 0.657 (the "R"

Column), which indicates a high degree of correlation (COR). The R<sup>2</sup> value (the "R Square" column) indicates how much of the total variation in the dependent variable, having PV bleeding, can be explained by the independent variables, history of trauma, taking alcohol or miss using drugs, history of operations on the uterus, time interval to get another pregnancy, history of hypertension with current pregnancy, smoke or chew tobacco, history of a serious medical condition, number of deliverance, history of passive smoking, number of pregnancies. In this case, 65.7% can be explained, which is very high.

**Table 7: Table showing risk factors of APH**

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95% Confidence Interval for B	
	B	Std. Error				Lower Bound	Upper Bound
1 (Constant)	-3.451	2.138		-1.614	.124	-7.943	1.041
number of pregnancies	-.985	.329	-4.399	-2.996	.008	-1.675	-.294
smoke or chew tobacco	1.086	.307	.925	3.534	.002	.441	1.732
taking alcohol or miss using drugs	-1.989	.757	-.896	-2.627	.017	-3.580	-.398
history of hypertension with the current pregnancy	-.053	.170	-.053	-.310	.760	-.410	.304
history of caesarian section	-3.149	.758	-2.680	-4.152	.001	-4.742	-1.556
history of serious medical condition	-.028	.253	-.017	-.109	.915	-.559	.504
number of deliverance	1.000	.323	4.238	3.100	.006	.322	1.678
history of operations on the uterus	3.086	.638	1.931	4.839	.000	1.746	4.426
time interval to get another pregnancy	.008	.049	.027	.171	.866	-.095	.112
history of trauma	4.212	.889	1.897	4.736	.000	2.344	6.081

Model - SPSS allows you to specify multiple models in a single regression command. This tells you the number of the model being reported and B - stands for the values of the regression equation for predicting the dependent variable from the independent variable. The table above

it shows that number of pregnancies of respondents has a coefficient of -0.985. So for every unit increase in the number of pregnancies of respondents, a 0.985 Unit decrease in having PV bleeding is predicted, holding all other variables constant. If a mother smokes or chews

tobacco it was shown that for every 1.086 Unit increase of smoke or tobacco, we expect a 1.086 Unit increase in the having PV bleeding, holding all other variables constant. Taking alcohol or miss using drugs respondents had the coefficient -1.989 showing that for every unit increase in taking alcohol or miss using drugs, we expect a -1.989 Unit decrease in the having PV bleeding keeping all other variables constant. The history of hypertension with current pregnancy of respondents had the coefficient -0.053 showing we expect a -0.053 Unit decrease in the having PV bleeding keeping all other variables constant. The history of the caesarian section of respondents had the coefficient -3.149 showing we expect a -3.149 Unit decrease in the PV bleeding keeping all other variables constant. The history of serious medical conditions of respondents had the coefficient -0.028 showing we expect a -0.028 Unit decrease in the having PV bleeding keeping all other variables constant. Number of the deliverance of respondents had a coefficient of 1.00 showing for every 1.00 Unit increase in the number of deliverance, we expect a 1.00 Unit increase in the PV bleeding keeping all other variables constant. Time interval to get another pregnancy of respondents had the coefficient 0.008 showing for every 0.008 Unit increase of time interval to get another pregnancy, we expect 0.008 Unit increase in the having PV bleeding keeping all other variables constant. History of operations on the uterus of respondents had the coefficient 3.086 showing we expect a 3.086 Unit increase in the having PV bleeding keeping all other variables constant. The history of trauma of respondents had the coefficient 4.212 showing we expect a 4.212 Unit increase in the having PV bleeding keeping all other variables constant. Std. Error - These are the standard errors associated with the coefficients. Beta - These are the

standardized coefficients. These are the coefficients that you would obtain if you standardized all of the variables in the regression, including the dependent and all of the independent variables, and ran the regression. By standardizing the variables before running the regression, you have put all of the variables on the same scale, and you can compare the magnitude of the coefficients to see which one has more of an effect. You will also notice that the larger betas are associated with the larger t-values and lower p-values. t and Sig. - These are the t-statistics and their associated 2-tailed p-values used in testing whether a given coefficient is significantly different from zero. Using an alpha of 0.05: The coefficients for the number of pregnancies, taking alcohol or miss using drugs, history of hypertension with current pregnancy, history of a serious medical condition, number of deliverance, and time interval to get another pregnancy of respondents are not significantly different from 0 because their p-values/ Sig. as shown in the table above, which are larger than 0.05. The coefficients for smoking or chewing tobacco, history of caesarian section, history of operations on the uterus and history of trauma of respondents are significantly different from 0 because its p-values/ Sig. as shown above, which is small than 0.05. The intercept is significantly different from 0 at the 0.05 alpha level. 95% Confidence Limit for B Lower Bound and Upper Bound - These are the 95% confidence intervals for the coefficients. The confidence intervals are related to the p-values and the coefficients were not statistically significant because the confidence interval does not include 0. These confidence intervals helped the researcher to put the estimate from the coefficient into perspective by seeing how much the value could vary.

## DISCUSSION

### Social Demographic Findings

In this study majority of the respondents were of the age group (26-30) years accounting for 33.3%, followed by (21-25) years accounting for 27.1%, and both (30-

35) years and above 35 years accounted for 18.8%. 91.7% of the respondents were married, 4.2% were divorced and 2.1% were widows. The majority were peasants accounting for 41.7%, followed by

employed ones at 31.2%, unemployed were 25.0% and lastly unspecified at 2.1%. These respondents were major in college/tertiary level of education accounting for 37.5%, followed by uneducated at 25.0%, secondary level at 22.9%, primary level were 10.9% and lastly post-graduate level at 2.1%. A prospective study on birth outcome and prevalence of postpartum morbidity among pregnant women who attended antenatal care in Gondar town, North West Ethiopia by Town, 2014 showed similar findings where the majority of the respondents were in the age group of (20-24) years and (25-29) years accounting to 38.91% and 33.00% respectively. In this same study, the majority were of a secondary level accounting for 48.28% of the respondents and 92.61 were married. These two studies show related information on social demographic findings.

More studies have shown the relationship between social demographic factors with APH which was the majority of the parturients, 45 (39.8%) were in age between 25 and 29 years and 98.2% were married according to [17]. About 70% of the respondents are in the 20-34 age group, slightly less than a quarter are 35 years old or above, while only 7.4% are in the teen years of 15 to 19 years. According to [18], the majority (87.4%) of the women are resident in rural areas. In terms of educational attainment, the bulk of the women (61%) have only primary education, while more than a fifth of the women (23%) have no formal education; only 16% have secondary or more education. All these studies reveal that respondents are mainly in the age group of (20-30) years and were married.

#### **Discussion of Risk Factors of APH**

This study reveals that factors which increased APH among women that participated in the study included the

In conclusion, this study has found that APH was common in mothers within the age group of (20-30) years and factors which increased APH among women that participated in the study included the following factors smoking or chewing

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following factors smoking or chewing tobacco, number of deliverance, history of operations on the uterus, time interval to get another pregnancy, and history of trauma. This made these major risk factors of APH. The more a mother increase in having these factors the ranger the risk of getting PV bleeding (APH). This study's "history of the caesarian section" reflected the decreased rate of APH (PV bleeding) which agrees with [17], where a caesarean section was generally accepted as a safe alternative mode of delivery in developed countries by both patients and caregivers. However [19], [20], gave a strong aversion to the procedure by women in sub-Saharan Africa but antepartum haemorrhage is one of the major indications for caesarean section. [21], [22] said that even though it is safe, it is not without important risks such as increased mean blood loss, febrile illness, thromboembolic disease, infection and a mortality risk of up to five times that of vaginal delivery. Another agreement with [17], is the history of anaemia which also happened to the factor with the highest chances of increased APH (PV bleeding) which was further reflected by another study which showed a higher prevalence of anaemia among the parturients with antepartum haemorrhage. This study reveals that factors like taking alcohol or miss using drugs, history of hypertension with current pregnancy, and history of serious medical condition showed less impact on increasing PV bleeding (APH) among mothers [23], [24]-[26], said that "though several studies have shown a relationship between haemoglobin levels above 13.2g/dl and below 10.4g/dl to be associated with adverse pregnancy outcomes such as stillbirths, pregnancy-induced hypertension, intrauterine growth restriction, low birth weight, preterm delivery, perinatal death."

#### **CONCLUSION**

tobacco, number of deliverance, history of operations on the uterus, time interval to get another pregnancy, history of trauma. This made these major risk factors of APH. There I recommended the government, sub-county, district and health workers to

educate mothers on the risk factors of APH especially those above.

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