ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCE DEPARTMENT OF NURSING AND MIDWIFERY

ASSESSMENT OF KNOWLEDGE AND PRACTICE OF WOMEN FOR BIRTH AND EMERGENCY PREPAREDNESS IN HAWASSA CITY, SNNPR, ETHIOPIA

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LIST OF ABREVIATIONS

AAU	Addis Ababa University
ANC	Antenatal care
CHW	Community health worker
CI	Confidence Interval
DHS	Demographic and Health Survey
BEOC	Basic essential obstetric care
BP/CR	Birth preparedness/Complication readiness
EmOC	Emergency obstetric care
EOC	Essential Obstetric Care
EMOH	Ethiopia Ministry of Health
HCS	Health Care System
K	Kebele
MMR	Maternal Mortality Ratio
OR	Odds Ratio
PMR	Perinatal Mortality Rate
MOH	Ministry of Health
SC	Sub-City
SP	Skilled provider
SRS	Simple random sampling
CSN	Centralized School of Nursing
SNNPR	Southern Nations, Nationalities, and Peoples Region
TTBA	Trained Traditional Birth Attendant

ABSTRACT

A cross-sectional community-based comparative study was conducted to assess knowledge and practices of birth preparedness and complication readiness and factors associated with their practices among women who gave birth in the last 12 months preceding the survey in Hawassa city, SNNPR, Ethiopia. The study was undertaken between October 2010 to April 2011 pre tested structured questionnaire was used to obtain relevant information. Data were obtained from 550 mothers. Including both unprompted and prompted responses, 85.6% of the respondents mentioned identifying place of delivery, 90.4% mentioned saving money, 45.5% mentioned identifying skilled provider and 81.8%mentioned identifying a mode of transportation as elements of birth preparedness. Two hundred twenty two (40.4%) of the respondents reported that they identified place of delivery, saved money and identified a mode of transport ahead of childbirth. In multivariate analysis birth preparedness was higher among literate mothers (OR= 2.41, 95% CI= 1.97,4.37), women who have a good income (OR=3.28, 95% CI= 1.91,5.64), women with history of still birth (OR= 3.37, 95% CI= 1.47,7.75), having ANC follow up (OR= 4.13, 95% CI= 1.33, 12.82)and awareness about BPCR (OR= 8.25,95% CI=4.47,15.22). About 82.2% of the respondents gave birth by a skilled provider. Skilled provider at birth was higher among those who were literate, with better income, first births, those who had ANC follow up and those who were birth prepared. The study identified poor comprehensive knowledge and practices of birth preparedness in general and very poor knowledge on danger signs in particular. Improve the information given during ANC follow up, with special emphasis given to birth preparedness in general and information on obstetric danger sign in particular, community education about birth preparedness, particularly about danger signs, empowerment of women, improving the information given during the ANC follow up with are recommended.

CHAPTER ONE

INTRODUCTION

1.1 Background

Worldwide, more than half a million women were dying each year from the complications of pregnancy and childbirth, with the vast majority of these deaths (99%) occurring in the developing world (1).The situation is most dire for women in Sub-Saharan Africa, where one of every 16 women dies of pregnancy related causes during her lifetime, compared with only 1 in 2,800women in developed regions (2). In Ethiopia, maternal mortality ratio is 673 per 100,000 live births, which is one of the highest in the world (3).

The main causes of maternal mortality are haemorrhage, infections, unsafe abortion, hypertensive diseases and obstructed labour (4). Many of the complications that result in maternal deaths are unpredictable, and their onset can be both sudden and severe. Delay in responding to the onset of labour and such complications has been shown to be one of the major barriers to reducing mortality and morbidity surrounding childbirth (5).

The Global safe motherhood initiative was launched in 1987in Nairobi with a goal to reduce the maternal mortality by 50% by the year 2000, and many safe motherhood programs at the country level focused on the training of traditional birth attendants (TBAs) and on risk screening during

antenatal care as the key interventions (1). Ten years later, use of skilled birth attendants and emergency obstetric care were found to be the most critical interventions to reduce maternal deaths (6).A skilled attendant refers to an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns(7).Unfortunately, uptake of skilled care is low even in settings where services are available. In Ethiopia, Only 18.4 percent of births are delivered with the assistance of a skilled attendant (8).

Maternal deaths are thought to occur due to three delays: delay in deciding to seek appropriate care; delay in reaching an appropriate health facility; and delay in receiving adequate emergency care once at a facility (4). In many societies in the world cultural beliefs and lack of awareness inhibit preparation of advance for delivery and expected baby. Since no action is taken prior to the delivery, the family tries to act only when the labour begins. When the complications occur the unprepared family will waste a great deal of time in recognizing the problem, getting organized, getting money, finding transport and reaching the appropriate referral facility. These delays can lead to maternal death (9).

Birth-preparedness and complication readiness is a comprehensive strategy to improve the use of skilled providers at birth, the key intervention to decrease maternal mortality. Birth preparedness helps ensure that women can reach professional delivery care when labour begins. In addition, birth preparedness can help reduce the delays that occur when women experience obstetric complications, such as recognizing the complication and deciding to seek care, reaching a

facility where skilled care is available and receiving care from qualified providers at the facility (10).The approach involve all stakeholders in maternal health (individual woman, their families, communities, providers, facilities and policy maker) by ensuring the women receive timely and appropriate care(6).

2.2 Statement of the problem

Women play principal role in the rearing of children and the management of family affairs, and their loss from maternity-related causes is a significant social and personal tragedy.The estimated Maternal Mortality in Ethiopia is 673 per 100,000 live births (3). This ratio is very high compared to a ratio of 11 in the United Kingdom per 100,000 live births (4). More than 70% of all maternal deaths are due to five major complications: hemorrhage, infection, unsafe abortion, hypertensive disorders of pregnancy, and obstructed labor.

The majority of maternal deaths (61%) occur in the postpartum period, and more than half of these take place within a day of delivery (11).In Ethiopia, Only 18.4% of births are delivered with the assistance of a trained health professional, that is, a doctor, nurse, or midwife (8). This situation very well explains the high maternal mortality in Ethiopia. Pregnancy related complications cannot be reliably predicted and it is necessary to design strategies to overcome those problems when they arise (12).Various international experiences in maternal mortality reduction programme shows that every pregnant woman is at risk for life threatening complication and that safe delivery and access to EMoC are essential (5,13).

Lack of advance planning for use of a skilled birth attendant for normal births, and particularly inadequate preparation for rapid action in the event of obstetric complications, are well

documented factors contributing to delay in recipient of skilled obstetric care. To address this problem, birth preparedness has been globally endorsed as an essential component of safe motherhood programs (14).This study tried to assess knowledge and practices with respect to birth and emergency preparedness and factors associated with their practices among women in Hawassa city.

1.3 Significance of the study

Literature reviewed indicates birth preparedness and complication readiness is one of the service interventions that have a potential to impact on the high maternal mortality. In Ethiopia, the level of maternal and infant mortality and morbidity is among the highest in the world. The Maternal Mortality in 2005 is 673/100,000 live birth and Infant Mortality Rate is 77/1000 live birth (3).

To find out the status of birth preparedness complication readiness interventions there is a need to assess the knowledge and practice of birth preparedness and complication readiness among women in the community. The findings of this study will be used by relevant stakeholders to amend the strategy and take corrective measure to improve the programme.

CHAPTER TWO

LITERATURE REVIEW

The World Health Organization (WHO) estimate that worldwide more than 529,000 women die every year from complications of pregnancy, childbirth and abortion. Ninety nine percent (99%) of these deaths are from the developing countries (15).Less than 1% of these deaths occur in more developed countries making maternal mortality a good indicator for the existence of greatest health disparity between developed and developing countries.

The situation is worst in sub-Saharan Africa where one in every 13 women dies of pregnancy related causes compared to only one in 4,085 women in developed countries. Ethiopia is one of the countries in Sub-Saharan Africa although the recent 2005 Ethiopia Demographic and Health Survey (EDHS) recorded a slight decrease in MMR from 816 per 100,000 live births in the year 2000 to 673 per 100,000 live birth, however, the figure remains one of the highest in sub-Saharan Africa and it is above the global average MMR of 400/100,000 live births (3, 14).

Around 80% of all maternal deaths are due to five major complications(2): hemorrhage (25%), infection(15%), unsafe abortion (13%), hypertensive disorders of pregnancy(12%), and obstructed labor(8%). The majority of maternal deaths (61%) occur in the postpartum period, and more than half of these take place within a day of delivery.

A study done on maternal mortality in Addis Ababa in 1983 showed MMR of 566 per 100,000 live births and mortality was highest for nuilipara, the unmarried, women employed as maids/janitresses and student. Abortion, hemorrhage, hypertensive disorders of pregnancy and rupture of uterus were common among the direct obstetric cause (16).A retrospective review of hospital maternal deaths at Jima Hospital, covering the period from September 1990 to May 1999, revealed a MMR of 1,965 per 100,000 live births and hemorrhagic complication of pregnancy, sepsis and hypertensive disorders of pregnancy were responsible for 94.9 % of all maternal deaths (17). Similarly, another study in Tikur Anbsa hospital (18), from September 2001 to Aug 2002, revealed a MMR of 1,107per100, 000 live birth with the top three-implicated cause of post abortion complications (28%), eclampsia (21%) and ruptured uterus (15%). Ethiopian Demographic Health Survey (DHS) 2005 shows the national antenatal coverage, proportion of delivery attendance by skilled attendant, and postpartum care offered by the health professional is, 28%, 6% and 10% respectively (3). Slightly more than ten (12%)women make four or more ANC visits during the entire pregnancy, with a marked variation between residing in the urban area (55%) and those in the rural area(8%).

According to an official report from the Ministry of Health (MOH), the national antenatal coverage is 67.7%, proportion of delivery attendance by skilled attendant is 18.4% and postpartum care offered by the health professional is 34.3% (8). These figures shows improving maternal health service utilization and may indicate a right way on the achieving the millennium development goal, however, the proportion of birth attended by skilled personnel still very low.

Based on the report from the EMOH, the proportion of Antenatal, delivery attended by skilled attendant, and postpartum care offered by the health professional for Addis Ababa is 111.5%, 62.5%, and 48.3%, respectively (8). Similarly report indicated that the proportion of Antenatal care, delivery attended by skilled attendant, and postpartum care offered by the health professional for SNNPR is 74%, 20%, and 39.7% respectively. Maternal age, marital status and number of children were not strongly related to ANC attendance; however the use of ANC was strongly associated with level of education (3).

Birth preparedness and complication readiness (BP/CR) is a relatively common strategy employed by numerous groups implementing safe motherhood programs. For example, the Prevention of Maternal Mortality (PMM) Program (1987–1997) found that inadequate funds and transport were key cause of delay in deciding to seek care and in reaching facilities. Interventions to address these problems included a community loan program and transportation systems (19).The Mother Care Project (1988–1998) included interventions to promote "birth planning" or "contingency planning." These interventions focused on planning for emergencies (20).A program in Bangladesh defined birth planning as taking a series of steps prior to birth to ensure that a pregnant woman is prepared for normal birth and complications. Key messages included: care for yourself during pregnancy and childbirth, knowledge of danger signs, identify a trained birth attendant, prepare for a clean childbirth, know which health facility to go to in case of an emergency, and plan for complications, including savings and transportation (21).

According to JHPIEGO/MNH Program BP/CR is defined as an overarching program approach to improve the use and effectiveness of key maternal and newborn health services, based on the

premise that preparing for birth and being ready for complications reduces all three phases of delays in receiving these services (1). Furthermore, this approach calls for agents at multiple levels—including women and their families, communities, providers, facilities, and policymakers—to engage in BP/CR actions.

Standard elements of birth and emergency preparedness included:- knowing the danger signs, choosing a birth location and provider, knowing the location of the nearest skilled provider,obtaining basic safe birth supplies, and identifying someone to accompany the woman, arranging for transportation, money, a blood donor, and temporary family care in case of emergencies, information on danger signs in the newborn, making arrangements for skilled early postpartum care, obtaining an HIV test during pregnancy to determine the need for prevention of mother to child transmission (PMTCT) interventions, and arranging medical and social support for the woman in case the HIV test is positive (22).

Knowledge of danger sign of obstetric complication is an essential step for recognition of complication and enables one to take action to access emergency care.

In a base line study in Nepal only 30.5% of women and 29.4% of family members were aware of vaginal bleeding as danger sign during pregnancy (23). A baseline report in Chandina, rural Bangladesh, showed that 19% and 6% of women were aware of edema and bleeding as complications relating to pregnancy, respectively (24). About 21% of women in Abhoynagar of Bangladesh perceived bleeding as complication during pregnancy and oedema and anemia were also mentioned by 42.5% and 24.5%, respectively (25).

An Indian study indicated that 79.2% of mothers were aware of at least one danger-sign of pregnancy and 78.5% were aware of that of delivery while 82.1% were ware of at least one newborn-related complication (26). But, another Indian study done on birth preparedness and complication readiness intervention revealed that only 18.6% of mothers had knowledge about these key danger signs (27). This study explained that very few of mothers and relatives knew about these key danger signs though the level of knowledge was shown increasing with education, socioeconomic status, and occupation.

A study done in Kenya showed that 67% of the respondent knew at least one obstetric danger sign during pregnancy, but only 6.7% knew three or more danger sign during pregnancy(28). All respondent completely lack on some of the danger sign such as fever, convulsion and difficulty in breathing. Similar study in Tanzania, discover that 51.1% of the women knew at least one obstetric danger sign (29). The percentage of women who knew at least one danger sign related to pregnancy was 26%, in relation to delivery 23%, and to the period after delivery 40%.A qualitative study done in Burkina Faso revealed that knowledge of danger signs was relatively low, with women spontaneously reporting an average of 5.67 danger signs in pregnancy, childbirth, after delivery, and for the newborn (30).

A study done in Adigrat showed that Only 10.9%,2.2% and 28 5.2% of the respondents spontaneously mentioned vaginal bleeding, blurred vision and swollen hands/face as danger signs during pregnancy, respectively(31). The corresponding numbers after prompting were 15.2%, 18.2% and 20.4%, respectively. In this study only 15.4% spontaneously mentioned at least one key danger sign, 2.6% mentioned at least two key danger signs and 0.4% mentioned all three key danger signs. In Aleta Wondo, study done on knowledge about obstetric danger signs among pregnant women revealed that 39.0% of women didn't know any danger signs of

pregnancy, 30.4%mentioned at least two danger signs during pregnancy and 63.6% believed that a woman could die of the above mentioned danger sign(33).

A baseline study in Nepal showed that 23.6%, 72.8% and 5.4% of women know severe vaginal bleeding, prolonged labor and retained placenta, respectively, as danger signs during child birth (23).Similarly 7%, 76% and 13% of women in Chandina mentioned severe vaginal bleeding, prolonged labor and retained placenta, respectively, as danger signs during child birth. About 27%, 70.5% and 40% of women in Abhoynagar perceived severe vaginal bleeding, prolonged labor and retained placenta, respectively, as danger signs during child birth (24, 25).

A study done in Tanzania showed that vaginal bleeding (13%) and prolonged labor (1.5%) were mentioned by the women as a danger signs during delivery (29). A study done in Adigrat town also showed that 16.5%, 0.6%, 11% and 7.1% of the respondents spontaneously mentioned severe vaginal bleeding, convulsions, prolonged labor and retained placenta as danger signs during labor/childbirth, respectively(31). This study also indicated only 23.8% of respondent spontaneously mentioned at least 1 key danger sign, 7.3% mentioned at least two key danger signs, 3.9% mentioned at least 3 key danger signs and 0.2% mentioned all four key danger signs. A study done in North Gondar on the other hand, showed that about 61.1 % of the respondents are aware of at least one life threatening obstetric complication during labor and delivery (32). The study done in Aleta Wondo also reviled that vaginal bleeding, difficulty of breathing, and loss of consciousness were mentioned as danger signs during childbirth by 45.9%, 14.1%, and 12.7% of respondents respectively (33).

A study done in Nepal showed that 61.8% and 23.3% of the women reported severe bleeding and high fever, respectively, as danger signs during the post partum period (23).Similarly 47.3%, 22.2% and 2.1% of women in a study in Abhoynagar perceived severe bleeding, fever more than three days and smelly vaginal discharge, respectively, as danger signs during the post partum period (24).A study done in Tanzania showed that sever vaginal bleeding, fever more than three days, and smelly vaginal discharge were perceived as danger signs during post partum period by 47.3%, 22%, and 2.1% of women respectively (23).

A study done in Adigrat showed that 16.7%, 1.1% and 1.5% of the respondents spontaneously mentioned severe vaginal bleeding, high fever, and foul smelling vaginal discharge as danger signs during post partum period, respectively(31). Only 17.2% spontaneously mentioned at least one key danger sign, 1.7% mentioned at least two key danger signs and 0.4% mentioned all three key danger signs.A study done in Northern Gonder indicated that excessive vaginal bleeding, prolonged labour and retained placenta were mentioned as key danger during post partum period by 55%, 23% and 7.6% of respondents respectively. According to the study done in Aleta Wondo, the danger signs of post partum period commonly mentioned include severe bleeding (59%), difficulty of breathing (17.9%), and loss of consciousness (14.4%) while 37.7% of respondents mentioned at least two serious danger signs during post partum period(33). Danger signs of serious health problems of newborn commonly reported according to this study, were fast or difficult breathing (49.4%), poor sucking or feeding (41.5%) and pus or discharge from umbilical cord (19.7%) of the respondents.

In the study for assessing birth preparedness and complication readiness intervention in Rewa District of Madhya Pradesh (27) revealed that a good level of knowledge exists about

financial assistance among mothers (78.1%).According to the study done in India, Over two-thirds (69.6%) of the mothers identified a trained birth attendant for delivery (26). Of those mothers who did not identify a trained birth attendant for delivery (30.4%), the most predominant reasons reported were: lack of perceived need (19.8%), economic constraints (4.5%), and faith in TBAs or traditional system of delivery (6.1%). About two-thirds (63.8%) of the mothers identified a health facility for obstetric emergency.

A qualitative study done in Burkina Faso showed the majority of women reported planning for birth in which 43.4% planned for a birth provider, 46.1% planned for transportation, and 83.3% planned to save money in case of emergency (30).

In the Adigrat study place of delivery, saving money, skilled provider, and means of transportation were spontaneously identified by 26.2%, 28.8%, 7.9%, and 10.1% of respondents respectively (31). Considering both unprompted and prompted responses, identifying place of delivery, saving money, identifying skilled provider and identifying a mode of transportation were mentioned by 86.9%, 83.7%, 40.4% and 40.8% of the respondents, respectively.

The study done in Rewa District of Madhya Pradesh reveled that Majority of the women had planned for skilled provider and transport but less than half (44.2%) of the mothers planned for saving money (27). Planning for transportation appears less concrete as majority had planned for private vehicle but more than half of them do not have sufficient savings. When asked about birth preparedness nearly half of the mother-in-laws and relatives were not in favor of making any prior arrangement before delivery. The study done in India showed large majority (76.9%) of the families saved some money where as for the remaining 23.1% of the families,

meager earnings which were mostly spent on household purchases (16.7%) or by husband on liquor (6.4%) were cited as reasons for not saving money from the mothers, 8% mentioned being members of the community health fund groups. According to this study preparedness for transport for emergency was low (29.5%). Overall, 47.8% of the mothers were well-prepared, and 52.2% were less-prepared (27).

A study done in Adigrat showed that majority 85.8% of the respondents reported that they made some arrangement for the birth of their baby (31). Of those 39.1% reported spontaneously that they identified place of delivery, 35.6% saved money, 10.5% identified skilled provider and 3.2% identified a mode of transportation. Considering both unprompted and prompted responses, place of delivery selection77% and saving money 69% were the most commonly identified components of birth preparedness and complications readiness. The study also revealed that 22.1% of the total respondents reported that they identified place of delivery, saved money and identified a means of transport ahead of childbirth.

HIV counseling and testing is importance because it enables women to know HIV status. Women who test negative are given information and supports remain uninfected. A positive HIV test allow the women to receive additional care to keep her health, prevent transmission to her baby and partner and help her to make decision about the future (34).In Kenya, the study revealed that 96.4% of respondent know the need of HIV testing (28).The study done in Adigrat showed that 54.4% of women received voluntary counseling and testing during pregnancy (31).

A study done in India revealed that the well prepared mother is tend to be literate and literate husband (26), availed of antenatal services, and had better knowledge about maternal/newborn danger-signs suggestive for seeking referral, mothers who reported a delivery-related complication, a higher proportion of well-prepared mothers. Similar study done in Adigrat showed that literacy is highly associated with BP/CR (31). Married women were more likely to be prepared for birth/complication than non-married. There was a statistically significant association between parity and preparation for birth and its complication. Women with parity range of 2 to 4 were more likely to prepare for birth and its complication than grand multiparas (more than 4 deliveries) and primiparous women (first time delivery). Women who had history of still birth were also more likely to prepare for birth and its complication than those who did not have still birth. Advice given on preparation for birth and its complication during ANC follow up was also significantly associated with preparation for birth/complication. Women who were advised about where to give birth and arrangements for money and transportation during their ANC follow up were more likely prepared for birth and complication than those were not given such advice.

Conceptual Framework for Birth Preparedness and Complication Readiness

This conceptual framework was developed by the researcher after reviewing relevant literature in the topic area of the study. It was used in this study to guide data collection, analysis, and interpretation.

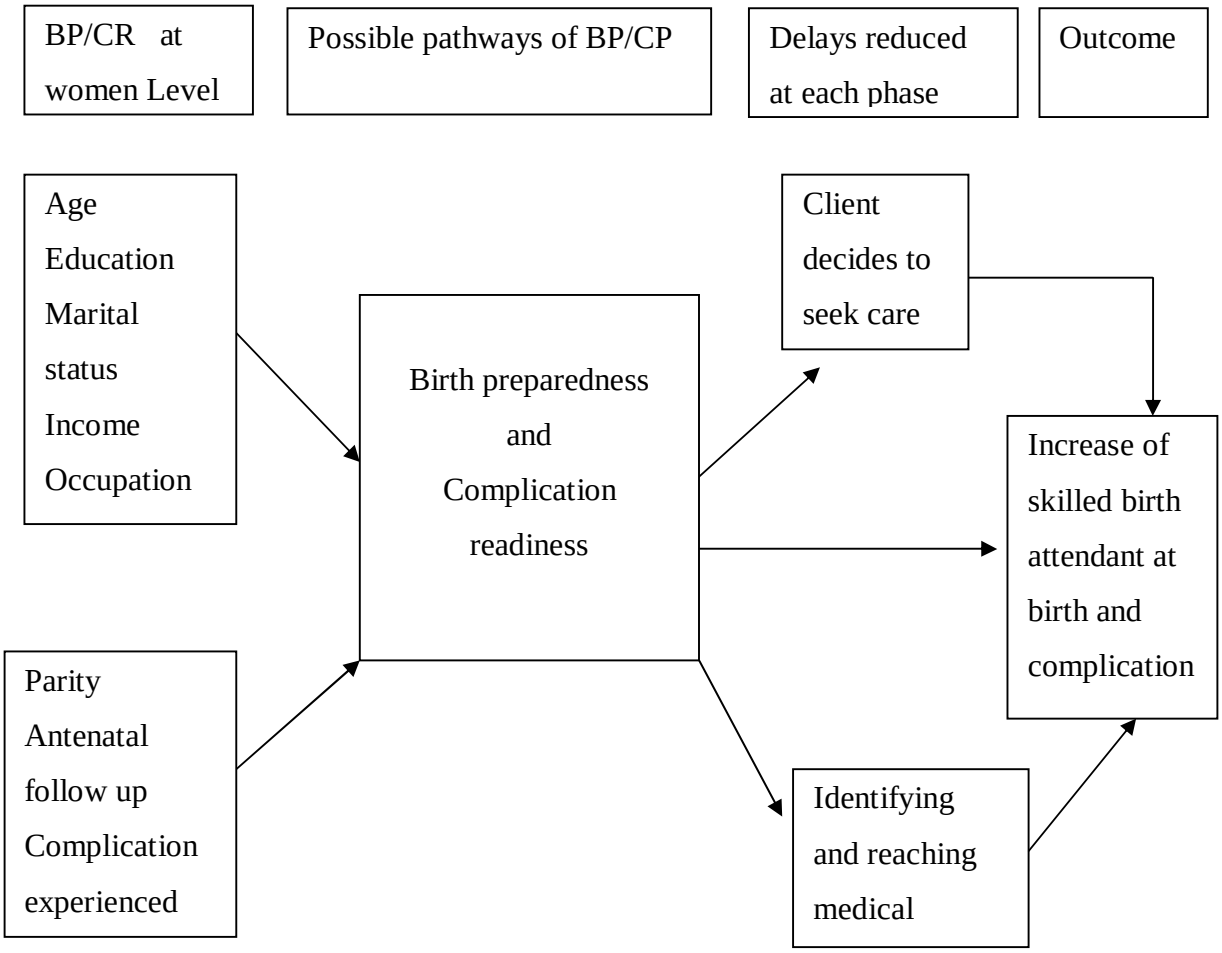


Figure1. Conceptual framework of birth preparedness and complication readiness was used in the collection, analysis, and interpretation of data.

CHAPTER THREE

OBJECTIVES

3.1 General Objective

To assess knowledge and practices with respect to birth preparedness and complication readiness and factors associated with their practices among women who gave birth in the last 12 months preceding the study in Hawassa city from Oct 2010 to April 2011.

3.2 Specific Objectives

- To assess knowledge about birth preparedness and complication readiness among women who gave birth in the last 12 months.
- To assess practice related to birth preparedness and complication readiness among women who gave birth in the last 12 months.
- To determine factors associated with the practice of birth preparedness and complication readiness among women who gave birth in the last 12 months.

CHAPTER FOUR

METHODOLOGY

4.1 Study Design

This study was a cross-sectional community-based survey.

4.2 Study Area and period

This study was conducted at Hawassa city between the month March and April 2011.Hawasa is a city in Ethiopia, on the shores of Lake Hawassa in the Great Rift Valley. Located in the Sidama Zone 270 km south of Addis Ababa via Debre Zeit, 130 km east of Sodo, 75 km north of Dilla, Hawassa is the capital of the Southern Nations, Nationalities, and Peoples Region. The city lies on the latitude and longitude of 7°3′N 38°28′E / 7.05°N 38.467°E Coordinates: 7°3′N 38°28′E / 7.05°N 38.467°E and an elevation of 1708 meters above sea level.

Hawassa is administratively divided in to seven urban and one rural sub cities , and with a total of 32 Kebeles, according to the 2008 population censes the population is about 280,544 with a male to female ratio of 0:3and around 820,071 female of reproductive age group (15-49year old) (35).There are 64 health institutions in the city which include 4 hospitals (3 private, and 1 government owned hospital), 5 health centers(4 governmental and 1 NGO owned health centers), 55 clinics categorized in to lower, medium, higher, and specialized types; this include privately owned and owned by non- government organizations(NGOs) (35,36).

4.3 Source population

All women of reproductive age group (age 15-49) in Hawassa city

4.4 Study Population

Women who had given birth in the last 12 months, irrespective of the outcome of the birth

Inclusion criteria

- Women who gave birth within the last 12 months prior to the data collection, despite the outcome of the birth.
- Women who were mentally and physically capable of being interviewed.

4.5 Sampling and sampling size

Sample size was calculated by using single population proportion formula with the following assumption:

- Based on previous related study finding, around 22% of pregnant mothers are prepared for birth and its complication (31).
- Confidence interval, design effect and expected non-response rate to be 95%, 2 and 5%, respectively

The sample size was calculated using the following single population proportion formula.

$$n = \frac{Z(\alpha/2)^2 \, p(1-p)}{d^2}$$

Where

n = the minimum sample size.

z = the standard normal variable or deviate, was 0.05 with 95% confidence interval.

d = Marginal error = 0.05.

p = Estimated proportion, it was taken as 22 % (0.22)

Therefore by using the above formula

$$n = \frac{(1.96)^2 \text{ X } 0.22\ (1\text{-}0.22)}{(0.05)^2} \qquad n = 263$$

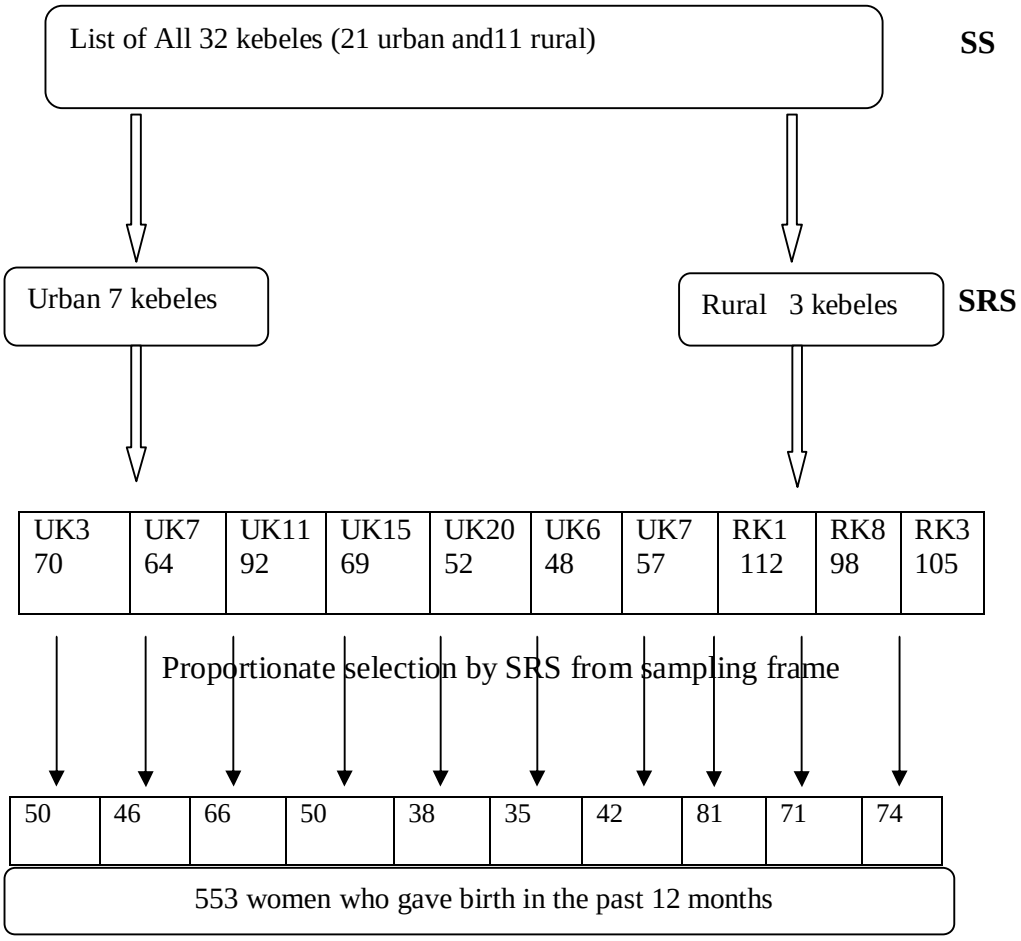
With design effect = 527(263x2)

With 5% non-response rate the total sample = 553

4.6 Sampling procedures

Multistage sampling was used to select the study subjects. First, all the Kebeles in the city were stratified in to urban and rural. Then 7 out of 21 urban and 3 out of 11 rural Kebeles were randomly selected. The calculated sample size was proportionally allocated to urban and rural selected kebeles based on the sampling frame. Cense was conducted in the selected kebeles, the eligible population were identified and a sampling frame which enlists all eligible study subject were prepared, then study participants were selected from the sample frame using simple random sampling proportional to size.

Figure 2:-The schematic presentation of sampling procedures



Key

k = kebele

SS = Stratified sampling

SRS = Simple random sampling

UK= Urban kebele

RK= Rural kebele

4.7 Data collection method

The actual data collection was carried out in March to April 2011. Data were collected by walking from house to house of the randomly selected respondents.

4.8 Data collection instrument

A structured questioner mainly adopted from monitoring birth preparedness BP/CR (1) was developed in English in such a way that it includes all the relevant variables to meet the objectives. An individual who has a very good knowledge translated the English version to Amharic for better understanding of the enumerators' and respondents. Another individual of similar ability then translated the Amharic version back to check for its original meaning.

4.9 Variables

4.9.1 Independent variables

- Socioeconomics and demographic factors (age, marital status, religion, ethnicity, education, income, family size).
- Obstetric factors (Parity, complications experienced, history of still birth).
- ANC follow up
- Knowledge on key danger sign of pregnancy, Labor/birth and post partum.

4.9.2 Dependant variable

- **Birth preparedness :**
  - Identify place of delivery
  - Saving money for child birth
  - Identifying mode of transport
- **Skilled provider at birth**

4.10 Recruitment and training

Four extension health workers who are fluent in the language were selected to collect the data. Data collection was supervised by one BSC nurse and the principal investigator. After recruitment a thorough training was given for 3 days by the principal investigator for both the interviewers and the supervisor. The training include briefing on the general objective of the study, discussion about general techniques of the interview and how to ask each specific question so as to minimize interviewer bias.

4.11 Pretest

The data collection tool was be pre-tested on 53 similar women in the city which were not be included the study before the initiation of the main study. The findings and experiences from the pre test were utilized in modifying the interview method and data collection tool.

4.12 Supervision and quality control

Both the interviewers and quality supervisor were be given an interview guide, which develop before the training. Supervision was conducted by the supervisor and the principal investigator, by observing how data collectors administer the questions to the respondent, checking some household are not left out without visits by the data collector. Each data collector checked the questioner for completeness before leaving each study participant. Five percent of the respondents were randomly revisited by the supervisor or the principal investigator. Each questioner was revised daily by supervisor and the principal investigator to check completeness and clarity and incomplete and unclear questionnaires were returned to the interviewer the next morning to get it completed.

4.13 Data Entry and cleaning

Each questionnaire was pre-coded by the principal investigator. The principal investigator prepared the template and entree the data using SPSS soft ware. Five percent of data were rechecked and any error identified at this time was corrected after revision of the original data using the code numbers.

4.14 Data analysis

Frequency and proportions were used for the description of the study population in relation to other relevant variables (age, marital status, gravidity, parity….).Statistical association were done by chi-square test for categorical variables.

The strength of association between independent and dependant variable were assessed by using cruds odds ratio with 95% confidence interval. Binary logistic regression analysis was performed to control relation to confounding variable.

4.15 Operational definition

Recently give birth: - a woman who gave birth within the last 12 months, including still birth.

Knowledgeable on key danger sign of pregnancy -: a woman is considered knowledgeable if she can mention at least two of the there key danger signs of pregnancy (vaginal bleeding, swollen hands/face and blurred vision) spontaneously or after prompting.

Knowledgeable on key danger sign of labor/childbirth -: a women is considered knowledgeable if she can mention at least three of the four key danger signs for labor/childbirth

(sever vaginal bleeding, prolonged labour (>12 hour), convulsion and retained placenta) spontaneously or after prompting.

Knowledgeable on key danger sign of post partum-: a woman is considered knowledgeable if she can mention at least two of the there key danger signs of postpartum (sever vaginal bleeding, foul smelling of vaginal discharge and high fever) spontaneously or after prompting.

Identifying place of delivery:-a place of delivery planned ahead of childbirth reported by a woman spontaneously or after prompting.

Save money: - money put aside by the women or her family for childbirth reported by a woman unprompted or after prompting**.**

Identified mode of transport:- any kind of transport which is identified ahead by a woman or her family for the purpose of transportation to place of childbirth or for the time of obstetric emergencies reported by a woman unprompted or after prompting.

Birth prepared- person considered as birth prepared if she identified place of delivery, saved money and identified a mode of transport ahead of childbirth.

Skilled provider:-person with midwifery skills (physician, health officers, nurses/midwifes) who can manage normal deliveries and diagnose, manage or refer obstetric complications.

Trained Traditional Birth Attendant (TTBA) - A TBA who has received a short course of training, usually of three months, through the modern health care sector to upgrade her skills.

4.16 Ethical consideration

The proposal was approved by the Addis Ababa University, Health Science College, Department of Nursing and midwifery Ethical review committee. An official letter was obtained from CSN to SNNPR Regional Health Bureau. The survey was commenced after official letter of permission written to Hawassa City health and administrative offices by SNNPR Regional Health Bureau. During data collection individual informed verbal consent was obtained from the study participants. Each respondent was inform about the objective of the study, procedures of selection, assurance of confidentiality and their names were not registered so as to minimize social desirability bias. Individuals were free to end the interview at any time.

4.17 Dissemination of the result

The thesis will be presented to Addis Ababa University, Health Science College, Department of Nursing and midwifery as partial fulfillment of The Degree of Master's of Science in Nursing. The result of the study will be communicated to the Ministry of Health, and Hawassa Health Bureau. Also the findings will be presented in different seminars, meetings and workshops and published in a scientific journal. Hard and soft copy will be available in the library of AAU, for graduate students as well as for other concerned readers.

CHAPTER FIVE

RESULTS

Response Rate

Out of 553 women identified for the study 550(99.4%) responded to the interview. Two women refused to participate in the study and one was severely ill.

Socio-demographic characteristics

As shown in Table 1 about 51.1% of the respondents were between ages of 25 and 34 years with median age of 25 years, 45.5% of them were protestant Christians and 27.3% were Wolayita ethnic group. Majority (69.6%) of the women was married and most of the respondents (63.3%) were housewives by occupation. Forty (7.3%) were illiterate and 89.7% of the respondents had formal education. In regard to income, 38.9% had monthly income of 500-1,500 Ethiopian birr, 33.3% had less than 500 birr and 27.8% had 1,500 birr or above.

Table 1:- Socio-demographic characteristics of the respondents, Hawassa city, Mar.-Apr. 2011.

Variables	Respondents (n=550)	Percent
Age in years		
15-24	237	43.1
25-34	281	51.1
35-44	32	5.8
Marital status		
Single	145	26.4
Married	383	69.6
Widowed	8	1.5
Divorced	14	2.5
Religion		
Orthodox	245	44.5
Protestant	250	45.5
Catholic	20	3.6
Muslim	31	5.6
Others*	4	7
Ethnicity		
Sidama	140	25.5
Wolyita	150	27.3
Amhara	129	23.5
Others**	131	23.8
Occupation		
Housewife	348	63.3
Farmer	8	1.5
Merchant	87	15.8
Govt. employee	96	17.5
Others***	11	2.0
Educational status		
Illiterate	40	7.3
Read & write	17	3.1
Grade1-8	259	47.1
Grade9-12	149	27.1
collage & above	85	15.5
Respondents' monthly income		
>=1,501	153	27.8
500-1,500	214	38.9
<500	183	33.3

Other* Jova Witness, traditional, ** Guraghe,Tigray, and Silite,

Other *** student, self employee, and jobless

Obstetric characteristics

Two hundred forty three (44.2%) women were primiparas and 7.1% were grand multiparas. Thirty seven (6.7%) of the respondents had history of still birth (Table 2).

Table2:- Obstetric characteristics of the respondents, Hawassa city Mar-Apr 2011.

Variables	Respondents (n=550)	Percent
Gravidity		
1	243	44.2
2-4	268	48.7
>=5	39	7.1
Parity		
1	261	47.5
2-4	256	46.5
>=5	33	6
History of still birth		
Yes	37	6.7
No	513	93.3
Birth in the last 12 month	543	98.7
Live birth	7	1.3
Still birth		

Experiences of respondents related to the index pregnancy, delivery and post partum period.

Majority (93.1%) of the respondents have attended ANC at least once. About 334 (60.7%) have ANC follow up more than four times. Among the ANC attendants 139(25.3%) reported that they were informed about danger signs of pregnancy; 236(42.9%) were informed about danger signs of labour and 126(22.9) were informed about danger signs of postpartum. About 85.6% were informed where they should deliver, 497(90.4%) about saving money, 427(77.6%) about arrangements for transportation, and 450(81.6%) about identifying birth companion.

Sixty (10.9%) women reported that they had serious health problem during pregnancy. The reported symptoms include blurred vision in 23 women, swollen hands/face in 19 women, vaginal bleeding and severe headache in 13 women, 7 women were experience loss of consciousness. Forty three (71.6%) of them sought modern health care for their problem. Majority (82.2%) of the women gave birth at health institutions and 17.8% delivered at home. Three hundred ninety six (71.6%) women gave birth at a place where they planned ahead but not for the 28%.

Obstetric complications during labor/childbirth was reported by 57(10.4%) of the respondents. The reported symptoms were prolonged labor in 37 women, severe vaginal bleeding in 27, retained placenta in 14 women, loss of consciousness in 13 women, severe headache in 21women, convulsions in 4 women and high fever in 18 women. Thirty women developed this problem while they were at hospital. Excluding those who developed the problem while they were at hospital, 22(38.6%) went to health facility to get assistance.

Obstetric complications during the post partum were reported by 47(8.5%) of the respondents. The reported symptoms were severe vaginal bleeding in 23 women, severe headache and severe weakness in 21 women, foul smelling vaginal discharge and swollen hands/face in 4 women, difficulty breathing and convulsions in 3 women, loss of consciousness and blurred vision in 10 women, and high fever in 15 women. Fourteen women developed this problem while they were at hospital. Excluding those who developed the problem while they were at hospital, 28(59.6%) went to health facility to get assistance.

Knowledge on danger signs during pregnancy

Only 23(4.3), 29(5.5%) and 5(0.9%) of the respondents spontaneously mentioned vaginal bleeding, swollen hands/face and blurred vision as danger signs during pregnancy, respectively. The corresponding numbers after prompting were 80 (14.5%), 83(15%) 88(16%), respectively (Table 3). Only 47(8.5%) spontaneously mentioned at least 1 key danger sign, 8(1.4%) mentioned at least 2 key danger signs and 2(0.4%) mentioned all 3 key danger signs.

Knowledge on danger signs during labor/childbirth.

Thirty four (6.2%), 13(2.4%), 53(9.6%) and 65(11.8%) of the respondents spontaneously mentioned severe vaginal bleeding, convulsions, prolonged labor and retained placenta as danger signs during labor/childbirth, respectively (Table 3). Only 146(26.5%) spontaneously mentioned at least 1 key danger sign,18 (3.3%) mentioned at least 2 key danger signs, 1(.2%) mentioned at least 3 key danger signs and no one mentioned all 4 key danger signs.

Knowledge on danger signs during post partum period.

Fifty three(9.8%), 29(5.3%) and 26(4.7%) of the respondents spontaneously mentioned severe vaginal bleeding, high fever, and foul smelling vaginal discharge as danger signs during post partum period, respectively (Table 3). Only 97(17.6%) spontaneously mentioned at least 1 key danger sign, 9(1.6%) mentioned at least 2 key danger signs and 2(0.4%) mentioned all 3 key danger signs.

Table 3:- Knowledge of respondents on danger signs during pregnancy, labor and post partum period, Hawassa city, Mar.-Apr. 2011.

Variables [¥]	Unprompted(n=550) N (%)	Prompted(n=550) N (%)	Total(n=550) N (%)
Pregnancy			
Vaginal bleeding	23(4.2)	80(14.5)	103(18.7)
Severe headache	11(2)	73(13.3)	84(15.3)
Blurred vision	5(.9)	88(16)	93(16.9)
Convulsions	9(1.6)	37(6.7)	46(8.4)
Swollen hands/face	29(5.5)	83(15)	112(20.4)
High fever	16(2.9)	48(8.7)	64(11.6)
Loss of consciousness	5(.9)	35(6.4)	40(7.3)
Other*	10	0	10(2.0)
Labor/childbirth			
Severe vaginal bleeding	34(6.2)	118(21.4)	222(40.4)
Prolonged labor	53(9.6)	159(28.9)	212(38.5)
Severe headache	25(4.5)	112(20.4)	146(26.5)
Convulsions	13(2.4)	115(20.9)	128(23.3)
High fever	21(3.8)	124(22.5)	145(26.4)
Loss of consciousness	9(1.6)	142(20.4)	151(27.5)
Retained placenta	65(11.8)	130(23.6)	195(35.4)
Other**	18(3.4)	0	18(3.4)
Post partum			
Severe vaginal bleeding	53(9.6)	59(10.7)	112(20.4)
Severe headache	12(2.2)	72(13.1)	84(15.5)
Blurred vision	18(3.4)	67(12.2)	85(15.5)
Convulsions	11(2)	52(9.5)	63(11.4)
Swollen hands/face	23(4.2)	36(6.5)	59(10.7)
High fever	29(5.3)	64(11.6)	93(16.8)
Loss of consciousness	28(5.1)	44(8)	72(13.1)
Difficulty breathing	14(2.5)	51(9.2)	65(11.8)
Foul smelling vaginal discharge	26(4.7)	71(12.9)	97(17.6)
Other***	8(1.5)	0	8(1.5)

[¥]Multiple responses were allowed

Other* weakness, reduced fetal movement, ** weakness, draft *** weakness, abdominal cramp

Knowledge of respondents about Birth preparedness

Majority of respondents (93%) spontaneously mentioned preparing flour for porridge as birth preparation. From the recommended elements which have to be done as birth preparedness, 24(4.4%) of the respondents spontaneously mentioned identify place of delivery, 86(15.6%) mentioned saving money, 32(5.8%) mentioned identifying skilled provider and 58(10.5%) mentioned identifying a mode of transportation. Considering both spontaneous and prompted answers, identifying place of delivery, saving money, identifying skilled provider and identifying a mode of transportation were mentioned by 85.6%, 90.4%, 45.5% and 81.8% of the respondents, respectively (Table 4).

Table 4:- Knowledge of respondents about preparation for birth, Hawassa city, Mar.-Apr. 2011.

Variables[¥]	**Unprompted(n=550) N (%)**	**Prompted(n=550) N (%)**	**Total(n=550) N (%)**
Identify place of delivery	24(4.4)	447(81.3)	471(85.6)
Saving money	86(15.6)	411(74.7)	497(90.4)
Preparing essential items for clean delivery & post partum period	98(17.8)	378(68.7)	476(86.5)
Identify skilled provider	32(5.8)	281(51.1)	250 (45.5)
Identify a mode of transportation	58(10.5)	395(71.8)	450(81.8)
Identify birth companion	43(7.8)	384(69.8)	427 (77.6)
Arranging blood donors	12(2.1)	231(42)	243(44.2)
Obtaining HIV testing	235(42.7)	216(39.3)	451(82)
Preparing flour for porridge	512(93)	0	512(93)

[¥]Multiple responses were allowed

Practices of respondents regarding Birth preparedness

Majority of the respondents (88.5%) reported that they made some arrangement for the birth of their baby. Of these 124(22.5%) spontaneously reported that they identified place of delivery, 136(24.7%) saved money, 42(7.6%) identified skilled provider and 30(5.4%) identified a mode of transportation. Considering both spontaneous and prompted answers, identifying place of delivery, saving money, identify skilled provider and identifying a mode of transportation were reported by 359(65.3%), 421(76.5%), 113(20.5%) and 254(46.2%) of the total respondents, respectively (Table 5). Two hundred twenty two (40.4%) of the total respondents reported that they identified place of delivery, saved money and identified a mode of transport ahead of childbirth. Regarding PMTCT 383(69.6 %) respondent were tested for HV.

Table 5: Practices of respondents on preparation for birth, Hawassa city, Mar. –Apr. 2011.

Variables[¥]	**Unprompted(n=550) N (%)**	**Prompted(n=550) N (%)**	**Total(n=550) N (%)**
Identify place of delivery	124(22.5)	235(42.7)	359(65.3)
Save money	136 (24.7)	285(51.8)	421(76.5)
Prepare essential items for clean delivery & post partum	96 (17.4)	310(5.6)	406(73.8)
Identify skilled provider	42 (7.6)	71(12.9)	113(20.5)
Identify a mode of transportation	30(5.4)	224(40.7)	254(46.2)
Identify blood donors	12(2.2)	60(10.9)	72(13.1)
VCT	182(33.1)	201(36.5)	383(69.6)
Preparing flour for porridge	68(12.1)	0	68 (12.1)

[¥]Multiple responses were allowed

Factors associated with Birth preparedness.

Maternal education and income were among the socio-demographic factors which were significantly associated with birth preparedness. Literate mothers were more likely to be birth prepared than illiterate and women who have a good income were more likely to be prepared than who have not (COR=2.78,95% CI=1.44,5.39 and COR=5.47, 95% CI= 3.41,8.78 respectively).

History of still birth and having ANC follow up were among the obstetric factors significantly associated with BP. Women who had history of still birth were more likely to be prepared for birth than those who did not have still birth and women who had ANC follow up were more likely to be prepared for birth and complication than their counterparts (COR= 3.825, 95% CI= 1.85, 7.91and COR=6.303, 95% CI=2.20, 18.02 respectively). Moreover, knowledge on key danger sign of, pregnancy, labour and postpartum and having knowledge concerning BP were also significantly associated with BP. women who have knowledge on BP were more likely to be prepared than women who have not (COR=10.79, 95% CI=6.02, 19.35 respectively).

Table 6:- Association of selected socio-demographic and obstetric factors of respondents with Birth preparedness, Hawassa city, Mar. - Apr. 2011.

Variables	Birth prepared(n=550) Yes N (%)	No N (%)	Crude OR(95%CI)	Adjusted OR(95%CI)
Maternal Age				
35-44	15(6.8)	17(5.2)	**1.51(1.06,2.16)***	1.41(.93,2.15)
25-34	125(56.3)	156(47.6)	1.67(0.79,3.21)	1.49(.61,3.67)
15-24	82(36.9	115(47.3)	1	1
Maternal education	210(94.6)	300(91.5)	**2.78(1.44,5.39)****	**2.41(1.97,4.37)***
Literate	12(5.4)	28(8.5)	1	1
Illiterate				
Respondents' monthly income				
>=1,501	97(43.7)	56(17.1)	**5.47(3.41,8.78)*****	**3.28(1.91,5.64)*****
500-1,500	81(36.5)	133(40.5)	**1.92(1.24, 2.99)****	**1.73(1.06,2.82)***
<500	44(19.8)	139(42.4	1	1
Had ANC				
Yes	218(98.2)	34(10.4)	**6.3(2.2,18.02)****	**4.13(1.33,12.82)***
No	2(1.8)	294(89.6)	1	1
History of still birth	26(11.7)	13(4)	**3.82(1.85,7.91)*****	**3.37(1.47,7.75)****
Yes	196(88.3)	315(96)	1	1
no				
Know key danger signs for Pregnancy	40(18.1)	27(8.2)	**2.45(1.45,4.13)****	1.43(.69, 2.98)
Yes	182(82)	301(91.8)	1	1
No				
Know key danger signs for labour	69(31.1)	39(17.6)	**3.34(2.11,5.18)*****	1.75(.98,3.11)
Yes	153(68.9)	289(88.1)	1	1
no				
Know key danger signs for pp	53(23.9)	28(8.5)	**3.(1.86,4.86)*****	0.744(.37,1.5)
Yes	169(76.1)	300(91.5)	1	1
no				
Knowledge About BP	208(93.7)	190(57.9)	**10.79(6.02,19,35)*****	**8.25(4.47,15.22)*****
Yes	14(6.3)	138(42.1)	1	1
no				

*P-value<0.05 **P-value< 0.01 ***P-value<0.0001

Factors associated with skilled provider at birth.

Maternal education, age, and maternal monthly income were the socio-demographic variables which were significantly associated with giving birth by a skilled provider. Literate mothers were more likely to give birth by a SP than illiterate (COR= 3.45, 95% CI= 1.92, 6.2). And women who had monthly income of 1,501 birr or above were more likely to give birth by a SP than those who earn less than 500 birr (COR= 8.71, 95% CI= 3.61,21).

Parity and having ANC follow up were strongly associated with Skilled Provider at birth. Women with first births were more likely to give birth by a SP than grand multi paras and women who had ANC follow up were more likely to gave birth by a SP than those who did not have ANC follow up(COR= 3.23, 95% CI= 1.44,7.23 and COR= 3.81, 95% CI= 1.92,7.57), respectively. Strong association was also found between preparation for birth and SP at birth. Women who were prepared for birth were more likely to give birth by a SP than those who were not prepared (COR= 7.77, 95% CI=3.94, 15.34) (Table 7).

Table 7:- Association of selected socio-demographic and obstetric factors of respondents with assistance of skilled provider at birth, Hawassa city, Mar. - Apr. 2011.

Variables	Skilled provider at birth (n=550)		Crude OR(95%CI)	Adjusted OR(95%CI)
	Yes N (%)	No N (%)		
Maternal Age				
35-44	205(45.4)	32(32.7)	**0.61(0.38,0.98)***	0.16(.35,1.08)
25-34	224(49.6)	57(58.2)	**0.4(0.17,0.94)***	0.439(1.45,1.33)
15-24	23(5.1)	9(9.2)	1	1
Maternal education	429(94.1)	81(90)	**3.45(1.92,6.2)*****	**2.24(1.16,4.33)***
Literate	23(5.1)	17(18.9)	1	1
Illiterate				
Maternal monthly income	147(32.5)	6(6.1)	**8.71(3.61,21)*****	**4.89(1.89,12.63)****
>=1,501	170(37.6)	44(49.9)	1.37(0.86,2.19)	1.34 (0.78,2.29)
500-1,500	135(29.9)	48(49)	1	1
<500				
Parity				
1	226(50)	35.7(13.9)	**3.23(1.44,7.23)****	**5.03(1.59,15.92)****
2-4	204(45.1)	52(53.1)	**1.96(0.89,4.3)***	2.85(0.99,8.2)
>=5	22(4.9)	11(11.2)	1	1
Had ANC				
Yes	430(95.1)	82(83.7)	**3.81(1.92,7.57)*****	**2.66(1.25,5.63)***
No	22(4.9)	16(16.3)	1	1
Know key danger signs for Pregnancy	63(13.9)	4(9.1)	**3.81(1.35,10.72)***	1.81(.57,5.79)
Yes	389(86.1)	94(95.9)	1	1
No				
Know key danger signs for labour	101(22.3)	7(7.1)	**3.74(1.68,8.32)****	1.02(.4.2,.62)
Yes	351(77.7)	91(92.9)	1	1
No				
Know key danger signs for pp	81(17.9)	3(3.1)	**6.91(2.14,22.37)****	2.99(.79,11.33)
Yes	371(82.1)	95(96.9)	1	1
No				
Birth prepared	211(46.7)	10(10.2)	**7.77(3.94,15.34)*****	**5.47(2.66,11.24)*****
Yes	241(53.3)	88(89.8)	1	1
No				

*P-value<0.05 **P-value< 0.01 ***P-value<0.0001

CHAPTER SIX

DISCUSSION

This community based study has attempted to assess the knowledge and practices of birth preparedness and factors associated with such practices in Hawassa city. Majority (93.1%) of the respondents have attended ANC at least once. This proportion is higher when compared to that of the Ethiopian DHS 2005 report of 28% national ANC coverage (3) and the recent official report from the Ministry of Health 74% ANC coverage in the SNNPR (8). Since this study was conducted in one of the major urban areas of the country, it does not include the rural areas where most of the non-attendants could be found. This could be the possible explanation for the difference.

In the present study, most of the respondents (60.7%) made the recommended number of 4 ANC visits. Earlier research has shown that women who receive 4 ANC visits with effective interventions are as likely to have good outcomes as women who receive more visits (37).

It is believed that if pregnant women and their family recognize danger signs of obstetric complications they may seek care and it can reduce first delay to seek health service (4). However, only 25.3% of the ANC attendants participated in this study were found informed

about danger signs of pregnancy, an issue which needs to receive great attention by the healthcare providers.

Money and transportation are important factors to facilitate the way for institutional delivery so as to have skilled provider at birth. Cost and availability of funds can help reduce delaying getting to hospital. Every pregnant woman should have a written plan for emergencies (38). But here 14.4%, 22.4 % and 9.6% of respondent were not informed for place of delivery, arrangements for transportation and arrangements for finances for childbirth, respectively, therefore this situation need attention.

Eighty two percent of the deliveries were attended by health professional which is higher when compared to that of Ethiopian DHS 2005 national coverage (3) and recent official report from the Ministry of Health regarding the SNNPR coverage (8). This could be because the DHS report for the region includes the rural areas where deliveries attended by health professional are very low; in contrast the present study was conducted from one of city in the country.

About 71.6% of the respondents gave birth at a place where they planned ahead but 28.4% of them did not. This shows that in some cases intention does not explain the actual practices for place of delivery, a scenario which imply the need for further study to shed light on why some mothers are not able to give birth at their planned places of delivery.

Around 80% of all maternal deaths are due to complication of hemorrhage , infection, unsafe abortion, hypertensive disorders of pregnancy, and obstructed labor and these complications suddenly arise without warning and may lead to death within a day of delivery,

therefore all mothers with obstetric complication should receive adequate and appropriate treatment without delay(2, 34). The findings of this study showed that 71.6% of those who developed obstetric complications during pregnancy, 88% during delivery and 82% during postpartum sought assistance. Though these are commendable proportions of achievement, there is still a need to work more for better improvement of the situation.

An important aspect of assessing BP/CR is measuring spontaneous knowledge of essential danger signs. Knowledge of the danger signs of obstetric complications is the essential first step in the appropriate and timely referral of EOC (1). When the spontaneous knowledge of danger signs for pregnancy are considered, only 4.3% mentioned vaginal bleeding which was 9.6% in that of Tanzania study, 20.8% in that of Abhoynghar, Bangladesh study(25) and 64.2% in that of Kenya study (28). Swollen hands/face was mentioned by 5.2% which was 6.9% in that of Tanzania study, and 42.5% in that of Abhoynghar. Blurred vision was mentioned by 0.9% but anemia was mentioned by 8.7% in that of Tanzania, and 24.5% in that of Abhoynghar.

Similarly the proportion of respondents who spontaneously mentioned danger signs during labor/childbirth was only 6.2% for severe vaginal bleeding, 9.6% mentioned prolonged labor and 11.8% mentioned retained placenta which was 26.6%, 70.5% and 40%, respectively, in that of Abhoynghar study (25). Only 13(2.4%) of the respondents mentioned convulsions which shows a very low awareness of this sign in particular.

In addition, the respondents' spontaneous responses for complications during the post partum period was 9.8% for severe vaginal bleeding which was and 47.3% in that of Abhoynghar, and 27.3% in that of Tanzania study, 5.3% mentioned high fever which was and 22.2% in that of

Abhoynghar, and 4.7% mentioned foul smelling vaginal discharge which was lower than comparable with that of Abhoynghar (2.1%). When compared to the other studies, the spontaneous knowledge of respondents about key danger signs is very low. This difference might be due to difference in socioeconomic status and health intervention activities in the areas.

More than 85% mentioned identifying place of delivery, 90.4% saving money, 81.8 % identifying skilled provider and 77.6% identifying a mode of transportation which are high compared to result of knowledge of obstetric danger signs in this study. This may be attributed to the reason that respondents may consider anything done before childbirth including traditional activities like preparation of flour and butter for porridge as BP. One of the limitations of this study is that women were not asked of the source of information of the danger signs as well birth preparedness. Therefore it is difficult to decide whether their knowledge come from the antenatal care, personal experiences or general awareness in the community.

About 65.3% of the respondents reported that they identified place of delivery ahead of childbirth. Identifying place of delivery is very important especially in our setup, where it is unlikely to get a skilled provider to attend home delivery; the main means to get a skilled provider for attending birth could be if she planned to deliver at health institutions.

The lack of money and transportation is a barrier to seeking care as well as identifying and reaching medical facilities (5). Money saved by the women or her family can pay for health services and supplies, transport, or other costs such as loss of work. If a woman can afford to pay for these costs, she is more likely to seek care (1). In the present study, 76.5% of the respondents saved money for childbirth which is comparable with study done in India (21) which reported

76.9% and Adigrat study (31) which reported 68.9%, and is higher when compared to a baseline study done in Nepal (35%) but lower than its follow up study in which 81.4% of currently pregnant women said they had planned financially (23).

Even when money is available, it can be difficult to secure transport at the last minute after a complication has arisen. Arranging transport ahead of time reduces the delay in seeking and reaching services (1). In this study, 46.2% of the respondents reported that they have identified transportation for childbirth which is higher when compared to the finding of Nepal's study (23) which reported 1.5% in the baseline and 13.9% in the follow up, Indian study (21) which reported 29.5%, and Adigrat study (31) which reported 24.7% .

Two hundred twenty two (40.4%) of the respondents were birth prepared which is comparable to the finding of Indian study (21) reported as 47.8% but higher than the finding of Adigrat study (31) reported as 22.1% . But it is low as every pregnant woman should get prepared for childbirth/complication.

HIV test during pregnancy is important to determine the need for prevention of mother to child transmission (PMTCT) interventions, and arranging medical and social support for the woman in case the HIV test is positive. In this study 69.6% of the respondents were tested for HIV which is higher than the finding of Adigrat study (31). This could be a reflection of the emphasis put on prevention of mother-to-child transmission (PMCT) in the health institution and the country as a whole in the recent years.

Literate mothers were more likely to be prepared for birth than illiterate (AOR= 2.24, 95% CI= 1.16, 4.33). This might be related to the fact that educated women have better power to make their own decision in matters related to their health.

This study found that mothers who have a good income were more likely to be prepared for birth than mothers who have poor income (AOR= 1.89, 95% CI= 1.16, 3.07). This might be because, when women are a good income, they might have the power to make their own decision in matters related to their own health and the expected expenses. This study also found women with history of still birth were more likely to be prepared for birth than those who did not have history of still birth (AOR= 3.37, 95% CI= 1.47, 7.75). This could be due to the reason that these women may perceive the seriousness of obstetric problems from their past experiences and tried to anticipate for the possible complications.

Similarly, mothers who had ANC follow up were more likely to be prepared for birth than their counterparts (AOR= 4.13, 95% CI= 1.33, 12.82). This finding implies the need to give more attention to increase ANC coverage because one of the most important functions of antenatal care is offering the woman advice and information about birth preparedness, danger signs of obstetric complication and emergency preparedness. Mothers who had a knowledge concerning BP were more likely to be prepared for birth than their counterparts (AOR= 8.25, 95% CI= 4.47, 15.22). This finding implies an emphasis to be given to the provision of appropriate information about birth preparedness during ANC follow up in promoting BP.

Ethiopian DHS 2005 revealed births to young mothers, and first births are more likely to be assisted by trained health professionals and educational and economic status of women has a positive relationship with delivery care. In line with this, the findings of this study, literate mothers were more likely to give birth by a SP than illiterate (AOR= 2.47, 95% CI= 1.25, 4.82) and women who earn >=1,501 were more likely to give birth by a SP than those who earn <500(AOR= 3.65, 95% CI=1.43, 9.28). Similarly, first births were more likely to be assisted by SP than subsequent births (AOR= 1.77, 95% CI= 1.01, 3.09). Which could be because, since they did not have the experience they may have fear of bad outcomes therefore they may prefer to give birth by a SP in addition to this there might be a possibility of these young primi gravidas to be more educated than the multigravidas who might not had a chance to get educated.

ANC follow up is found to be one of the determinants of skilled provider at birth. Those who attend ANC were more likely to give birth by a skilled provider as compared to non-attendants (AOR= 2.66, 95% CI= 1.25,5.63).This finding is consistent with other local studies (32) which shows the importance of ANC follow up in influencing women's preference.

Birth preparedness is found to be a determinant of skilled provider at birth. Women who were prepared for birth were more likely to give birth by a SP than those who were not prepared (AOR= 5.47, 95% CI= 2.66, 11.24). This could be because as the women become prepared for birth they may demand to deliver by SP. Since the main way to ensure SP at birth in our set up is having institutional delivery, these mothers may have planned for institutional delivery, arrange a way of transportation to reach at the health institutions and saved money for the opportunistic

costs. This may facilitate early decision and arrival to health facilities so as able to give birth with a skilled provider.

STRENGTHS AND LIMITATIONS OF THE STUDY

STRENGTHS

The study tried to address an issue about which relevant studies are limitedly done in our country. Selection bias was minimized since it was community-based house-to-house survey with probability sampling method. Recall bias is also minimized since it focused on births in the last 12 months preceding the study. Utilization of appropriate data collection procedures and statistical methods played a role in minimizing bias & confounding factors.

LIMITATIONS

Since the study is a cross sectional study establishing cause and effect relationship is difficult. Data collectors were community health workers and there may be some socially desirable responses for some of the variables even though a great effort was made to minimize it during the training and data collection period.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

- The present study identified poor comprehensive knowledge and practices of BP in the study area in general, and very poor knowledge on danger signs of obstetric complications in particular.
- Maternal literacy, having a good income, ANC attendance, history of still birth and knowledge on birth preparedness component were found to be strong determinants of birth preparedness.
- Maternal literacy and monthly income, first birth, ANC attendance, and birth preparedness were found to be strong predictors of giving birth by a skilled provider.
- ANC and delivery service utilization is very high as compared to most places in the country.

RECOMMENDATIONS

Strengthening of health services in promoting ANC attendance and antenatal care should place emphasis on birth preparedness and complication readiness to improve access to skilled and emergency obstetric care which have been shown to be critical in reducing maternal and/or perinatal mortality and morbidity.

Improve the information given during ANC follow up, with special emphasis given to birth preparedness in general and information on danger sign of pregnancy, delivery and post partum period and the need for immediate action when complications arise in particular. In addition to the antenatal care counseling, other sources of information including community-based radio messages and educational sessions about birth preparedness and obstetric danger signs.

Empowering women by expanding educational opportunities and increase women's autonomy within the family to enhance their ability to earn and control household savings. Promote further studies at individual, family and community level both on similar and different settings.

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ANNEX A

GUIDE FOR THE INTERVIEWER

This guide provides directions to the interviewer on how to conduct an interview and how to fill out the questionnaires, and clarifies some possible points of confusion.

Survey Objectives

- To assess knowledge about birth preparedness and complication readiness among women who gave birth in the last 12 months.
- To assess practice related to birth preparedness and complication readiness among women who gave birth in the last 12 months.
- To determine factors associated with the practice of birth preparedness and complication readiness among women who gave birth in the last 12 months.

Interviewer's Role

The interviewer occupies the central position in the survey because she collects information from respondents. Therefore, the success of the survey depends on the quality of **each** interviewer's work. In general, the responsibilities of a survey interviewer include the following:

- Locating the structures and households in the sample that are assigned to her, and completing the Prototype Household Safe Motherhood Questionnaire
- Identifying all eligible women in those households
- Interviewing all eligible women in the households assigned to her using the questionnaire
- Checking completed interviews to make sure that all questions were asked and the responses neatly and legibly recorded
- Returning to households to interview those women she could not contact during initial visits. These tasks will be described in further detail during training.

Training of Interviewers

Training will consist of a combination of classroom training and practical experience. Before each training session, you should study this manual carefully along with the questionnaires, writing down any questions you have. Ask questions at any time to avoid mistakes during actual interviews. You will see and hear demonstration interviews conducted in front of the class as examples of the interviewing process. You will practice reading the questionnaire aloud to another person several times so that you may become comfortable with reading the questions aloud. Another means of training is role-playing, in which you practice by interviewing another trainee.Your training as an interviewer does not end when the formal training period is completed. Each time a supervisor meets with you to discuss your work in the field, your training continues. Continued observation and supervision during the fieldwork completes the training process. This is particularly important during the first few days of working in the field.

Supervision of Interviewers

Observation and supervision throughout the fieldwork are part of the training and data collection process. Supervisor will:

- Observe some of your interviews to ensure that you are conducting yourself well, asking the questions in the right manner, and interpreting the answers correctly.
- Spot check some of the addresses selected for interviewing to be sure that you interviewed the correct households and the correct women.
- Review each questionnaire to be sure it is complete and consistent.
- Uncover and take action on apparent omission of stillbirths and births the respondent has had or improper recording of dates of birth and stillbirths.

- Meet with each member of the team on a daily basis to discuss performance and give out future work assignments.
- Help you solve any problems that you might have with finding the assigned households, understanding the concepts in the questionnaires, or dealing with difficult respondents.
- The survey director may release from service any interviewer who is not performing at the level necessary to produce the high-quality data required to make the survey a success.

Survey Regulations

The following survey regulations have been established and will be strictly enforced:

1. Every position on the survey staff is vital to the success of the survey. If you are chosen to be on a team and accept the position, your presence is required for each day of fieldwork.
2. Except for illnesses, any person who is absent from duty during any part of the training or any part of the fieldwork period (whether it is a whole day or part of a day) without prior approval from his/her supervisor may be dismissed from the survey team.
3. There is a great deal of work to be done over the next few weeks, so arriving late to the training sessions will not be tolerated.
4. The selection of the survey team members is competitive; it is based on performance, ability, and testing results during the training.
5. Throughout the survey training and the fieldwork period, your conduct must be professional and your behavior must be congenial in dealing with the public.
6. For the survey to succeed, each team must work closely together, sharing in the difficulties and cooperating and supporting each other.

7. It is critical that the data gathered during fieldwork be both accurate and valid. To control for inaccurate or invalid data, spot checks will be conducted.
8. Survey data are confidential. They should not be discussed with anyone, including your fellow interviewers.

CONDUCTING AN INTERVIEW

In this section you will find a number of general guidelines on how to build rapport with a respondent and conduct a successful interview.

Building Rapport with the Respondent

1. Make a good first impression. Open the interview with a smile and greeting such as "good afternoon" and then proceed with your introduction.
2. Stress confidentiality of responses when necessary. Explain the information you collect will remain confidential, no individual names will be used for any purpose, and all information will be grouped together to write a report.
3. Answer any questions from the respondent frankly.
4. Interview the respondent alone.

Tips for Conducting the Interview

1. Be neutral throughout the interview.
2. Never suggest answers to the respondent.
3. Do not change the wording or sequence of questions.
4. Handle hesitant respondents tactfully.
5. Do not form expectations.
6. Do not hurry the interview.

FIELD PROCEDURES

Preparatory Activities

When you receive your work assignment, review it and ask any questions you might have; remember that your supervisor will not always be available to answer questions when the work begins. You should be sure that:

1. You have a Questionnaire for each household you are assigned;
2. You fill in the identification information on the cover page of each Household Questionnaire;
3. You know the location of the selected households you are to interview, and have sufficient materials (maps, written directions, etc.) to locate them;
4. You understand any special instructions from your supervisor about contacting the households you are assigned;
5. You have several blank Questionnaires.

Allocate a Questionnaire for each eligible woman identified in the household. Fill in the identification information on the cover sheet of a Questionnaire for each eligible woman identified in the Household Census. If after completing the interviews, you find that there are two women eligible for the individual interview, you will return to your supervisor with questionnaires.

Contacting Households

1. Locating sample households.

Prior to interviewing in the cluster or enumeration area, the team will:

- Prepare up-to-date maps to indicate the location of structures,
- Record address information for each structure or describe their location (for areas lacking street names or numbers on structures),

- Write numbers on structures, and
- Make a list of the names of the heads of all the households living in the structures.

2. Problems in contacting a household.

In some cases, you will have problems locating the households that were selected because the people may have moved or the listing teams may have made an error. Here are examples of some problems you may find and how to solve them:

- **The selected household has moved away and the dwelling is vacant**. If a household has moved out of the dwelling where it was listed and no one is living in the dwelling, you should consider the household absent and record Code '2' (HOUSEHOLD ABSENT) for RESULT on the cover sheet of the Household Questionnaire.
- **The household has moved away and a new one is now living in the same dwelling**. In this case, interview the new household.
- **The structure number and the name of the head of household do not match with what you find in the field**. Say, for example, that you have been assigned a household headed by Sola Ogedengbe that is listed as living in structure number SM-003. But when you go to SM-003, you find that Mary Kehinde heads the household living there. Consider whichever household isliving in SM-003 as the selected household. In this case, you would interview the household headed by Mary Kehinde.
- **The household selected does not live in the structure that was listed**. If there is a discrepancy between the structure number and the name of the head of household, interview whoever is living in the structure assigned to you. Inform your supervisor about any such situations you find.

- **The listing shows only one household in the dwelling, but two households are living there now**. In this case, interview both households, and make a note on the cover page of the household that was not on the listing. Your supervisor will assign this household a number, which you should enter on the Household Questionnaire. However, if the listing shows two households, only one of which was selected, and you find three households there now, only interview the one that had been selected and ignore the other two. In either case, inform your supervisor of the situation.
- **The head of the household has changed**. In some cases, the person listed as the head of household may have moved away or died since the listing. If this is the case, interview the household that is living there.
- **The house is all closed up and the neighbors say the people are on the farm (or away visiting, etc.) and will be back in several days**. Enter Code '2' (HOUSEHOLD ABSENT) for RESULT. The house should be revisited at least two more times to make sure that the household members have not returned.
- **The house is all closed up and the neighbors say that no one lives there; the household has moved away permanently**. Enter Code '2' (HOUSEHOLD ABSENT) for RESULT.
- **A household is supposed to live in a structure that, when visited, is found to be a shop and no one lives there**. Check very carefully to see whether anyone is living there. If not, enter Code '2' (HOUSEHOLD ABSENT) for RESULT.
- **A selected structure is not found in the cluster, and residents tell you it was destroyed in a recent fire**. Enter Code '4' (DWELLING NOT FOUND) for RESULT.

- **No one is home and neighbors tell you the family has gone to the market**. Enter Code '5' (NO COMPETENT RESPONDENT AT HOME) for RESULT, and return to the household at a time when the family will be back (later in the day or the next day).Remember that the usefulness of the survey sample in representing the entire district depends on the interviewers locating and visiting all the households they are assigned.

Problems in Obtaining Women's Interviews

The following are examples of the kinds of problems the interviewer may experience in obtaining an interview with an eligible woman:

- **Eligible respondent not available**

If the eligible respondent is not at home when you visit, enter Code '5' (NO COMPETENT RESPONDENT AT HOME) for RESULT of the visit on the cover sheet of the Questionnaire and ask a neighbor or family member when the respondent will return. You should contact the household at least three times, trying to make each visit at a different time of day.

- **Respondent refuses to be interviewed**

The respondent's availability and willingness to be interviewed will depend in large part on the initial impression you make when you meet her. Introduce yourself and explain the purpose of the visit. Read the introduction printed on the Verbal Consent Form. If the respondent is unwilling to be interviewed, it may be that the present time is inconvenient. Ask whether another time would be more convenient and make an appointment. If the respondent still refuses to be interviewed, enter Code '7' (REFUSED) for RESULT of the visit on the cover sheet and report it to your supervisor.

- **Interview not completed**

A respondent may be called away during the interview or may not want to answer all the questions at the time you visit. If an interview is incomplete for any reason, you should try to arrange an appointment to see the respondent again as soon as possible to obtain the missing information.

Make sure that you record on the cover sheet of the questionnaire that the interview is incomplete by entering Code '6' (INCOMPLETE INTERVIEW) for RESULT and indicate the time you agreed on for a revisit. You should also report the problem to your supervisor.

Making Callbacks

Because each household has been carefully selected, you must make every effort to conduct interviews with the households assigned to you and with the eligible women identified. Sometimes a household member will not be available at the time you first visit. You need to make at least three different visits when trying to obtain a household interview. At the beginning of each day, you should examine the cover sheets of your questionnaires to see whether you made any appointments for revisiting a household or eligible respondent. If no appointments were made, make your callbacks to a household or respondent at a different time of day than the earlier visits. Scheduling callbacks at different times is important in reducing the rate of non-response (i.e., the number of cases in which you fail to contact a complete a women's interview).

Returning Work Assignments

At the end of fieldwork each day, check that you have filled out the cover sheet of a Questionnaire for each household assigned to you, whether or not you managed to complete an interview.

ANNEX B: ENGLISH QUESTIONNAIRE

Addis Ababa University Medical Faculty School of Nursing

Hello, my name is _____ I am working in a research team of Addis Ababa University, department of Nursing and Midwifery. This study aim to assess knowledge and practices with respect to birth preparedness and complication readiness and factors associated with their practices among women who gave birth in the last 12 months preceding this study. In our study we interview women who are lived in Hawassa and who gave birth in the last 12 months preceding the study. The information you provide will be combined with other information which will be gathered and will be used to improve the care you are receiving from the health institutions. The results of the study will be discussed with the concerned authorities and seek for betterment.

I have questions to ask you about your last pregnancy and child birth and your genuine response is extremely important to have a good understanding of the existing level of services concerning birth and emergency preparedness.

Your name will not be asked and unique identification is not required. You do not have to discuss issues that you do not want to in any questions. If you want to withdraw from the study any time along the discussion process, you will not be obliged to continue or give reasons for doing so.

Refusing to participate or withdrawing from the study along the process will not have any consequences on you and the services provided to you. However, we encourage you to answer all questions. The information you provide during the discussion will help greatly to understand the status of the Birth preparedness and complication readiness intervention service provision in the facilities.

The questions may take not more than 20 minutes and I would like to appreciate your help in responding to my questions. If you have any questions or anything that is not clear please fill free to ask. Thank you very much!!

For any question or more clarification or any problems you can contact principal investigator.

Principal Investigator: MESERET TSEGAYE NEGASH

Address: Addis Ababa University School of Nursing PHONE NO. 0911 – 90-40-85

Consent Form

Addis Ababa University Medical Faculty School of Nursing

Good morning/afternoon. My name is _____. (Interviewer)

I temporarily represent Addis Ababa University, Medical faculty, school of nursing and midwifery. This is a study to be conducted with the objective of assessing knowledge and practices with respect to birth preparedness and complication readiness and factors associated with their practices among women who recently gave birth. As the study is directly related to women who gave birth recently, you are one of the women who have been selected randomly to participate in this study. Therefore, you are kindly requested to participate in this study and provide the information required from you. I would like to ask you a few questions if I may, but you can refuse to answer any question I ask. You may end the interview at any time. You can also refuse to participate in the study entirely. Your refusal will not restrict you from obtaining the required medical care when you need. The interview will last approximately 20 minutes.

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 in the planning and implementation of intervention activities to prevent delays and improve maternal and neonatal survival.

Are you voluntary to respond to the questions? Yes_____; proceed with the interview.

No _____; thank her and End.

Name of interviewer who sought the consent _____

Date_____ Signature _____

Name of supervisor_____

Date _____ Signature _____

Household ID No _____

Interviewer visits

Number of Visits			
Result	1	2	3

Result codes:

1 = Completed

2 = Women absent (specify the reason)

4 = Incomplete interview

5 = Refused

3 = Time and date set for later 6 = other (specify) _____

Identification Information

001. Code No. _____

002. Kebele _____ House no_____

Section 1: Socio-demographic information

Q.#	Question	Codes	Go to Q.
101	Age in completed years	_____	
102	Marital status	Single……1 Married……2 Widowed……3 Divorced……4	
103	Religion	Orthodox ……1 Protestant ……2 Catholic……3 Muslim……4 97.Others (specify)_____	
104	Ethnicity	Sidama…… 1 Welayta……2 Gurage……3 97.Other……(specify)	
105	Educational status of the wife	Illiterate Read and write Primary education(1-8) Secondary (9-12) College and above	
106	Occupation of the wife	Housewife Farmer Merchant/Trade Employee Other (specify) _____	
107	Monthly income of the households in Ethiopian birr.	_____	

Section 2: Gravidity and parity

Q.#	Question	Codes	Go to Q.
201	Have you given birth in last 22 months?	Yes_____ 01 No_____ 02	
202	How many times in total you become pregnant?	_____	
203	How many times in total you gave birth?	_____	
104	How many of your pregnancies resulted in a baby that was born alive?	_____	
105	How many of your pregnancies resulted in a baby that was born dead?	_____	
106	Did the birth in the last 12 months result in a baby that was born alive or dead?	Live birth_____1 Month _____ year_____ Still birth_____2 Month _____Year_____	

Section3: Knowledge

Q. #	Question	Codes	Go to Q./Sec.
301	Do you know any/some serious health problem/s that occurs during pregnancy that could endanger the life of pregnant women?	Yes……01 No …… 02	→ 303
302	Can you mention them? (Probe: which of the following do you think a health problem/s?	01. Vaginal bleeding….1. Yes 2. no 02. Severe headache…..1. Yes 2. no 03. Blurred vision…….1. Yes 2. no 04. Convulsion ……..1.Yes 2. no 05. Swollen hand /face.1. Yes 2.no 06. High fever……1. Yes 2.no 07. Loss of consciousness..1. Yes 2.no 08. Difficulty of breathing..1. Yes 2.no 97.Other_____(specify)	Put tick mark (√) for spontaneous answers.
303	Do you know any/some serious health problem/s that occur <u>during labour and child birth</u> that could endanger the life of pregnant women?	Yes…… 01 No …… 02	→305

304	Can you mention them? (Probe: which of the following do you think a health problem/s?	01. Vaginal bleeding……1. Yes 2. no 02. Severe headache……..1. Yes 2. no 03. Convulsion ……1. Yes 2. no 04. High fever……..1. Yes 2. No 05. Loss of consciousness..1. Yes 2. No 06. Labor lasting >12 hours..1. Yes 2. No 07. placenta not delivered 30 min after baby ……,.1. Yes 2. No 97. Other_____ (specify)	Put tick mark (√) for spontaneous answers.
305	Do you know any/some serious health problem/s that occur during the first 42 days after birth that could endanger the life of pregnant women?	Yes……..01 No ……..02	→ 307
306	Can you mention them? (Probe: which of the following do you think a health problem/s?	01. Vaginal bleeding……1. Yes 2. no 02. Severe headache……..1. Yes 2. no 03. Blurred vision……1. Yes 2. no 04. Convulsion ……1. Yes 2. no 05. Swollen hand /face…..1. Yes 2.no 06. High fever……1. Yes 2.no 07. Loss of consciousness..1. Yes 2.no 08. Difficulty of breathing..1. Yes 2.no 09. malodorous vaginal discharge……1. Yes 2.no 97. Other_____(specify)	Put tick mark (√) for spontaneous answers.
307	Do you think ahead Preparation for birth is necessary?	Yes……..01 No ……..02	
308	Can you mention them? (Probe: which of the following do you think a preparation for birth?)	01. Identify place of delivery…1.Yes 2.no 02. Save money……1. Yes 2.no 03. prepare essential item for clean delivery…… 1.Yes 2.no 04. Identify skilled provider…1.Yes 2.no 05. Identify birth companion…1.Yes 2.no 06. Getting blood donor……..1.Yes 2.no 07. Arranging transport……1. Yes 2.no 08. Obtaining HIV test……1. Yes 2.no 97.Other_____(specify)	Put tick mark (√) for spontaneous answers.

Section 4: Personal experience related to last pregnancy

Q.#	question	Codes	Go to Q./Sec.
401	Did you have antenatal care during your last pregnancy?	Yes……..01 No……..02	
402	How many times in total did you receive antenatal care during last pregnancy?	No. of times ……..1	
403	During this pregnancy did you experience any serious health problems related to the pregnancy?	Yes……..01 No……..02	→ Sec.5
404	What problem did you experience? (Probe: ask for the problems which are not mentioned spontaneously). Recorded all problem mentioned.	01. Vaginal bleeding……1. Yes 2. no 02. Severe headache……1. Yes 2. no 03. Blurred vision……1. Yes 2. no 04. Convulsion ……1. Yes 2. no 05. Swollen hand /face……1. Yes 2.no 06. High fever……1. Yes 2.no 07. Loss of consciousness……1. Yes 2.no 08. Difficulty of breathing……1. Yes 2.no 97.Other_____(specify)	
405	Did you seek assistance for this problem?	Yes……..01 No……..02	
406	Why did you not seek assistance for this problem (probe: anything else)? Recorded all the reason mentioned.	Respondent didn`t think necessarily……1. Yes 2. No No transport……1. Yes 2. No Too expansive……1. Yes 2. No Use home remedy……1. Yes 2. No 97. Other_____ (specify)	

Section 5: Personal experience related to last birth

Q.#	Question	Codes	Go to Q.Sec.
501	Where did you give birth to your last child?	Respondent's home ……..01 TTBA home ……..02 health institution …….. 03 Other_____97(specify)	
502	Did you plan to give birth at this place?	Yes…….. ..01 No……..02 Don't known……98	
503	Prior to this birth, did you or your family make any arrangements for the birth of this child?	Yes……..01 No……..02	
504	What arrangement did you or your family makes for the birth of this child? (Probe: which of the following arrangement?) Record all arrangement motioned.	01. Identify place of delivery…..1. Yes 2.no 02. Save money……1. Yes 2.no 03. prepare essential item for clean delivery……1. Yes 2.no 04. Identify skilled provider ……1. Yes 2.no 05. Identify birth companion……1. Yes 2.no 06. Getting blood donor……1. Yes 2.no 07. Arranging transport……1. Yes 2.no 08. Obtaining HIV test……1. Yes 2.no 97.Other_____(specify)	Put tick mark (√) for spontaneous answers.
505	If gave birth other than home, what type of transportation did you use to get there?	Ambulance……..01 Private care……..02 Taxi……..03 97.Other_____(specify)	
506	If gave birth other than home, who accompanied you to the place where you give birth?	01. No one……1. Yes 2.no. 02. Husband…… 1. Yes 2.no 03. Respondent's mother……1. Yes 2.no 04. sister/brother……1. Yes 2.no 97. Other_____ (specify)	
507	Who assisted with birth? (Probe: anyone else? And record all mentioned.)	01.doctor 02.health officer 03.nurse/midwife 97.other_____(specify)	
508	During labor & birth did you Experience any serious health problems related to birth?	Yes……..01 No……..02	→Sec 6

509	What problem did you experience?(probe: ask for the problems which are not mentioned spontaneously) Record all the problems mentioned.	01. Vaginal bleeding……1. Yes 2. no 02. Severe headache……1. Yes 2. no 03. Convulsion ……1. Yes 2. no 04. High fever……1. Yes 2. No 05. Loss of consciousness……1. Yes 2. No 06. Labor lasting >12 hours……1. Yes 2. No 07. placenta not delivered 30 min after baby……1.Yes 2. No 97.Other_____(specify) 98.Don`t known	
510	Where were you when you develop this problem?	Respondent's home ……01 TTBA home ……02 health institution …… 03 Other_____97(specify)	
511	Did you seek assistance for this problem?	Yes……01 No……02 Don`t known……98	
512	Why did you not seek assistance for this problem(probe :anything else/) Recorded all the reason mentioned.	Respondent didn`t think necessarily……1. Yes 2. No No transport……1. Yes 2. No Too expansive……1. Yes 2. No Use home remedy…… 1. Yes 2. No 97.Other_____ (specify) 98. Don`t known	

Section 6: Personal experience related to last birth (postpartum)

Q.#	Questions	Codes	Go. to Q
601	During the first 42 days after the last birth ,did you experience any serious health problems related to birth?	Yes……01 No……02 Don`t known……98	
602	What problems did you experience (probe: ask for the problem s which has not mentioned spontaneously) Recorded all the problems mentioned.	01. Vaginal bleeding……1. Yes 2. No 02. Severe headache……1. Yes 2. no 03. Blurred vision……1. Yes 2. no 04. Convulsion ……1. Yes 2. no 05. Swollen hand /face…… ……1. Yes 2.no 06. High fever……1. Yes 2.no 07. Loss of consciousness……1. Yes 2.no 08. Difficulty of breathing……1. Yes 2.no 09. malodorous vaginal	

		discharge……1. Yes 2.no 97.Other_____ (specify)	
603	Where were you when you develop this problem?	Respondent's home ……01 TTBA home ……02 health institution ……03 97.Other……(specify)	
604	Did you seek assistance for this problem?	Yes……01 No……02	
605	Why did you not seek assistance for this problem(probe :anything else/) Recorded all the reason mentioned.	Respondent didn`t think necessarily……1. Yes 2. No No transport……1. Yes 2. No Too expansive……1. Yes 2. No Use home remedy……1. Yes 2. No 97.Other_____ (specify)	

ANNEX C: AMHARIC AVERSION QUESTIONNAIRE

በአዲስ አበባ ዩኒቨርሲቲ ህክምና ትምህርት ክፍል የነርስ ት/ቤት

የመረጃ ቅፅ

ሰላምታ

ስሜ----------ይባላል፡፡ እኔ በአዲስ አበባ ዩኒቨርሲቲ ህክምና ትምህርት ክፍል የነርስ ት/ቤት ከጥናት ቡድን ጋር አብሬ እየሰራሁ ነው፡፡

የዚህ ጥናት አላማበሀዋሳ ከተማየሚኙእናቶች በወሊድና ከወሊድ ጋር በተገናኘ ለሚፈጠሩ ተዛማች ችግሮች በሚደረጉ ቅድመ ዝግጅቶች ያላቸውን ዕውቀትና አተገባበር ማጥናት ነው፡፡

በዚህ ጥናት ወስጥ በሀዋሳ ከተማየሚኖሩና ከወለድአንድአመት ያልበለጣቸውን እናቶች ቃለ ማጠየቅ ይደረጋሉ፡፡ እርስዎ የሚሰጡት መረጃ ከሌሎች በቃለ ማጠይቁ ከሚሰተፉእናቶች ከሚኘውመረጃ ጋር በአንድነት የጠፍ አገልግሎት አሰጣጡን በማሻሻል ረገድ ትልቅ ጠቀሜታ ይኖረዋል፡፡ ከዚህ ጥናት የሚኘውመጠቅ ለሚመለከተውባለስልጣን እንዲታወቅ ይደረጋል፡፡

እኔምከርስዎ ጋር በእርግዝና እና በወሊድ ወቅት ስለነበሩ ሁኔታዎች ጥያቄዎችን እጠይቀዎታለሁ፡፡ የጠፍ አገልግሎች አሰጣጡን በማሻሻል ረገድ ሁኔታዎች የእርስዎ እወነ ተኛ ምላሾች በጥናቱ እጅግ በጣምአስፈላጊ ናቸውብለን እናምናለን፡፡ ስለሆነ ም እርሶዎምአስፈላጊወን መረጃ በማጠት የጥናቱ ተሳታፊ እንዲሆኑ በአክብሮት እንጠይቃለን፡፡የርስዎ ስምበማናቸውም ሁኔታ አይጠቀስም፡፡ በዚህም ጥናት የሚሰተፉት በሙሉ ፍቃደኝነት ይሆናል እንዲሁም በቃለ ማጠይቁ ያለማሰተፍም ሆነ በማንኛውም ሠዓት ቃለ ማጠይቁን የማቋረጥ መበትዎ የተጠበቀ ነው፡፡ ነገር ግን እርስዎ የሚሰጡት መረጃ ለወሊድና ከወሊድ ጋር ተያይዘውለሚጣጡ ችግሮች በሚደረገውየ ቅድመዝግጅት አገልግሎት አሰጣጥ በጠፍ ድርጅቶች ያለበትን ደረጃ ለማወቅ ከፍተኛ ጠቀሜታ አለው፡፡

ጥያቄዎቹን በሃያ ደቂቃ ወስጥ የሚጠናቀቁ ይሆናሉ፡፡ ጥያቄዎቼን ለመመለስ ፍቃደኛ በመሆንዎ ላመሰግንዎት እወዳለሁ፡፡

ማንኛውምግልፅ ያልሆኑ ነገሮች ካሉዎት ማጠየቅ ይችላሉ፡፡ ለተጨማሪ መረጃዎች የጥናቱ መሪ አጥኚ በሚከተለውስልክ ቁጥር ማሽ ጋገር ይችላሉ፡፡

ዋና አጥኚ፡ - ሰላረት ፀጋዬ ነጋሽ

አድራሻ፡ - አዲስ አበባ ዩንቨርሲቲ የነርስ ትምህርት ክፍል፡፡

0911-904085

አዲስ አበባ ዩንቨርሲቲ የህክምና ትምህርት የነርስ ትምህርት ቤት

ሰላምታ፡፡ ስሜ---------- ይባላል፡፡ (የጠያቂው ስም)

እኔ በአዲስ አበባ ዩንቨርሲቲ ህክምና ትምህርት ክፍል የነርስ ት/ቤት የጥናት ቡድን ጋር አብሬ እየሰራሁ ነው፡፡ የዚህ ጥናት አላማ በሀዋሳ ከተማ የሚኙ እናቶችን በወሊድና ከወሊድ ጋር በተገናኘ ለሜፈጠሩ ተዛማቾ ችግሮች የሚደረጉ ቅድመ ዝግጅቶችን በተመለከተ ያላቸውን ዕውቀትና አተገባበር ማጥናት ነው፡፡ እርስዎም በዕጣ ከተመረጡትና በቃለ መጠይቁ ከሚሳተፉ እናቶች አንዷ መሆንዎ ለመግለፅ እወዳለሁ፡፡ ስለሆነም እርስዎ አስፈላጊውን መረጃ በመስጠት የጥናቱ ተሳታፊ እንዲሆኑ በማክበር እንጠይቃለን፡፡ እርስዎን በተመለከተ ጥያቄዎች አቀርብሎታለሁ፡፡ በዚህ ጥናት የሚሳተፉት በሙሉ ፈቃደኝነት ይሆናል፡፡ ማቾውም የሚሰጠዋቸው መረጃዎች ሚስጢራዊነታቸው የተጠበቀ ነው፡፡ ቃለ መጠይቁ የሜፈጀው ጊዜ ሃያ ደቂቃ ይገሆናል፡፡ እንዲሁም በቃለ መጠይቁ ያለመሳተፍም ሆነ በማንኛውም ሰዓት ቃለ መጠይቁን የማቋረጥ መብትዎ የተጠበቀ ነው፡፡ ነገር ግን የሚሰጡት መረጃ በእናቶች ጠፍ አገልግሎት ላይ የሚሰጡን የጠፍ አገልግሎቶች በማሻሻል በሚደረገው ጥረት ከፍተኛ ጠቀሜታ አለው፡፡ ጥያቄዎቹን ለመመለስ ፈቃደኛ ነዎት? ሀ. አዎ-------- (ወደ ጥያቄዎቹ ይግቡ)

ለ. አይደለም---------(አመስግነው ይመለሱ)

የጠያቂው ስም----------

ቀን ----------ፊርማ----------

የገምጋሚው ስም ----------

ቀን ----------ፊርማ----------

የቤት ቁጥር ----------

የጠያቂው ጉብኝት

ውጤት	ጉብኝቱ በቁጥር		
	1	2	3

የመረጃ መሰብሰቢያ ቅፅ

1. የተሞላ
4. ያልተሞላ
2. በቤት ያልተገኘች እናት (ምክንያቱ ይጠቀስ) 5. ለመሳተፍ ፍቃደኛ ያልሆኑ
3. በቀጠሮ የተመለሰ 6. ሌላ (ይጠቀስ) ----------

4. የማከይቁ የመለያ መሪ

001.ካርድ ቁጥር ----------

002.ቀበሌ---------- የቤት ቁጥር ----------

ክፍል አንድ፡ - ስለ ህዝብና ማህበራዊ ሁኔታ መረጃ

101. ዕድሜ ----------

102. የጋብቻ ሁኔታ

ሀ. ያላገቡ----------1

ለ. ያገቡ/አብረው በአንድ ቤት የሚኖሩ ----------2

ሐ. ባል የሞተባቸው----------3

መ.የተፋቱ/አብረው አንድ ቤት የሚይኖሩ----------4

103. ሀይማኖት

ሀ. አርቶዶክስ----------1

ለ. ፕሮቴስታንት-------2

ሐ. ካቶሊክ----------3

መ. ሙስሊም----------4

ሠ. ሌላ ከሆነ ይገለፅ----------97

104. ብሔር

ሀ. ሲዳማ----------1

ለ. ወላይታ----------2

ሐ. ጉራጌ----------3

መ. ሌላ ከሆነ ይገለፅ----------47

105. የሴት የትምህርት ደረጃ

ሀ. ትምህርት ቤት ያልገቡ----------1

ለ. መፃፍ ማንበብ የሚችሉ----------2

ሐ. ከ1-8ኛ ከፍል የተማሩ----------3

መ. ከ9-12ኛ ከፍል የተማሩ----------4

ሠ. ኮሌጅና ከዚያ በላይ ----------5

106. የሴት የሥራ ሁኔታ

ሀ. የቤት እመቤት----------1

ለ. ገበሬ ----------2

ሐ. ነጋዴ ----------3

መ. ተቀጣሪ----------4

ሠ. ሌላ ከሆነ ይገለፅ----------97

107. የቤተሰቡ ጠቅላላ የወር ገቢ ----------

ክፍል ሁለት፡ የእርግዝና እና የወሊድ ሁኔታ

201. በዚህ አንድ አመት ውስጥ ልጅ ወልደው ነበር?

ሀ. አዎ

ለ. አልወለድኩም

202. በአጠቃላይ የተከሰተው የእርግዝና ቁጥር----------

203. በአጠቃላይ የተወለዱ የልጆች ቁጥር----------

204. በህይወት የተወለዱ ልጆች ቁጥር ----------

205. የተወለዱ ልጆች ቁጥር----------

206. በዚህ አንድ ዓመት ጊዜ ውስጥ የተወለደው ህፃን በህይወት ነበር?

ሀ. በህይወት የተወለደ----------1

ለ. የተወለደበት ወር ---------ዓመት----------

ሐ. ሞቶ የተወለደ----------2

መ. ወር ---------ዓመት----------

ክፍል ሦስት፡ - እወቀት

301፡ - በእርግዝና ወቅት በእርጉዝ እናቶች ላይ የሚሰቱና ህይወትን ለአደጋ የሚያጋልጡ የጠፍ ችግሮችን ያውቃሉ?

ሀ. አውቃለው----------01

ለ. አላወቅም-------02----------ከሆነ ወደ ጥያቄ ቁጥር 303 ይሂዱ

302. ምን ምን እንደሆኑ ሊነግሩኝ ይችላሉ? ወይም (በዝርዝሩ ካሉት ውስጥ የትኞቹ የጠፍ ችግር ናቸው ይላሉ) መልሱ በአፋጣኝ ከተመለሰ ራይት ይስጡ

01. በሚህፀን በኩል ደም መፍሰስ -----ሀ. ነው ለ. አይደለም

02. ከፍተኛ ራስ ምታት ----------ሀ. ነው ለ. አይደለም

03. የአይን ብዥታ ---------- ሀ. ነው ለ. አይደለም

04. የሰውነት መንቀጥቀጥ ----------ሀ. ነው ለ. አይደለም

05. የእጅ የፊት ማበጥ----------ሀ. ነው ለ. አይደለም

06. ከፍተኛ ትኩሳት----------ሀ. ነው ለ. አይደለም

07. ራስን መሳት----------ሀ. ነው ለ. አይደለም

08. የአተነፋፈስ ችግር----------ሀ. ነው ለ. አይደለም

97. ሌላ ችግር ከተጠቀሰ ይግለፅ----------

303. ለወሊድ ወቅት በወላድ እናቶች ላይ የሚሰቱ ህይወትን ለአደጋ የሚያጋልጡ የጠፍ ችግሮችን ያውቃሉ?

ሀ. አውቃለሁ ----------01

ለ. አላወቅም----------02--------- ካሉ ወደ ጥያቄ 305 ይሂዱ

304. ችግሮችን ሊጠቅሱልኝ ይችላሉ? (ከሚከተሉት ዝርዝሮች የጠፍ ችግር ሊሆን ይችላሉ የሚሉትን ይምረጡ)

01. ከሚህፀን የሚወጣ ደም---------- ሀ. ነው ለ. አይደለም

02. ከበድ ያለ እራስ ምታት----------ሀ. ነው ለ. አይደለም

03. የሰውነት መንቀጥቀጥ ----------ሀ. ነው ለ. አይደለም

04. ከፍ ያለ ትኩሳት---------- ሀ. ነው ለ. አይደለም

05. ራስን መሳት ----------ሀ. ነው ለ. አይደለም

06. ከ12 ሰዓት በላይ ምጥ----------ሀ. ነው ለ. አይደለም

07. ህፃኑ ከተወለደ በኋላ ከ30 ደቂቃ በላይ የሚቆይ እንግዴልጅ ሀ. ነው ለ. አይደለም

ሌላ ከሆነ ይገለፅ----------97

305. አንዲት ያረገዘች ሴት በመጀመሪያ 45 ቀናት (1 ወር ከ15 ቀን) ውስጥ ሊገጥሟት የሚችሉትን የጠፍ ችግሮች ያውቃሉ?

ሀ. አውቃለሁ ----------01

ለ. አላወቅም----------ወደ ተራቁጥር 307 ይሂዱ

306. ችግሮችን ሊጠቅሱልኝ ይችላሉ? ከሚከተሉት ዝርዝሮች የትኛው የጠፍ ችግር ሊሆኑ ይችላሉ?

01. ከሚህፀን በኩል ደም መፍሰስ ----------ሀ. ነው ለ. አይደለም

02. ከፍ ያለ ትኩሳት ----------ሀ. ነው
ለ. አይደለም

03. ከበድ ያለእራስ ምታት ----------ሀ. ነው
ለ. አይደለም

04. ራስን መሳት ----------ሀ. ነው
ለ. አይደለም

05. የአይን ---------- ሀ. ነው
ለ. አይደለም

06. የአተነፋፈስ መቅበድ ---------- ሀ. ነው
ለ. አይደለም

07. የሰውነት መወራጨት ----------ሀ. ነው
ለ. አይደለም

08. በጣም የሚሸት ከብልት የሚወጣ ፈሳሽ --------ሀ. ነው ለ. አይደለም

09. የእጅና የፊት እብጠት ----------ሀ. ነው
ለ. አይደለም
97. ሌላ ከሆነ ይገለፅ ----------
307. ከወሊድ በፊት ቀድሞ አንዳንድ ዝግጅቶችን ሚድረግ አስፈላጊ ነው ይላሉ?
ሀ. አዎ----------01
ለ. አይደለም----------02----- አይደለም ሚሉ ከሆነ ወደ ተራ ቁጥር 308 ይሂዱ
308. ሊጠቅሱልኝ ይችላሉ? ወይም ከሚከተሉት ውስጥ የወሊድ ቅድመ ዝግጅቶች ሊሆኑ ይችላሉ የሚሉአቸውን ይምረጡ
01. የመወለጃ ቦታን መለየት ----------ሀ. አዎ
ለ. አይደለም
02. ገንዘብ እየቆጠቡ ሚቀመጥ----------ሀ. አዎ
ለ. አይደለም
03. ለመወለድ የሚያስፈልጉ ንፁህ ዕቃዎችን ማዘጋጀት -------ሀ. አዎ ለ. አይደለም
04. የጤና ባለሞያ መለየ----------ሀ. አዎ
ለ. አይደለም
05. በወሊድ ጊዜ አብሮ የሚሆን ሰው ማዘጋጀት ----------ሀ. አዎ ለ. አይደለም
06. ደም የሚለግስ ሰው ማዘጋጀት----------ሀ. አዎ
ለ. አይደለም
07. ትራንስፖርት ማዘጋጀት----------ሀ. አዎ
ለ. አይደለም
08. የኤች አይቪ ምርመራ ሚድረግ----------ሀ. አዎ
ለ. አይደለም
97. ሌላ ከሆነ ይገለፅ ----------

ክፍል አራት፡ - ከሜጨረሻው እርግዝና ጋር የተያያዙ አጋጣሚዎች

401. በሜጨረሻው እርግዝና የቅድመ ወሊድ ክትትል አድርገው ነበር?
ሀ. አድርጊያለሁ ----------01
ለ. አላደረግሁም----------02
402. በአጠቃላይ ለምን ያህል ጊዜ ክትትሉን አደረጉ? የጊዜው ብዛት----------1
403. በዚህ እርግዝና ከበድ ያለ የጠፍ እክል አጋጥሞዎት ነበር?
ሀ. አጋጥሞኛል----------01
ለ. አላጋጠመኝም----------02------ካሉ ወደ ክፍል አምስት ይሂዱ

404. ምን አይነት ችግር ነበር ያጋጠሞት? (በቃል ያልተገለፁትን በምርጫው መሰረት ይጠይቁ)
01. በሜህፀን ደሞ መፍሰስ---------- ----ሀ. ነው ለ. አይደለም
02. ከፍተኛ የራስ ምታት ----------ሀ. ነው ለ. አይደለም
03. አይን ነብዥ ማለት----------ሀ.ነው ለ. አይደለም
04. የሰውነት መንቀጥቀጥ ----------ሀ. ነው ለ. አይደለም
05. የፅጅና የፊት ማበጥ----------ሀ. ነው ለ. አይደለም
06. ከፍተኛ ትኩሳት----------ሀ. ነው ለ. አይደለም
07. ህሊናን መሳት ----------ሀ. ነው ለ. አይደለም
97. ሌላ ከሆነ ይገለፅ----------
405. ለዚህ ችግር እርዳታ ለማግኘት ሞክረው ነበር?
ሀ. ሞክሬ ነበር----------01
ለ. አልሞከርኩም----------02
406. ለምን ነበር እርዳታ ለማግኘት ያልሞከሩት?
01. አስፈላጊ ነው ብዬ ስላመንኩ ----------ሀ ነው ለ. አይደለም
02. መነጋገር ስላልነበረ----------ሀ. ነው ለ. አይደለም

03. በጣም ወድ በመሆኑ----------ሀ. ነው ለ. አይደለም
04. በቤት ወስጥ ህክምና ስለተረዳሁ----------ሀ. ነው ለ. አይደለም
97. ሌላ ከሆነ ይግለፁ----------

ክፍል አምስት፡ - በሚጨሻ የወሊድ ጊዜ የነበሩ ሁኔታዎች

501. የሚጨሻ ልጅን የት ነበር የወለዱት
ሀ. በቤቴ ----------01
ለ. በሠለጠነ ልምድ አዋላጅ----------02
ሐ. በጤፍ ተቋም----------03
መ. ሌላ ከሆነ ይግለፁ----------97

502. በዚህ ቦታ ለመወለድ አስቀድመው አቅደው ነበር?
ሀ. አቅጄ ነበር----------01
ለ. አላቀድኩም----------02

503. ለዚህ ወሊድ ቀደሞ ብለው አስፈላጊ ዝግጅቶችን አድርገው ነበር?
ሀ. አድርጌ ነበር----------01---------
ለ. አላደረግሁም----------02--------- ከሆነ ወደ ጥያቄ 505 ይሂዱ

504. እርስዎ ወይም ቤተሰብዎ ምን አይነት ዝግጅት ነበር ያደረጉት?
01. የመውለጃ ቦታ መወሰን----------ሀ. አዎ ለ. አይደለም
02. ብር ማስቀመጥ----------ሀ. አዎ ለ. አይደለም
03. ንፁህ የሆለጃ እቃዎችን ማዘጋጀት-----ሀ. አዎ ለ. አይደለም
04. የጤፍ ባለሙያን መምረጥ ----------ሀ. አዎ ለ. አይደለም
05. እርዳታ ለማጠት አብሮ የሚሄድ ሰው ማዘጋጀት------ሀ. አዎ ለ. አይደለም
06. ደም የሚለግስ ሰው ማዘጋጀት ----------ሀ. አዎ ለ. አይደለም
07. በጎጎጉ ማዘጋጀት----------ሀ. አዎ ለ. አይደለም
08. ኤችአይቪ ኤድስ ምርመራ ማድረግ----------ሀ. አዎ ለ. አይደለም
97. ሌላ ከሆነ ይግለፁ----------

505. ከቤት ወጭ ከወለድ ምን አይነት መጓጓዣ ነበር የተጠቀሙት?
ሀ. አምቡላንስ----------01
ለ. የግል መኪና----------02
ሐ. ታክሲ----------03
97. ሌላ ከሆነ ይግለፁ ----------

506. ከቤት ወጭ ከወለዱ ማን ነበር አብሮዎት ወደ ወለዱበት ቦታ የሄደው?
ሀ. ማንም አልነበረም----------ሀ. አዎ ለ. አይደለም
ለ. ባለቤት የትዳር አጋር----------ሀ. አዎ ለ. አይደለም
ሐ. እናት----------ሀ. አዎ ለ. አይደለም
መ. እህት/ወንድም----------ሀ. አዎ ለ. አይደለም
ሠ. ሌላ ከሆነ ይገለፅ----------

507. በወሊድ ወቅት እርዳታ ያደረገልዎት ሰው ማን ነበር?
01. ዶክተር
02. የጤፍ መካንን
03. ነርስ/አዋላጅ ነርስ
97. ሌላ ከሆነ ይገለፅ----------

508. በወሊድ ወቅት ያጋጠሞት ችግር ነበር?
ሀ. ነበር----------01
ለ. አልነበረም ----------02----------ከሆነ ወደ ክፍል 6 ይሂዱ

509. ያጋጠሞት ምን ምን ነበር

01. በማህፀን በኩል ደም መፍሰስ ----------ሀ. ነው ለ. አይደለም
02. ከፍተኛ ራስ ምታት ---------- ሀ. ነው ለ. አይደለም
30. የሰውነት መንቀጥቀጥ ----------ሀ. ነው
ለ. አይደለም
04. ከፍተኛ ትኩሳት----------ሀ. ነው ለ. አይደለም
05. ህሌናን መሳት ----------ሀ. ነው ለ. አይደለም
06. ከ12 ሰዓት በላይ የቆየ የወሉድ ጊዜ----------ሀ. ነው ለ. አይደለም
07. የእንገዴ ልጅ ከ30 ደቂቃ በላይ መዘግየት-------ሀ. ነው ለ. አይደለም
97. ሌላ ከሆነ ይግለፅ ----------
510. ይሕ ችግር ሚፈጠር የት ነበሩ?
ሀ. በቤቴ ----------01
ለ. በስለጠነ ልምድ አዋላጅ ቤት----------02
ሐ. በጠፍ ድርጅት ወስጥ----------03
መ. ሌላ ከሆነ ይገለፅ----------97
511. ለዚህ ችግር እርዳታ ለማግኘት መኪራ አድርገው ነበር?
ሀ. አድርጌ ነበር----------01----------ከሆነ ወደ ተራ ቁጥር 601 ይሂዱ
ለ. አላደረግኩም----------02
512. ለምን ነበር እርዳታ ለማግኘት መኪራ ያላደረጉት?
01. አስፈላጊ ነው ብዬ ስላላሰብኩ ----------ሀ. ነው ለ. አይደለም
02. በመነጣጥ ችግር ----------ሀ. ነው ለ. አይደለም
03. ወድ ስለነበር----------ሀ. ነው ለ. አይደለም
04. የቤት ወስጥ የራሴን ህከምና ስላደረግሁ----------ሀ. ነው ለ. አይደለም
97. ሌላ ከሆነ ይገለፅ----------

ክፍል ስድስት፡ - በሚጪሻ የወሊድ ጊዜ የነበሩ ሁኔታዎች

601. ወልደው በ42 ቀን ወስጥ ከበድ ያለ የጠፍ ችግር አጋጥሞት ነበረ?
ሀ. ነበረ----------01
ለ.አልነበረም----------02
602. ምን አይነት ችግር ነበረ ያጋጠሞት?
01. ከማህፀን ደም መፍሰስ ----------ሀ. ነው ለ. አይደለም
02. ከፍተኛ ራስ ምታት ----------ሀ. ነው ለ. አይደለም
03. የአይን ብዥታ ----------ሀ. ነው ለ. አይደለም
04. የሰውነት መንቀጥቀጥ ----------ሀ. ነው ለ. አይደለም
05. የፊት የእጅ ማበጥ----------ሀ. ነው ለ. አይደለም
06. ከፍ ያለ ትኩሳት----------ሀ. ነው ለ. አይደለም
07. ራስን መሳት----------ሀ. ነው ለ. አይደለም
08. የአተነፋፈስ ችግር----------ሀ. ነው ለ. አይደለም
09. በጣም የሚሸት የማህፀን ፈሳሽ---------- ሀ. ነው ለ. አይደለም
97. ሌላ ችግር ከነበረ ይግለፅ----------

603. ከላይ የጠቀሟቸው ችግሮች ሊከሰቱ የት ነበሩ?

ሀ. ቤት----------01

ለ. ልምድ አዋላጅ ቤት----------02

ሐ. ጠፍ ድርጅት----------03

መ ሌላ ይግለፅ ----------97

604. ለደረሰብዎት ችግር ዕርዳታ ፈልገው ነበር?

ሀ. አዎ ----------01

ለ. አልፈለግኩም----------02

605. ለምንድነው ዕርዳታ ያልፈጉት?

05. የሚያስፈልግ ስላልሟለኝ----------ሀ. ነው ለ. አይደለም

06. ትራንስፖርት ስላልነበር ----------ሀ. ነው ለ. አይደለም

07. አገልግሎቱ ወድ ስለሆነ ----------ሀ. ነው ለ. አይደለም

08. የቤት ወስጥ ዕርዳታ አግኝቼ ----------ሀ. ነው ለ. አይደለም

97. ሌላ ካለ ይግለፅ----------