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Original Research Article

Assessment of knowledge, enablers, and barriers to healthcare-seeking behaviours for urinary tract infections among pregnant women at Banadir Maternal and Child Hospital, Somalia

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ABSTRACT

Background: Urinary tract infections (UTIs) are common during pregnancy causing serious issue to both maternal and infantile health. However, little research has been conducted regarding what women know and do about UTIs in Somalia.
Methods: A cross sectional mixed-methods approach was employed in this study to obtain both quantitative data and qualitative findings of women knowledge, experiences, and health-seeking behaviours related to UTIs. Between August and December 2024, 200 women participated in a quantitative survey, among which 21 were selected for qualitative interviews.
Results: The majority (55%) of women reported having symptoms related to UTI, with the most common symptoms being fever or chills (54%), lower abdominal pain (50%), and frequent urination (42%). Only 33.5% had tested positive for UTIs in their urine. Before seeking medical attention, a large percentage of women (51%) turned to traditional remedies, such as camel milk and herbal teas. The main obstacles to accessing healthcare were transportation concerns (20.5%) and financial limitations (49.5%). Some people believed that spiritual factors caused UTIs, while others believed that poor hygiene (43%) or sexual activity (41.5%) were the main causes. The qualitative analysis revealed that people's understanding of UTIs varied; many were aware of the symptoms but not the causes or complications. Cultural factors influenced healthcare-seeking, with women frequently avoiding medical care out of fear of judgment and stigma.
Conclusions: The study underscores the need of better UTI education; the integration of biomedical and traditional practices can help in early detection and seeking healthcare at the appropriate time.

Keywords: Cultural barriers, Healthcare-seeking behaviour, Knowledge, Mogadishu, Pregnancy, Somalia, Urinary tract infections

INTRODUCTION

Reproductive health is a cornerstone of women's overall health with significant implications for maternal outcomes and the ability to achieve reproductive goals.[1,2] One of the noticeable issues in reproductive health is Urinary Tract Infections (UTIs), which are common in pregnancy and can lead to serious maternal and foetal complications.[3,4] Pregnancy causes hormonal changes and urinary stasis in the women body making them more likely to get UTIs.[5] If not treated, urinary tract infections can have serious effects on both the mother and the baby. A meta-analysis revealed a significant association between urinary tract infections during pregnancy and preterm delivery, as well as low

birth weight.[6] Another study found that pregnant women with UTIs had preterm labour and low birth weight rates of 30.3% and 24.5%, respectively.[7] Urinary Tract Infections may also cause or exacerbate other pregnancy complications, like hypertension and anaemia, which are worth monitoring in antenatal care.[8]

In the East African region, specifically in Somalia, UTIs are of high concern, particularly in pregnant women. According to a study conducted in Somalia, 78.6% of pregnant women who received prenatal care had this condition.[9] A systematic review in Ethiopia found that the pooled prevalence of UTIs was 15.37%, while a study in Kenya found that the prevalence was 15.7%.[10,11] Furthermore, according to a meta-analysis, the global prevalence of UTIs in pregnant women was 23.9%.[12] In Somalia, particularly in conflict and rural regions, inadequate access to health services and poor hygiene have promoted the problem of urinary tract infections (UTIs) since access to basic health services remains constrained, especially in regions with ongoing instability.[13,14]

The majority of pregnant women are not aware of UTI symptoms, attributing them to normal pregnancy pains, and thereby delaying appropriate clinical intervention.[15,16] Moreover, low socioeconomic status, lack of education, and certain cultural beliefs are a few factors accounting for delayed treatment. These barriers are even more acute in rural communities where healthcare access is limited, and myths about the aetiology of UTI and what treatments are available still persist, which heighten the risk of catastrophic maternal and foetal complications.[17,18] Although urinary tract infections (UTIs) are highly prevalent among Somali pregnant women, their knowledge and attitudes concerning the symptoms, risks, and significance of urinary tract infections (UTIs) are not well understood.[9] The limited information on their level of awareness generates several research questions: i) What is the level of awareness and knowledge about UTIs among pregnant women in Mogadishu? ii) What are the healthcare-seeking habits of pregnant women for UTIs, and what are the hindrances to seeking healthcare? iii) What is the role of cultural, social, and economic factors in women's UTI decisions during pregnancy? Knowledge of what hinders people from going for medical care and how cultural and social factors shape healthcare choices will help in creating healthcare programs and interventions that will improve pregnant women's attitudes towards UTIs. This study was therefore carried out to assess knowledge, experience, and healthcare-seeking behaviours regarding UTIs among pregnant women attending antenatal care (ANC) at Banadir Maternal and Child Hospital in Mogadishu, Somalia.

METHODS

Study design

In this research, a mixed-method approach including both quantitative and qualitative approaches was applied to investigate the knowledge, experience, and UTI healthcare-seeking practices among pregnant women. A structured questionnaire was used to collect quantitative data on sociodemographic details, reproductive health, understanding of UTI symptoms and causes, access to healthcare services, and healthcare barriers. Field guides were employed to derive elaborate and detailed information, which were subsequently analysed by thematic analysis to identify the key themes concerning UTI awareness and management among pregnant women.

Study site

The study was conducted at Banadir Maternal and Child Hospital in Mogadishu, Somalia. The hospital was established in 1976 and is one of the largest and most comprehensive government health facilities in Somalia. It is a major teaching and referral centre, providing a wide range of inpatient and outpatient services to the community. With over 700 beds and nearly 400 health workers, the hospital is a significant contributor to child and maternal health care, offering services including delivery, ANC, and postnatal care. The hospital admits on average 2,500 to 3,000 patients per month, making it a significant healthcare resource in the area. The hospital boasts well-equipped diagnostic and treatment facilities with a Diagnostic and Research Centre where laboratory testing and antimicrobial resistance tests were conducted for this study.

Inclusion/exclusion criteria

Women pregnant, 18 years and older who attended antenatal care (ANC) visits at Banadir Maternal and Child Hospital during the period of study were included. All the participants were requested to provide verbal or oral consent and agreement to take part in semi-structured interviews on their perception/experience and knowledge related to urinary tract infections (UTIs).

Sample size and sampling technique

The sample size for this study was determined using Cochran's formula, based on a previously reported UTI prevalence of 78.6% among pregnant women at Banadir Hospital.[19] A sample size of 263 was required at a 95% confidence level with a 5% margin of error. However, due to logistical constraints and the unwillingness of some women to participate, only 200 participants were enrolled. Participants were systematically selected once they attended the hospital during the study period and agreed to participate in the study.

Survey data collection and procedure

From August to December 2024, data were collected from the sampled pregnant women attending Banadir Maternal and Child Hospital for antenatal care using a standardized interviewer-administered questionnaire. The questionnaire was designed to collect data on sociodemographic

characteristics, reproductive health profile, UTI knowledge, access to healthcare, and barriers to seeking healthcare. The tool was initially drafted in English, translated into Somali, and pilot-tested with 20 pregnant women attending ANC at the same hospital but not part of the final survey sample. Pretest feedback was utilized to refine question clarity, order, and cultural sensitivity.

In-person individual interviews were conducted with all the women who were present during their ANC visits. For most of the participants, it was convenient to interview at the hospital. Where there was poor privacy due to the congested environment, the interview was conducted in a quiet area within the hospital or at any other suitable location. All interviews were conducted by trained Somali-language enumerators who were well familiar with the cultural and linguistic dynamics of the community.

The data was captured on questionnaires and then entered into a password-enabled computer database by the research team for analysis. This practice enabled having a wide collection of data from all the eligible women attending ANC and acquiring an in-depth insight into their knowledge, attitudes, and healthcare-seeking behaviour regarding UTIs during pregnancy.

Interview participants sampling and procedure

Out of 200 pregnant women who attended antenatal care (ANC) clinics of Banadir Maternal and Child Hospital between August and December 2024, 21 women were selected through purposive sampling to build a representative and varied sample. Participants of different socioeconomic status, parity, and gestational age were included. Selected women were invited personally during ANC visits and requested to participate in structured interviews. The interviews were constructed to obtain vivid discussion about their experience, knowledge, and seeking behaviour for urinary tract infections (UTI) during pregnancy.

Data were collected through structured interviews from the 21 selected pregnant women. Interviews were conducted in Somali and lasted 30 to 45 minutes. An interview topic guide was used to guide the interviews while providing opportunity for the participants to recount their unique experiences more fully. The interviews were carried out in a private area within the hospital to guarantee confidence and comfort. Audio recordings were obtained with the consent of participants, and exhaustive field notes were recorded during the interviews. Sociodemographic data such as age, level of education, occupation, and UTI history were gathered. Knowledge, experience, and health-seeking behaviours regarding urinary tract infections (UTIs) were also queried during the interviews.

Ethical considerations

Ethical clearance of the study was obtained from the Joint Ethics Review Committees of University College Hospital, University of Ibadan, Nigeria, and Banadir Maternal and Child Hospital, Mogadishu, Somalia (Ref: UI/EC/24/0303). The study conformed to all the ethical guidelines, which include respect for the confidentiality of the participants, autonomy, and safety.

Data management and analysis

Quantitative data were interred in Excel Microsoft and analysed using STATA 18. Descriptive statistics were used to present sociodemographic characteristics of the quantitative research participants, reproductive health indicators, and UTI knowledge. Participants' UTI knowledge was scored 0-16. One accurate response was scored as 1 and erroneous or incomplete responses scored as 0. The overall scores were then cut off into poor knowledge (score <8) and good knowledge (score ≥8) to facilitate meaningful comparison. The association between participants' UTI knowledge level and sociodemographic characteristics was tested by conducting chi-square tests. The significance level for all the tests was $p<0.05$.

Audio-recorded interviews were all verbatim transcribed and subsequently translated into English by bilingual research assistants. To ensure that the translation and transcription were accurate, the transcripts were carefully reviewed for completeness and fidelity with the original content. Braun and Clarke's (2006) thematic analysis approach was employed to analyse the qualitative data. An inductive coding process was employed to examine the data, where themes were derived directly from what the participants were saying. The data were coded independently by two coders to seek out emerging patterns and themes. Disagreement between the coders was resolved through discussion until agreement was obtained. Such themes were then categorized into broader categories with the main areas of the participants' experience and knowledge. Taguette, an electronic platform, was used for data coding and sorting of the emerging themes. To gain validity of the findings, member checking was done, where a sample of participants reviewed the initial outcomes to ascertain that they reflected their own points of view. Moreover, peer debriefing was also practiced among the research team members to critically examine the findings, challenge the assumptions, and validate the rigor of the analysis process. Data were stored securely, and ethical principles were adhered to stringently to maintain participants' privacy and confidentiality throughout the analysis process.

RESULTS

Demographic characteristics, healthcare access, and UTI management among pregnant women

The majority of participants (44.5%) were between the ages of 24 and 32, and 38.5% had no formal education (Table 1). Most were unemployed (25.5%) and married (78.5%), and many worked in semi-skilled (15%) or unskilled (30%) jobs. With two to three pregnancies

(38%) and in the second trimester (40%), majority of women (69.5%) were multigravida. In terms of access to healthcare, 55% of pregnant women reported having a UTI, and 44.5% of women first sought prenatal care between weeks 17 and 32. Nevertheless, 51% used conventional UTI treatments, and only 33.5% had a urine test for UTI. Financial constraints (49.5%), transportation problems (20.5%), and cultural or religious beliefs (14%), were among the obstacles to accessing healthcare. Language barriers (5%) and a lack of healthcare facilities in the area (11%) were also observed.

Table 1: Sociodemographic and reproductive health characteristics of the study participants.

Variable	Category	Frequency	Percent (%)
Age (completed years)	15-23	76	38.00
	24-32	89	44.50
	33-41	35	17.50
Education level	No formal education	77	38.50
	Primary education	28	14.00
	Secondary education	56	28.00
	Tertiary education	39	19.50
Marital	Divorced	29	14.50
	Married	157	78.50
	Single	2	1.00
	Widowed	12	6.00
Occupation	Student	3	1.5
	Housewife	12	6.0
	Unemployed	51	25.5
	Unskilled	60	30.0
	Semi-skilled	30	15.0
	Skilled	27	13.0
	Professional	17	8.5
Gravidity	Primigravida	61	30.5
	Multigravida	139	69.5
Parity	0-1	34	17.00
	2-3	76	38.00
	4-5	85	42.50
	≥6	5	2.50
Pregnancy gestational age	First trimester	64	32.00
	Second trimester	80	40.00
	Third trimester	56	28.00
Gestational age at first ANC (antenatal care) visit (weeks)	8-16	87	43.50
	17-32	89	44.50
	≥33	24	12.00
UTI symptoms this pregnancy	No	90	45.00
	Yes	110	55.00
Urine test for UTI this pregnancy	No	133	66.50
	Yes	67	33.50
UTI traditional treatment	No	98	49.00
	Yes	102	51.00
Challenges in accessing healthcare	Cultural or religious beliefs	28	14.00
	Financial constraints	99	49.50
	Lack of nearby healthcare facilities	22	11.00
	Language or communication barriers	10	5.00
	Transportation issues	41	20.50

Knowledge and management of urinary tract infections among pregnant women

The study evaluated pregnant women's knowledge, symptoms, causes, effects, and preventive strategies regarding urinary tract infections (UTIs) (Table 2). Fever or chills (54%), lower abdominal pain (50%), and frequent urges to urinate (42%), were the most frequently cited symptoms of a UTI. Participants cited holding urine (48%) and poor hygiene (43%) as major contributors to

UTIs. Untreated UTIs were known to have consequences; 40.5% of respondents linked them to low birth weight, and 46% linked them to preterm labour. Drinking water (29.5%) and practicing good hygiene (50%) were common preventive measures. Regarding UTI management and prevention, 34.5% of participants had good knowledge (score 8-16), while 65.5% had poor knowledge (score <8).

Table 2: Knowledge of urinary tract infections symptoms and management practices among pregnant women.

Variables	Yes (%)	No (%)
Knowledge on symptom of UTIs		
Painful burning urination	60 (30.00)	140 (70.00)
Frequent urge to urinate	84 (42.00)	116 (58.00)
Blood in urine	61 (30.50)	139 (69.50)
Lower abdominal pain	100 (50.00)	100 (50.00)
Fever or chills	108 (54.00)	92 (46.00)
Knowledge on cause of UTIs		
Poor hygiene	86 (43.00)	114 (57.00)
Holding urine	96 (48.00)	104 (52.00)
Sexual intercourse	83 (41.50)	117 (58.50)
Use of public Toilets	101 (50.50)	99 (49.50)
Knowledge on effect of untreated UTIs		
Kidney infections	78 (39.00)	122 (61.00)
Preterm labor	92 (46.00)	108 (54.00)
Low birth weight	81 (40.50)	119 (59.50)
Preeclampsia	80 (40.00)	120 (60.00)
Knowledge on preventive methods		
Drink water	59 (29.50)	141 (70.50)
Good hygiene	100 (50.00)	100 (50.00)
Urinate before/after sex	67 (33.50)	133 (66.50)
Wear cotton underwear	95 (47.50)	105 (52.50)
Knowledge level		
Poor knowledge (score < 8)	131	65.50
Good knowledge (score 8-12)	69	34.50

Chi-square tests (Table 3) revealed no significant associations between knowledge category and factors such as education level, marital status, socioeconomic status, age, occupation, gravidity, parity, urine test use, or UTI symptoms (p-values ranging from 0.318 to 0.929).

Theme analysis of individual interviews on urinary tract infections among pregnant women

The theme analysis of the individual interviews yielded four broad domains: knowledge and awareness, healthcare-seeking behaviour, testing and early detection, and cultural and social determinants. Participants had varying degrees of awareness of UTIs, opting for traditional remedies and delaying medical attention for cost, social stigma, and inaccessibility to healthcare. While a few participants were tested during pregnancy, routine screening and early detection were not widespread practices. Health-seeking behaviours were greatly influenced by family and cultural beliefs in a significant way, with the majority fearing being judged when seeking healthcare.

Table 3: Chi-square test results for factors affecting knowledge of urinary tract infections among pregnant women.

Variable	Chi-Square Statistic($\chi 2$)	p-value
Knowledge category and education level	7.0321	0.318
Knowledge category and marital status	6.1491	0.407
Knowledge category and socioeconomic status	2.7709	0.597
Knowledge category and age group	2.3760	0.667
Knowledge category and occupation group	5.7045	0.457
Knowledge category and gravidity group	1.1287	0.980
Knowledge category and parity group	2.5127	0.867
Knowledge category and urine test for UTI	0.9746	0.614
Knowledge category and UTI symptoms	0.1469	0.929

Awareness and understanding of UTIs

Participants demonstrated varying levels of awareness about urinary tract infections (UTIs). While most women were familiar with the term "UTI" and its typical symptoms such as painful micturition and frequent urination, in-depth knowledge was lacking. Participant 6, for instance, said, "*I knew about UTIs from my sister who had it once. I just assumed it was a mere infection.*" On the contrary, others were not familiar with its cause and prevention, as Participant 3 indicated, "*I didn't know that UTIs could be because of poor hygiene*.". I always thought it was just a normal infection." The majority of the participants had learned about UTIs during pregnancy, generally through antenatal care programs, with Participant 12 stating, "*I heard about UTIs for the first time at my pregnancy checkups. They told me that it is normal, especially during pregnancy*.".

Symptoms of UTIs

Participants' knowledge of UTI symptoms varied. Most of the participants identified symptoms like painful urination, tenderness in the lower abdomen, and urinary frequency as symptoms of a UTI. For instance, Participant 7 said, "*I have burning pain while passing urine, and my lower tummy hurts, I know it's a UTI*." But there were some participants who attributed the symptoms as being less severe diseases or confused with other conditions.

Participant 5 said, "*I didn't know whether the pain was a UTI or not at first. It just felt like discomfort.*" Participants also attributed the symptoms to menstrual cramps or other causes unrelated to UTIs, to treatment delay, as in Participant 4, who said, "*I thought it was just regular bladder pain from my period, but then it worsened, and I had to see the doctor*."

Table 4: Thematic domains, themes, and sub-themes identified in the analysis of healthcare-seeking behaviours and knowledge of UTIs.

Domain	Theme	Sub-theme
Knowledge and awareness	Knowledge of UTIs	- General awareness - Pregnancy-related awareness - Knowledge gaps
	Symptoms of UTIs	- Recognized symptoms - Variability in recognition - Misinterpretation of symptoms
	Beliefs about UTIs	- Biomedical understanding - Mixed beliefs - Cultural/spiritual views
Healthcare-seeking	Traditional practices	- Herbal remedies - Dietary practices - Family influence
	Barriers to seeking care	- Economic barriers - Social stigma - Access to healthcare
Testing and early detection	Awareness and testing	- Testing during pregnancy - Routine testing gaps - Importance of screening
Cultural influence	Cultural beliefs and stigma	- Family/community influence - Stigma around UTIs
Healthcare access	Access barriers	- Economic & geographic barriers - Male involvement in healthcare decisions

Causes and beliefs regarding UTIs

Respondents described a range of beliefs surrounding the aetiology of UTIs from biomedical to more culturally situated perspectives. The majority of respondents knew that UTIs are caused by bacteria, most commonly attributed to failure to practice good hygiene or having sex. Participant 9 explained, *"I know UTIs are caused by microbe from improper hygiene or sexual activity*." However, some of the women combined biomedical explanations with popular conceptions, as was evident with Participant 15, stating, "*My mom said it might be because of bad food or stress, but I also know it's because of bacteria*." Moreover, some participants attributed UTIs to spiritual or cultural explanations, with Participant 11 stating, "*Some people believe UTIs come from evil spirits or bad luck*.". "*My grandmother told me it's not about food and health but it is related to spirits*.", added participant 20.

Traditional practices for treating UTIs

The traditional treatments for UTIs were frequently cited among the participants. The herbal teas were used commonly as a first measure, as Participant 2 said, *"I use boiled herbs like mint and ginger; it's something my mother would do for me when I was a child."* Additionally, food remedies like camel milk and lemon water were used, as Participant 17 said, "*I use camel milk because I heard it clears the bladder and helps infections.*" Physical cures, such as a warm compress or washing with saltwater, were used by some of the women. Participant 19 went on, *"I would put warm salt water on my tummy whenever I felt the pain, my grandmother said it does the job."* Family members, particularly the elderly generations, were the ones who would recommend such treatments, as evident from Participant 8, who expressed, *"My mother-in-law always prescribes herbal tea before we go see the doctor."*

Healthcare-seeking behaviours and barriers

Barrier to healthcare-seeking was experienced by the majority of participants. Economic barriers to entry, such as the cost of transportation and health care, were significant. Participant 20 stated, *"I don't have money for transportation or medicine, so I try to do it at home until I can't do it anymore."* Social and cultural factors were also mentioned. Stigma, fear of judgment, and spousal permission were cited as barriers. Participant 9 added, *"I want my husband to take me to the clinic. I don't want people to think that I am always sick."* Furthermore, logistical issues such as traveling long distances to health facilities were widespread. Participant 18 explained, "*The*

clinic is far, and the road is bad. I won't go unless I have to."

The value of early detection and testing

During the interviews, differing awareness levels among participants towards UTI testing importance were established. Participant 1 observed, *"I had a urine test during pregnancy, and the doctor said it was good to catch it early to avoid kidney damage."* Although most participants underwent UTI screening during pregnancy, many only tested upon the onset of symptoms. Participant 14 explained, *"I only get tested when I have pain," and Participant 21 admitted, "I had no idea that doing it regularly was important."* Similarly, Participant 16 explained, *"I didn't know about early testing until I was pregnant."* One participant who did not know the importance of routine testing when one is not pregnant stated, "I used to think that it was only needed when you were sick."

However, Participant 11 highlighted the benefits of routine testing by saying, *"If we had regular tests, maybe we could prevent serious infections like kidney problems,"* highlighting the importance of routine testing in preventing complications.

DISCUSSION

The study was carried out to assess the knowledge, experience, and healthcare-seeking behaviors about urinary tract infections (UTIs) among pregnant women who attended antenatal care (ANC) at Banadir Maternal and Child Hospital in Mogadishu, Somalia. While a majority of the participants recognized common symptoms such as dysuria and urgency to urinate, their knowledge of the aetiology, risk factors, and complications of UTI was low. These findings are consistent with previous research that revealed pregnant women often lack adequate knowledge about UTIs, with most having average or poor understanding.[15,16,20] This evidently necessitates greater education during prenatal visits to inform women more about the cause of UTIs, prevention, and early diagnosis.

The study also revealed that there was inadequate routine screening of UTIs even among pregnant women who had access to healthcare. While some women were screened for UTIs while pregnant, most only visited for screening when symptoms started to show. Since early diagnosis and treatment of UTIs during pregnancy are crucial to preventing complications like kidney infection or preterm labour, this testing delay is concerning.[21] According to Stepankova et al, there is evidence that UTI screening is not used to its full potential in the majority of low-resource healthcare facilities, where the healthcare system may not be supportive of preventive services.[22] In order to facilitate prompt diagnosis and treatment, routine UTI screening is essential for inclusion in routine prenatal care.

Regarding therapy, the study found that prompt medical attention was necessary. Although the majority of women were aware that antibiotics were needed for UTI treatment, there was limited understanding of correct antibiotic selection and adherence. This lack of awareness is consistent with other research from other regions of the globe, where pregnant women also fail to complete their antibiotic courses, leading to repeat UTIs and antibiotic resistance.[23] It is essential that doctors in Mogadishu prioritize education about the need to complete antibiotic regimens to prevent repeat UTIs and improved maternal health outcomes.

The women's perceptions of causes and treatment of UTI were also influenced by family and cultural beliefs. The majority of women attributed spiritual causes to UTIs, i.e., "evil spirits" or "bad luck," a reflection of biomedical and local conceptualizations blending together. This aligns with a study conducted by Leydon et al highlighting the blend of biomedical and cultural awareness which may make the decision to go for formal medical care harder, as women may not want to use conventional medicine in line with their beliefs.[24] Healthcare programs need to address these cultural factors and try to blend traditional practice with professional medical care in such a way that women will be receptive to seeking professional care when necessary. This study demands active public health intervention for the eradication of information gaps and healthcare barriers against UTIs among pregnant women.[25]

Many participants turned to traditional remedies, such as herbal teas and camel milk, as their first response to UTI symptoms, a practice consistent with findings in other low-resource settings like Ethiopia and Jordan.[26,27] According to Akour et al, popular herbs for UTI treatment include parsley, chamomile, and barley.[26] Although traditional therapy provides relief for some time, it does not cure the infection, leading to delayed treatment and severe complications. Such reliance on traditional remedies shows the vast cultural influence in Somali populations, where family traditions, particularly of earlier generations, mostly decide how disease conditions are handled. The overarching influence of family advice on guiding healthcare-seeking behaviour further highlights the necessity for family-based health education programs.

Health-seeking behaviour is greatly influenced by cultural and socioeconomic factors. Economic constraints, including medical bills and transportation costs, were cited by several respondents as a barrier to timely medical treatment. These findings are consistent with studies conducted in other settings with limited resources, where pregnant women encounter significant financial obstacles when trying to obtain essential health care.[28,29] The high cost of healthcare, combined with poor rural infrastructure, makes it difficult for most women to access care until symptoms are severe, resulting in late presentation and more complications. Outpacing these costs could be vital in increasing maternal health access in Somalia.

Stigma also contributed to deferment of healthcare-seeking attitudes. Most women indicated fear of being judged upon going for medical care, particularly for diseases that are perceived as not serious. Fear of judgment is also prevalent in other countries like United Arab Emirates and United States of America, where women will avoid going for medications due to the stigma associated with disease or imagined weakness.[30,31] Eradicating this stigma by publicizing that seeking medical care is most vital to improve healthcare utilization and offer women timely treatment for UTI is essential.

This study has some limitations even though it offers useful information about pregnant women's health-seeking behaviour and knowledge on UTI. There is inability to generalise the results to other groups, such as rural-based women and those not in attendance at healthcare due to the small number of the sample and also because the study included only ANC clients from a single hospital. Besides, the validity of the data may be compromised by translation issues, especially of the culturally distinctive terminology, and recall and social desirability bias in self-reported data.

CONCLUSION

This study provides important information on knowledge, attitudes, and health-seeking behaviour regarding urinary tract infections (UTIs) among pregnant women visiting for antenatal care at Banadir Maternal and Child Hospital in Mogadishu, Somalia. While most of the respondents knew usual symptoms of UTI, their knowledge regarding the cause, risk factors, and long-term consequences of UTI during pregnancy was not satisfactory. Cultural beliefs and traditional values, such as the practice of herbal medicines and cultural perceptions of the disease, had significant contributions in shaping health-related behaviour often delaying professional medical care. Additionally, economic limitations, stigma fear, and lack of access to healthcare services were significant barriers to receiving timely and appropriate interventions.

Recommendations

These findings suggest that health education initiatives should be strengthened to improve pregnant women's understanding of UTIs, with a focus on early detection and treatment, and to incorporate culturally competent strategies that incorporate indigenous and biomedical practices. Economic and logistical obstacles to healthcare should be minimized.

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