



COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

INCREASING SKILL DELIVERY ATTENDANCE AT GEBRETSADIK SHAWO
GENERAL HOSPITAL ,BONGA, ETHIOPIA

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ABBREVIATIONS

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric Newborn Care
CEmONC	Comprehensive Emergency Obstetric Newborn Care
EDHS	Ethiopian Demographic Health Survey
FGD	Focused Group Discussion
HEW	Health Extension Worker
HEP	Health Extension Program
KPI	Key Performance Indicator
LB	Live Birth
MDGs	Millennium Development Goals
PNC	Postnatal Care
SBAs	Skilled Birth Attendants
SNNPR	South Nation Nationality People Region
SMT	Senior Management Team
TV	Television
WHO	World Health Organization

OPERATIONAL DEFINITION:

Skilled birth attendant :- people with midwifery skills (midwives, doctors and nurses with additional midwifery education) who have been trained to proficiency in the skills necessary to manage normal deliveries and the immediate postnatal period and diagnose, manage or refer obstetric complications .

Birth preparedness :- A package of interventions measured as a composite variable of 5 items: planed to save money, planed to arrange transport, planed to give birth in health facility, planed to be attended by skilled attendant and planed to arrange blood donor. Mothers who fulfilled three or more of the five items were considered as 'well prepared' and otherwise 'not well prepared'.

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ABSTRACT:

Background

Utilization of skilled delivery attendance services was still low with a high number of deliveries being attended by unqualified persons at home. Promotion of universal ANC follow-up and encouragement of mothers regarding the need for SBAs during childbirth is of paramount importance. Increase the awareness of mothers and their partners about the benefits of institutional delivery and SBAs and use of different means of behavioural change communication is very fundamental .

Objective

To increase skilled birth attendance at Bonga Gebretsadik Shawo General Hospital from 120 to 180 per month by the end of 2010 E.C

Methodology

A pre–post intervention study to examine the increase in skilled birth attendance before and after the intervention . Baseline data was collected in January 2010 and intervention period was from February to may 2010 E.C and final evaluation was conducted at the end of may 2010 E.C, after 4 months of implementation. For the assessment data Hospital Key performance indicator was used. Root cause analysis method is Focused group discussion and fishbone diagram . Effect of intervention was assessed by reviewing and comparing Antenatal and delivery room registration for intervention group .

Result

Low partner involvement on maternal health activity was identified as real root cause for low skilled birth attendant and Birth preparedness plan with the involvement of male is selected as best intervention .

Implementation of the intervention which is birth preparedness plan with the involvement of male partner was conducted for ANC 4 visitors and skilled delivery attendant was increased from 120 to 180 on average per month.

Conclusion

Birth preparedness and complication readiness has significant effect on skilled delivery care use but Only a small numbers of ANC visitors were found to be prepared for birth and its complications in their last pregnancy during ANC follow up .

1. Introduction

2. Introduction to Health Facility

Keffa is a Zone in the Ethiopian Southern Nations Nationalities, and Peoples' Region (SNNPR). Keffa is bordered on the south by Debub Omo, on the southwest by Bench Maji, on the west by Sheka, on the north by the Oromia Region, and on the east by Konta. Gojeb River runs along part of the northern border of this zone.

Kaffa zone has a total area of 10602.7 square kilometer and it lies at an altitude ranging from 500 to 3500 meters above sea level. The total population of the zone is 1,116,125 with a population density of 90 persons per Kilometer Square.

The zone is sub- divided in to ten woredas namely: Gesha, Chena, Gimbo ,Menjjeo, Tello, Cheta, Bita, Gewata, Saylem & Decha woreda. As regards the agro climatic condition, out of the total area that the zone has, Dega shares 11.64%,Weynadega 59.45%, and Kolla shares 28.91%. The mean annual temperature of the zone ranges from 10.1 to 27.5°C and the mean annual rainfall of the zone ranges from 1001 to 2200 mm. Of the total area of land, that the zone has, 23.1 percent is cultivated, 31.54 percent is forestland, 6.03% grazing land, 24.9% cultivable land and the remaining balance is uncultivable land. The agro – ecological condition of Kaffa zone is very suitable for the growing of coffee, tea, spices and other crops.

Bonga is the administrative center of the zone situated at a distance of 468 Km. south west of Addis Ababa. Topographically it lies at an altitude of 1650 meters above sea level and has a Woyena dega type of climate. Its average annual rainfall is 1750 millimeters. Bonga town is one of the 22 towns identified as autonomous provisional city in the region. In order to facilitate the socio- economic development of the town, it is structured in to 3 kebles. The town has all infrastructure facilities vital for the implementation and operation of industrial activities. Presently, the town receives an electric supply from a High tension power supply. It has a pipe water supply, banking, and telecommunication facilities.

Bonga Gebre tsadik shawo hospital is General Hospital in kafa zone ,SNNPR one of the 14 General Hospitals found in SNNPR, Established in 1990 E.C and Serves around 1.8 million catchment population .There are 42 Health centre in the zone of those one Health centre is found in the capital town Bonga and Estimated number of pregnant women in the zone is 39,744 . The hospital Has 70 beds of those 20 were for maternal service and 25 midwives and 04 Integrated emergency obstetric officers and total of 176 professionals and 120 administrative staff and 22 contract total 343 staff available in the Hospital . Bonga Town has three urban kebele .

3. Statement of the problem

Ten countries account for 58 percent of global maternal deaths: 17%, 14%, 7% ,4% ,3% ,3% ,3% ,2% ,2% &2% in India ,Nigeria ,Democratic Republic of the Congo , Ethiopia, Indonesia Pakistan , United Republic of Tanzania , Kenya , China and Uganda respectively (1).

According to the EHDS 2011 report pregnant women who had the recommended four visit of ANC is only 19% of those less than 10 percent delivered their last child in a health facility and 7% received postnatal care during the first two days of delivery (1).

Based on EDHS 2014 report births in Ethiopia were assisted 16% by a skilled provider: 5% by a doctor and 11% by a nurse or midwife. About 2% of births were assisted by a Health Extension Workers (HEW), and 51% of births were assisted by a relative or some other person and 27% by a traditional birth attendant while 5% of births were unattended (1).

Every two minutes a woman dies of pregnancy-related complications, the four most common causes being: severe bleeding after childbirth, infections, high blood pressure during pregnancy, and unsafe abortion. Ninety-nine per cent of maternal deaths occur in developing countries and most could be prevented . The coverage of skilled attendant was only 46%, 64% and 95% in low-income ,lower middle-income and upper middle-income countries respectively . According to the report of health facilities in Ethiopia reproductive health problems account for 12.3 % & 2.6% of inpatient & delivery related causes of mortality among females respectively . On the other hand utilization maternal health services that are proven to have effect in reducing maternal mortality are very low. The utilization of the existing maternal health services in Ethiopia is very low (9)

Postpartum hemorrhage and retained placenta were the commonest complications of home delivery and similar third stage complications have also been reported study conducted in Nepal and India .Home delivery have a very high risk of maternal mortality. Family tradition and poor socioeconomic condition of the family appear to be the main reasons for choosing to deliver at home(17).

4. OBJECTIVES:

- ✓ To increase skilled birth attendance at Bonga Gebretsadik Shawo General Hospital from 120 to 180 per month by the end of 2010 E.C

5. ROOT CAUSE ANALYSIS:

5.1. Fishbone Diagram:

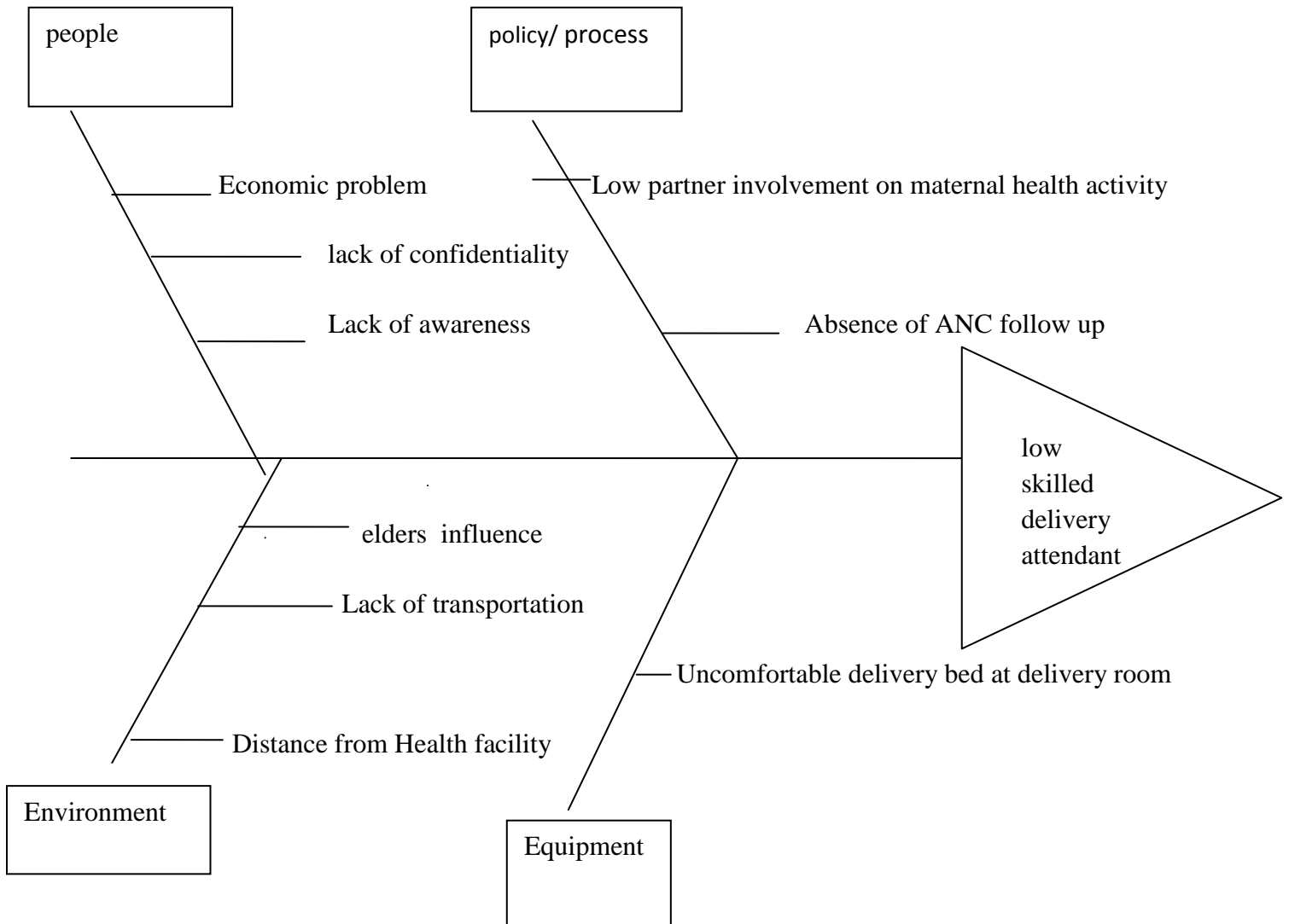


Figure 5 1 :- fishbone diagram (causes for low skill delivery attendant)

5.2 Verification of the root cause using available data ,documents and interview with staff

1. Economic problem

currently the Ethiopian government is providing maternal and child service free of charge , the community is using community based health insurance to avoid out of pocket treatment , ambulance service is available for transportation , maternity waiting area home is constructed in each health facility so economic problem is not the root cause for low skilled delivery attendant (Rejected)

2. Lack of awareness

According to information obtained from kaffa zone health department there is no study conducted awareness towards skilled birth attendant recently and with in the community there is strong one to five Health development army and pregnant forum which discuss on issue related to pregnancy and other health agenda and health facility visit so every one in the family is award about pregnancy and related health condition so lack of awareness is not root cause for low skill delivery attendant .(Rejected)

3. Elders influence

As motioned above Health development army follows each and every health out come in the community elders and traditional birth attendants are in forced to send pregnant mothers to Health extension worker or inform to one to five leader (Rejected)

4. Lack of transportation

In each kebele there is rural road , there is ambulance in each woreda(1-2) ,and traditional ambulance is also available so lack of transportation is not the root cause for low skilled birth attendant (Rejected)

5. Distance from Health facility

Health facility are available in 10 km radius i.e the distance from health center to health post and health post to health post so distance is not the root cause for low skilled birth attendant rate (Rejected)

6. Lack of confidentiality

As i witnessed the delivery room has four beds and each bed is separated by screen and confidentiality is maintained only with in the department so lack of confidentiality is not the root cause problem for low skilled delivery attendant(Rejected)

7. Low partner involvement on maternal health activity

We reviewed ANC and postnatal registration book male involvement is very low and even on HIV testing partner involvement and test rate is very low so Low partner involvement on maternal health activity is the root cause and **accepted**

8. Low uptake of ANC follow up

There are 39,535 & 40,465 expected pregnant women in kafa zone in 2009 and 2010 E.C respectively , of those who receive antenatal care four are 83% & 77% in 2009 & 2010 and skilled delivery is 40% & 60%_in 2009 and 2010 so there is acceptable number of ANC follow up so Low uptake of ANC follow up is not the root cause for low skilled delivery attendant (Rejected).

9. Uncomfortable delivery bed

As evidenced from department head and delivery case team staff mothers have the right to be in her preference place with in the delivery room so Uncomfortable delivery bed is not the root cause for low skilled delivery attendant .

As shown above the root cause for low skilled delivery attendant is Low partner involvement on maternal health activity so the possible intervention to improve or uptake of skilled delivery attendant are

- I. Social mobilization
- II. Including males (partners) on birth preparedness plan
- III. Enforce using community leader
- IV. Conducting male partner forum

6 . Comparative analysis of alternative intervention

Table 6 1 = Comparative analysis of alternative intervention

Alternative intervention	Impact	Cost	Time	Feasibility	Total
Social mobilization	3	3	3	3	12
Including males (partners) on birth preparedness plan	5	5	4	5	19
Enforce male using community leader	2	5	3	2	12
Conducting male partner forum	3	3	4	3	13

5= Most ideal 1= Least ideal

so the best intervention is Including males (partners) on birth preparedness plan

7. LITERATURE REVIEW:

The target of National Reproductive Health Strategy of Ethiopia is to increase the proportion of births attended by skilled health personnel is to 60% and reducing maternal mortality to 350 deaths per 100,000 live births by 2015 . (4)

Antenatal care service increase from 27% in 2000 to 62 % in 2016 , institutional delivery have increased from 5% in 2000 to 26% in 2016 and home delivery decreased from 95% in 2000 to 73% in 2016 . (19)

Utilization of skilled delivery attendance services was still low with a high number of deliveries being attended by unqualified persons at home. Promotion of universal ANC follow-up and encouragement of mothers regarding the need for SBAs during childbirth is of paramount importance. Increase the awareness of mothers and their partners about the benefits of institutional delivery and SBAs and use of different means of behavioral change communication is very fundamental (4).

The use of skilled delivery is desirable as it is recognized to yield positive delivery outcomes by reducing maternal and infant morbidity and mortality(8).

According to EDHS 2016, 26% of births in Ethiopia were assisted by a skilled provider: (6% by a doctor , 20% by a nurse or midwife, 2% by Health Extension Workers (HEW), 42% by a traditional birth attendant). (19).

Despite evidence that social contexts are key determinants of health, research into factors associated with maternal health service utilization in Ethiopia has often focused on individual and household factors(13)

Age and educational status of the mothers and husbands, frequency of antenatal visit, birth order, and maternal knowledge and prior experience of delivering at a health facility were independent predictors of skilled birth attendance as shown Study conducted in Sidama zone SNNPR (14).

Proportion of births with a skilled attendant is very low even for women who have access to the services and the major constraints are shortage of supply , shortages of skilled mid wives, weak referral system at health centre levels, inadequate availability of BEmONC and CEmONC equipment, and under-financing of the service and On the demand side, cultural and societal norms, distances to functioning health centers' and financial barriers (14).

Factors affecting utilization of skilled attendants are parity, having ANC, women`s and their husbands educational status, occupational status, having TV and Radio, urban residence, history of family planning use, younger age, economic status, knowledge about danger signs of pregnancy, availability and attitude towards health professionals, husband`s approval and involvement (15).

8. PROJECT DESIGN/METHODOLOGY:

8.1. Project Setting:

Bonga Gebre tsadik shawo hospital is General Hospital in kafa zone ,SNNPR ,located south west part of country 468 km from Addis Ababa and 738 km from Hawassa , one of the 14 general Hospitals found in SNNPR, Established in 1990 E.C and Serves around 1.8 million catchment population .There are 42 Health centre in the zone of those one Health centre is found in the capital town Bonga and Estimated number of pregnant women in the zone is 39,744 . The hospital Has 70 beds of those 20 were for maternal service and 25 midwives and 04 Integrated emergency obstetric officers and total of 176 professionals and 120 administrative staff and 22 contract total 343 staff available in the Hospital . Bonga Town has three urban kebele .

8.2. Sample Population:

Sample population for FGD was pregnant women in the catchment population who visit the hospital for maternal health service .

8.3. Sampling Procedure:

Sampling technique was purposive sampling method and Health care attendants from maternity waiting area , antenatal care clinic and postnatal clinic was selected .

8.4. Study design

A pre–post intervention study to examine the increase in skilled birth attendance before and after the intervention . Baseline data was collected in January 2010 follow-up data at min time and final evaluation in may 2010 E.C, after 4 months of implementation. For the assessment data from Hospital Key performance indicator was used.

8.5. Data collection procedure

Mothers on maternity waiting area , postnatal care , and who visit the hospital For immunization program after delivery was selected for the study and focused group discussion was conducted using questionnaire for real root cause identification and review of documents in antenatal and delivery room was reviewed for pre and post test comparison .

8.6. Indicators

Number of Skilled delivery attendant in Gebretsadik Shawo General Hospital is out come indicator and number of birth preparedness plan is process indicator .

8.7. Data quality Assurance

Data quality is assured by using well trained and experienced modulator for FGD and using well structured questioner and in addition closer supervision was made during the data collection process.

8.8. Data Analysis procedure:

Socio-demographic was analyzed using computer , root cause was analyzed using fishbone diagram and pre and post intervention data using bar graph .

8.9. Ethical consideration:

Ethical approval for the study was obtained from AAU school of public health ethical review committee. An official letter of approval was written to kafa zone health department and Gebretsadik Shawo General Hospital

During data collection, individual informed verbal consent was obtained from the study participants. Each participant of FGD was informed about the objective of the study, procedures of selection and assurance of confidentiality moreover their names were not registered to minimize social desirability bias and enhance confidentiality. Individuals were free to withdraw from the interview at any time.

Permission to conduct FGDs in the client was sought from SMT of hospital. Confidentiality with regard to their participation and anonymity with regard to their stored data was assured, and each participant was asked for his or her verbal consent to participate in FGDs. Permission to audio-record the discussions was also sought and obtained. Participants did not receive any monetary incentive for participating in the discussions and participation was solely voluntary

9. INTERVENTION

9.1. Intervention chosen

Participating males (partners) on birth preparedness plan

9.2. Implementation accomplishments:

For every pregnant women her partner should accompany at the second visit of antenatal care and should have birth preparedness plan on the place of delivery and other related activity like HIV testing .

9.3 Monitoring and Evaluation of the project:

Monitoring on the implementation of the project was observed every week for the appropriateness of the process and evaluation of the post intervention result was compared before two week of the final project period.

10. RESULT

Table 10 1:-Socio-demographic characteristics of the respondents (clients)

Variables	Number	Percent (%)
Age		
< 20	0	0 %
20-34	11	45.83 %
35-49	13	54.16 %
Sex		
M	0	0 %
F	24	100 %
Educational Background		
Illiterate/No education	2	8.3 %
Primary	15	62.5 %
Secondary	5	20.83 %
Diploma	2	8.3 %
Degree	0	0 %
Place of Residence		
Urban	8	33.33 %
Rural	16	66.67 %
Marital Status		
Married	24	100 %
unmarried	0	0 %
Divorced	0	0 %

10.2. Data on number Skilled delivery attended : (KPI)

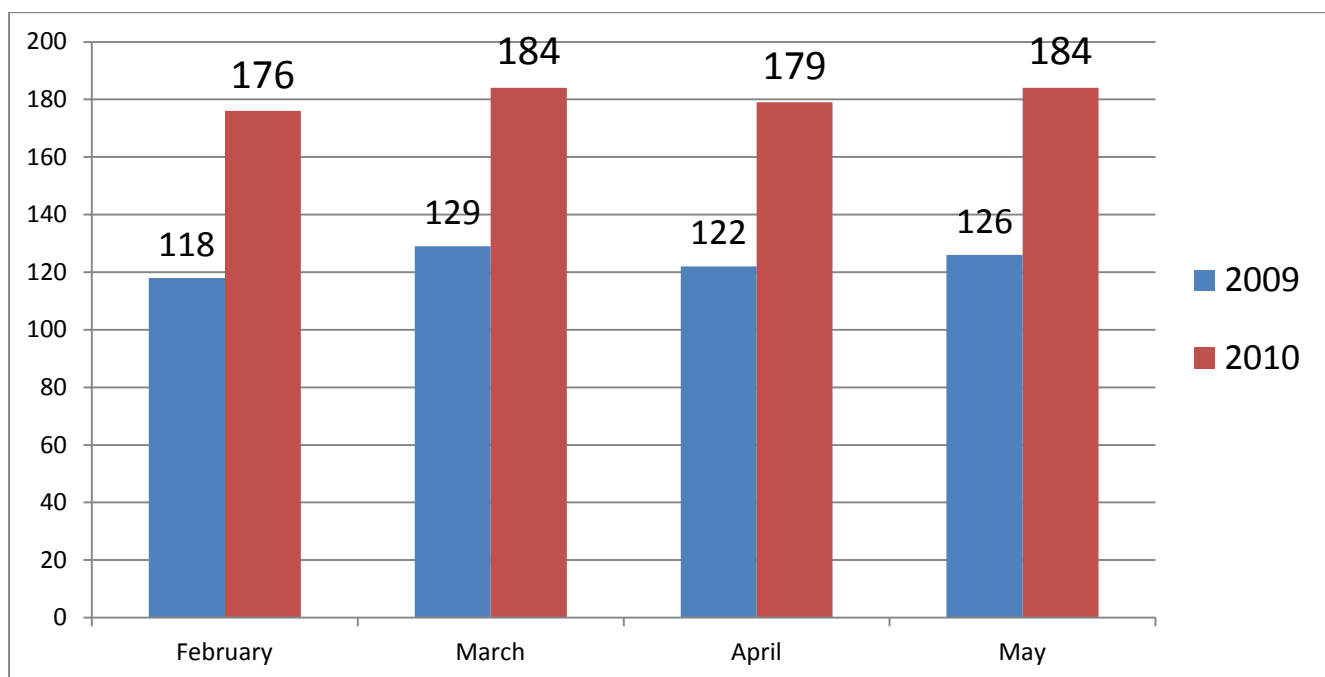


figure 10 1 :- Comparison of number Skilled delivery attended in 2009 & 2010 E.C at gebretsadik shawo General Hospital

Table 10 2 :- Comparisons of pre and post test result for Skilled birth attendant after implementation at Gebretsadik shawo General Hospital in 2010 E.C

PRE		POST	
October	127	February	167
November	118	March	184
December	131	April	179
January	136	May	186

Table 10 3:- Comparisons of pre and post test result for Birth preparedness plan in ANC Department at Gebretsadik shawo General Hospital in 2010 E.C

Number of Birth preparedness plan conducted before the intervention		Number of Birth preparedness plan conducted after the intervention	
October	0	February	55
November	0	March	47
December	0	April	66
January	0	May	45

Table 11 1 :- Comparison of number of SBA with birth preparedness plan and with out birth preparedness plan (among the intervention group)

PRE			POST		
Month	Number of ANC with out birth preparedness plan	Number of mothers who gave birth in the Hospital	Month	Number of ANC with birth preparedness plan	Number of mothers who gave birth in the Hospital
October	62	47(76%)	February	55	51(93%)
November	59	39(66%)	March	47	44(94%)
December	72	54(75%)	April	66	62(94%)

10.5. Dissemination of result:

The capstone project will be submitted to Addis Ababa University, Gebretsadik Shawo General Hospital and kaffa zone health Department .

11. DISCUSSION:

This study identified the status of skilled care use was found to be low in the study area. The root cause identified for low skilled delivery attendant is low partner involvement on maternal health service and best intervention identified was Participating males (partners) on birth preparedness plan and birth preparedness plan was not conducted for all ANC attendant so after implementation of the intervention skilled delivery attendant is increased .

In this study even though federal Minister of Health and world Health organization recommends birth preparedness plan during ANC it is not being implemented as one part of focused ANC .

Similar study conducted in Goba woreda Oromia region showed that 29.9% study subjects were prepared for birth and its complication in their last pregnancy where as the remaining 70.1% study subject did not so our study in agreement with this study about low performance of birth preparedness plan (18)

In similar study conducted in Sidama zone Different reasons were mentioned for preference home delivery to facility delivery with the most common being presence of traditional birth attendants (52.8%) nearby. The participant also said they seek health facility service for getting better care (68.2%) followed by occurrence of a problem during labor and delivery. the FDG participants shared this perception and related the lower utilization of health facility service to lower knowledge on risk of labor and delivery and lower decision making power of women to choose where to give birth in addition to shortage of equipment and supplies in health facilities (14).

According to EDHS 2016 among women who receive antenatal care 56% of pregnant women are informed about birth preparedness plan at national level and 54.2% in SNNPR .

12. Strength, Challenges and limitations to conduct and implement the project:

One of the limitation of the study is the study participant are service utilizes so they may have shortage of information on reason for non- attendants of the service and the time period of the study is short to evaluate the out come of the intervention .

13. Conclusions and Recommendations:

The World Health Organization (WHO) strongly recommends that every pregnancy should be delivered under skilled care and Birth preparedness and complication readiness had significant effect on skilled care use but Only a small numbers of ANC visitors were found to be prepared for birth and its complications in their last pregnancy during ANC follow up.

Kafa Zone Health department , Woreda Health office and Gebretsadik shawo General Hospital should confirm that Birth preparedness and complication readiness is being introduced at ANC clinic and male partner involvement on maternal service .

Birth preparedness with participation of male partner was found to have direct effect on increment on skilled delivery attendant . Therefore, health professionals during antenatal care should give due emphasis on birth preparedness and complication readiness plan to improve access to skilled and emergency obstetric care

Hospital data indicate that of majority of women who attended ANC at the hospital, only very small numbers of pregnant women were prepared for birth and its complication. Therefore, any interested researcher should conduct further study on quality of ANC in focus of birth preparedness and complication readiness to assess whether health professionals appropriately advise and provide health information concerning birth preparedness and complication readiness.

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15. ANNEXES:

Questionnaire

I. Socio-demographic data for FGD

1. Age

18-24

25-34

35-49

2. Sex M F

3. Educational Back ground

Illiterate /No education

primary

Secondary

Diploma

Degree

4. Place of Residence Urban Rural

5. Marital Status

Married

unmarried

Divorced

1. what makes you to come to deliver at this Hospital?
2. what are the possible reason for home delivery ?
3. what are the causes of low uptake of skilled birth attendant in hospital?
4. what problem do you see in Maternal service that de-satisfy clients ?

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