ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

WHAT FACTORS DETERMINE DELIVERY PRACTICES OF PREGNANT WOMEN?

COMPARTIVE ANALYSIS OF FINDINGS FROM BEHAVIORAL MODELING AND FOLLOW UP OF ACTUAL PRACTICES

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN PUBLIC HEALTH
DCH,AAU

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BY

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DECLARATION

I the undersigned, declare that this thesis is my original work and has never been presented in this or any other university, and that all resources and materials used in herein, have been duly acknowledged.

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This thesis has been submitted for examination with my approval as a university Advisor.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ACRONYMS

ANC-Ante natal care

BEOC-Basic Essential obstetric

CEOC-Comprehensive essential obstetric care

EOC-Essential obstetric care

HD-Home delivery

HF- Health facility

HS-Health service

ID-Institutional delivery

MMR-Maternal morality ratio

PMR-Perinatal Mortality rate

SDA-Skilled delivery attendant

ABSTRACT

Background:- Ensuring a skilled delivery attendant at each child birth is the most critical intervention in reducing maternal and neonatal mortality and morbidity. In Ethiopia the proportions of births attended by skilled personnel is very low and even for women who have access to the services. The proportion of birth occurring in health facilities is very low.

Objective:- This study aims at identifying the factors that influence intention of pregnant women for their delivery and the factors that determine actual delivery service utilizations.

Methods:- A prospective community based follow up study is conducted in Jimma town. Women in their child trimester were identified by a complete household survey. Subsequently relevant data were collected in two separated household survey.

Results:- A total of 207 women were included in the study. Maternal age and educational status are significantly associated with place of delivery. Woman between 35-39 are less likely to deliver in HFs when compared to those between 15-39 (OR = 0.06 and 95% CI=0.01 to 0.52) and those with formal education are more likely to deliver in HFs(OR=2.82 and 95%CI1.09 to 7.23). Women who attended ANC follow up (OR = 2.63 and 95%CI= 1.11 to 6.23) women to whom their husbands and relatives prefer SDA (OR = 4.78 and 95% CI=2.25 to 10.21) and those who can decide by themselves about getting ID services (OR = 2.75 and 95 % CI = 1.3 to 5.78) are more likely to deliver in HFs.

Conclusions:- Empowering disadvantaged women. Promoting ANC follow up and improving the information provision during the follow up. Interventions targeted at husbands and other relatives to direct their influence in favorable fashion and reaching out more women to provide relevant information about ID services are recommended

Background

Given that, vast majority of deaths from obstetric complications are preventable and that every pregnancy faces risk which may not always be detected through the risk assessment approach during ANC, the best way to assure safe and successful delivery outcomes remains to be ensuring skilled personnel attendance of every child birth. The aims of delivery care include achieving clean and safe delivery as well as recognition, early detection and management or referral of complications at health center or hospitals(1).

Models of successful delivery care developed by Koblinsky et al, 1999 shows that, when lay providers recognize delivery complications and family organizes access to EOC facility (Model 1) MMR >100 and Perinatal mortality >30 like in rural china (MMR 115), while when labor is attended at home and professionals recognize complications and family or provider organizes EOC referral (Model 2), MMR and PMR were found to be <50 and <20 respectively. In model 3, labour attended at BEOC facility where professionals recognize complications, provide BEOC or organizes referral to CEOC. In model 4 professional recognize complications and provide B and CEOC but it does not guarantee MMR of less then 100 (US: MMR 12, while Mexico city 114 (1988). According to their findings, models 2 and 3 with functioning referral system are optimum ones(2). Where does the Ethiopia's situation fit in regard to the models?. In Ethiopia, delivery attended by health professionals is only 5.6% and 94.8% of deliveries occur at home(3). Accordingly, our situation very well fits model 1, where most deliveries occur at home

and they are attended by lay personnels. This situation very well explains the high MMR in Ethiopia, which is around 850 per 100,000 live births, one of the highest in the world (4).

Global experiences show that ANC use is higher than delivery by a professional in the large majorities of countries in the developing world. And similarly in our country, 27% of women attend ANC, while only 5.6% of women have their deliveries attended by health professionals (3). Why majority (80%) of the women who were attending ANC during their pregnancy, women who at least have access to one of the maternal health care services provided in health facilities, are not utilizing the facilities for the delivery services? What factors determine women's intentions and actual practices related to places of delivery?

This study tried to identity important factors in our context. Some of the specific research questions are where does pregnant women prefer to give their childbirth and why? What factors are important in influencing women's' intention of utilizing delivery services? And what are the factors that determine the actual delivery service utilization of pregnant women?

Frameworks developed by combining relevant constructs from behavioral models(5,6) and based on the findings from previous studies done on similar research topic are used to identify personal, environmental and behavioral factors that are important in

influencing pregnant women's intentions and actual practices related to different delivery practices(Annex 1,2).

The findings from this study will give a highlight into the factors that determine delivery service utilization of pregnant women and this will be helpful for the relevant stakeholders in the planning and implementation of intervention activities to improve the delivery service utilization of pregnant women in the country.

Literature Review

According to the Ethiopian DHS, 2000, national ANC coverage was 26.7%. The coverage was 27.0%, 83.1% and 57.6% for Oromiya, Addis Ababa and Dire Dawa respectively, and the use of ANC services is highly associated with the mother's level of Education. Majority of births (95%) were attended at home, with urban and rural differentials of 68.3 and 97.9% respectively (3). A longitudinal community based study conduced in southwest Ethiopia, which includes urban and rural residences of Jimma Zone, Showed ANC Utilization Rate Of 52.6%. Only 16.7% Of the women have delivered in health institutions. The same study showed that 19.6% of deliveries are attended by health personnel with urban rural differentials of 39.8 and 2.4 percent respectively (7).

Even though the national ANC coverage is only 27%, there is a considerable difference between the regions, the lowest 14.6% for Somali region and the highest 83.1% for Addis Ababa. Studies conducted in Jimma town show that ANC coverage for the town is 75%(8).

Again the proportion of Institutional Delivery, show a very considerable difference between the regions ranging from 2.8% in Amhara to 67% in Addis Ababa, even though the national carriage is 5% (3).As the Ethiopian DHS and other studies in Gondar and Addis Ababa suggest institutional deliveries are more common among women who had ANC visits during their pregnancy and preference to deliver at home was higher for those who are not attending ANC (3, 9, 10).

Improving maternal health is one of the eight millennium development goals. The target to be achieved in this regard demands a reduction of the MM ratio by three quarters in

the years between 1990 and 2015 and one of the indicators for this goal is proportions of births attended by skilled personnels. Ethiopia, as one of the countries which have adapted these goals, is supposed to reduce this ratio by ¾, but 14 years have passed and only 11 years are remaining and yet not showing the necessary reduction (11).

WHY DO WOMEN NOT SEEK HEALTH SERVICES?

Studies have shown that there are several factors for women not to seek services during pregnancy and child birth. But the various determinants can be summarized as sociodemographic, obstetric, predisposing, Enabling and Reinforcing factors in addition to ANC, women's decision making power and immediate obstetric problems. (Refer annexes 1 and 2).

SOCIODEMOGRAPHIC AND OBSTETRIC FACTORS

Studies have shown that women's preferences and practices in utilizing maternal health services like ANC and delivery services is influenced by their socio-demographic background, their economic and social status in addition to obstetric factors like parity and history of past obstetric problems. Births to young mothers (under 35 years), first births and births to women with better educational status are more likely to be assisted by a trained health professional (3). Preferred place of delivery was significantly associated with educational status and parity. Also a study conducted in north Gondar, shows Socio demographic factors like mother's educational status, have significant association with place of delivery. Mothers with better educational status, are more likely to have a safer delivery practice. Obstetric factors that influence delivery practices include birth order and past history of pregnancy complications. As birth order

increases utilization of safe delivery services decreases. And mothers with past history of intrapartum complication were likely to seek safe delivery care than those with no such history(9).

As a woman's social status and her health are intrinsically related, her low status is often the cause of poor access to essential health care (12,13). And a study in India shows that women with higher education and better income are more likely to deliver in HF_s. Even after adjusting for other factors women's education and family income were found important predictors of their place of delivery (14).

PREDISPOSING FACTORS

Regarding the associations between women's knowledge about pregnancy and delivery, with their place of delivery, other studies show contradictory findings.

According to a study done in Gulele district , Addis Ababa ,knowledge of mothers about maternal and child health care was significantly lower for women who wanted to deliver at home when compared to those who wanted to deliver at health institutions(10).And a study done in rural Bangladesh shows that knowledge of mothers about pregnancy and delivery services was very low and the level of women's knowledge has increased after awareness-raising activities are done which include provision of pictorial cards which describe about delivery complications. Women who have received pictorial cards were more likely to follow ANC and deliver in HF_s when compared to those who did not receive. This finding is in favor of the assumptions that

women's knowledge is important in influencing ANC & ID service utilizations. But findings contrary to this view are reported from the same area (15, 16, 17).

Women's perception about the benefits of getting ID care is one important factor which influences service utilization by the women, because if women perceive the need for care they are more likely to utilize the services(18).

The levels of potential barriers perceived by the women which may prevent them from getting ID services is one reason for women not to utilize ID services, because some of the problems perceived by women which prevented them from accessing these cares include unavailability of HFs , distant HFs , opportunity costs and lack of money (3,15,18).

ENABLING FACTORS

Availability of services and their accessibility (both geographic and economic) are important factors which determine maternal HC utilizations and they are usually determined by women's household income, place of residence and its distance from health services, costs (direct fees as well as the cost of transportation, drugs, supplies), multiple demand on women's time. These are important set of factors that prevent women from getting health services (1,3,9,10).

As a reflection of availability and geographic accessibility of HFs, the large differences observed between urban and rural residents in terms of ANC follow up and ID may give some idea. As Ethiopian DHS and a study in southwest Ethiopia show ANC follow up is 66.6% and 71% for urban but only 21.6% and 35% for rural residents and the same studies show that delivery in health institutions also shows similar differences, 31.5% and 34.1% for urban but only 1.9% for rural areas (3,7). And in terms of geographic

accessibility, women who were living in areas more than one hour walking distance from the health facility were found to be less likely to utilize ID services (9).

In terms of economic accessibility household income, occupational status are also important factors which affect ID service utilizations. Women with poor household income, and those who are unemployed were less likely to utilize ID services (9,19).Additionally, direct costs related to accessing the services are other important subset of factors that influence women's practices in utilizing health services. A study conducted in rural Zimbabwe to assess ANC utilization has found that, a quarter of women (24.3%) were not attending ANC, only because they cannot afford to pay for the service (20).

REINFORCING FACTORS

Reinforcing factors refer to a feedback from other people that may encourage or discourage a certain behaviour or practice. The influences from other people are important in determining intentions and practices of the women, and these influences from can be reflected in terms of their perceptions and their preferences about place of delivery and delivery attendants(5).On the same line

a study conducted in Equatorial Guinea to evaluate ANC utilization has found that hospital workers, husbands and parents were the greatest influence on ANC attendance of the women (21). Women whose husbands or partners have favorable attitude towards ANC follow up were found more likely to prefer delivering in health facilities (9). And women whose families perceive the need for maternal health care are more likely to utilize such services (18, 22).

Influences from husbands and other relatives is some times very crucial in determining ID service utilization by the women, because the influences from these people may not

always end by only encouraging or discouraging the women to utilize the services, as in some instances these same people might be the primary decision makers about ID service utilization of the women as demonstrated in a series of studies conducted in rural Bangladesh, which finds out that the influences of husbands, mothers and mother in laws were important in determining women's ID service Utilization, and to complicate the matter more these same people are the primary decision makers in regard to who should be consulted for obstetric care (15,16,17).

Studies conducted in rural Butajira and Adamitulu revealed that 88% and 83% mother preferred to give birth at home (23,24).A in Gullele district, Addis Ababa most pregnant women (55.3%) preferred to deliver in a hospital, 18.1% preferred a health center or health station while 24.3% of the women preferred to deliver at home. Reasons for preferring to deliver in a particular health institution was high quality of service, closeness to health facilities and health workers approach at the health institution. Some women wanted to deliver at home where relatives are nearby and out of whom 67% of them wanted the deliveries to be conducted by traditional birth attendants, while 25% preferred the deliveries to be conducted by close relatives(10).

Women's decision making power in relation to delivery service utilisation is another critical factor, because whether the previously discussed factors are favourable or not favourable to have ID services, the most important step in intending or actually getting the services largely relies on whether they have the power to make the final decision to get ID, if they wanted to or if they have to. Accordingly a study conducted in rural Zimbabwe has shown that, where a good number of women (41.8%) were decision makers

regarding ANC attendance, the attendance was as high as 79.3% (20) and a study conducted in Pakistan to assess determinants of utilization of ANC, shows that social status and economic condition of a woman, which may empower them to make their own decisions are important determinant of utilization of ANC (25).

IMMEDIATE OBSTETRIC FACTORS

The studies conducted in North Gondar, Ethiopia and rural Zimbabwe have found that obstetric complications during pregnancy and delivery are strong predictors of institutional delivery (9,19) .But a study done in rural Bangladesh shows, out of women who were referred from HCs to a higher level of health care, a good proportion of them(51%) do not go for various reasons such as they did not feel to go (41%), did not understand the need to go (24%), their husbands objected (7%) and the HF_s were too for away (7%)(15). This finding implies that even in the presence of obstetric risk factors, which need medical help, in certain instances, other factors might operate more in determining women's place of delivery.

In addition to the findings from other studies, the concepts of three behavioral models (the PRECE DE model, the Health Belief Model and the theory of planned behavior) are applied to develop & conceptual frame works (Annex I & II) to present the fetors in a comprehensive manner.

PRECEDE Model is a framework designed to diagnose important factors that determine health behavior, which directs for a highly focused subset of the factors as

targets for intervention (5) specific for this study, educational diagnosis phase of this model is adapted to identify predisposing, enabling & reinforcing factors which determine pregnant women's intentions and their actual practice in relation to delivery service utilization (Annexes I, II and III)

Health Belief Model (HBM) is a paradigm used to product and explains health behaviors based on people's beliefs or perceptions (6). For this study women's perceptions about their susceptibility to and severity of delivery complications their eruptions about benefits of getting SDA as well as potential barriers perceived by the women which may prevent them from getting ID services were identified to assess their effect in determining women's intentions and practices related to delivery service utilization (Annexes I, II and III)

The theory of planned Behavior is a theory which assumes that people's intentions and their perceived control over the behavior are immediate predictions of their practices. The theory further assumes that people's intentions to wards performing a certain behavior are in turn influenced by their attitudes to wards the behavior and their beliefs about what would be the response of other influential people if they perform the behavior (6). To serve the purpose of this study in the view of the assumptions from the theory, women's attitudes towards ID services, their beliefs about the preferences of their husbands and relatives towards place of delivery and delivery attendants. Woman's intentions about their place of delivery as well as their power to decide about

getting ID services if they wanted to are assessed to determine the effect of these factors in influencing woman's ID service utilization (Annexes I,II&III)

Overview of the previous studies done on this topic have tried to identify various factors which determine delivery service utilization, but the literature review indicates that most of the studies are cross – sectional ones, in which if will be difficult to establish the temporal relationship between explanatory factors and the outcome (ID service utilization). Additionally, the factors under study were found to be inconsistent, in some studies, while they were not considered in others, which make the studies and the findings less comprehensive

In this study, a prospective follow up study design was applied to clearly establish the temporal relationships between explanatory factors and the outcome of interest and comparison of two groups of women (ANC attendants and non – attendants) was done to make the findings more conclusive. On top of this, all the factors identified from the literatures reviewed so far, are assessed to make the study and its findings more comprehensive.

OBJECTIVE

General objective

- To identify factors that influence utilization of delivery services by pregnant women

Specific objectives

1. To identify factors that predict intentions of pregnant women to utilize institutional delivery services
2. To determine factors that influence actual delivery practices of pregnant women

Methodology

Study design- prospective follow up study

Study period –from October 2004 to February 2005

Study area- the study was conducted in Jimma town, which is located 335 kms south west of Addis Ababa. The town was divided in to 19 kebeles, which are now merged in to 13 kebeles, because of a recent administrative restructuring. And its population is estimated to be 120,000 (projected from the 1994 census). There is one specialized teaching hospital, the Jimma Hospital, one health center and one MCH clinic, in addition to two non-governmental clinics mainly rendering reproductive Health services, as well as private clinics.

Source population –of the study are all pregnant women in Jimma town identified by visiting all households in the town.

Study population – the study population are pregnant women who were in their third trimester of pregnancy at the time the census was done in the town. During the census the women's gestational age, estimated by the women themselves, and their ANC follow up status were assessed and those women with 6 to 9 months of pregnancy were identified as eligible for the study.

Sample size determination

Sample size calculation was made based on the following assumptions.

1. Pregnant women in the town are estimated to be about 2% of 120.000 =2400 pregnant women.

2. Assuming that, pregnant women in their third trimester are roughly one third of the pregnant women, we expected to find 1/3 of 2400 =800 pregnant women in their third trimesters.
3. Considering it as a major predictor of institutional delivery. ANC attendance was taken as an exposure status.

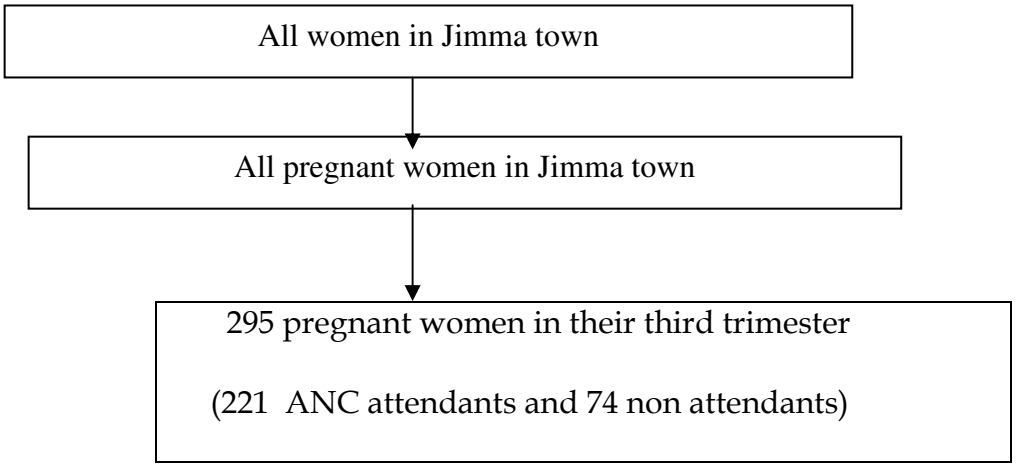
Based on previous studies conducted in the town, ANC attendance is about 75%

Therefore the ratio of exposed to non-exposed women i.e the ratio of ANC attendants to non-attendants =3:1.

4. Proportion of Institutional Delivery among ANC attendants = 14.2 %

   Proportion of Institutional Delivery among Non- attendants = 2%
5. Considering α = 5% and power of the study= 80%

Therefore, based on the above assumptions 268 pregnant women in their third trimester (ANC attendants and non attendants) and after including 10% non response rate 295 women were required for the study as eligible study participants



SAMPLING PROCEDURE

First a census was conducted in the town to register all pregnant women, their gestational age, ANC follow up status and their place of residences .Based on these informations , a sampling frame which enlists all eligible study subjects is prepared ,a list which includes all third trimester pregnant women according to their ANC follow up status .And all the women from this list are included in the survey.

Data collection instruments

Data was collected by using questionnaires developed for each phase, which are designed in such a way that they include all the relevant variables to meet the objectives of each phase. The questionnaires were developed in English and translated into Amharic for better understanding of enumerators and the respondents. During the training given for the data collectors and supervisors, the PI has tried to validate the Amharic version was really reflecting the contents and meanings of the questions from the English version. Finally, the Amharic version was utilized for data collection.

PHASES OF DATA COLLECTION

Phase I. Identification of study participants

The study subjects considered eligible for this survey were pregnant women who are in their third trimester. And they were identified through a census done in the town. Informations related to women's gestational age, ANC attendance and addresses of their residences were collected so that it will be possible to relocate the eligible women for further follow up.

Phase II- Interview of pregnant women to assess intention about their delivery practices

The objective of this phase was to identify future intentions of pregnant women about their delivery practices and factors influencing them. To achieve this objective the sampled eligible study subjects were interviewed by medical students using a structured questionnaire developed for this purpose.

Based on theoretical assumptions from behavioral modeling and findings from previous studies, relevant factors that may influence intentions to utilize delivery services were identified and a hypothetical framework was developed to depict the factors in a logical and comprehensive manner(Annex I). Factors comprised in the framework include knowledge, beliefs and attitudes as well as perceptions of the women about delivery complications and delivery services, availability and accessibility of ID services, influences from other people about ID service utilization and their decision making power on delivery service utilization, additionally ANC attendance is included in the framework as an exposure status(major predictor)of the outcome of interest, which is women's intentions about their place of delivery.

A questionnaire which includes relevant variables to measure these factors, as well as sociodemographic and obstetric characteristics of the pregnant women was developed and used.**(Annex Iv)**

Phase III. Interview of women after they deliver

The pregnant women who were interviewed in phase II were followed until they deliver, for about three months, and they were interviewed again to assess their actual delivery practices. Data was collected by using a structured questionnaire developed for this purpose and it includes actual place of delivery and delivery outcomes (both maternal and newborn's), their reasons for ending in the respective places of delivery, immediate obstetric problems, if any. The major outcome of interest for this phase is women's actual place of delivery. (Annex IV)

Variables

Outcome variables

A. Future intention of women about place of delivery (phaseII)
B. Actual delivery place of the women (phase III)

- **Explanatory variables**

A. Socio demographic, obstetric factors, ANC follow up knowledge, beliefs and attitudes as well as perceptions of women about delivery complications and services, availability and accessibility of ID services, influences from other people about delivery place and attendants, women's preference and their decision making power about place of delivery
B. Future intentions of women about place of delivery, immediate obstetric problems.

N.B Variables in A are used as explanatory variables for assessing future intentions of the women, while all the variables in A and B are used as

explanatory variables in order to assess actual delivery places of the women.

Selection and training of data collectors

Phases I and III were collected by 7 male and 3 female JU (first year business ,law and pharmacy extension) students, while phase II data collection was done by 6 fifth year medical students who are capable of taking obstetric histories. Data collection was supervised by 2 general practitioners from Jimma University and the principal investigator.

Training was given for 3 days by the principal investigator, to data collectors and supervisors prior to each phase of data collection. Emphasis was given on the significance and appropriate meanings of each question as well as on techniques of presenting the questions in understandable manner for the respondents.

Field testing

- The research methods and data collection tools (questionnaires) were pre-tested on 18 pregnant women, in the town who are not eligible, before the initiation of the main research (study).
- Findings and experiences from the pre-test were utilized in modifying and reshaping the research methods and the data collection tools. During the pretest it was observed that some women may not be available during the first visit ,therefore separate items were included in the questionnaire to register number of visits ,the reasons for not availing the women and favourable timings for revisits and this information is applied for planning and coordinating further revisits.

Supervision and quality control

- Supervision was conducted by two supervisors and the principal investigator, by observing how data collectors administer the questions to the respondents, by checking some households to make sure that they are the residences of the eligible women, also to check that some households are not left out without visits by the data collectors.
- To ensure data quality, each data collector checked the questionnaires for completeness before winding up their visit to each study participant.
- Some respondents(5 % of thewomen) were randomly revisited by supervisors or the PI.
- Each questionnaire was reviewed daily by supervisors and the PI to check for completeness and further edition.

Data Entry, cleaning and Analysis

- Data were entered onto SPSS version 11.0 computer program after preparing a template. Data were cleaned using SPSS.Description of the study population is done by analyzing the distribution of the respondents by the variables in terms of frequencies and percents. In order to assess the association of relevant factors with the outcomes of interest the following procedures were applied.

- A number of variables were included in the questionnaire to measure the explanatory factors in the study, ranging from 1 to 12.
- Those factors represented with a single variable such as, ANC follow up, availability of ID services, women's preference and their decision making power about place of delivery, future intentions & actual delivery places as well as acute obstetric problems - are included in the analysis as their own, without data manipulation.
- But other factors like knowledge, beliefs and attitudes, perceptions, accessibility of ID services, influences from other people about delivery place and attendants have several component variables (ranging from 3 to 12) included to measure them. In order to assess the association of these factors, with outcomes of interest , a composite scaling was done by doing the following procedures to represent each factor as a single variable in the analysis.
- Scores are given to the responses of each woman for each question in the respective factor. Responses which are considered to be in favor of ID were given 2 points ,those in disfavour 0 points and 1 point is given to responses which are neither in favour nor in disfavor of ID.
- Then the scores in each factor are summed up, to come up with a single scoring for each factor, for every respondent.

Operational definitions were done based on the scores of the respondents for each factor, such that those women who scored $\geq$ 75% for a factor are categorized as women with score favoring ID for the respective factor and those with score < 75 % for a factor

are categorized as those disfavoring ID for the respective factor. This will give us two groups of women for each factor- those favoring or disfavoring ID for that respective factor.

Chi-square tests are done to assess any association and measure strength of association between each explanatory factor and the outcomes of interest (crude ORs). Multiple logistic regression is applied to assess any association and strength of association between explanatory factors and outcomes after adjusting for the effects of other factors (Adjusted ORs).

Ethical Considerations

The study was approved by the ethical review committee of the Faculty of medicine, AAU. The consent of the administrative officials in the respective study areas and individual consents of the study participants were obtained. Additionally, a uniform set of health information regarding the danger signs of possible delivery complications and how to respond to them was given to all the study participants they were advised to seek professional help during delivery.

Operational Definitions

Behavior- An action that has a specific frequency, duration and purpose whether conscious or unconscious.

Behavioral intention- Readiness or willingness of an individual to perform a certain behavior.

Behavioral modelings - An attempt to identify and propose a working set of determinant factors which are thought to be the most important ones in affecting or influencing behaviors.

Educational diagnosis- identification of factors that predispose, enable and reinforce a specific health behavior.

Enabling Factors – are usually thought as barriers to behavior changes created by societal factors. Example . limited facilities, lack of income ….

Health Belief model- A paradigm used to predict and explain health behavior based on people's perception.

Health education- Any designed combination of methods to facilitate voluntary adaptation of behavior conducive to health.

Maternal deaths- Deaths of women while pregnant or within 42 days after termination of pregnancy, irrespective of the site and duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Non- Receptive perception - perception of pregnant women resulting in non-acceptance of institutional delivery.

Perceived severity- woman's perception towards severity of the possible delivery complications and their outcomes.

Perceived susceptibility- women's perception that they are susceptible to the possible delivery complications and their outcomes.

Perceived benefits- women's perception about the benefits of having a skilled delivery attendant in preventing the untoward outcomes of delivery complications.

Perceived barriers - women's perception about barriers that obstacle them from having skilled delivery attendance.

PRECEDE Model- A frame work designed to diagnose important factors that determine health behavior, which directs for a highly focused subset of the factors as targets for intervention.

Predisposing factor- any characteristic of an individual which facilittae or hinder behavior related to health.

Receptive perception- perception of pregnant women in favor of accepting institutional delivery.

Skilled attendant at birth- people with midwifery skills who have proficiency in skills necessary to manage normal deliveries, and diagnose, manage or refer obstetric complications.

Reinforcing Factors - are usually societal feedback that encourage or discourage behavior change.

Factor favourable for ID service utilization is more than or equal to 75 % 0f the score for the respective factor.

Factor unfavourable for ID service utilization is less than 75 % 0f the score for the respective factor.

RESULTS

A total of 236 pregnant women in their third trimester were identified through the census. And among them, 29 were not included in the study, because 15 delivered before the survey, so they are no more eligible for the survey, 7 could not be accessed for various reasons (4 households cannot be reallocated during the suevey, 3 women have left the town), 4 women were found not eligible for the study, because their gestational age was earlier than 6th months of pregnancy and 3 refused to participate in the study.

Out of the 207 pregnant women 78% are between ages of 20 and 34 years, 45% of them are orthodox Christians and Oromos and 77% of them have a minimum of primary education.In regard to their husbands, only 3.6% of them are unemployed, the rest are either private or government employees and 89% of them with a minimum of primary education. For 33% of the women the current pregnancy is their first, and 12% of them have 5 to 9 pregnancies so far. Majority (87%) of the women have not faced any obstetric problems, while the rest have faced at least one problem including vaginal bleeding headache, severe abdominal pain and dizziness.

Among the ANC attendants 57% have started their follow up while the pregnancy was between 3 and 6 months and 30% have started during the first there months of pregnancy. And 81% of them know at least one advantage of the follow up. And during the follow up, only 83(53%) of them were informed about possible delivery complications, out of whom 76 (91.6%) of them were informed about danger signs related to delivery complications and only 87(55%) of the women were informed about

where they should deliver, out of whom almost all 86 of them were informed to deliver in health facilities.

Regarding their knowledge about the advantages of pregnancy and delivery related services ,78 % of the women know at least one advantage of the services.

Coming to their attitudes to institutional delivery service, 70.4%, have good attitudes, only (3) 1.5% of them have bad attitudes .In regard to their perceptions about pregnancy and child birth complications as well as importance of getting skilled help at child birth, 87% of the women feel that they may be susceptible to develop delivery complications,93 %of them perceive that delivery complications can be hazardous to their health and 95 .2 % of them agreed that if they get a skilled attendant during delivery, it will be beneficial to their health and the health of their newborns(table 1).

In Jimma town, there are three government health facilities and other private clinics where delivery services are provided. In relation to availability of facilities where they can get skilled delivery attendants (SDAs), 94.2% of them said that such facilities are available in the town and 90.3% of them can get these facilities, near by to their place of residence.

According to the responses (beliefs) of the study participants, majority of the husbands prefer institutional delivery (69%) and SDA (72%) for these women. Again, majority of their family members prefer ID (67%) and SDA (70%). Moreover, 76% of the pregnant women prefer to deliver in institutions, while , 24% prefer to deliver at home ,and in regard to delivery attendants, 81.2% preferred SDA, while 19.8 % preferred TTBAs and their relatives or family members.

Regarding women's decision making power in relation to getting ID services, 62.3% can make this decision by themselves, while the rest should get the decisions either from their husbands or their relatives.

Majority 73% of the women were intending to deliver in health facilities, while 24% intended to deliver at home. Out of 184 women who have been interviewed after they deliver, 67.4% of them have delivered in health facilities, while the rest 32.6% have delivered at home(table 1).

Table1.Distribution of predisposing, enabling, reinforcing factors, women's preference, intention, decision making power and their place of delivery, Jimma town,2004.

FACTORS	FREQUENCY	PERCENT
Knowledge on at least one advantage of delivery services		
Yes	159	77.6
No	15	7.3
Do not know	31	15.1
Attitudes towards ID		
Favorable	145	70.0
Unfavorable	3	1.4
Indifferent	59	28.6
Perception about benefits of getting SDA		
Agree	197	95.2
Disagree	4	1.9
Indifferent	6	2.9
Ability to get HFs nearby		
Yes	187	90.3
No	11	5.3
Cannot assess	9	4.4
Husbands preference to place of delivery		
ID	143	69.1
HD	36	17.4
Do not know	28	13.5
Relatives preference to place of delivery		
ID	140	67.9
HD	40	19.3
Do not know	27	13.1
Women's preference to place of delivery		
ID	158	76.2
HD	49	23.8
Women's preference to delivery attendants		
SDA	168	81.2
Unskilled attendant	39	18.8
Decision maker		
The woman herself	129	62.3
Husband/partner	84	40.6
Relatives	9	4.3
Women's intentions about place of delivery		
ID	151	72.9
HD	49	23.7
Not decided	7	3.4
Women's actual place of delivery		
ID	124	67.4
HD	60	32.6

Which factors influence intentions of pregnant women?

Crude analysis was done by applying chi-square tests to assess any association between socio demographic variables and women's intentions. Among the socio demographic variables, maternal age and their educational status as well as, educational status of husbands and monthly income of the family are significantly associated with future intentions of the women (p-values< 0.05).

But by applying Multiple Logistic regression ,when they were adjusted for other socio demographic variables, only educational status of husbands and monthly income of the family are significantly associated with future intentions(p-values< 0.05). Women whose husbands have formal education are likely to intend to deliver in HFs (OR=4.6 and 95% CI = 1.64 to 3.49) and women whose families have better income are likely to intend delivering in HFs (OR = 5.46 and 95% CI = 1.08 – 27.55).

Maternal age , their educational and occupational status have shown no significant difference between women who have intended to deliver in HFs and those who intended to deliver at home(Table 2).

Crude analysis done by applying chi-square tests to assess the association of predisposing, enabling and reinforcing factors, ANC follow up and women's decision making power with their intentions in utilizing ID services, revealed that, all the factors, knowledge, attitudes, perceptions, availability and accessibility of ID services, influences from other people about delivery place and attendants, ANC follow up and

women's decision making power are all significantly associated with women's intention (P- values < 0.05). But by applying Multiple Logistic regression ,when they were adjusted for sociodemographic variables, predisposing, enabling and reinforcing factors as well as ANC follow up and decision making power only women's attitudes and influences from other people about place of delivery and delivery attendants and their decision making power were found significantly associated with their intentions about place of delivery (P< 0.05). Women's knowledge and perception about pregnancy and delivery services, availability and accessibility of ID services, as well as ANC attendance have shown no significant difference between women who have intended to deliver in HFs and those who intended to deliver at home (P- values < 0.05). (Table 3).

Women's attitudes towards delivery services have shown significant difference between women who have intended to deliver in HFs and those who intended to deliver at home and the odds of intending to have ID is 6 times for women who have favorable attitudes to ID services (Adjusted ORs = 5.55 and 95% CI =1.6 to 19.24) when compared to women with unfavorable attitudes (Table 3).

Influences from husbands and relatives about place of delivery and delivery attendants have shown significant difference between women who have intended to deliver in HFs and those who intended to deliver at home, and the odds of intending to have ID is 9 (Adjusted OR =9.17 and 95% CI = 1.13.to 74.7) and 13 (Adjusted OR= 13.1 and 95% CI=1.9 to 89.9) times for women to whom their husbands and relatives prefer ID and

SDA when compared to women to whom these people prefer HD and other unskilled attendants(Table 3).

Women's decision making power about getting ID services has shown significant difference between women who have intended to deliver in HFs and those who intended to deliver at home and the odds of intention to have ID is 8 times for women who can decide by themselves to have ID services (Adjusted OR=8.25 and 95% CI =2.19 to 30.96) when compared to women for whom the decision about getting ID services should be made by other people(Table 3).

Table 2.Womens intentions about place of delivery versus sociodemographic

Variables adjusted for sociodemographic Variables, October 2004

Factors	ID	HD	Crude ORs (95% CI)	Adjusted ORs (95% CI)
Maternal age				
15- 19	25	7	1	
20-24	45	17	0.74(0.27-2.23)	0.57(0.17-1.93)
25-29	56	12	1.31(0.46-3.7)	1.32(0.38-4.57)
30-34	21	5	1.18(0.32-4.26)	1.39(0.26-7.5)
35-39	4	6	0.19(0.04-0.85)*	0.27(0.05-1.58)
Religion				
Orthodox	71	21	1	
Protestant	22	8	0.81(0.32-2.09)	1.15(0.28-4.78)
Muslim	56	20	0.83(0.41-1.67)	1.39(0,48-4.07)
Women's occupation				
No job	116	40	1	
Some job	34	9	1.3(0.57-2.95)	2.48(0.69-8.85)
Women's education				
No formal education	27	20	1	
Formal education	124	29	3.16(1.56-6.41)*	1.99(0.7-5.69)
Husbands occupation				
No job	4	3	1	
Some job	138	40	2.58(0.56-12.04)	0.98(0.15-6.42)
Husbands education				
No formal education	10	12	1	
Formal education	132	31	5.11(2.02-12.89)*	4.6(1,64-12.89)*
Monthly income				
<150	30	18	1	
150-500	74	23	1.93(0.91-4.08)	1.48(0.63-3.49)
>500	26	2	7.8(1.65-36.84)*	5.46(1.08-27.55)*

* Significant at 5%

**Adjusted for sociodemographic Variables

Table 3. Women's intentions about their place of delivery versus predisposing, Enabling and Reinforcing factors,ANC Follow up, decision- making power adjusted for sociodemographic Variables , predisposing, Enabling and Reinforcing factors, ANC follow-up and their decision making power, Jimma,October 2004

FACTORS		ID	HD	Crude ORs and their 95 % CIs	Adjusted ORs and their 95 % CIs **
Knowledge about delivery services-	Good	140	38	3.68(1.48-9.15)*	0.2(0.04-1.13)
Women's attitudes towards ID	Poor	11	11	1	
	Favorable	131	17	12.33(5.8-26.19)*	5.55(1.6-19.2)*
Women's Perceptions about delivery complications and services	Unfavorable	20	32	1	
	Receptive	140	39	3.26(1.29-8.25)*	2.39(0.69-8.31)
Women's Perceptions about Barriers to have ID	Non receptive	11	10	1	
	Receptive	137	33	4.75(2.11-10.68)*	1.17(0.2-6.77)
Availability of ID services	Non receptive	14	16	1	
	Yes	146	42	5.2(1.41-19.34)*	0.27(0.02-3.03)
Accessibility of ID services	No	4	6	1	
	Yes	135	30	5.34(2.46-11.58)*	1.89(0.64-5.59)
Influence from husbands and relatives about place of delivery	No	16	19	1	
	Favorable	126	4	56.7(18.7-171.9)*	9.17(1.13-74.68)*
Influence from husbands and relatives about delivery attendants	Unfavorable	25	45	1	
	Favorable	132	5	61.1(21.5-173.4)*	13.08(1.9-89.9)*
Women's Decision making power	Unfavorable	19	44	1	
	Yes	104	20	3.09(1.59-6.05)*	8.25(2.19-30.96)*
ANC follow up	No	47	28	1	
	Yes	125	27	3.92(1.94-7.92)*	2.93(0.85-10.14)
	No	26	2	1	

*Significant at 5%

**adjusted for sociodemographic Variables , ANC follow up and decision making power, predisposing, Enabling and Reinforcing factors

Which factors determined actual delivery places of the women?

Crude analysis was done by applying chi-square tests to assess any association between socio demographic variables and women's place of delivery.

Among the socio demographic variables, families monthly income, women's as well as their husbands educational status and maternal age are significantly associated with their place of delivery(p-values <0.05). But by applying Multiple Logistic regression ,when they were adjusted for other socio demographic variables only maternal age and their educational status are significantly associated with their place of delivery(p-values <0.05). And women between 35-39 years are less likely to deliver in HFs when compared to those between 15-19 years (OR = 0.06 and 95% CI= 0.001 -0.52) and women who have formal education are more likely to deliver in HFs when compared to those who have no formal education (OR = 2.82 and 95%CI = 1.09 to 7.23) (Table 4).

A crude analysis done by applying chi-square tests to assess any association between predisposing, enabling and reinforcing factors, ANC follow up, intentions and their decision making power and obstetric problems during the index child birth with women's place of delivery, without adjusting for other factors revealed that women's beliefs and attitude towards ID services, accessibility of ID services influences from other people in regard to place of delivery and delivery attendants, ANC follow up, intentions and their decision making power were found to be significantly associated with actual place of delivery (P-values <0.05) .

But when adjusted for sociodemographic variables, predisposing, enabling and reinforcing factors, ANC follow up, obstetric problems, women's intentions and their decision making power, only influence from other people about delivery attendants, ANC follow up and women's decision making power have persisted to be significantly associated with their actual place of delivery (P- values <0.0.5).

But women's knowledge and perceptions about pregnancy and delivery related services, availability of ID services and obstetric problems during the index childbirth were never associated with women's place of delivery (P values >0.05), both in the crude and adjusted analysis(Table 5).

Even tough the crude analysis shows that women's intentions about their place of delivery was associated with their actual place of delivery (p-value<0.05), the association did not persist when their intentions were adjusted for other factors (p-value>0.05).

Influences from husbands and relatives about delivery attendants has shown significant difference between women who have delivered in HFs and those who delivered at home (p-value<0.05). And women to whom their husbands and other relatives prefer SDA are 5 times more likely to deliver in HFs when compared to women to whom these people prefer unskilled attendants (adjusted OR= 4.78 and 95% CI = 2.25 to 10.21) (Table 5).

ANC attendance during the index pregnancy is significantly associated with women's place of delivery (p-value<0.05) and women who were attending ANC follow up during the current pregnancy, are 3 times more likely to deliver in HFs when compared to women who were not attending ANC (adjusted OR= 2.63 and 95% CI = 1.11 to 6.23). Women's decision making power about getting ID services has shown significant difference between women who delivered in HFs and those who delivered at home(p-value<0.05). Women who can decide by themselves to get ID services, are 3 times more likely to deliver in HFs, when compared to women for whom this decision should be made by other people like their husbands and relatives (Adjusted OR = 2.75 and 95% CI =1.3 to 5.78) (Table 5).

Table 4.Womens actual place of delivery versus sociodemographicVariables adjusted for sociodemographic Variables,October 2004

Factors	ID	HD	Crude ORs(95% CI)	Adjusted ORs(95% CI)**
Maternal age				
15- 19	21	8	1	
20-24	41	16	0.98(0.36-2.65)	0.49(0.13-1.83)
25-29	42	19	0.84(0.32-2.24)	0.52(0.15-1.73)
30-34	15	8	0.71(0.22-2.33)	0.43(0.09-2.2)
35-39	2	8	0.09(0.02-0.55)*	0.06(0.01-0.52)*
Religion				
Orthodox	63	20	1	
Protestant	13	15	0.27(0.11-0.68)	0.22(0.07-1.71)
Muslim	44	25	0.56(0.28-1.23)	0.72(0.3-2.71)
Women's occupation				
No job	93	52	1	
Some job	28	8	1.96(0.83-4.61)	3.05(0.87-10.72)
Women's education				
No formal education	18	23	1	
Formal education	104	37	3.59(1.74-7.39)*	2.82(1.09-7.23)*
Husbands occupation				
No job	2	4	1	
Some job	115	52	4.4(0.78-24.92)	2.56(0.26-24.72)
Husbands education				
No formal education	7	13	1	
Formal education	110	43	4.75(1.78-12.71)*	3.52(0.98-12.66)
Monthly income				
< 150	25	16	1	
150-500	57	34	1.07(0.5-2.29)	0.74(0.29-1.89)
>500	24	2	7.68(1.59-37.0)	4.28(0.75-24.26)

*Significant at 5% **Adjusted for sociodemographic Variables

Table 5. Women's actual place of delivery versus predisposing, Enabling and Reinforcing factors, ANC follow-up, immediate obstetric problems , intentions and their decision making power, adjusted for sociodemographic Variables , predisposing, Enabling and Reinforcing factors,ANC follow-up , immediate obstetric problems , intentions and decision making power, October 2004

FACTORS		ID	HD	Crude ORs (95 % CIs)	Adjusted ORs (95 % CIs) **
Knowledge about delivery services	Good	113	53	1.66(0.59-4.69)	1.6(0.35-7.33)
	Poor	9	7	1	
Women's attitudes towards ID	Favorable	98	38	2.36(1.18-4.71)*	0.93(0.33-2.6)
	Unfavorable	24	32	1	
Women's Perceptions about delivery complications and services	Receptive	111	50	2.02(0.81-5.06)	2.39(0.69-8.31)
	Non receptive	11	10	1	
Women's Perceptions about Barriers to have ID	Receptive	107	48	1.78(0.77-4.09)	0.38(0.1-1.43)
	Non receptive	15	12	1	
Availability of ID services	Yes	116	58	0.4(0.05-3.5)	0.1(0.01-1.14)
	No	5	1	1	
Accessibility of ID services	Yes	106	42	2.84(1.33-6.08)*	1.89(0.64-5.59)
	No	16	18	1	
Influence from husbands and relatives about place of delivery	Favorable	92	27	3.75(1.95-7.21)*	0.28(0.04-1.92)
	Unfavorable	30	33	1	
Influence from husbands and relatives about delivery attendants	Favorable	100	26	5.94(2.98-11.83)*	4.78(2.25-10.2)*
	Unfavorable	22	34	1	
Women's Decision making power	Yes	83	28	2.36(1.25-4.45)*	2.75(1.3-5.78)*
	No	39	31	1	
ANC follow up	Yes	102	40	2.55(1.24-5.24)*	2.63(1.11-6.23)*
	No	20	20	1	
Immediate obstetric problems	No	49	88	1.52(0.63-3.69)	1.81(0.56-5.85)
	Yes	4	13	1	
Women's Intentions about place of delivery	ID	105	28	7.0(3.29-14.86)*	2.74(0.76-9.83)
	HD	15	28	1	

*Significant at 5%

**Adjusted for sociodemographic, predisposing, Enabling and Reinforcing factors, ANC follow-up , immediate obstetric problems , intentions and decision making power

DISCUSSION

This study tried to assess determinants which influence women's intentions and their actual practices related to the place of delivery in an urban context. Based on several assumptions, the sample size calculated for this study was 268 to be identified from 12 randomly selected kebeles. But it was not possible to get this size from 12 kebeles and the remaining 7 kebeles were included in the census. Ever after visiting all the house holds in the town, only 236 third trimester pregnant women were found. And out of whom twenty-nine eligible study subjects were not included in the study for various reasons such as some women have already delivered before they were visited and for others their households could not be relocated, the rest were found not-eligible. And finally ,207 women participated for the first interview and after they were followed up until they deliver,184 of them were interviewed ,but the rest were lost to follow up for several reasons like some were not available at home during the visit, other have left the town (some permanently, others to deliver in another place), few have not yet delivered during the visit.

The number of participants included in this study is less than the required sample size, which was calculated based on several assumptions .In ability to get adequate sample size is one of the limitations of this study. And this discrepancy between the calculated sample size and the size of study participants included in the study could not be avoided during the field work, because there was no other way of getting the calculated number of pregnant woman in the town, as all the women identified though a community based census done by visiting all the households in the town are all included in the study. Additionally, as this is a

comparative study, the total number of study participants included in the study is not a major factor which affects the validity of the study, in such studies the most important factor in affecting the validly of the study is the power of the test, in terms of its ability to detect the assumed difference between the two groups of women.

For this study the sample size calculation was done with the assumption of detecting a 12.2% difference in the proportion of ID between ANC attendants and non – attendants (3), but this study shows that this difference is 22.2 % and hence, if the sample size was calculated with this assumption a total of 220 woman would have been enough to maintain the power of the study as 80%. Additionally, with the 207 women included in this study, to detect a 22.2% difference in the proportion of ID between 157 ANC attendants and 50 non – attendants, this study has a power of 78%, implying that even though the size of study participants included in the study was lower than the calculated size, the study was still powerful enough and also valid to detect the actual difference in the proportion of ID between these two groups of women

Some eligible women identified by the census were not included in the survey. This is another limitation of the study, which arose because of practical difficulties that could not be solved during the field work. Once the women are identified as eligible, they could have been included in the study if phases I and II of data collection were conducted simultaneously, which was practically impossible because the data collectors for the two phases were two different groups of people and it was not possible to deploy both groups of data collectors simultaneously because of logistic & time

constraints. Based on this it can be recommended that, for similar studies where the factors under study might change over short period of time, it is better to shorten the gap between the phases of identifying study subjects and the first interview and if possible to conduct them simultaneously.

Another limitation of this study is related to the final phase of data collection, where a number of women were lost to follow up for various reasons and in order to reduce loss to follow up, some women were revisited 2 to 3 times and for others the possible information was gathered from adult inhabitants in the same household, especially information related to place of delivery, which is the most important outcome of interest and a variable that can be easily known and remembered by other people. As a result it was possible to contain the loss to follow up at 12%, not a very significant proportion to affect validity of the study.

Even though both intentions and actual practices related to delivery service utilization are studied previously, the studies are conducted on separate groups of women rather than on same women. Previous studies on future intentions of women were conduced by interviewing pregnant women about their intentions, and come up with identifying factors that influence their future intentions, and the assumption from these studies is that, based on their intentions it will be possible to predict actual practices and assuming that the factors which influence intentions are also equally important in influencing the actual practices. Even though, intentions may predict practices, one cannot absolutely be sure that they will always predict practices and factors that

influence intentions would similarly influence actual practices, especially practices related to delivery service utilization, which may be subject to other more serious and urgent influences from various factors that may arise around the circumstances of labour and delivery.

Previous studies done on actual delivery practices have used women who had at least one delivery experience in the last few years (1 to 5 years) and tried to assess factors that have influenced their delivery practices. The finding from such studies might shade some light on what factors influence actual delivery practices, but these studies are most likely subjected to the following biases. The study participants in these studies are women who had at least one delivery experience prior to the studies, 1 to 5 years before the study, making their responses largely subjected to recall bias. The other serious problem with this approach is the chicken egg dilemma between explanatory factors and the outcome. Except for some factors which remain relatively stable such as Sociodemographic factors, other factors especially those related to knowledge, beliefs & attitudes, perceptions, women's intentions…etc are largely subjected to be influenced by the actual practice itself making the situation very difficult to judge whether the actual practice have influenced the underlying factors, or the underlying factors have really determined the practices. Thus the best approach to tackle these problems or biases, is to measure the underlying factors while the women are still pregnant and to assess their actual practice after the women deliver. This study has tried to correct these limitations by measuring the underlying factors while the women were still pregnant and by following them until they deliver to assess their actual delivery practices. This approach

not only minimizes the recall period only to a maximum of 3 months but also proves that the underlying factors represent the situation well before the practices happen and one can be sure that the explanatory factors are never influenced by the practice.

Since both intentions and actual practices are studied on the same women ,in addition to addressing the aforementioned biases ,this study design will also help to assess the importance of intentions in terms of their ability to predict actual practices.

Review of the literatures done so far on this research topic show that, the studies have included different set of factors for study, showing that some factors studied in one are not included in other studies. And even more some factors that are not included in one study were found as important ones in other studies (9,10,14,15,16,17). In this study, it has been tried to include all the relevant factors identified by the literature review done so far. In addition to the findings from other studies, by referring to relevant behavioral models, some constructs and factors considered as important are also included for study in this survey. In order to present the factors in a clear and comprehensive manner, a framework (model) is constructed.

From this prospective follow up study it is found that women between 15-19 years are more likely to deliver in HFs when compared to those between 35-39 years, and this might be because as ANC follow up is one determinant of place of delivery from this study, women who are on follow up might have been recommended to deliver in HFs because their age is one of the obstetric risk factors and this is most likely their first birth

which demand ID services, according to the risk assessment approach of ANC. Additionally, studies have shown that first births and births to young mothers are more likely to be delivered in HFs(3,9).

Women with formal education level are also more likely to deliver in HFs when compared to those with no formal education and this might be because, when women are educated, they might have the power to make their own decision in matters related to their place of delivery and this same study has shown that women with such power are more likely to deliver in HFs. Again, this finding is also consistent with other studies which show that women, who are educated are more likely deliver in HFs (3,14) .

Even though some studies have shown that women with better knowledge and perceptions about pregnancy and delivery related services as well as the benefits of utilizing them are more likely to deliver in HFs (16,18), this study shows that women's knowledge and their perceptions about pregnancy and delivery services are not important predictors of their place of delivery. And this finding is consistent with another study, which shows that these factors are not important predictors of place of delivery (17).

ANC follow up is one of the factors identified from this study as determinants of women's place of delivery, those attending ANC being more likely to deliver in HFs when compared to those not attending. This finding is consistent with findings from other local studies which show that ANC follow up is important in influencing women's preferences and their place of delivery (3,10).The importance of ANC follow up in

determining actual place of delivery, may be explained in such a way that, exposure of the women to the health service in general and the information as well as the experiences they have gathered during the follow up in particular, might have influenced them to deliver in HFs. Another possible explanation may be, considering facts that ANC follow up is service utilization by itself and both ANC and ID services are a continuum of pregnancy and delivery related service, factors which influence utilization of ANC might have influenced ID service utilization in a similar manner.

Recent updates on ANC; suggest that one of the interventions during ANC which are of proven effectiveness, to maximize the usefulness of ANC follow up, in promoting and ensuring safer pregnancy and childbirth is provision of information about danger signs and symptoms which may signal pregnancy and delivery complications to the women and their families, so that they will be able to make an informed decision on the delivery plan. (1) But the findings from this study suggest that only half of the ANC attendants are informed about such signs. Additionally, as current recommendations regarding childbirth suggest, every childbirth should be attended by a skilled delivery attendant. In our country, where it is very unlikely for home births to be attended by SDAs (3)the best way which ensures that every childbirth is attended by a SDA, is if the women deliver in health facilities. And this can be promoted by informing women about where they should deliver; at least those women who are on ANC follow up. But this was not the case for the women, under this study, where only half of them are informed about where to deliver.

Based on these findings it can be observed that, even tough ANC attendance is important factor which promotes ID, it is not fully utilized as a conducive opportunity to provide pregnant women with the relevant information about pregnancy and child birth. But ,as this is just an observation from a study which is not designed to assess the quality of ANC services, these findings cannot be considered as conclusive ones, and hence, more comprehensive studies are recommended to evaluate whether the services related to ANC are provided appropriately or not.

According to some behavioural models human behaviours are sometimes influenced largely by the preferences or attitudes of influential people towards the behaviour or practice (5). In view of this assumption, and based on the finding from this study which shows that women to whom their husbands and relatives prefer SDA are more likely to deliver in HFs suggests that the influences from these people are important determinants of women's delivery place. This finding is consistent with findings from other studies, which showed that if families and other relatives perceive the need for obstetric care, women are likely to use such services (15,16,17,18).

Women's decision making power in relation to delivery service utilisation is another critical factor, because whether the other factors are favourable or not, the most important step in intending or actually getting the services largely relies on whether the women have the power to make the final decision to get ID, if they wanted to or if they have to (5). Consistent to this point this study shows that women who have the power to

decide on this issue just by themselves are more likely to deliver in HFs, suggesting that this decision making power is an important predictor of their place of delivery. Again, this is consistent with findings from another study conducted in India , which shows that lack of decision-making power by women could result into lesser timely health seeking behavior and the same study finds out that utilization of ID services was higher for women who have full health care autonomy, the autonomy of deciding to utilize the services (14).

The finding from this study which shows that women to whom their husbands and relatives prefer SDA and those who have the power to decide on delivering in HFs, are more likely to deliver in HFs is a very important point. Because, sometimes, the discouraging or encouraging influence from other people about delivery attendants may not always be limited by giving suggestions to the women about their place of delivery because in certain instances, these same people may be the primary decision makers in terms of utilizing ID services. And this implies that in such scenarios, women who are discouraged by other people from getting ID services and those who still cannot decide by themselves to get ID services are very unlikely to deliver in HFs. This relationship between influences from other people and decision-making power of women is demonstrated by a series of studies, which include baseline surveys, interventions and post-intervention assessment focusing on improving maternal health care utilizations conducted in rural Bangladesh(15,16,17).

According to the studies, after interventions to raise awareness among the community about pregnancy and delivery care are conducted, a post intervention assessment revealed that, not only the level of knowledge among the community has increased but also, the ID service utilization has risen to from its baseline 0.7 % to 4.2%. And this improvement is ascribed, to the interventions, which have improved the level of awareness about benefits of delivering in HFs, among women and other influential people. And based on this,the authors have finally concluded by recommending that in order to improve the service utilization to a better level, further activities should be strengthened by targeting husbands, mothers and mothers in laws. This judgment sounds correct when combined with another finding from the same studies, which revealed that women's husbands, mothers and mother in laws are usually the primary decision makers with regard to the person to be consulted for obstetric care (15,16,17).

Some previous studies done indicated that intentions are important predictors of actual practices, but this study shows that intentions of pregnant women about their place of delivery do not predict their actual place of delivery. One possible explanation may be whatever intentions the women had while they were pregnant, other more important factors such as time the labour, transportation, influences from other people, immediate obstetric problems might have determined their practices. Moreover, the situations, which have influenced the women about their respective intentions, might have changed while the women approached childbirth and even more the situations might have changed drastically around the circumstances of labour and delivery. Studies

conducted in rural Bangladesh show that among the women who were intending to attend ANC follow up,19.3 % of them were not on the follow up for reasons like economic constraints, family reasons and bad attitudes to the health facilities. And out of the women who were intending to deliver in HFs 14 % delivered at home because their husbands objected and the HFs were too far away (15,16,17).

Looking deeper into the determinant factors from this study,the sociodemograhic factors which influence women's intentions and their practices are completely different, family income and husbands educational status for the former, while maternal age and their educational status for the later. And among the other factors identified, favourable influences from husbands and relatives about delivery attendants and decision-making power of the women are important predictors of both intentions and actual practices. This is a logical finding in view of the complex relationships between these two factors. But attitudes of the women towards delivery services which were predictors of their intentions, do not predict their actual practices, while ANC follow up which does not predict their intentions was found to be an important predictor of their actual place of delivery. This suggests that, for women with similar set of influences from husbands and relatives and similar decision-making power, their beliefs and attitudes are important predictor of their intentions but not their actual practices, while ANC follow up, which is not a predictor of their intentions , is important predictor of their actual practices. These findings suggest that there are some factors which influence women's intentions, while there are some other more important factors which determine their

actual practices, and this may be considered as one possible explanation on why, intentions of these women did not predict their actual place of delivery.

Finally, since this study is conducted in an urban town where heath facilities are optimally available, the findings can only be generalized to similar settings with comparable sociodemographic and health service coverage profiles. And hence similar studies are recommended in various settings, to come up with more representative findings which will be helpful in planning and implementing more contextual interventions to improve the delivery service utilization in the county.

CONCLUSIONS

1. Maternal age ,their educational status, influence from their husbands and relatives in relation to delivery attendants, women's power to make the decision in terms of getting ID services and ANC follow up are important predictors of their place of delivery,
2. Utilization of ID services is higher among educated women, women who have the power to decide by themselves about delivering in HFs and those women who have favourable influences from their husbands and relatives about their delivery practices, while it is lower among disadvantaged women.
3. Even though, the services provided in terms of information provision to the women during ANC follow up is quite unsatisfactory, ANC attendants are more likely to deliver in HFs when compared to non-attendants.
4. Women's intentions about their place of delivery, which they have made during pregnancy, are not important predictors of their actual practices.

RECOMMENDATIONS

1. Relevant stakeholders should be involved to promote empowerment of disadvantaged women through integrated activities including girls education will be helpful to enable them decide by themselves about their delivery practices.
2. Interventional IEC activities focusing on women's husbands and other relatives will be helpful in utilizing these people, so that their influences can be directed in the line of encouraging women to utilize ID services. Additionally, this will have a far reaching advantage, since the positive impacts of the favorable influences form these people in promoting ID service utilization will be reflected through the role of these influences in directing the decision making process on matters related to women's delivery practices.
3. Health services should be involved in promoting ANC attendance and improving the services given during the follow up, may be helpful to maximize the contribution of the follow up in promoting safer pregnancy and childbirth.
4. Reaching out more women to provide the relevant information about ID services might help in promoting utilization of the services.
5. Similar studies should be conducted in various settings (both similar and different settings) to come up with more representative findings, which will be helpful in designing interventional activities targeted at improving ID service utilization.

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ANNEX I

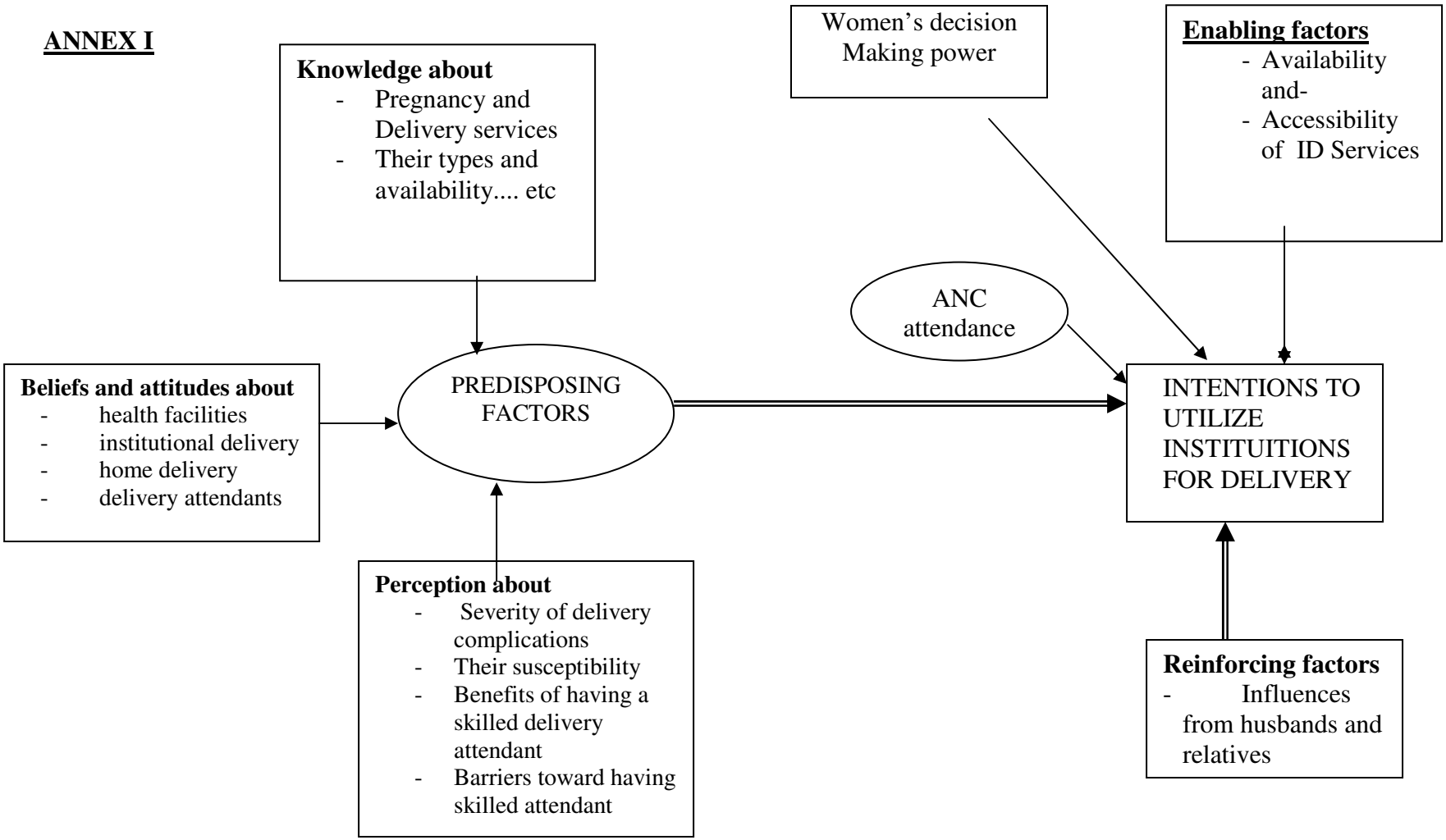

Figure 1.: Schematic presentation of the MODEL adapted to identify determinants that influence **intentions** of pregnant women to utilize institutions for delivery

ANNEX II

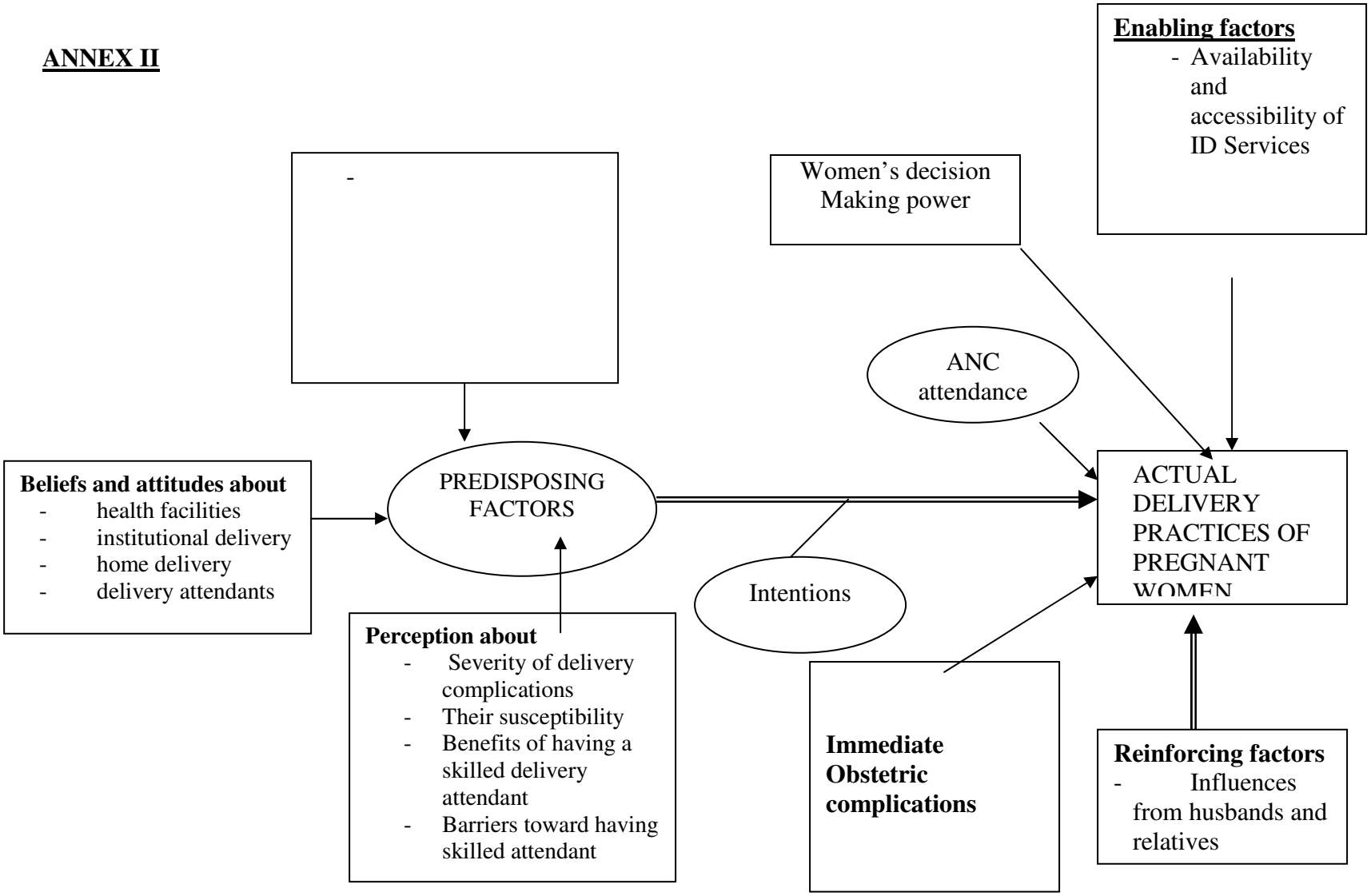

Figure 2.: Schematic presentation of the MODEL adapted to identify determinants that influence **actual delivery practices** o Pregnant women

ANNEX III. POINTS ABOUT BEHAVIORAL MODELS

THE THEORY OF PLANNED BEHAVIOR

A major assumption in this theory is that people are usually rational and make predictable use of the information available to them. it states that intentions are the most immediate influence on behavior. Thus if a person intends to perform a behavior them it is likely he or she will do so and if the person doesn't intend to perform it, then the behavior is unlikely to be performed.

Intentions are influenced by attitudes. i.e good feeling about performing the specific behavior and by subjective norms i.e. the person's perceptions of influences from significant others, or influential people, about performing the behavior. The theory further hypothesizes that attitudes are determined by people's perception about what that the control the people have in relation to the behavior is another factor, which determines, their intentions towards performing the behavior.

Thus the theory predicts that a person is most likely to perform a behavior when he/she feels. God about performing the behavior, if he/she feels influences from influence people about performing the behavior and if he/she feels that he has personal control over the behavior

THE HEALTH BELIEF MODEL

This is oldest and most widely used model specifically developed to explain health behavior and it states that thee are four major types of beliefs that influence that likelihood of taking action that is relevant.

1 Perceived susceptibility refers to the subjective perception about probability of getting or developed condition.

If people feel that they would develop a certain disease or adverse out come they are likely to take precautions to prevent

2 Perceived severity refers to person's perception or feeling about severity of the condition or disease.

3 Perceived benefits. Refer to people's perception about benefits of taking actions in preventing a certain disease/ outcome

4. perceived barriers- refer to people's perception that it may not be feasible to take some action for various reasons or barriers.

-if people feel that, they have some problems or barriers which may prevent them taking some action, they are unlikely to take the action.

THE PRECEDE-PROCEED MODEL

This model has nine phases, which range from identifying health problems to conducting intervention activities and evaluating their effectiveness. And one of the phases is making educational diagnosis-identifying factors which promote or prevent from forming a health – conducive behavior.

The model suggests that there are three groups of factors influence heath behaviors and they are

1. Predisposing factors: refer to situation which increase or decrease the motivation for performing the behavior.

   E.g cognitive factors as knowledge, beliefs and attitudes, perception related to behavior

2. Enabling factors: refer to factors, which may prevent people from performing a behavior.

   E.g limited facilities, lack of income

3. Reinforcing factors: refer to feedback or influence from other people that encourages or discourage people from performing behavior.

* The model suggests that the predisposing, enabling and reinforcing factors that have the most direct effects on the target behavior should be identified, prioritized and the intervention should be designed to impact the most important factors.

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ኮሙኒቲ ሄልዝ ዲፓትመንት

ይህ ጥናትና ምርምር እርጉዝ ሴቶች የተለያዩ የወሊድ አገልግሎቶቸን እንዲጠቀሙ የሚያበረታታቸውን ወይንም እንዳይጠቀሙ የሚያግዳቸውን የተለያዩ ምክንያቶች ለማጥናት ያገለግለናል .... ከዚህ ጥናት የሚገ□ው ውጤት የወሊድ አገልግሎትን አቅርቦትና ጥራት ለማሻሻል አስፈላጊ የሆኑ እርምጃዎችን ለመውሰድ ከፍተኛ ድር አለው፡፡

ይህ የወሊድ አገልግሎት በቀጥታ የሚመለከተው እርጉዝ እናቶችን በመሆኑ ይህ ጥናት ለመውለድ የተቃረቡ እርጉዝ እናቶች ላይ ያተኮረ ነው፡፡ በመሆኑም ከነዚህ ሴቶች ውስጥ የተወሰኑትን በዕጣ መርጠናል፡፡ ከመረጥናቸው ሴቶች መካከልም እርሶ አን በመሆንዎ በዚህ ጥናት ውስጥ ለመሳተፍ ፍቃደኛ እንዲሆኑ በትህትና እንጠይቃለን፡፡

ለጥያቄዎቹ የሚሰጣቸው መልሶች በሙሉ ሚስጥራዊነታቸው የተጠበቀ ይሆናሉ፡፡ ስለዚህ ስለማንነትዎ እና ስለሰጧቸው መልሶች በሚስጥር መጠበቅ ምንም አይነት ስጋት አይግባዎት፡፡

በተጨማሪም ከወለዱ በኋላ ቃለ መጠይቅ አድራጊዎች በጣም አጠር ላለ ቃለምልልስ በድጋሚ ወደርስዎ ይመጣሉ፡፡

የርስዎ በዚህ ጥናት ውስጥ ተሳታፊ መሆን ለጥናቱ በተሳካ ሁኔታ መጠናቀቅ ብቻ ሳይሆን ለወሊድ አገልግሎቱም መሻሻል ከፍተኛ አስተዋፅኦ ስለሚኖረው አሁንም በድጋሚ በዚህ ጥናት ውስጥ እንዲሳተፉ በአክብሮት እንጠይቃለን፡፡

<u>የመለያ መረጃዎ ቅጽ</u>

001የመለያ (ኮድ) ቁጥር-----------
002.የተጠያቂ ሴት ስም ----------
003.የመኖሪያ አድራሻ ----------
ክፍተኛ ---------- ቀበሌ---------- የቤት ቁጥር ----------

101. የተጠያቂዋ ሴት እድሜ /በአመት/ ----------
102. የጋብቻ ሁኔታ

1. ያገባች 2. ያላገባች 3. የተፋታች 4. ባለቤቷ የሞተባት ☐

103. ሐይማኖት

1. }∅ϒε **2.** }ϑϒ **3.** ⌈αζε{ ।

4.ΠεϑΤ **5. ሌሎች** ☐

104. ብሔር

1. ኦሮሞ 2. አማራ 3.ትግሬ 4.ጉራጌ 5.ኩሎ 6. ከፋ
7.ሌሎች
☐

105. የስራ ሁኔታ

1. የቤት እመቤት 2. የመንግስት ተቀጣሪ 3. የግል ተቀጣሪ 4. ሌሎች ☐

106. የትምህርት ሁኔታ

1. ምንም ያልተማረች
2. P ϖξ O⌊J
3. 1ኛ ደረጃ ትምህርት የተማረች
4. 2ኛ ደረጃ ትምህርት ወይም ከዚያ በላይ ☐

107. የቤተሰብ ወርሃዊ ገቢ. /በብር/ ----------
108. የቤተሰብ ብዛት
በትዳር ላይ ለሚገኙ ሴቶች የሚከተሉትን ጥያቄዎች ይጠይቁ
109. የባለቤትዎ ዕድሜ ----------
110. የባለቤትዎ የስራ ሁኔታ

1. ስራ የላቸውም 2. የመንግስት ተቀጣሪ 3. የግል ተቀጣሪ 4. ሌሎች ☐

111. የባለቤትዎ የትምህርት ሁኔታ

1. ምንም ያልተማሩ **2.**P ϖξ O⌊J
3. የመጀመሪያ ደረጃ ትምህርት የተማሩ
4. ሁለተኛ ደረጃ ትምህርት ወይንም ከዚያ በላይ

ከወሊድ ጋር የትያያዙ ጥያቄዎች

201. ለመጀሪያ ጊዜ ትዳር ሲመሰርቱ እድሜዎ ስንት ነበር ? /በአመት/----------

202. ለመጀመሪያ ጊዜ እርጉዝ ሲሆኑ እድሜዎ ስንት ነበር ? /በአመት/----------

203. የአሁኑን ጨ•ሮ እስከአሁን ድረስ ምን ያህል ግዜ አርግዘዋል? ----------

204. ምን ያህል ልጆች በሕይወት አሉዎት? ----------

205. ምን ያህል ልጆች ከዚህ በፊት ሞተውቦታል ? ----------

<u>የአሁኑን እርግ≥ና በተመለከተ የሚጠየቁ ጥያቄዎች</u>

300. HO⇔[ι ©± ≠♦ ¯ ϖω …⊿ϖ| ♦ο| / **LMP/** _____

301. እርጉዝ ከሆኑ ምን ያህል ጊዜ ሆንዎታል ?

/የአሁኑ እርግዝና ምን ያህል ወራት አስቆጥሯል ?/ ----------

302. ተጠያቂዋ ሴት ይወልዳሉ ተብሎ የሚጠበቅበት ቀን / **EDD/** ----------

/ መረጃ ሰብሳቢዎች አስልተው የሚሞሉት ነው/

303. በዚህ እርግዝና ወቅት ከሚከተሉት የትኞቹ ችግሮች/ሕመሞች አጋጥሞዎታል ?

1. ምንም ችግር አላጋጠመኝም
2. በማህፀን ደም መፍሰስ
3. እራስ ምታት
4. ከፍተኛ የሆድ ሕመም
5. ራስ ማዞር
6. ሌሎች ካሉ ይጥቀሱ ----------

304. በዚህ እርግ•ና ወቅት ወደ ጤና ማዕከል ተገዘዋል ?

1. አዎን
2. የለም አልሄድኩም

305. ለጥያቄ ቁጥር 304 መልሱ አዎን ከሆነ ... ይህንን ጥያቄ ይጠይቁ::

ወደ ጤና ማዕከል ሄደው ከሆነ የሄዱበት ምክንያት ምን ነበር ?

1. ከእርግዝና ጋር የተያያዘ ችግር ስላጋጠመኝ
2. ከእርግዝና ጋር ያልተገናኘ ሌላ የጤና ችግር ስላጋጠመኝ
3. ለቅድመ ወሊድ ክትትል
4. ሌላ ምክንያት ከሆነ ይጥቀሱ ----------

306. በዚህ እርግዝና ወቅት የቅድመ ወሊድ ክትትል ያደርጉ ነበር ?

1. አዎን አደርጋለሁ
2. የለም አድርጌ አላውቅም::

በአሁኑ የእርግዝና ወቅት ቢያንስ አንድ ጊዜ የቅድመ ወሊድ ክትትል ሳደረጉ እናቶች የሚጠየቁ ጥያቄዎች

307. ለቅድመ ወሊድ ክትትል ምን ያህል ጊዜ ወደ ጤና ማዕከል ሂደዋል ? ----------

308. የቅድመ ወሊድ ክትትል የሚያደርጉበት የጤና ማዕከል የትኛው ነው ?

1. ጅማ ሆስፒታል
2. ጅማ ጤና ጣቢያ
3. ከፍተኛ 2 የእጤ ክሊኒክ
4. የቤተሰብ ጤና መምሪያ ክሊኒክ
5. የግል ክሊኒክ
6. ሌላ ከሆነ ይጥቀሱ ----------

309. ከላይ የጠቀሱልኝ የጤና ማዕከል ለቅድመ ወሊድ ክትትል ለማድረግ የመረጠዎት ምክንያት ምንድነው ?

1. ለመኖሪያ ቅርብ በመሆኑ
2. የተሻለ የጤና ባለሙያዎች ስለሚገኙ
3. ክፍያው ተመጣጣኝ በመሆኑ
4. ሌላ ምክንያት ይጥቀሱ

310. የቅድመ ወሊድ ክትትል የጀመሩት መ ነ•?

1. በእርግዝና የመጀመሪያ ሶስት ወራት ውስጥ
2. እርግዝናው ከሶስት ወራት እስከ ስድስት ወራት በሆነበት ወቅት
3. እርግዝናው ስድስት ወር •ለፈው በኋላ

311. የቅድመ ወሊድ ክትትል ማድረጉ ጠቃሚታው ምን ይOስልዎታል ?

1. የእናትየወን የጤና ሁኔታ ለመከታተል
2. የፅንሱን የጤና ሁኔታ ለመከታተል
3. የፅንሱን አቀማመጥ ለመከታተል
4. በወሊድ ወቅት ሊያጋጥሙ የሚችሉ አንዳንድ ችግሮችን ቀድሞ ለመገመት
5. ጠቀሜታው ምን እንደሆነ አላወቅም
6. ሌላ ጠቀሜታ •ለው ይጥቀሱ ----------

312. በእርግዝና ጊዜ እንዳሁም በወሊድ ወOት ሊያጋጥሙ ≠ሚችሉ የጤና ችግሮችን በተመለከተ መረጃ ተሰጥቶዎት ነበር
/በቅድመ ወሊድ ክትትል ወቅት ማለት ነው/?

1. አዎን
2. የለም
3. አላስታወስም

313. በእርግዝና ጊዜ እንዲሁም በወሊድ ወቅት ሊያጋጥሙ ≠ሚችሉ የጤና ችግሮችን በተመለከተ መረጃ ተሰጥ••ት ከነበረ እነዚህ የጤና ችግሮች ስለሚያሳዩዋቸው ምልክቶች ተነግሮዎታል ?

1. አዎን
2. የለም
3. አላስታውስም

ለጥያቄ 313 መልስ አዎን ከሆነ ... ጥያቄ 314 እና 315 ይጠይቁ መልሱ የለም ከሆነ ይዝለሉ።።

314. ከሚከተለት የትኞቹ ምልክቶች እርግዝናና ወሊድን ተከትለው የሚመጡ የጤና ችግሮችን የሚያመለክቱ እንደሆኑ ተነግሮዎታል ?

1. በማህፀን ደም መፍሰስ
2. ራስ ምታት
3. ከፍተኛና ፈጣን የክብደት መጨመር
4. የራስ ማዞር
5. የፅንስ እንቅስቃሴ ማቆም
6. ሌሎች ምልክቶች ከሆኑ ይጥቀሱ ----

315. ከላይ ከተጠቀሱት ምልክቶች ውስጥ የትኞቹን ሲያጋጥምዎት ወደ ጤና ማዕከል በመሄድ የሕክምና እርዳታ ማግኘት እንዳለብዎት ተነግሮዎታል ?

316. ምጥ በሚጀምርበት ወቅት የት መውለድ እንዳለብዎት መረጃ ተሰጥቶዎታል ?

1. አዎን
2. የለም

ለጥያቄ 316 መልስ አዎን ትሰጥቶኛል ከሆነ ጥያቄ 317 ይጠየቅ መልስ የለም ከ ሆነ ይዝለል

317. የት መውለድ እንዳለብዎት መረጃ ከተሰጠዎት የት እንዲወልዱ ነው የተመከሩት ?

1. የጤና ማዕከል ውስጥ
2. ቤት ውስጥ

318. ምጥ በሚጀምርዎት ወቅት ምጡን እንዲከታተል /እንዲያዋልድዎ ወይንም ደግሞ ሌሎች እርዳታዎችን እንዲሰጥዎ የማንን እርዳታ ማግኘት እንዳለብዎት የሚገልፅ መረጃ ወይም ምክር ተሰጥቶዎታል ?

1. አዎን ተሰጥቶኛል
2. የለም አልተሰጠኝም

ለጥያቄ 318 መልስ አዎን ከሆነ ጥያቄ 319 ይጠየቅ መልሱ የለም ከሆነ ይዘለል

319. በወሊድ ወቀት ማን ሊያዋልድዎት እንደሚገባ ምክር ከተሰጠዎት ከነዚህ ውስጥ ማን እንዲያዋልድዎ ነው ምክር የተሰጠዎት ?

1. የሰለጠነ የጤና ባለሙያ
2. ያልሰለጠነ የልምድ አዋላጅ
3. የሰለጠነ የልምድ አዋላጅ
4. ዘመድ
5. ሌሎች የቤተሰብ አባላት
6. ሌላ ከሆነ ይጥቀሱ

የእርጉዝ ሴቶች• እርግዝና ወሊድን የተመለከተ እምነትና አመለካከትን በተያያዘ የሚጠየቁ ጥያቄዎች

የሚከተሉትን ጥያቄዎች ጥሩ ነዉ መ•ፎ ነዉ ወይም ምንም አስተያየት የለኝም በማለት ይመልሱ!

501 በጤና ማዕከላት ውስጥ ስለሚሰጡ የተለያዩ የጤና አገልግሎቶች በተመለከተ ያለዎት አመለካከት

1-ጥሩ ነዉ 2- መጥ ፎ ነዉ 3- ምንም •ስተያየት የለኝም

ለጥያቄ 501 ••ሶ ጥሩ ነዉ ከሆነ ... ጥያቄ 502 ይጠየቁ.. መልሱ መጥፎ ነዉ ከሆነ ጥያቄ 503 ን ይጠየቁ::

502 ለጤና አገልግሎቶች ያለዎት አመለካከት ጥሩ የሆነበት ምክንያት ምንድነዉ?

1- ጥራት ያለዉ አገልግሎት ስለሚሰጥ

2- ≠ጤና ባHሞያዎቹ አቀራረብ ጥሩ በመሆኑ

3- ዋጋዉ ከአገልግሎቱ ጋር ተመጣጣኝ በመሆኑ

4- የአገልግሎቶቹ ወጤት ብቷ ጊዜ አመሪቂ በመሆኑ

5- ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

503 ለጤና አገልግሎቶቹ ያለዎት አመለካከት መጠ• የሆነበት ምክንያት ምንድነዉ ?

1- የአገልግሎቶቹ ጥራት የደከመ በመሆኑ

2- የጤና ባለሞያዎቹ አቀራረብ መጥፎ በመሆኑ

3- የአገልግሎቶቹ ዋጋ ውድ በመሆኑ

4- የአገልግሎቶቹ ውጤት ብዝ ጊዜ መጥፎ በመሆኑ

5.ሌላ ምክንያት ካሎት ይጥቀሱ ----------

በእርሶ ወይም በሌሎች ሰወች የወሊድ ፅምድ ላይ በመመርኮዝ ቤት ውስጥ ወይም የጤና ማዕከላት ውስጥ ስለ.ከሰቱ፡ የወሊድ አገልግሎቶች ያለዎት አስተያየት ይስጡ::

504. .ጤና ማዕከላት ውስጥ ስለ.ሰጠው የወሊድ አገልግሎት ...ለዎት አስተያየት

1 ጥሩ ነዉ 2 መጥፎ ነዉ 3 ምንም እስተያየት የለኝም

ለጥያቄ 504 አስተተያየዎ ጥሩ ... ከሆነ ጥያቄ 505 ይጠየቁ መልሱ መጥ. ከሆነ ጥያቄ 506ን ይጠየቁ::

505 .ጤና ማዕከላት ውስጥ ስለሚሰጠዉ የወሊድ አገልግሎት አስተያየትዎ ጥሩ የሆነበት ምክንያት ምንድነዉ ?

1.ጥራት ያለዉ አገልግሎት ስለሚሰጥ

2.የጤና ባለሞያዎቹ አቀራረብ ጥሩ በመሆኑ

3..ዋጋዉ ከአገልግሎቱ ጋር ተመጣጣኝ በመሆኑ

4.የጤና ማዕከላት ውስጥ መዉለድ ዉጤቱ ጥሩ በመሆኑ

5.ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

506. .ጤና ማዕካላት ውስጥ ስለሚሰጠዉ የወሊድ አገልግሎት አስተያየትዎ መጥፎ የሆነበት ምክንያት ምንድነዉ ?

1.የአገልግሎቱ ጥራት የደከመ በመሆኑ

2.የጤና ባለሙያዎቹ አቀራረብ መጥፎ በመሆኑ

3.የአገልግሎቱ ዋጋ ውድ በመሆኑ

4.የጤና መ.ከላት ውስጥ መዉለድ ውጤቱ ብዙ ጊዜ አስከፊ በመሆኑ

5.ቤት ውስጥ መዉለድ የተሻለ ነዉ ብዬ ስለማምን

6.ሌላ ምክንያት ካለዎት ይ.ቀሱ ----------

507.በጤና ማዕከላት ውስጥ ስላለው የወሊድ አገልግሎት ጥራት ያ.ዎት አስተያየት ?

1.ጥሩ ነዉ 2.መጥፎ ነዉ 3.ምንም አስተያየት የለኝም

508.ቤት ውስጥ መውለድን እንዴት ይመለከቱታል ቤት ውስጥ መውለድ

1.ጥሩ ነዉ 2.መጥፎ ነዉ 3.ምንም አስተያየት የለኝም

ቤት ውስጥ መውለድ ጥሩ ነዉ ብለው ካሰ• ጥያቄ 509 ይጠየቁ መጥ• ነዉ ብለው ካሰብ ጥያቄ 510 ይጠየቁ::

509.ቤት ውስጥ መውለድ ጥሩ ነዉ ብለዉ ካሰ• ምክንያትዎ ምንድ ነዉ?

1.ቤት ውስጥ መሆኔ ራሱ •በለጠ ይመቸኛል

2.ከቤተሰቤና ዘመዶቼ እንክብካቤ ስለማገኝ

3.ከዚህ በፊትም የምወልደዉ ቤት ስለሆነ

4.ጤና ማ•ከላት ውስጥ ያለው አገልግሎት ስለማልወደው

5.ከዚህ በፊት ጤና ማዕከላት ውስጥ ወልጄ መጥፎ ነገር ስላጋጠመኝ

6.የጤና ባለሙያዎቹ አቀራረብ መጥፎ በመሆኑ

7.ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

510.ቤት ውስጥ መውለድ መጥ• ነዉ ያሉበት ምክንያት ምንድነዉ ?

1.ጤና ማ•ከላት ውስጥ ያለዉ አገልግሎት ጥሩ ስለሆነ

2.ጤና ማ•ከላት ውስጥ መውለድ ውጤቱ የተሻለ ስለሆነ

3.የጤና ባለሙያዎች አቀራረብ ጥሩ በመሆኑ

4.ቤት ውስጥ መዉለድ ውጤቱ አስከፊ ስለሆነ

5- ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

እርጉዝ እናቶች ከወሊድ ጋር ስለትያያዙ ችግሮች አስከፊነት እና የሰለጠነ ባለሙያ እርዳታ ማ ግኘት በወሊድ ውጤት ላይ የሚያስከትለውን ለውጥ በትመለከት የሚጠየቁ ጥያቄዎች

የሚከትሉትን ጥያቄዎች አስማማለሁ.. አልስማማም ወይም ምንም አስትያየት የለኝም በማለት ይመልሱ....

601. ማንኛውም እርጉዝ ሴት በወሊድ ምክንያት ለሚመጡ የጤና ችግሮች የተጋለጠች ነች••

1. እስማማለሁ **2.** አልስማማም **3.** ምንም አስተያየት የለኝም

602. እኔ እንደማንኛዋም እርጉዝ ሴት በወሊድ ምክንያት ለሚመጡ የጤና ችግሮች የተጋለጥኩ ነኝ ••

1. እስማማለሁ **2.** አልስማማም **3.** ምንም አስተያየት የለኝም

603. በወሊድ ምክንያት የሚመጡ የጤና ችግሮች አስቸጋሪ በመሆናቸው በጤናዬ ላይ አስከፊ ውጤትን ሊያስከትሉ ይችላሉ፡፡

1. እስማማለሁ **2.** አልስማማም **3.** ምንም አስተያየት የለኝም

604. በወሊድ ምክንያት የሚመጡ የጤና ችግሮች አስቸጋሪ በመሆናቸው በምወልደዉ ልጅ ጤና ላይ አስከፊ ውጤትን ሊያስከትሉ ይችላሉ፡፡

1. እስማማለሁ **2.** አልስማማም **3.** ምንም አስተያየት የለኝም

605. በወሊድ ወቅት የሰለጠነ የጤና ባለሙያን እርዳታ •ገኘሁ ከወሊድ በኋላ የተሻለ የጤ ሁኔታ ሊኖረኝ ይችላል፡፡

1. እስማማለሁ **2.** አልስማማም **3.** ምንም አስተያየት የለኝም

606. በወሊድ ወቅት የሰለጠነ የጤና ባለሙያ እርዳታ ገኘሁ የልጇ የጤና ሁኔታ የተሻለ ሁኔታ ሊኖረዉ ይችላዉ፡፡

1. እስማማለሁ **2.** አልስማማም **3.** ምንም አስተያየት የለኝም

<u>በወሊድ ወቅት የሰለጠነ የጤና ባለሙያን እርዳታ ማግኘት ብፈልግ እን•ን በሚከተሉት ምክንያት ይህን አገልግሎት ማግኘት የምችል አይመስልኝም፡፡</u>

607. የጤና ማዕከል ባለመኖራቸው **1.** አዎን **2.** የለም

608. በጤና ማዕከላት ውስጥ የሰለጠነ የጤና ባለሙያ ባለመኖሩ **1.** አዎን **2.** የለም

609. የአገልግሎቱን ዋጋ መክፈል ስለማልችል **1.** አዎን **2.** የለም

610. የመጓጓዣ አገልግሎት ማግኘር ስለማልችል **1.** አዎን **2.** የለም

611. ለመጓጓዣ አገልግሎት መክፈል ስለማልችል **1.** አዎን **2.** የለም

እርጉዝ እናቶች በወሊድ ወቅት የጤና አገልግለት መገ□ትና የአገልግሎቱን አቅርቦት በተመለከተ ያላቸው አመለካከት

ሀ. የጤና አገልግሎቱ መኖርን በተመለከተ

701. የሰለጠነ የጤና ባለሙያ የሚገኝበት የጤና ማዕከል በጅማ ከተማ ውስጥ ያለ ይመስልዎታል ?

1. አዎን 2. የለም 3. እኔ አላውቅም

702. የጥያቄ 701 መልስዎ አዎን ከሆነ ... ከሚከተሉት የጤና ማዕከል በየትኛዉ ውስጥ የሰለጠነ የጤና ባለሙያ የሚገኝ ይመስልዎታል ?

1. ጅማ ጤና ጣቢያ 2 ጤና ክሊኒክ 3. ከፍተኛ ጅማ ሆስፒታል 4. ሌላ ካለ ይጥቀሱ

ለ. የጤና አገልግሎት አቅርቦት በትመለከት

703. የሰለጠነ የጤና ባለሙያ ያለባቸው የጤ ማዕከል በአቅራቢያዎ ማግ••ት የሚችሉ ይመስልዎታል?

1. አዎን 2. የለም 3. እኔ አላውቅም

704. በወሊድ ወቅት የሰለጠነ የጤና በለሙያ እርዳታ ለማግኘት የመክፈል አቅም ያለዎት ይመስልዎታል?

1. አዎን 2. የለም 3. እኔ አላውቅም

705. በሚወል•በት ጊዜ የሰለጠነ የጤና ባለሙያ ወጀሚገኝበት የጤና ማዕከል ለመሄድ የሚያስፈልገውን የመጓጓዣ አገልግሎት ማግኘት የሚችሉ ይመስልዎታል ?

1. አዎን 2. የለም 3. እኔ አላውቅም

706. በሚወል•በት ጊዜ የሰለጠነ የጤና ባለሙያ ወደ ሚገኝበት የጤና ማዕከል ለመሄድ ለሚያስፈልግው የመጓጓዣ አ•ልግሎት መክፈል የሚችሉ ይመስልዎታል

1. አዎን 2. የለም 3. እኔ አላውቅም

<u>የእርጉዝ ሴቶች ባቤቶች፡ የቤትሰብ አባላት እንዲሁም ሌሎች የሕብረትሰብ አካላት ቤት ውስጥ እና በጠ ,ና ማዕከል ውስጥ ስለሚሰጡ የወሊድ አገልግሎት በትመለከት አመለካከት የሚ ጥያቂዎች</u>

707. ባለቤትሥ እርሶ በወሊድ ወቀት የት እንዲወልዱ የሚመርጡ ይመስልዎታል ?

1. ቤት ውስጥ 2. በጤና ማዕከል ውስጥ 3. እ• አላውቅም

708. ባለቤትሥ እርሶ በወሊድ ወቅት ማን እንዲያዋልድዎት የሚመርጡ ይመስልዎታል ?

1. የሰለጠነ የጤና ባለሙያ
2. የሰለጠነ የልምድ አዋላጅ
3. ያልሰለጠነ የልምድ አዋላጅ
4. ዘመድ ወይም ለላ የቤተሰብ አባል
5. እኔ አላውቅም

709. ሌሎች የቤተሰብ አባላት በወሊድ ወቀት የት እንዲወልዱ የሚመርጡ ይመስልዎታል?

1. ቤት ውስጥ 2. በጤና ማዕከል ውስጥ 3. እኔ አላውቅም

710. ሌሎች የቤተሰብ አባላት ማን እንዲያዋልድዎት የሚመርጡ ይመስልዎታል ?

1 የሰለጠነ የጤና ባለሙያ
2. የሰለጠነ የልምድ አዋላጅ
2. ያልሰለጠነ የልምድ አዋላጅ
4. ዘመድ ወይም ለላ የቤተሰብ አባል
5. እኔ አላውቅም

711. ሌሎች የሕብረተሰብ አካላት በወሊድ ወቅት የት እንዲወልዱ የሚመርጡ ይመስልዎታል?

1. ቤት ውስጥ 2. በጤና ማዕከል ውስጥ 3. እኔ አላውቅም

712. ሌሎች የሕብረተሰብ አካላት ማን እንዲያዋልድዎት የሚመርጡ ይመስልዎታል?

1የሰለጠነ የጤና ባለሙያ
2.የሰለጠነ የልምድ አዋላጅ
3.ያልሰለጠነ የልምድ አዋላጅ
4. ዘመድ ወይም ለላ የቤተሰብ አባል
5. እኔ አላውቅም

<u>ወሊድን በተመለከተ የእርጉዝ ሴት ምርጫ</u>

<u>801. ምጥ በሚመጣብዎት ወቅት የአሁኑን ልጅዎን መውለድ የሚፈልጉት የት ነው?</u>
<u>1. ቤት ውስጥ 2. የጤና ማእከል ውስጥ</u>

<u>ምርጫቸው ቤት ውስጥ መውለድ ከሆነ ጥያቄ 802 ይጠይቁ፤ ምርጫቸው በጤና ማእከል ውስጥ ከሆነ ጥያቄ 803 ይጠይቁ፡፡</u>

<u>802. ቤት ውስጥ መውለድ የመረጡበት ምክኒያት ምንድነው?</u>

1. ቤት ውስጥ መሆኔ ራሱ •በለጠ ይመቸኛል

2.ከቤተሰቤና ዘመዶቼ እንክብካቤ ስለማገኝ

3.ከዚህ በፊትም የምወልደዉ ቤት ስለሆነ

4.ጤና ማ•ከላት ውስጥ ያለው አገልግሎት ስለማልወደው

5.ከዚህ በፊት ጤና ማዕከላት ውስጥ ወልጄ መጥፎ ነገር ስላጋጠመኝ

6.የጤና ባለሙያዎቹ አቀራረብ መጥፎ በመሆኑ

7.ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

803. በጤና ማእከል ውስጥ መውለድ የመረጡበት ምክኒያት ምንድነው?

1. ጤና ማ•ከላት ውስጥ ያለዉ አገልግሎት ጥሩ ስለሆነ

2.ጤና ማ•ከላት ውስጥ መውለድ ውጤቱ የተሻለ ስለሆነ

3.የጤና ባለሙያዎች አቀራረብ ጥሩ በመሆኑ

4.ቤት ውስጥ መዉለድ ውጤቱ አስከፊ ስለሆነ

5.,ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

804. በወሊድ ወቅት ከሚከተሉት ሠዎች የትኞቹ ቢያዋልድዎት ይመርጣሉ?

1. የሠለጠነ የጤና ባለሙያ
2. የሰለጠነ የልምድ አዋላጅ
3. ያልሠለጠነ የልምድ አዋላጅ
4. ዘመድ ወይንም ሌላ የቤተሠብ አባል
5. ሌሎች ምርጫ ካለዎት ይጥቀሱ.....

805. በወሊድ ወቅት እነዚህ ሠዎች እንዲያዋልዱዎ የመረጡበት ምክንያት ምንድነው?

_____

ወሊድን በተመለከተ የእርጉዝ ሴቶች የወደፊት ዕቅድ

901. ምጥ በሚመጣብዎት ወቅት የአሁኑን ልጅዎን የት ለመውለድ አቅደዋል?

1. ቤት ውስጥ 2. በጤና ማዕከል ውስጥ 3. ገና አልወሰንኩም

እቅዳቸው ቤት ውስጥ ለመውለድ ከሆነ ጥያቄ 902 ይጠይቁ፤ እቅዳቸው የጤና ማእከል ውስጥ ከሆነ ጥያቄ 903 ይጠይቁ ፡፡

902. ቤት ውስጥ ለመውለድ የወሰኑበት ምክንያት ምንድነው?

1. ቤት ውስጥ መሆኔ ራሱ •በለጠ ይመቸኛል

2.ከቤተሰቤና ዘመዶቼ እንክብካቤ ስለማገኝ

3.ከዚህ በፊትም የምወልደዉ ቤት ስለሆነ

4.ጤና ማ•ከላት ውስጥ ያለው አገልግሎት ስለማልወደው

5.ከዚህ በፊት ጤና ማዕከላት ውስጥ ወልጄ መጥፎ ነገር ስላጋጠመኝ

6.የጤና ባለሙያዎቹ አቀራረብ መጥፎ በመሆኑ

7. በጤና ማዕከል ውስጥ ለሚሰጠው አገልግሎት መክፈል ስለማልችል

8. ወደ ጤና ማዕከል ለመጓጓዝ የመጓጓዣ አገልግሎት ስለሌለ

9. ለመጓጓዣ አገልግሎት መክፈል ስለማልችል

10. ሌላ ምክንያት ካለዎት ይጥቀሱ .....

903. በጤና ማዕከል ውስጥ ለመውለድ የወሰኑበት ምክንያት ምንድነው?

1.ጤና ማ•ከላት ውስጥ ያለዉ አገልግሎት ጥሩ ስለሆነ

2.ጤና ማ•ከላት ውስጥ መውለድ ውጤቱ የተሻለ ስለሆነ

3.የጤና ባለሙያዎች አቀራረብ ጥሩ በመሆኑ

4.ቤት ውስጥ መዉለድ ውጤቱ አስከፊ ስለሆነ

5.,ሌላ ምክንያት ካለዎት ይጥቀሱ ----------

904. በጤና ማዕከል ውስጥ መውለድ ቢፈልጉ ይህንን በተመለከተ የመጨረሻውን ውሳኔ የሚወስነው ማን ነው?

1. እኔ እራሴ
2. ባለቤቴ
3. ዘመዶቼ
4. ሌሎች ሠዎች ከሆኑ ይጥቀሱ.....

የእርጉዝ እናቶችን የመለዱበት ሁኔታ ለማጥናት የተዘጋጀ መረጃ መሰብሰቢያ ቅጽ

ይህ መጠይቅ ከዚህ በፊት እርጉዝ እናቶችን የትለያዩ የወሊድ አገልግሎቶችን እንዳይጠቀሙ የ ሚያግዷቸው ሁኔታዎች ለማጥናት ትመርጠው የነበሩ ሴቶችን ይመለከታል። እነዚህ ሴቶች እ ርጉዝ በነበሩበት ወቅት ቃለመጠይቅ የትደረገላችው ሲሆን ከዚያም ልጆች እስከሚወልዱ ድርስ ጠበቅናችው አሁን ደግሞ ይህንን መጠይቅ እንዲመልሱ ትደርጓል።

ጥናቱ የትሟላ እንዲሆን መጠይቁ የሚደረግላችወ ሴቶች ከዚህ በፊት ያሳዩንን ቀና ት ብብር አሁንም እንዲያሳዩን በትህትና እንጠይቃለን።

መጠይቁ 3 ክፍሎች አሉት

ክፍል አንድ - ስሁለም ሴቶች የሚጠየቁ ጥያቄዎች

ክፍል ሁለት - በጤና ማዕከላት ውስጥ ለወለዱ እናቶች ብቻ የሚቀርቡ ጥያቄዎች

ክፍል ሶስት - ቤት ውስጥ ለወለዱ አናቶች ብቻ የሚቀርቡ ጥያቄዎች

001. የሴትየዋ መለያ ቁጥር ----------

002. የሴትየዋ ስም ----------

003. አድራሻ

ክፍተኛ ---------- ቀበሌ ---------- የቤት ቁጥር ----------

መረጃው የተሰበሰበበት ቀን ----------

የመረጃ ሰብሳቢው ስም ----------

የመረጃ ሰብሳቢው ፊርማ ----------

የተቆጣጣሪው ስምና ፊርማ ----------

ክፍል አንድ: ለሁሉም ሴቶች የሚቀርቡ ጥያቄዎች

101. የመጨረሻ ልጅዎን የወለዱት የት ነው? 1 ቤት ውስጥ 2. የጤና ማዕከል ውስጥ

102. ምጥ ከመጀመሩ በፊት ወይንም በምጥ ወቅት ከእርግዝና ጋር የተያያ ችግር ገጥሞት ነበር?

1. አዎን 2. የለም አላጋጠመኝም

መልሱ አዎን ከሆነ ጥያቄ 103 ይጠየቅ - መልሱ የለም አልገጠመኝም ከሆነ ጥያቄ 103 ይዘለል

103. ከሚከተሉት ውስጥ የትኛው የጤና ችግር ገጥምዎት ነበር

1. ምጥ ከመጀመሩ በፊት በማህፀን ደም መፍሰስ
2. ምጥ ከመጀመሩ በፊት የሽንት ውሃ መፍሰስ
3. ቀኑ ከመድረሱ በፊት የምጥ መጀመር
4. የደም ግፊት መጨመር
5. በምጥ ወቅት ከፍተኛ የሆነ የደም መፍሰስ
6. የሽሉ እንቀስቃሴ ማቆም
7. ሌሎች ችግሮች ካሉ ይጠቀሱ _____

104. ምጡ ለምን ያህል ጊዜ ቆይቶብዎት ነበር?

1. ከግማሽ ቀን ያነሰ
2. አንድ ቀን/አንድ ሌሊት
3. ለአንድ ቀን ከግማሽ ያህል
4. ከአንድ ቀን ከግማሽ በላይ
5. በትክክል አላስታውሰውም

105. ከራስዎ ጤንነት ጋር በተያያዘ የምጡንና የወሊዱን ሁኔታ እንዴት ይመዝኑታል?

1. በጣም ጥሩ ነበር
2. ምንም አይልም ነበር
3. መጥፎ ነበር
4. መመዘን/መገመት ይከብደኛል

106. ከወሊድ በኋላ/ጤና ችግር አጋጥምዋት ነበር?

1. ምንም ችግር አልገጠመኝም
2. አዎን አጋጥሞኛል ካሉ በዝርዝር ይገለፁ _____ _____

107. አዲስ የተወለደው ልጅ የነበረው ሁኔታ ምን ይመስል ነበር?

1. በህይወት ነው የተወለደው
2. በህይወት ነበር የተወለደው ነገር ግን ወዲያውኑ ሞቷል/ለች
3. ሞቶ/ታ ነበር የተወለደው/ችው
4. ሌላ ሁኔታ ከነበር ይጠቀሱ _____

108. አዲስ የተወለደው ልጅ የተወለደው በህይወት ከሆነ ከዚያ በኋላ የጤና ችግር ገጥሞት ነበር?

1. ምንም አይነት የጤና ችግር አልገጠመውም
2. ችግር ገጥሞት ከነበር ችግሮቹ ይዘርዘሩ _____

109. በዚህኛው ወሊድ ወቅት የት መውለድ እንዳለብዎት ወሳኔውን የሰጠው ማነው?

1. እኔው ራሴ
2. ባለቤቴ
4. ሌሎች ዘመዶች
5. ሌሎች ሰዎች ከሆኑ ይጥቀሱ _____

3. የባለቤቱ ዘመዶች

<u>ክፍል ሁለት፡ በጤና ማዕከላት ውስጥ ለወለዱ ሴቶች ብቻ የሚጠየቁ ጥያቄዎች</u>

200. በየትኛው የጤና ማዕከል ውስጥ ነው የወለዱት?
   1. ጅማ ሆስፒታል
   2. ጅማ ጤና ጣቢያ
   3. ከፍተኛ 2 ቀበሌ 3 ክሊኒክ
   4. የግል ክሊኒክ
   5. ሌላ ቦታ ከሆነ ይጥቀሱ _____

201. ልጅዎን የወለዱበት በምን መልኩ ነው ?
   1. በማህፀን በኩል ያለምንም መሳሪያ
   2. በማህፀን በኩል በማወላጃ መሳሪያዎች ተጠቅመው
   3. በሆዴ በኩል ቀዶ ጥገና ተደርጐልኝ
   4. በትክክል አላስታውስም
   5. በሌላ ሁኔታ ከሆነ ይጥቀሱ _____

202. በጤና ማዕከል ውስጥ የወለዱበት <u>ዋነኛ</u> ምክንያት ምንድነው?
   1. ጤና ማዕከል ውስጥ መወለድ ስለመረጥኩ
   2. ሁልጊዜም የምወልደው ጤና ማዕከል ውስጥ በመሆኑ
   3. ከዚህ በፊት ቤት ወልጄ መጥፎ ነገር ስላጋጠመኝ
   4. ጤና ማዕከል ውስጥ መውለድ እንዳለብኝ ስለተነገረኝ
   5. ጤና ማዕከል ውስጥ እንድወለድ የሚያስገድድ የወሊድ ችግር ስላጋጠመኝ
   6. ሌላ ምክንያት ካለዎት ይጥቀሱ _____
   7. ሌላ ምክንያት ካለዎት ይጥቀሱ _____
   8. ሌላ ምክንያት ካለዎት ይጥቀሱ _____

203. የወለዱበት የጤና ማዕከል ከመኖሪያዎ አካባቢ ያለው ርቀት ምን ይመስላል?
   1. በጣም ሩቅ ነው
   2. መካከለኛ ርቀት ነው
   3. የእግር መንገድ ብቻ ነው (በጣም ቅርብ ነው)
   4. አላውቀውም

204. በጤና ማዕከል ውስጥ ለመውለድ የከፈሉት ገንዘብ መጠን እንዴት ይመዝኑታል?
   1. በጣም ውድ ነው
   2. ምንም አይልም
   3. በጣም ቀላል ነበር
   4. አላስታውሰውም

205. ወደወለዱበት የጤና ማዕከል ለመጓዝ የሚያስፈልገውን የመጓጓዣ አገልግሎት ለማግኘት ተቸግረው ነበር?
   1. አዎን በጣም ተቸግሬ ነበር
   2. በመጠኑ ተቸግሬ ነበር
   3. ምንም አይነት ችግር አልገጠመኝ
   4. አላስታውሰውም

206. ለመጓጓዣ የከፈሉትን የገንዘብ መጠን እንዴት ይመዝኑታል?
   1. በጣም ውድ ነው
   2. ምንም አይልም
   3. በጣም ቀላል ነበር
   4. አላስታውሰውም

207. በጤና ማዕከል ውስጥ የሚሰጠው የወሊድ አገልግሎት በፊት እንደጠበቁት ሆኖ ነው ያገኙት?
   1. አዎን እንደጠበቅሁት ጥሩ ነበር
   2. አዎን እንደጠበቅሁት መጥፎ ነበር
   3. አስቀድሜ ጠብቄው የነበረ ሁኔታ የለም

የመጨረሻውን ..የአሁኑን.. ልጅዎን ሲወልዱ ለጤና ማዕከሉ በትነነዝቡት ነገር ላይ በመመሥረት የሚከ ትሉትን ሁኔታዎች እንዴት ይመዝኗቸዋል?

208. የአገልግሎት ጥራቱ 1. በጣም ጥሩ 2. መካከለኛ
3. መጥፎ 4. መመዘን አልችልም

209. የጤና ባለመያዎቹ ችሎታ /ብቃት/
1. በጣም ጥሩ 2. መጥፎ 3. መካከለኛ 4. መመዘን አልችልም

210. የጤና ባለሙያዎቹ አቀራረብ፤
1. በጣም ጥሩ 2. መጥፎ 3. መካከለኛ 4. መመዘን አልችልም

ወደ ጤና ማዕከል ሄደው ለመውለድ ባሰቡ ወቅት፤ የነዚህ ሰዎች አስትያየት ምን ይመስል ነበር?

211. ባለቤትዎ 1. ወደ ጤና ማዕከል ሂጂ እንድወልድ አበረታትቶኝ ነበር
2. ወደ ጤና ማዕከል እንዳልሂድ ትቃወሞኝ ነበር
3. ምንም ዓይነት አስትያየት አልሰጠኝም

212 የባለቤትዎ ዘመዶች 1. ወደ ጤና ማዕከል ሂጂ እንድወልድ አበረታትቶኝ ነበር
2. ወደ ጤና ማዕከል እንዳልሂድ ትቃወሞኝ ነበር
3. ምንም ዓይነት አስትያየት አልሰጠኝም

213 ሌሎች ዘመዶችዎ 1. ወደ ጤና ማዕከል ሂጂ እንድወልድ አበረታትቶኝ ነበር
2. ወደ ጤና ማዕከል እንዳልሂድ ትቃወሞኝ ነበር
3. ምንም ዓይነት አስትያየት አልሰጠኝም

214በወለዱበት የጤና ማዕከል ወስጥ የነበረዎትን ቆይታና የወሊዱንም ውጤት በመንትራስ ወደፊት እር ጉዝ ቢሆኑ የት ነው መውለድ የሚመርጡት?
ምርጫችው ጤና ማዕከል ውስጥ ከሆነ ጥያቄ 215 ይጠየቅ፤ ቤት ውስጥ ከሆነ ጥያቄ 216 ይጠየቅ፤

215ወደፊት በጤና ማዕከል ውስጥ መውለድ የመረጡበት ዋነኛ ምክንያት ምንድነው?
1. በጤና ማዕከል ውስጥ የትሰጠኝ የወሊድ አገልግሎት ስላረካኝ
2. በራሴ ጤና ላይ የትሻለ ወጤት ስላገኘሁበት
3. በትወለደው ልጅ ጤና ላይ የትሻለ ወጤት ስላገኘሁበት
4.
ቤት ወስጥ ወልጄ ቢሆን ኖሮ፤ በወሊድ ወቅት ለገጠሙኝ ችግሮች በቂ እርዳታ ማግኘት አልች ልም ነበር፤
5. ሁልጊዜም ቢሆን ጤና ማዕከል ወስጥ መውለድ እንዳለብኝ ስለትነገረኝ
6. ሌላ ምክንያት ካለዎት ይጥቀሱ_____
7. ሌላ ምክንያት ..ካለዎት ይጥቀሱ_____
8. ሌላ ምክንያት ..ካለዎት ይጥቀሱ_____

216. ወደፊት በቤት ውስጥ መውለድ የመረጡበት ዋነኛ ምክንያት ምንድነው?
1. በጤና ማዕከል ውስጥ የትሰጠኝ የወሊድ አገልግሎት ጥሩ ስለነበር
2. በጤና ማዕከል መውለዴ ለራሴ ጤንነት ላይ አስከፊ ውጤት ስለነበረው
3. በጤና ማዕከል ውስጥ መውለዴ በልጄ ጤንነት ላይ አስከፊ ወጤት ስለነበረው

4. በጤና ማዕከል ውስጥ ያገኘሁት የወሊድ አገልግለት፤ ቤት ውስጥ ከመውሊድ የትለየ ሆኖ ስላላገኘሁት

5. ሌላ ምክንያት ካለዎት ይጥቀሱ_____

6. ሌላ ምክንያት ..ካለዎት ይጥቀሱ_____

7. ሌላ ምክንያት ..ካለዎት ይጥቀሱ _____

ክፍል ሦስት ቤት ውስጥ ለወለዱ ሴቶች ብቻ የሚጠየቁ ጥያቄዎች

301. ቤት ውስጥ በወለዱበት ጊዜ ያዋለደዎ ማን ነበር?
1. የሠለጠነ የጤና ባለሙያ 3. ያልሠለጠነ የልምድ አዋላጅ
2. የሠለጠነ የልምድ አዋላጅ 4. ዝመዶቼ
5. ሌሎች ሰዎች ከሆነ ይጥቀሱ_____
302. ቤት ውስጥ የወለዱበት ዋነኛ ምክንያት ምንድ ነው?
1. ቤት ውስጥ መውለድ ስለመረጥኩ
2. ሁልጊዜም የምወልደው ቤት ውስጥ በመሆኑ
3. በጤና ማዕከል ውስጥ ለመውለድ የገንዝብ አቀም ስላልነበረኝ
4. ከዚህ በፊት በጤና ማዕከል ውስጥ ወልጄ መጥፎ ነገር ስለገጠመኝ
5. ምጡ ስላላስችገረኝና ወደ ጤና ማዕከል ውስጥ እንድሄድ የሚገፋፋ የጤና ችግር ስላላጋጠመኝ፤
6. ቤት ውስጥ እንድወልድ ስለትነገረኝ
7. ሌሎች ምክንያት ካለዎት የጥቀሱ_____
8. ሌላ ምክንያት ..ካለዎት ይጥቀሱ_____

ቤት ውስጥ ለመውለድ ሲያስቡ፤ ከነዚህ ሰዎች የመቃወም ወይም የመደገፍ አስትያየት ትሰጥቶዎት ነበር ::
303. ባለቤትዎ፤ 1. አዎ ትቃውሞኝ ነበር 3. ምንም ዓይነት አስትያየት አልሰጠኝም
2. አዎ አበረታትቶኝ ነበር

304. የባለቤትዎ ዝመዶች 1. አዎ ትቃውሞኝ ነበር 3. ምንም ዓይነት አስትያየትአልሰጠኝም
2. አዎ አበረታትቶኝ ነበር
305. ሌሎች ዝመዶችዎ
1. አዎ ትቃውሞኝ ነበር 3. ምንም ዓይነት አስትያየት አልሰጠኝም
2. አዎ አበረታትቶኝ ነበር

306. በምጥዎ ወቅት ወደ ጤና ማዕከል ሄደው መውለድ ቢያስፈልጉ በቀላሉ መሄድ ይችሉ ነበር?
1. አዎን በጣም ቀላል ነበር 4. መሄድም አልችለም ነበር
2. አዎን ግን በጣም ቀላል አልነበረም 5. አሁን መመዝን ይከብደኛል
3. በጣም ይከብደኝ ነበር

መልሳችው በጣም ይከብደኝ ነበር ወይንም ደግሞ መሄድ አልችልም ነበር ከሆነ ጥያቄ 307 የጠየቁ መ ልሳችው ከነዚህ ውጭ ከሆነ ግን ጥያቄ 307 ይዝለል::

307. ወደ ጤና ማዕከል መሄድ ቢያስፈልግዎ ሄደው መውለድ የማይችሉበት ወይም በጣም ከባድ የነበረበት ምክንያት ምንድነው?
1. የጤና ማዕከላት ባለመኖራችው 4. መጓጓዣ ማግኘት ስለማልችል
2. የጤና ማዕከላት ሩቅ በመሆናችው 5. ለመጓጓዣ መክፈል ስለማልችል
3. ለጤና ማዕከሉ መክፈል ስለማልችል 6. ሌላ ምክንያት ካለዎት ይጥቀሱ_____
ቤትዎ ውስጥ መውለድ አስበው በምጥ ላይ እያሉ የተለያዩ ያልተጠበቁ ሁኔታዎች ሊያጋጥሙ ይችላሉ:: ከነዚህ ውስጥ የትኞቹ ሁኔታዎች ቢገጥምዎ ነው ወደ ጤና ማዕከል ሄደው ለመውለድ የሚወስኑት::

308. ከፍተኛ መጠን ያለው ደም ከማህፀን መፍሰስ
1. አዎን **2.** የለም **3.** አሁን መናገር አልችለም

309. ምጡ በጣም ቢቆይብዎትና ቶሎ መውለድ ባይችሉ
1. አዎን **2.** የለም **3.** አሁን መናገር አልችለም

310. ሽሉ ሆድ ውስጥ የሚያደርገው እንቅስቃሴ ቢቆም
1. አዎን 2. የለም 3. አሁን መናገር አልችለም

311. ልጁ ከመወለዱ በፊት ምጡ ቢቆም
1. አዎን 2. የለም 3. አሁን መናገር አልችለም

312. ምጡን በመከታተል ላይ ያሉት አዋላጅ ወደ ጤና ማዕከል እንዲሄዱ ቢመክሩም
1. አዎን 2. የለም 3. አሁን መናገር አልችለም

313. የመጨረሻ ልጅዎን ሲወለዱ ቤት ውስጥ በገጠመዎ ሁኔታና ከወሊድ በኋላ በነበረው ውጤት ላይ በመመርኮዝ <u>ወደፊት</u> እርጉዝ ቢሆኑ መውለድ የሚመርጡት የት ነው?
1. በጤና ማዕከል ውስጥ 2. ቤት ውስጥ 3. ምንም ምርጫ የለኝም

ምርጫቸው <u>በጤና ማዕከል ውስጥ</u> ከሆነ ጥያቄ 314 ይጠየቅ። ምርጫቸው <u>ቤት ውስጥ</u> ከሆነ ጥያቄ 315 ይጠየቅ

314. የወደፊት ምርጫዎ በጤና ማዕከል ውስጥ መውለድ የሆነበት <u>ዋነኛ</u> ምክንያት ምንድነው?
1. ቤት ውስጥ መውለዴ በጤናዬ ላይ አስከፊ ውጤት በማምጣቱ
2. ቤት ውስጥ መውለዴ በልጄ ላይ አስከፊ ውጤት በማምጣቱ
3. አሁንም ቤት ውስጥ የወለድኩ ያለእቅዴ በመሆኑ
4. ሌላ ምክንያት ካለዎት ይጥቀሱ _____
5. ሌላ ምክንያት ካለዎት ይጥቀሱ _____
6. ሌላ ምክንያት ካለዎት ይጥቀሱ _____

315. የወደፊት ምርጫዎ ቤት ውስጥ መወለድ የሆነበት <u>ዋነኛ</u> ምክንያት ምንድነው?

1. **ቤት ውስጥ መውለዴ ምንም አይነት ችግር ስላልደረሰ**
2. **ቤት ውስጥ መውለዴ በልጄ ላይ አስከፊ ውጤት በማምጣቱ**
3. **ሁልጊዜም የምወልደው ቤት ውስጥ በመሆኑ**
4. **ቤት ውስጥ መውለድ ምንም ችግር እንደማያመጣ ስለተገነዘብኩ**
5. **ሌላ ምክንያት ካለዎት ይጥቀሱ _____**
6. **ሌላ ምክንያት ካለዎት ይጥቀሱ _____**
7. **ሌላ ምክንያት ካለዎት ይጥቀሱ _____**

ADDIS ABABA UNIVERSITY
MEDICAL FACULTY
DEPARTMENT OF COMMUNITY HEALTH

Questionnaire I

This is a study to be conducted with the objectives of identifying factors which may encourage or discourage pregnant women living in Jimma town, to deliver in health facilities. As the study is directly related to pregnant women, those women who are close to delivery are identified. And you are one of the women who are selected to participate in this study, therefore you are kindly requested to participate in this study and provide the information required from you. Your participation in this study is completely on voluntary basis and you have the right to refuse from participating.

Your responses will be kept confidential and there will be no way of linking your individual responses to the final results of the study findings.

We would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful improving the delivery service utilization.

We would also like to inform you that, you will be revisited for a very short interview after you deliver.

- Number of visits. 1/2/3/4
- if the women is not available, the reason for not being available

  _____
- Conducive timing for revisits _____

Identification Information

001 code No _____

002 Kefetegna _____

003 kebele _____

Socio demographic factors

101 Age in Years

102 Marital. Status 1. Married 2. Single 3. Divorced 4. Widowed

103 Religion 1. Orthodox 2.Catholic 3. Protestant 4. Muslim 5. Others

104 Ethnicity 1. Oromo 2. Amharic 3. Tiger 4. Gurage 5. kulo 6. Kefa 7. Other

105 Occupation 1. Housewife 2. Gout employee 3. private employees 4. other

106 Educational Status 1. Illiterate 2. Read and write 3. primary Education 4. 2nd and above

107 Monthly income in birr _____

108 Family size _____

109 Husband's age _____

110 Husband's occupation 1. Not employed 2. Government employee 3. private 4. other

111 Husband's educational Status 1. Illiterate 2. Read & write 3. Primary education. 4. 2nd and above

Obstetric factors

201. Age at first marriage _____

202. Age at first pregnancy _____

203. Gravidity _____

204. Children alive _____

205. Children dead _____

300. LMP _____

301. Gestational age in months _____

302. EDD _____

303. Problem during current pregnancy

1. No problem 2. Vaginal bleeding 3. Headache
4. Severe abdominal 5. Drowsiness 6. Others, specify

304. Any visit to HF during current pregnancy 1. Yes 2. No

305. Reason for visit to HF

1. pregnancy related problem 3. For ANC
2. H. Problem not related to pregnancy 4. Other, specify

306. Do you attend ANC for current pregnancy?

1. yes 2. No

For women who are attending ANC

307. Number of ANC visits _____

308. Were do you attend ANC follow up?

1. Jimma Hospital 4. FGA clinic
2. Jimma H. center 5. Private clinic
3. H 2 MCH clinic 6. other, specify

309. Why do you prefer this health facility?

1. close to my residence 3. Fair price
2. Competent H. worked 4. Other, specify

310. When did you start ANC follow up?

1. First trimester 2. Second trimester 3. Third trimester

311. What do you think are advantages of ANC follow up?

1. to assess material health conditions
2. to assess fetal health condition
3. to assess fetal lie
4. to anticipate possible delivery complications
5. I don't know the advantage
6. Other advantages, specify _____

312. During ANC follow up, did you receive any info, regarding possible pregnancy & delivery complication? 1. Yes 2. No 3. do not know

313. If yes, were did you informed about danger sings of possible complications

1. Yes 2. No 3. Do not remember

314. Which danger signs are you informed about?

1. Vaginal bleeding 2. Head ache 3. Marked & fast weight signs
4. Drowsiness/dizziness 5. Fetal met cessation 6. Other, specify

315. For which danger signs are you informed to seek medical help?

1. Vaginal bleeding 2. Head ache 3. Marked & fast weight signs
4. Drowsiness/dizziness 5. Fetal met cessation 6. Other, specify

316. Were you informed about where to deliver?

1. Yes 2. No

317. If yes to 316, where are you recommended to delivery?

1. Health facility 2. Home

318. Were you informed about who should attend you during delivery?

1. Yes 2. No

319. If yes to 318, who is recommended to attend your delivery?

1. Skilled delivery attendant 2. TBA 3. TTBA
4. Relatives 5. Other family members 6. Other, specify

KNOWLEDGE

401. Are there any health facilities which provide pregnancy & delivery services?

1. Yes 2. No 3. Do not know

If yes, which health services are provided

402. ANC 1. Yes 2. No 3. Do not know
403. Attending Normal delivery 1. Yes 2. No 3. Do not know
404. Preventing delivery cxns 1. Yes 2. No 3. do not know
405. Managing delivery cxns 1. Yes 2. No 3. do not know
406. Care to the NB 1. Yes 2. No 3. do not know
407. Managing health problem in the NB 1. Yes 2. No 3. do not know

408. Which HF provide the above services.

1. Jimma Hospital 2. Jimma HC 3.MCH Clinic
4. FGA clinic 5. In none of the HF 6. Do not know

Knowlege on Advantages of Pregnancy & delivery related services

409. Anticipating problems 1. Yes 2. No 3. Do not know
410. Early detection of H. Problems 1. Yes 2. No 3. do not know
411. app. Management of H. problems 1. Yes 2. No 3. do not know
412. Better health care to the women 1. Yes 2. No 3. do not know
413. better care to the newborn 1. Yes 2. No 3. do not know

BELLEFS AND AITITUDES

501. Attitude to the general health service 1. Yes 2. No 3. do not know
502. Why good attitude to the general HS?
    1. Better quality of service 4. Good out comes of services
    2. Good approach of h. workers 5. Other specify
    3. Fair price of services
503. Why bad attitude to the general HS?
    1. Poor quality of services 4. Poor out comes of services
    2. Unpleasant approach of H. worker 5. others, specify _____
    3. Unfair expensive price
504. Attitude to wards delivery services?
    1. Good 2. Bad 3. Indifferent
505. Why good attitude to the delivery services?
    1. poor quality of services 4. Better out comes of institutional delivery
    2. Good approach of h. workers 5. other specify
    3. Fair price
506. Why bad attitude to the delivery services?
    1. Poor quality of services 4. Poor out comes of institutional delivery
    2. Unwelcoming approach of h. workers 5. I believe it is better to delivery at home

3. Expensive price 6. Other specify _____

507. How do you evaluate the quality of institutional delivery services?

1. Good 2. Bad 3. Indifferent

508. Attitude to home delivery

1. Good 2. Bad 3. Indifferent

509. Why good attitude to home delivery?

1. I feel more comfort being at home
2. To get care and attention from family members
3. If is my usual practice
4. I don't like the services in the HF
5. I have experienced poor out come in institutional delivery
6. Unwelcoming approach of H. workers
7. Other, specify

510. why bad attitude to home delivery?

1. better services in HF 4. poor out comes from home delivery
2. better out comes from ID 5. other specify
3. good approach of H. workers

perceptions (perceived severity, susceptibility, benefits ante barriers)

601. Any pregnant women is susceptible to face delivery cxns.

1. I agree 2. I disagree 3. Indifferent

602. Like any pregnant women, I am susceptible to face delivery cxns.

1. I agree 2. I disagree 3. Indifferent

603. Delivery cxns can be severe and may be hazardous to my well being.

1. I agree 2. I disagree 3. Indifferent

604. Delivery cxns can be severe and may be hazardous to the newborn.

1. I agree 2. I disagree 3. Indifferent

605. Being attended by a skilled delivery attendant may be beneficial to my well being.

1. I agree 2. I disagree 3. Indifferent

606. Being attended by a skilled delivery attendant may be beneficial to the newborns well being. 1. I agree 2. I disagree 3. Indifferent

Even if I wanted to get a skilled help during child birth, I may not get it, because of the following reasons.

607. Unavailability of H. facilities 1. Yes 2. No

608. Unavailability of skilled attendant in HF 1. Yes 2. No

609. I can not pay for services 1. Yes 2. No

610. I can not pay for services 1. Yes 2. No

611. I can not get transportation services 1. yes 2. No

612. Very distant H. facilities 1. Yes 2. No

ENABLING FACTORS (Availability & Accessibility of services)

701. Is there HF with skilled delivery attendant in Jimma town?

1. Yes 2. No 3. Do not know

702. If yes to 701, In which health facility?

1. Jimma Hospital 2. Jimma HC 3. H2 clinic 4. Others ____

703. Is there a HC with skilled Da inyour nearby?

1. Yes 2. No 3. do not know?

704. Can you afford to pay for services from SDA?

1. Yes 2. No 3. do not know

705. Can you got transportation services to visit HC with SDA?

1. Yes 2. No 3. Do not know

706. Can you afford to pay for transportation services to visit HC?

1. Yes 2. No 3. Do not know

REINFORCING FACTORS

707. preference of husband to place of delivery

1. HD 2. ID 3. Do not know

708. Preference of husband as your deliver attendant

1. Skilled DA 2. TTBA 3. TBA

4. Relatives of family members 5. Do not know

709. preference of other family members as your place of delivery

1. HD 2. ID 3. Do not know

710. Preference of other family members about your delivery attendant

1. Skilled AD 2. TTBA 3. TBA

4. Relatives or family members 5. Do not know

711. Preference of other community members as your place of delivery

1. HD 2.ID 3. Do not know

712. preference of other community members as your delivery attendant

1. Skilled DA 2. TTBA 3. TBA

4. Relative or family members 5. Do not know

preference of Pregnant woman

801. Where do you prefer to deliver (this specific child?)

1. Home 2. HF

802. Why do you prefer to deliver at home?

1. I feel more comfortable just being at home
2. close attention from relatives & family members
3. It is my usual practice
4. I don't like the service in the HC
5. Previous bad experience from institutional delivery
6. Unwelcoming approach of to workers
7. Others, specify _____

803. Why do prefer to deliver in health institutions?

1. Better service 4. Poor out comes from HD
2. Better outcomes from ID 5. Other, specify _____

804. Your preferences about delivery attendant

1. Skilled personnel 2. TTBA 3. TBA
4. Relatives or family members 5. Others, specify _____

805. Why do you prefer them as your delivery attendant?

Intentions of Pregnant woment

901. where do you intend to deliver (current pregnancy?)

1. Home 2. health facilities 3. Not decided yet

902. Why do you intend to deliver at home?

1. I fell more comfortable just being at home
2. Close attention from relatives & family numbers
3. My usual practice
4. I don't like the service in the HD
5. Previous bad experience from ID
6. Unwelcoming approach fromhealth workers
7. Can not afford to pay for health services
8. No transportation services
9. Can not to pay for transportation services
10. Other reasons, specify

903. why do you intend to deliver in HF?

1. better services inthe HF
2. Better out come of ID
3. Good approach of H. worked
4. Poor out come of HD
5. Other, specify

Women's decision making power

904. If you wanted to deliver in health facilities, who will make the fianl decision?

1. Just me
2. My husband/ partner
3. My relatives
4. Other people, _____

Data of data collection _____

Name of data collector _____

Code of Data collector _____

Signature of Data collector _____

Name and signature of supervisor _____

ADDIS ABABA UNIVERSITY

DEPARTMENT OF COMMUNITY HEALTH

DATA COLLECTON INSTRUMENT

To assess actual delivery practices of pregnant women, who were previously interviewed to assess factors that influence their future intentions in relation to delivery service utilization. The respondents were initially visited while they were in their third trimester and they were followed up until they deliver.

001. Code Number _____

002. Name of the respondent _____

003. Address

Keftegna _____ kebele _____ house Number _____

Section I Questions for all women

101. where do you deliver your last child

1. At home 2. In health facilities

102. Have you faced any pregnancy related health problems prior to or during labor

1. yes 2.No

If yes to Q 102,ask Q 103, if no to Q 102, skip to Q 104.

103. If yes, which of the following problems

1. Ante partum hemorrhage
2. premature rupture of membranes
3. preterm labour
4. Elevated blow pressure
5. Excessive bleeding during labor
6. Intrauterine fetal death
7. others specify _____

104. How long was the duration of labour ?

1.Less than half a day
2. one day or one night
3. More than one and half day
4. do not exactly remember

105. How do you rate the delivery outcome, in terms of your health ?

1. Very Good 2.Fair 3. Bad 3. Indifferent

106. How was the newborn born?

1. Born alive 2.Born alive but died immediately
3. Born dead 4. Other situations, specify _____

107. If the newborn was born alive, has he faced any problems so far?

1. No
2. Yes, specify them _____
   _____
   _____

108. Have you faced any health problems after delivery ?

1. No
2. Yes , specify them _____
   _____
   _____

109. Who made the final decision about your place of delivery ?

1. Just me
2. My husband
3. My relatives
4. Other people, specify _____

Section II. Questions for women who have delivered in heath facilities

201.what was the mode of delivery

1. spontaneous vaginal (SVD) 3. Cesarean section (C/S)
2. Assisted vaginal delivery(AVD) 4. others specify_____

202. why you deliver in health facilities ?

1. It was my preference
2. It is my usual practice
3. Based on my previous bad experience from home delivery
4. I was informed to deliver in health facilities
5. I have faced obstetric problems which forced me to deliver in health facilities
6.others, society

203. How do you rate the distance of health facility where you deliver ,from your Residence? 1. Very long 2. Fair 3. Short 4. I cannot assess it.

204. How do you rate the price of the delivery service ?

1. Expensive 2. Fair 3. Cheap 4. I cannot assess it

205. How do you rate the easeness of getting transportation service ?

1.Difficult 2. Fair 3. Easy 4. I cannot assess it

206. How do you rate price of transportation service

1. Expensive 2. Fair 3. Cheap 4. I cannot assess it

207. Were the institutional delivery services according to your expectations?

1. Yes, good 2. Yes, poor 3. I was not having specific expectations

Based on your experience from your last child birth, how do you rate the following, in regard, to institutional delivery services?

208. Quality of services 1. Very Good 2.Fair 3. Poor 4. Indifferent

209. Competence of health workers 1.Very Good 2.Fair 3. Poor 4. Indifferent

210. Approach of health workers 1. Very Good 2.Fair 3. Poor 4. Indifferent

What was the suggestion of the following people while you try to get institutional delivery services

211.Your husband 1. He encouraged me 2 .He discouraged me.
3. He gave no suggestions 4. I don't remember.
212.Your relatives 1. They encouraged me 2 .They discouraged me.
3. They gave no suggestions 4. I don't remember.

213. Based on your experience and delivery out come from your last childbirth in health facility, what would be your preference for future place of delivery?
1. Institutional delivery 2. Home delivery 3. No preference

If they prefer institutional delivery ask Q 214, but if they prefer
Home delivery skip to Q 215.

214. If you prefer institutional delivery what is your main reason?
1. I am satisfied with the quality of delivery services in health facilities
2. I had better outcome in terms of my health.
3. It had better outcome in terms of the health of the Newborn.
4. I have observed that some of the problems that I faced during delivery, could not have been handled at home.
5. I am informed that I should always deliver in health facilities.
6. others, specify ----------
7. others ----------
8. other ----------

215. If you prefer home delivery what is your main reason?
1. I am not satisfied with the quality of services in the health facilities.
2. I have faced poor outcome from institutional delivery.
3. The newborn has faced poor out come from institutional delivery.
4. I have felt that, the delivery services in the health facilities are not any different from delivering at home.

5. Others, Specify ----------
6. Others ----------
7. Others ----------

Section III Questions for women who delivered at home

301. Which of the following people have attended your delivery?

1. Health professionals (SDA)
2. TTBA
3. TBA
4. Relatives or family members
5. other people, specify ----------

302. Why do you deliver at home?

1. It was my preference.
2. It is my usual practice
3. I can not afford to deliver in HF
4. Because of previous bad experience from institutional delivery.
5. The labor was going well and I faced no obstetric problems which forced me to go for institutional delivery.
6. I was informed that I can deliver at home
7. Others, specify ----------
8. Others, specify ----------
9. Others, specify ----------

What was the suggestion of the following people while you deliver at home?

303.Your husband 1. He encouraged me 2 .He discouraged me.
4. He gave no suggestions 4. I don't remember.

304.Your relatives 1. They encouraged me 2 .They discouraged me.
3. They gave no suggestions 4. I don't remember.

305. How do you rate the easenes for you to get instituitional delivery services if the need arises.

1. Very easy
2. Fair
3. Very difficult
4. It was impossible
5. I cannot assess.

307. If very difficult or impossible to Q305, why ?

1. Health facilities are not available 4. No transportation service
2. health facilities are not nearby 5. Cannot pay for transportation
3. I cannot pay for the services 6. Other reasons specify ----------

During the progress of your labour at home imagine that you have faced any of the following situations. For which one of them do you think that, you were most likely to go to health facilities for delivery.

307. Excessive vaginal bleeding 1. Yes 2. No 3. Cannot say
308. Unusually prolonged duration of labour 1. Yes 2. No 3. Cannot say
309. Cessation of fetal movement 1. Yes 2. No 3. Cannot say
310.Cessation of labor before delivery 1. Yes 2. No 3. Cannot say
311. If advised by your delivery attendant 1. Yes 2. No 3. Cannot say

312. Based on your experience and delivery outcome from the last child birth at home what would be your future preference for place of delivery?

1. Institutional delivery 2. Home delivery 3. No preference

If they prefer instituiotional delivery ask Q313,
if they prefer home delivery SKIP to Q 314.

313. If you prefer institutional delivery, What is your main reason?

1. I have faced poor outcome from home delivery
2. The new born has faced poor outcome from home delivery
3. It was against my intention that I delivered at home.
4. Other reasons, Specify ----------
5. Other reasons, Specify ----------
6. Other reasons, Specify ----------

315. If you home delivery, what is your main reason?

1. I have faced better out come from home delivery
2. The newborn has faced better outcome from home delivery
3. It is my usual practice.

4. I have observed that, deliveries can be handled at home.
5. Other reasons, specify ----------
6. Other reasons, Specify ----------
7. Other reasons, Specify ----------

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