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ASSESSMENT OF MALE INVOLVEMENT IN BIRTH PREPAREDNESS AND COMPLICATION READINESS FOR EMERGENCY REFFERAL AT WOLAITA ZONE, SODO TOWN, SOUTHERN NATION NATIONALITY PEOPLE REGION, ETHIOPIA,2017.

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List of acronyms and abbreviations

ANC ……..….Antenatal Care

BP ……...…Birth Preparedness

BP/CR…….Birth Preparedness and Complication Readiness

CR……. .Complication Readiness

JHPIEGO…….John Hopkins Program for International Education in Gynecology Obstetrics

FMOH…….Federal Ministry of Health

HEWS…….Health Extension Workers

MMR …….Maternal Mortality Ratio

MCH……Maternal and Child Health

MDG……..… Millennium Development Goal

SDG…….Sustainable Development Goal

SNNPR…….Southern nation nationality and peoples region

Abstract

Background:-Avoidable maternal mortality remains a huge burden more especially in sub-Saharan Africa. The involvement of husband during pregnancy and its complication helps an expectant mother to make timely decisions to avoid delays that brings about complications that could result in morbidity or mortality.

Objective:-To asses male involvement in birth preparedness and complication redness for emergency referral at Wolaita Zone, Sodo Town, SNNPR, Ethiopia.

Methods:-Institution based cross sectional study was conducted at Wolaita Zone Sodo Town among mothers how came to hospital and admitted to MCH due to emergency obstetric referral. Data was collected by interviewer administered structured questionnaire and it was entered by Epdata, cleaned and analyzed by using SPSS for windows version 23.0. A descriptive analysis was done using frequency, mean, quartile and standard deviation. Crude and adjust logistic regression were used to see relationship between independent variable with outcome variable in order control confounding factors. Significance level of $P<0.05$ and association of variables were tested by using 95% confidence interval (C.I) and odd ratio.

Result: - Data were obtained from 233 women, yielding a response rate 100%. The prevalence of male partner's involvement in in birth preparedness and complication redness for emergency referral was 30.9%. After adjusting for the effect of confounding variables using logistic regression, variables like distance of health facility, having ANC follow-up and experience of obstetric complication have statistically significant association with male partner's involvement in birth preparedness and complication readiness for obstetric referral.

Conclusion and recommendation: - In general, the study has revealed that male partner's involvement in birth preparedness and complication readiness for obstetric referral was low. The government and other responsible bodies should make efforts to increase community based health education, awareness creation and improve male partner's involvement in birth preparedness and complication readiness for obstetric referral and Encourage women to come with her husband for the first ANC visit early in pregnancy and for adequate frequency of ANC visits

Keywords: Male involvement, Birth, Obstetric Complication

CHAPTER ONE

1. Introduction

1.1 Background

Pregnancy and child birth could threaten a woman's life because of obstetric complications. Every year, Universally maternal deaths contribute a more than half a million of deaths, and of these, 99% occur in developing countries(1). According to the World Health Organization (WHO) report, developing countries accounted for 286,000 of maternal deaths as a consequence of preventable complications to 2013 (2). These deaths are caused from pregnancy, childbirth or postpartum complications. A key policy that can decrease the number of women dying from such complications is composing a birth plan that contains and comprises birth-preparedness and complication readiness procedures for pregnant women, their husbands and their families (3). In our country Ethiopia, the ratio of maternal mortality (MMR) is estimated to be 412 deaths per 100,000 live births and which is among one of the highest in globally. Millennium Development Goal 5 (MDG5), calls for the improvement in maternal health, with a goal of reducing the maternal mortality ratio (MMR) by three-quarters over the period 1990-2015. Accordingly, the Federal Ministry of Health (FMOH) has applied a multi-pronged strategies to reduce maternal and newborn morbidity and mortality by educating and refining access to and reinforcement of facility-based maternal and newborn services (4).

Birth preparedness and complication readiness (BP/CR) is a wide-ranging and inclusive package aimed at encouraging timely access to skilled maternal and neonatal services, promotes active preparation and decision making for delivery by pregnant women and their families (5). This stems from the point that every pregnant woman faces risk of unexpected and erratic life threatening complications that could end in death or injury to herself or to her infant (6). The most important components of birth plan package include Recognition of danger sign, a plan for birth attendant, a plan for place of delivery, saving money for transport or other costs in case the need arise (6). In sub-Saharan Africa, pregnancy and childbirth remain to be viewed merely as women issues (6). A male companion during perinatal care is unusual and rare in many

communities, it is unthinkable to fined male companions accompanying a woman to the labor room during delivering (7). Nevertheless, manes have social and economic power, especially in Africa, and have significant control over their partner. They decide the timing and condition of sexual relation, family size, whether their partner will utilize available maternal health care(8). Hence this condition makes male partners participation critical if improvement in maternal health and reduction of maternal morbidity and mortality is to be realized. Strategies for involving men in maternal health services should aim at raising their awareness about emergency obstetrics conditions, and engaging them in birth preparedness and complication readiness (6).

1.2 Statement of the problem

Hundreds of thousands of women are still passing away due to complication from pregnancy and /or childbirth every year universal. Several of these deaths go immeasurable. Attaining the Sustainable Development Goal (SDG) of a global MMR below 70 will require reducing global MMR by an average of 7.5% each year between 2016 and 2030. This will require more than three times the 2.3% annual rate of reduction observed universally between 1990 and 2015 (9).

Maternal mortality and morbidity associated to pregnancy and childbirth could be prevented if women and their families identify when and where to seek help, have access to the healthcare system during pregnancy, childbirth and the postpartum period and subsequently receive care from skilled provide(10). Lack of husband participation in birth preparedness plans and delays in care seeking for obstetric emergencies are main contributing factor of maternal death. Birth preparedness has been found to be effective against decreasing these delays. Male involvement is essential for improving birth preparedness because of patriarchy which agree to men to control women's access to and utilization of maternal health care and safe motherhood programs which may be affected by male partner participation because husbands were the most influential decision-maker and as the key member of the family (11).

In Ethiopia, only 28% of the delivers are attended to by health professionals. This condition well clarifies the maternal mortality ratio of 412 per 100,000 live births, which is one of the highest in the world (4). Studies shown that hemorrhage, hypertensive disorders and ruptured uterus were among the origins of maternal deaths.

This situation makes husbands critical partners for the improvement of maternal health and reduction of maternal mortality by participating in birth preparation. Studies conducted on pregnant mother in Ethiopia at Maichew Town, Southern Tigray showed that one of the factors of affecting prenatal care (15.5% husband's disapproval of antenatal attendance, and only 21% of pregnant mother were accompanied by their husbands to the antenatal clinic) which is the best time for giving information about birth preparedness and preparing to complication redness, starting point to setting a plan for the anticipated birth and emergency conditions (12).

According to the study conducted in Chencha district, Gamo Gofa Zone of southern Ethiopia. South nation nationality and peoples Region (SNNPR) even if which is a region with the highest fertility rets and fecundity male involvement is very low, 42% of men had awareness of danger sign and 9.4% of men were involved in birth preparedness practice (13).

Despite the great ability of Birth Preparedness and Complication Readiness in reducing the maternal and newborn deaths its importance is not well known in most of sub-Saharan Africa. The low status of women, socio-cultural obstacles to seeking care: women's mobility, ability to command resources, decision-making abilities, beliefs and practices surrounding childbirth and delivery has great impact on women's health. Most of the reproductive health programs fail to address these factors in Ethiopia.

Improvement of male involvement is necessary in culturally dynamic societies like Ethiopia to improve the women's health and reduce maternal morbidity and mortality. Therefore, male involvement in maternal health is vital to ensuring considerable reduction in maternal mortality. This study will conduct to discover male involvement in Birth preparedness and complication readiness strategy for emergency referral as important support structures to help reduce delays in accessing maternal health care especially during emergencies.

1.3 Significance of the study

Despite few local studies conducted in different parts of the country, no adequate study tried to identify the husbands ' participation on birth preparedness and complication readiness for obstetric emergency referral in study area which is Wolaita zone, Sodo Town, SNNPR, Ethiopia. Hence, there is a need to carry out a research to come up with the determinants of Husbands' Participation on Birth Preparedness and Complication Readiness for obstetric emergency. Nurses and midwifes who work in maternity centers and in the community setting could use the result from this research as a baseline in their counseling/health education session to minimize the maternal mortality rate and strengthen the good practices.

The finding of this study can provide policy makers and NGOs (nongovernmental organizations) with relevant information for future planning and interventions of appropriate strategies to promote and maintain male involvement in Birth Preparedness and Complication Readiness for obstetric emergency.

The finding of this study will also help as a baseline data for those who are interested in carrying out further research with this regard.

CHAPTER TWO

2. Literature review

2.1 The Concept of Birth Preparedness and Complication Readiness

The birth of a baby should be a happy end to a pregnancy for the mother and her family. Yet the physiological function of reproduction brings with it a number of possible results including grave risks of death and disability for the mother and her baby, predominantly in low and middle income countries (1).

There have been significant reductions in maternal and newborn mortality over the last two decades. Yet in 2010, still there were approximately 287 000 maternal deaths, 2.6 million stillbirths and neonatal deaths, developing mostly from complications during and following pregnancy and childbirth (1).

In spite of the great potential for Birth Preparedness and Complication Readiness in reducing the maternal and newborn deaths its significance is not well known in most of sub-Saharan Africa (4). Get ready for a safe delivery may include factors related to identifying and reaching care at the onset of labour, identifying and reaching care if a complication should arise, or planning to travel closer to care before labour if emergency referral is not feasible. It is also essential to consider that, with increasing urbanization, women living in peri-urban and urban settings may move when near term to their village of origin to deliver at their mother's home. So preparation for labour is also relevant to urban and peri-urban antenatal clinics.

Many packages that aim to improve maternal health have comprised efforts to improve preparation for birth and readiness for complications (14). Experience and practice indicate that discussions about arranging for birth should occur not only to pregnant women but with the husband and communities that support them. The aim is education, motivation, cohesion and mobilization of pregnant women, families and communities. Community and families participatory approaches are most effective. A project that used such an approach from Kampong Chang in Cambodia was assessed and found that community engagement was a feasible, effective and cost-effective way to familiarize birth preparedness. Similarly this project improved referrals to hospital by 281% (15)

Effective interventions to prevent and treat maternal and perinatal complications are well known. Most maternal and perinatal deaths are preventable if life-saving preventive and beneficial interventions are provided at the right time – in fact, what are well-known as the "three delays" are major obstacles to improving chances on survival: 1) delay in recognizing and seek care when complications occur, 2) delay in reaching a health facility, and 3) delays in receiving appropriate care within the health facility. Recognition of such important links between development and women's health in specifically led to "Improve maternal health" being set as one of the Millennium Development Goals (1). Birth preparedness and complication readiness (BP/CR) is a shared strategy employed by numerous groups implementing safe motherhood programs, although the definitions differ. Some of the standard and fundamental elements of birth preparedness are knowledge of 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. It also consists of arranging for transportation, money, and a blood donor. The emphasis is on the "helper, supporter during perinatal period and accompanies" that is, the individual, family and community, spatially on pregnant mothers husbands and partners (16).

The Maternal and Neonatal Health Program relied on these commonly cited factors can be prevented with advance preparation and prompt action, thus reducing the delays in seeking, reaching or receiving care. This is the core of Birth Preparedness and Complication Readiness (BP/CR). BP/CR is a comprehensive matrix that comprises the woman and her family, as well as the community, healthcare providers, facilities that serve them, and the policies that affect care for the woman and the newborn (6).

A study conducted in India suggested that Birth preparedness and complication readiness inspires women, households, and communities to make arrangements such as identifying or establishing available transport, set aside money to pay for service fees and transport, and identifying a blood donor in order to facilitate quick decision making and reduce delays in reaching care once a problem arises. Birth preparedness and complication readiness reduces delays in deciding to seek care. Birth preparedness encourages people to plan to have a skilled health care provider and complication readiness raises awareness of danger signs among women, families, and communities, thereby improving problem recognition and reducing the delay in

deciding to seek care. In general, birth preparedness and complication readiness promotes the use of a skilled provider at birth through increasing demand and improving access (17).

similarly prospective follow-up study conducted in south Ethiopia also found that birth preparedness and complication readiness plan has significant effect in increasing skilled care usage during delivery and decreasing maternal mortality and morbidity (18).

2.2 Male involvements in birth preparedness and complication readiness plans

Male involvement, an all-inclusive term which refers to "the various ways in which men relate to reproductive health problems and programmes, reproductive rights and reproductive behavior", is considered an important intervention for improving maternal health (8).

A study conducted on medical anthropological viewpoint on men's influents on women's reproductive health stated that one of the most significant areas of reproductive health affected by men is pregnancy care and its consequences. Yet, men's involvement in and influence on prenatal care is poorly understudied (19).

A cross-sectional study conducted at Kabale regional hospital maternity ward among 140 women admitted as emergency obstetric referrals in antenatal, labor or the postpartum period in Uganda shown that 42.9% were accompanied by the husband to the antenatal clinic, whereas 43.4% were accompanied to the labor ward by the husbands. Parity, maternal age, education level, age and occupation of spouse and presence of pregnancy complications were associated with having a birth plan (20). Similarly a cross sectional descriptive study conducted among 240 consenting husbands of primigravidae attending the ANC at Tertiary and Secondary Health facilities in Ogbomoso, south western Nigeria stated that Only 43.8% of respondents had ever accompanied their wife to ANC, majority (56.2%) have not accompanied their wives to ANC (21).

According to prospective multi-Centre observational study comprising 506 pregnant women at eight health facilities in Ilorin, Nigeria suggested that 82.4% women want male partner to accompany them to antenatal clinic and 59.1% have experienced this at least once during current pregnancy. Among the 83.4% of participants who have had ultrasound scan in index pregnancy, 40.8% were accompanied by the partner. In general, 80.8% women want male partners of pregnant women to be educated about pregnancy especially concerning how to take care of

pregnant women 77.0% and sex during pregnancy 25.2% (22). 84.4% women desire companionship during labour and delivery whereas 80.8% preferring the male partner. The commonest explanations for preferring the male were for the men to appreciate the value of women 57.7%. Majority of women who required the partner excluded opined that men do not play any role in labour and delivery 39.3%. 14.2% of the men were present at previous deliveries of the partners and 84.4% of the women were gratified with the men's presence (22).

A study assessed birth preparedness, complication readiness and male participation in maternity care among 389 married men in Ungogo, a northern Nigerian community reveled that only 32.1% of husbands accompanied their spouses at least once to the hospital for antenatal, delivery or postnatal care. Men who had formal education were more likely to participate in maternity care compared to those with non-formal education. Besides, a higher proportion of non-Muslim men participated in maternity care compared to their Muslim counterparts (8).

Demographic and Health Surveys conducted in eight sub-Saharan African countries pointed that in the majority of countries, male accompaniment to ANC was not uncommon. About 45.7% of all men in the study participant reported being present during one of his partner's antenatal check-ups. There were substantial differences by country. Country-level analytic samples included: Rwanda (n = 1,211), Burundi (n = 1,042), Senegal (n = 505), Zimbabwe (n = 459), Malawi (n = 1,353), Mozambique (n = 414), Uganda (n = 428) respectively. Rwanda had the maximum proportion of men who accompanied their partners to AN C (86.8 %) while Burundi had the lowest proportion (18.2 %). In Senegal and Zimbabwe, roughly a third of men (32%) were present during at least one check-up, with slightly higher accompaniment rates in the remaining countries: Malawi (41.0%), Mozambique (44.2%), Burkina Faso (45.2%), and Uganda (49.7%), respectively (23).

A cross-sectional study conducted on birth preparedness, complication readiness and male partner involvement for obstetric emergencies in rural Rwanda stated that Male involvement in pregnancy and antenatal care is low. Men's role was found to be predominantly in the area of financial support. The level of men ANC attendance was low (29.4%), while (22.3%) women were accompanied to the labor ward. Yet, there was a strong opposition to the physical presence of male partner in the labor room (50.9%). The main reason mentioned by women opposing male

partner presence is that it is opposing to their culture for a man to eyewitness the delivery of a baby (24).

A community based cross-sectional study was conducted among 376 husbands in Mekelle town reveled that about 60% of the male partner had involved in birth preparedness and complication readiness (BP/CR). Similarly the study suggested that husbands were more likely to participate in birth preparedness if they had better awareness and understanding in postnatal danger signs and with good & better knowledge on birth preparedness (25).

A cross-sectional quantitative study was conducted among sample of 422 married women in Akaki Kality Sub City Addis Ababa revealed that Husbands involvements were comparatively higher during childbirth, moderate in Birth preparedness and complications readiness, and relatively lower during ANC. This study determined the prevalence of husband involvement during ANC (65.5%), whereas labor (80.8%). Women with educational level of primary and below were less likely to be accompanied by husbands at ANC than those with secondary and above. husbands attendance at ANC are lower for women whose husbands had primary and below level of education compared to those whose husbands who had secondary and above. Also Women with husbands occupation formal employment had significant association with BP/CR (26).

2.3 Seeking skilled birth attendances

A main part of preparing for birth is seeking contact with and obtaining the services of a skilled birth attendant. Developing birth plan can help the woman to decide where she needs to give birth and which attendant she feels most comfortable with. The modern agreement of those working in safe motherhood is that, if people are aware of the significance of having care from a skilled birth attendant, know where to go in an emergency, and plan accordingly for costs and other practical matters, it is more likely they will get the support they need in these circumstances (10).

According to community-based, cross sectional study conducted in Yangon, Myanmar, Tokyo, Japan, stated that Concerning birth preparedness, the majority of husbands prepared for skilled birth attendance (91.1%), delivery place (83.6%), before their spouses gave birth. The

majority of husbands supported their spouse s' maternal care services use financially; however, they were less involved in birth preparedness and postnatal care (27).

A study conducted on Birth Preparedness, Complication Readiness and Fathers' Participation in Maternity Care among 389 married men in a Northern Nigerian Community reveled that there was very little preparation for skilled assistance during delivery (6.2%),There is a necessity to increase involvement of men in their partner's maternity care through peer-led, culturally-sensitive community education and appropriate health system reforms (8).

A prospective follow-up study was conducted among randomly selected 3472 mothers in Southwest Ethiopia stated that the condition of skilled care use was found to be low. The status of skilled care use was 17.5%. Birth preparedness and complication readiness had significant effect on skilled care usage and reducing maternal mortality and morbidity. Besides that educations were found to increase the likely hood of skilled care use significantly as compared to not having formal education. Similarly, women whose husbands were employed or merchants, were more likely to use skilled care as compared to those whose husbands were farmers (18).

A cross-sectional community-based study conducted among 417 pregnant women in Jimma zone, Southwest Ethiopia clearly showed that birth preparedness and complication readiness practice in the study area was not satisfactory which is about (6.7%) prepared by identifying a skilled delivery attendant and similarly age and parity significantly associated with birth preparedness and skilled care use (28).

Another community based cross sectional study conducted in Southern Ethiopia among 743 pregnant women stated that male involvement in birth preparedness and complication redness practice was found to be low. Only a quarter (20.5%) of pregnant women identified skilled provider. Whereas only 8.1% identified health facility for delivery and/or for obstetric emergencies (29).

According to community based cross-sectional study conducted among 578 pregnant women in Duguna Fango District, Wolaita Zone, Ethiopia reveled that similarly as previous study birth preparedness practice in the study area was found to be low. only one tenth (10.7%) of pregnant women identified skilled provider and whereas (43.6%) identified health facility for delivery and/or for obstetric emergencies (30).

A study from male involvement and skilled delivery care utilization among 635 couples in Mareka woreda, Southern Ethiopia, stated that male involvement on skilled delivery care utilization has a significant effect on women's' use of skilled birth attendants at delivery. Overall, 32.9% of women used skilled delivery care and 41.3% of husbands' involved on skilled delivery care utilization on their recent child birth. Similarly husband age below 35 years and educational level had significant association with skilled car utilization (31).

3.4 Knowledge of danger sign and obstetric emergency

Maternal deaths can be prevented partially through increasing awareness and knowledge of danger signs of obstetric complications and involving husbands (male) in birth preparedness practice which is one of the fundamental component of birth preparedness and complication readiness(13).

A qualitative study was conducted in four rural hill villages in the Gorkha district of Nepal Found that even though some husbands were knowledgeable about aspects of pregnancy and childbirth, there were significant gapes. Many husbands were aware of the profits of delivering in health facility and pointed that they would prefer their wives to have an institutional delivery attending by trained health worker. The result also demonstrated some awareness of potential obstetric complications such as obstructed labour. However, overall the husband's knowledge of the range of danger sign in pregnancy, during delivery, and in the neonatal and postnatal periods was deficient (32)

Another Cross sectional descriptive study among 240 consenting husbands of prim gravida attending the ANC in Nigeria on situation they considered as "danger signs" in pregnancy, more than half of respondents reflected bleeding per vagina (66.3%), cessation of fetal movement (61.3%), loss of consciousness (58.8%), swelling of hands and feet (55.8%), abdominal pain (58.3%), convulsion (55.4%) and drainage of liquor (55.4%) as danger signs of pregnancy. Only 49.2% and 44.2% considered fever and vomiting respectively as danger signs. Whereas majority (57.9%) were not saved money specifically for antenatal emergencies. It also revealed that the educational status, occupation, type of marriage and average income earned per month were statistically significant and associated with husband involvement in birth preparedness (21).

Another community based cross-sectional study was done Southern Ethiopia revealed that the prevalence of men awareness of danger sign was low and male involvement in birth preparedness practice was very low. 42% of men had awareness of danger sign. The results showed a clear association of men's awareness of danger signs of obstetric complications with male involvement in birth preparedness practice in the district. Furthermore occupation, economic status was also significantly associated with men's awareness of danger signs of obstetric complications (13).

3.5 Health care seeking behavior of expectant male in birth preparedness and complication readiness

A study conducted among 900 households from three communities in Nigeria reveled that in case of obstetric situations requiring emergency care, majority of the respondents (86.8% for men and 86% for women) mentioned that the woman could decide where to go especially in the absence of her husband. The men do not claim that their pregnant spouse go to a particular place. The men must however know where his wife goes for medical attention. There was high level of awareness of emergency obstetric conditions by men, predominantly in relation to pregnancy signs and labour pains (53.2%). Respondents reported that men play critical roles during their partner's obstetric conditions (89.2%). Women take decisions on health-seeking behavior during emergency obstetric conditions in the absence of the male partner (33).

A study conducted in northern Nigeria reveled that only 19.5% of respondents made saving money for obstetric emergencies and whereas 10.5% identified a decision-making process in case of obstetric emergency. Similarly, decision on place of delivery, arrangement for skilled assistance at delivery and arrangements for blood donation were made by only 9.0%, 6.2% and 0.8% of respondents respectively (8).

According to community based cross-sectional study conducted among 374 husbands with wife in the reproductive age in Ambo Town found that more than half about 60.7% decisions making to seek health care facility were made by male partner alone and 53.7% had good knowledge of general danger signs in the study area. Occupation husband, educational states and family income were strongly associated with birth preparedness and complication readiness (34).

A cross-sectional quantitative study was conducted in Addis Ababa pointed that concerning decision making on where to attend ANC 252(66.3%) of the respondents mentioned that they

have decided jointly with husbands,66(17.4%) and 62(16.3%) of them reported respondents and husbands have decided respectively. Husbands jointly plan of where to deliver were, 49(14.3%). Among the respondents who reported they had saved money in case of emergency either alone or with husbands jointly. Most of respondents (63.6%) said that respondents and husbands jointly, 28.9% and 7.5% reported husbands alone and respondents alone respectively had saved money in situation of emergency (26).

cross- sectional facility based study was conducted among 420 women with obstetric complications and their spouse at north Shewa reveals that (23.2%) of the interviewed cases made a decision to seek emergency obstetric care on time, out of the cases made a decision on time sixty seven (69%) of them were made by their male partners. Also the study revealed that male partner education secondary and, spouse saved money for emergency funds, spouse discussed on obstetric emergency plan, women faced life threaten complications were found to be significantly association with reducing delay in making decision to seek emergency obstetric care (35).

2.6 Conceptual frame work

Concepts that are directly and indirectly related to the major variables of the study that Male partner's involvement in birth preparedness and complication redness for emergency referral are developed from different literature reviews and adapted from JHPIEGO tools and indicators in Maternal & Neonatal Health, 2004. This conceptual framework considers person related factors as well as associated factors. The person related factors include the male partner's socio-demographic characteristics, male partner's knowledge on danger sing during pregnancy, labour, postnatal time, knowledge of birth preparedness, family health and decision making power need of involving male in birth preparedness and complication redness for emergency referral of spouses'. Wife's socio-demographic characteristics, saving money, transportation access, quality care, health service access, community health and access to media mainly influence of male

partners involvement in birth preparedness and complication redness for emergency referral of spouses of spouse.

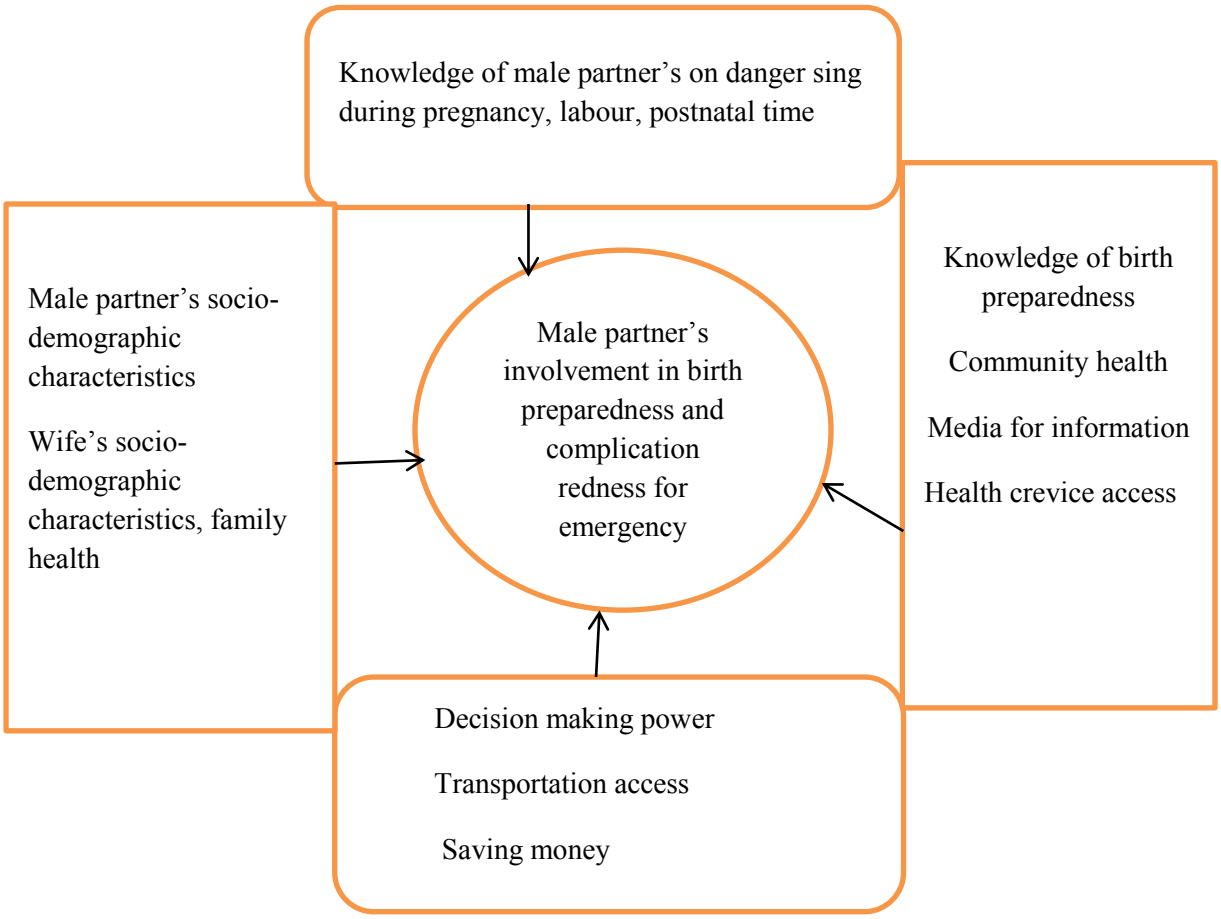

Figure 1: Conceptual frame work on birth preparedness and complication readiness among husbands. (Adapted from JHPIEGO tools and indicators in Maternal & Neonatal Health, 2004).

CHAPTER THREE

3. Objectives

3.1 General objective

- To asses male involvement in birth preparedness and complication readiness for emergency referral at Wolaita Zone, Sodo Town SNNPR, Ethiopia, 2017

3.2 Specific objectives

- Determine the prevalence of male involvement in birth preparedness and complication readiness for emergency referral.
- Examine factors associated with male involvement in birth preparedness and complication readiness for emergency referral.

CHAPTER FOUR

4. Methods

4.1 Study area

The study was conducted in Wolaita zone, one of the 14 zones in Southern Nations Nationalities and Peoples Region (SNNPR), Ethiopia. The zone has total area of 4512 square kilometers, administratively divided into 12 districts (locally termed "woredas") and 3 town administrations with total population of nearly 1.7 million. In the zone are currently 1 governmental and 2 nongovernmental hospital and 11 health centers aged 5 years or above as of establishment. Sodo or Wolaita Sodo is a town and separate woreda in south-central Ethiopia. The administrative center of the Wolaita Zone of the Southern Nations, Nationalities, and Peoples Region, it has a latitude and longitude of 6°54′N 37°45′E . It was part of the former Sodo woreda which included Sodo Zuria which completely surrounds it. Sodo is located 332 km south of Addis Ababa and 122 km south of Hawassa. Sodo has one governmental hospital and one non-governmental hospital and 3 health center in the town which serves total population of 86,050.

4.2 Study period

The study was conducted from February 10-April 10-2017 Wolaita Zone, Sodo Town.

4.3 Study design

Institution based cross-sectional study design was used.

4.4 Source population

- All married women available in selected ward of the hospital in MCH department.

4.5 Study population

- All married women admitted to the hospital as an emergency referral in antenatal, labor or the postpartum period during the study period.

4.6 Inclusion and Exclusion Criteria

4.6.1 Inclusion Criteria

- Being admitted to the hospital as an emergency referral in antenatal period.
- Being admitted to the hospital as an emergency referral in labor or the postpartum period.
- Willingness to consent for participation in the study

4.6.2 Exclusion criteria

- Those women who come to hospital at the study period who were unable to speak, sick and unconscious
- Those women who come to hospital at the study period who were not due to obstetric referral.

4.7 Sample size determination

Sample size was determined by using single population proportion based on the following assumptions: 95% confidence level, prevalence of male involvement in birth preparedness and complication readiness is 60.4% from previous study(25), and a 5% margin of error.

n= ((Zα/2)2 × p(1 − p))/d2

Where: - n= sample size

z = critical value = 1.96 for 95% CI

p = prevalence of male involvement on birth preparedness and complication readiness = 60.4%

d = precision (marginal error) = 5%

n= (1.96 × 1.96 × 0.604 × 0.396)/ (0.05 × 0.05)

n= 368

∴ Since total population of this study is women referred to hospital due to obstetric complications and there expected number was less than 10,000 population correction formula is used. Sample size is 212.

$$n = \frac{n}{1 + n/N} = \frac{368}{1 + 368/500} = 212$$

Expecting a 10% or 21 non-response rate are considered for eligible women who may refuse to participate, missed, the final sample size is calculated to be 233.

4.8 Sampling procedure

Since Sodo town has two hospitals from them one is governmental the other is non-governmental hospital both hospitals were taken and sample size calculated is allocated proportionally. Systematic randomized sampling technique was used for allocating number of

study participants in each hospital. The first study Participants were picked randomly at each MCH unit of the hospitals and ever k interval of the participant was selected till sample size reaches.

Multiple allocations was avoided by first excluding women had previously been administered the questionnaire.

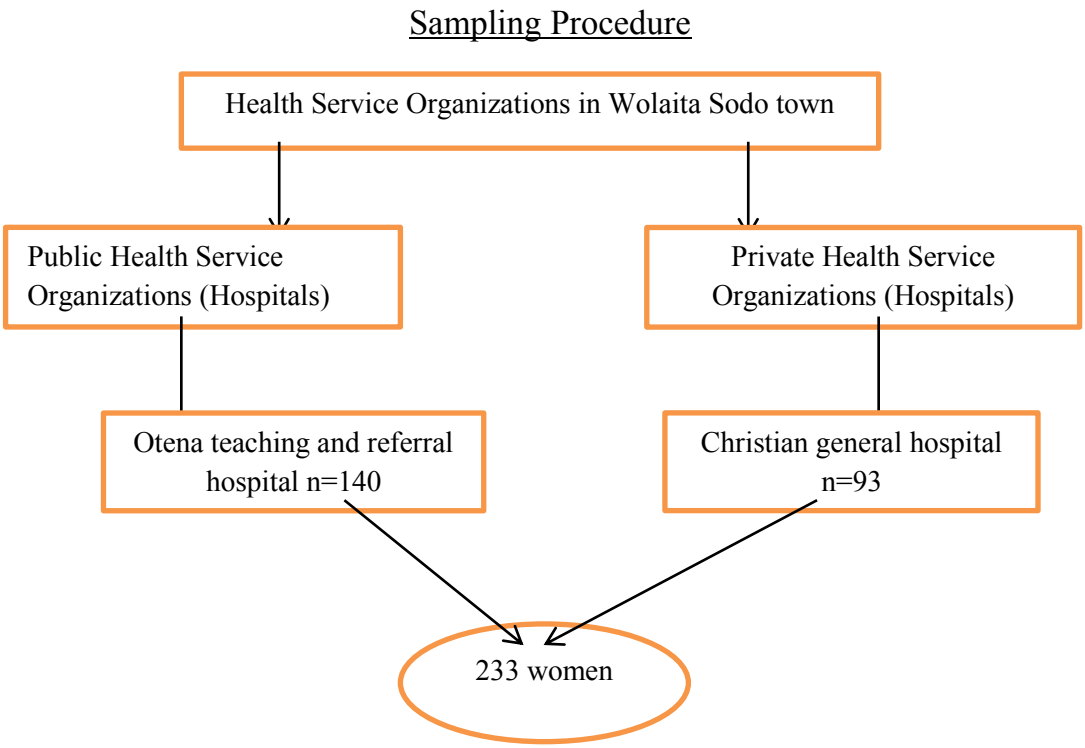

Figure: 2 schematic framework of sampling procedure

4.9 Study variables

4.9.1Dependent variables

Male involvement in birth preparedness and complication redness for emergency referral

4.9.2 Independent Variables

- **Socioeconomic and demographic characteristics**

Age, Religion, Ethnicity, Educational level, Occupation , Husband's Age, husband's religion, husband's ethnicity, husband's educational level, husband's occupation

- **Obstetric** (prenatal care and counseling, birth preparedness and complications readiness, Childbirth and causes of referral)

- **Health services related factors**: Accessibility of services
- **Other variable**: knowledge, means of information, availability of means of transport.

4.10 Operational Definitions

Husband involvement in Birth preparedness and complications readiness for emergency referral: refers that the actual involvement of husband in joint decisions on where to attend ANC, joint decisions on where to deliver, save money for emergency, knowing and deciding earlier where to go during emergency. Those participations that had involvement in all case were considered as male involvement.

Husband involvement during pregnancy and childbirth: refers that the husband is involved at ANC, make joint decisions on where to attend ANC, make the plan of where to deliver, save money in case of emergency, accompany during labor.

Means of Mass media exposure: refers that the household has a radio or television or both

Availability of means of transport: refers that the household has bicycle, motorcycle, TVS scooter, or car/truck.

Occupation: was measured Gov. and NGO or private, merchant, daily laborer, farmers or other (drivers not included in other category and others). Housewife was included under respondent's occupation. For analytical purposes it was categorized in to formal (Gov. and NGO or private org. employed) and informal employment (merchant, daily laborer, farmers, drivers not included in other category and, Housewives).

Knowledgeable: Women who knew obstetric complications more than mean average score during any of the three phases (pregnancy, childbirth, or postpartum period).

Not knowledgeable: women who knew obstetric complications less than mean average score during the three phases.

Age: Age of both spouses was categorized based on the means of their ages and standard deviations

4.11 Data collection procedures

Interviewer administered questionnaires and in-depth interviews were conducted for the quantitative study. The questionnaires was first prepared in English then translated to Amharic, then translated back to English to maintain its consistency. The questionnaire was adapted from the survey tools developed by JHPIEGO Maternal and Neonatal Health Program (14). It is divided into four parts. The first section inquired about personal data, including age, occupation, ethnicity, religion and educational level. The second part elicited information about Knowledge of obstetric complication and Sours of information. The third section assessed birth preparedness and complication readiness and health seeking behaviors.

Data collections were undertaken by nurses and midwife in the MCH department of the Wolaita Zone Sodo town referral hospital and christen general hospital. Data collection was take place in the MCH department when admitted to the hospital as an emergency referral in antenatal, labor or the postpartum period.

Training was given for data collectors and supervisors about the objectives and process of data collection. Pre-testing of the questionnaire was undertaken on 15 individuals to identify problems with the questionnaire and procedures of data collection. The principal investigator was coordinated the data collection process of quantitative study. Communicate and discuss every day with the supervisors and data collectors about problem faced during data collection process and collect the completed questionnaires every day and check for inconsistencies and omissions.

4.12 Data Management and Quality Assurance

Questionnaires were checked for completeness, consistencies and missing values. The principal investigator was checked whether the data collectors and supervisors were using the right data collection process and techniques. Data entered by EPdata and cleaning was done by SPSS version 23.0. After data collected and entered in to a computer separate numerical codes were assigned for separate answers and missing values. Data was checked for values that are inconsistent with other information gathered in the study. The data was also checked for missing item and decisions was made as to simply disregard missing data items during analysis.

4.13 **Data Analysis**

Data analysis was done by computer statistical package for social science (SPSS) version 23.0. On univariate analysis, Frequency tables and Charts was used to describe categorical variables. Graphs, means, mode, medians and standard deviations were used to describe numerical variables. Both bivariate and multivariate logistic regression analysis was used to determine the association of each independent variable with the dependent variable. Variables significant in bivariate analysis (P< 0.2) were entered into a multivariate logistic regression model to adjust the effects of cofounders on the outcome variable. Odds ratio with their 95% confidence intervals were computed to identify the presence and strength of association, and statistical significance was declared if $p < 0.05$.

4.14 Ethical consideration

Ethical clearance letter was obtained from Addis Ababa University Department of Nursing and Midwifery research committee and College of Health Sciences Institutional Review Board. Written permission was requested from Wolaita Sodo zone health bureau. Moreover, all the study participants were informed verbally about the purpose and benefit of the study along with their right to refuse and verbal consent was obtained. Furthermore, the study participants are reassured for an attainment of confidentiality and consent information is also taken.

4.15 Dissemination and Utilization of results

Result of the study was disseminated to Addis Ababa University School of Nursing as partial fulfillment of master's degree in maternity and reproductive health nursing. The findings this study was presented in hard and soft copy were available in the library of Addis Ababa University for graduate students as well as for other concerned readers.

CHAPTER FIVE

5. Results

5.1. Socio-demographic characteristics of respondents and husbands.

A total of 233 Married women who had come to hospital due to emergency obstetric referral were interviewed with response rate of 100%. Majority of the respondents were in the age group of 25 and above (72.5%) with mean age of 26.7 ± 4.8 standard deviation, while most of husbands were in the age group of 30 and above years of age (73%) with mean age of 31.9 ± 4.9 standard deviation. Majority of the respondents (57.5%) and husbands (58.8%) were Wolaita and Gamo (12.9%) and (15.0%) respectively. Most of respondents (33.5%) had primary level of education followed by secondary (22.7%), tertiary (22.3%) and no formal education (21.5%). 36.5% of husbands had primary level of education followed by tertiary (33.9%), secondary (21.5%) and no formal education (8.2%). (Table1) Most of the respondents are housewives (47.5%) whereas the husbands are Gov. Organization employed (38.3%) followed by merchant (27.0%). (Table 1)

Table 1: Socio-demographic characteristics of the Respondents and Husbands in Wolaita zone Sodo town, 2017 (N=233)

Variables	Category	Frequency	Percentages (%)
Age category of women	Below 25	64	27.1%
	25 and above	169	72.5%
Husband's Age category	Below 30	63	27%
	30 and above	170	73%
Religion	Protestant	124	53.2%
	Orthodox	73	31.3%
	Muslim	24	10.3%
	Catholic	10	4.3%
	Other	2	.9%
Husband's Religion	Protestant	124	53.2%
	Orthodox	74	31.8%
	Muslim	24	10.3%
	Catholic	9	3.9%
	Other	2	.9%
Ethnicity	Wolaita	134	57.5%
	Gamo	30	12.9%

	Amhara	22	9.4%
	Siltie	18	7.7%
	Guragie	13	5.6%
	Oromo	8	3.4%
	Other	8	3.4%
Husband's Ethnicity	Wolaita	137	58.8%
	Gamo	35	15.0%
	Guragie	16	6.9%
	Siltie	15	6.4%
	Amhara	15	6.4%
	Oromo	7	3.0%
	Other	8	3.4%
Educational Level	No Formal Education	50	21.5%
	Primary(1-8)	78	33.5%
	Secondary(9-12)	53	22.7%
	Tertiary(above 12)	52	22.3%
Husband's Educational Level	No Formal Education	19	8.2%
	Primary(1-8)	85	36.5%
	Secondary(9-12)	50	21.5%
	Tertiary(above 12)	79	33.9%
Occupation	Gov.Org.Employed	45	19.3%
	NGO or Private Org.Employed	3	1.3%
	Merchant	49	21.0%
	Daily Laborer	7	3.0%
	Housewife	111	47.5%
	Other	18	7.7%
Husband's Occupation	Gov.Org.Employed	66	28.3%
	NGO or Private Org.Employed	14	6.0%
	Merchant	63	27.0%
	Daily Laborer	38	16.3%
	Farmer	51	21.9%
	Other	1	.4%

5.2 Knowledge of obstetric complication and Source of information

. From the total of respondent forty six (19.7%), women were found to be knowledgeable about obstetric complications which can occur during pregnancy 62(26.6%) women were found to be knowledgeable about obstetric complications which can occur during child birth and delivery and 45(19.3%) women were found to be knowledgeable about obstetric complications which can occur during first 2 days after birth that could endanger the life of the woman. which was measured by mean score at three stages. Majority of the respondents reported bleeding from serious health problems at three stages. The percentage of respondent who knew vaginal bleeding related to pregnancy was (19.7%), in relation to delivery (26.6%) and in relation to postpartum period (19.3%).

Regarding about source of health information about birth preparedness and complication readiness majority of respondent 138(59.2%) were not seen, heard or read any information about birth preparedness and complication readiness. 95(40.8%) from those how seen, heard or read any information about birth preparedness and complication readiness most of respondent 49(21%) reported that they heard information from radio, 23(9.9%) Interpersonal sours, 7(3%) from TV and 34(14.6%) heard from other source. (Table 2)

Table 2: Source of information about birth preparedness and complication readiness in Wolaita zone Sodo town, 2017 (N=233)

Source of information about BP/CR				
Variables		Category	Frequency	Percentages (%)
seen, heard or read any information		Yes	95	40.8%
		No	138	59.2%
Variables	Category		Frequency	Percentages (%)
which source(s) did you see, hear, or read	Radio	Yes	49	21%
		No	46	19.7%
	TV	Yes	7	3%
		No	88	37.8%
	Interpersonal sours	Yes	23	9.9%
		No	72	30.9%
	Other	Yes	34	14.6%
		No	61	26.2%

5.3 Birth preparedness and complication readiness plan

Majority of the respondents were found to be planed for delivery 214(91.8).Both respondent and husband made plan for delivery were 213(91.4%) and 18(7.7%) respondent only were made plan for deliver respectively. Majority of respondents 223(95.7%) were previous delivery at health facility and Ten (4.3%) of respondent delivered at home. From those respondent 4(1.7%) mentioned distance from health facility is too far as reason for home delivery. One hundred and eighteen (50.6%) respondent and husband both paid for the cost of transport and 90(38.9%) respondent and husband both paid for the cost of health facility care. Majority of respondents 119(51.1%) were assisted with delivery of baby by midwifes/nurse and 100(42.9%) assisted by doctors.

Among the respondents who said they had saved money in case of emergency either alone or with husbands jointly. One hindered and twenty nine (55.4%) respondent and husband both were found to be saved money in case of emergency.

Twenty one 21(9%) were experienced problem during pregnancy and 13(5.6%) women said that they experienced bleeding during pregnancy. 14(6%) respondent reported that had seek assistance and 14(6%) women sad that respondent and husband both made decision about to seek assistance for problem. 12(5.2%) women said that they assisted by doctor for obstetric complications. 13(5.6) respondent and husband both were made the final decision where to give birth. (Table 3)

Table 3: Birth preparedness and health seeking behaviors in Wolaita zone Sodo town, 2017(N=233)

Variables		Category	Frequency	Percentages (%)
made a plan for deliver		Yes	214	91.8%
		No	19	8.2%
Variables	Category		Frequency	Percentages (%)
Who made plan for deliver	Respondent only		18	7.7%
	Respondent and husband both		213	91.4%
	Husband only		2	.9%
Place of deliver	Home		10	4.3%
	Health facility		223	95.7%
why didn't you deliver in a health facility	Cost too much	Yes	2	.9%
		No	8	3.4%

	Too far	Yes	4	1.7%
		No	6	2.6%
	No transportation	Yes	1	.4%
		No	9	3.9%
	Other	Yes	3	1.3%
		No	7	3%
Who paid for the cost of Transport	Respondent only		12	5.2%
	Respondent and husband both		118	50.6%
	Husband only		48	20.6%
	Relatives		12	5.2%%
	Others		43	18.5%
Who paid the cost for health facility care	Respondent only		11	4.7%
	Respondent and husband both		90	38.6%
	Husband only		45	19.3%
	Relatives		16	6.9%
	Not paid		67	28.8%
	Others		4	1.7%
Who assisted with the delivery of the baby	Doctor		100	42.9%
	Nurse or midwife		119	51.1%
	Health officer		2	.9%
	HEW		7	3%
	Others		5	2.1%
Who saved money in case of emergency	Respondent only		19	8.2%
	Respondent and husband both		129	55.4%
	Husband only		59	25.3%
	Other		26	11.2%
ANC at least once	Yes		225	96.6%
	No		8	3.4%
who decided for ANC	Respondent only		25	10.7%
	Husband only		12	5.2%
	Respondent and husband both		187	80.5%
	Other		1	.4%
Experience of problem during this pregnancy	Yes		21	9%
	No		212	91%
problems experienced	Bleedings	Yes	13	5.6%
		No	8	3.4%
	Severe headache	Yes	2	.9%
		No	19	8.2%
	Convulsion	Yes	1	.4%

		No	20	8.6%
	High fever	Yes	1	.4%
		No	20	8.6%
	Loss of consciousness	Yes	3	1.3%
		No	18	7.7%
	Other	Yes	3	1.3%
		No	18	7.7%
Variables		Category	Frequency	Percentages (%)
seek assistance for this problem		Yes	14	6%
		No	7	3%
Variables	Category		Frequency	Percentages (%)
Why did you not seek assistance for this problem	Husband disproval		2	.9%
	Facility too far		2	.9%
	No transportation		3	1.3%
Who made final decision about whether or not seek assistance for this problem	Respondent only		6	2.6%
	Respondent and husband both		14	6%
	Husband only		1	.4%
seek health care during problem and complications		Yes	16	6.9%
		No	5	2.1%
Variables	Category		Frequency	Percentages (%)
Whom did you see for assistance for this problem	Doctor		12	5.2%
	Nurse or midwife		3	1.3%
	HEW		1	.4%
Who made the final decision where you would give birth	Respondent only		6	2.6%
	Respondent and husband both		13	5.6%
	Husband only		2	.9%

5.4. Level of husband involvement on decision for antenatal care follow-up

Two hundred and twenty five (96.6%) women said that they had ANC at least once during pregnancy of last child. Majority of respondent and husband both 187(80.5%) were found to be decided for ANC follow up.

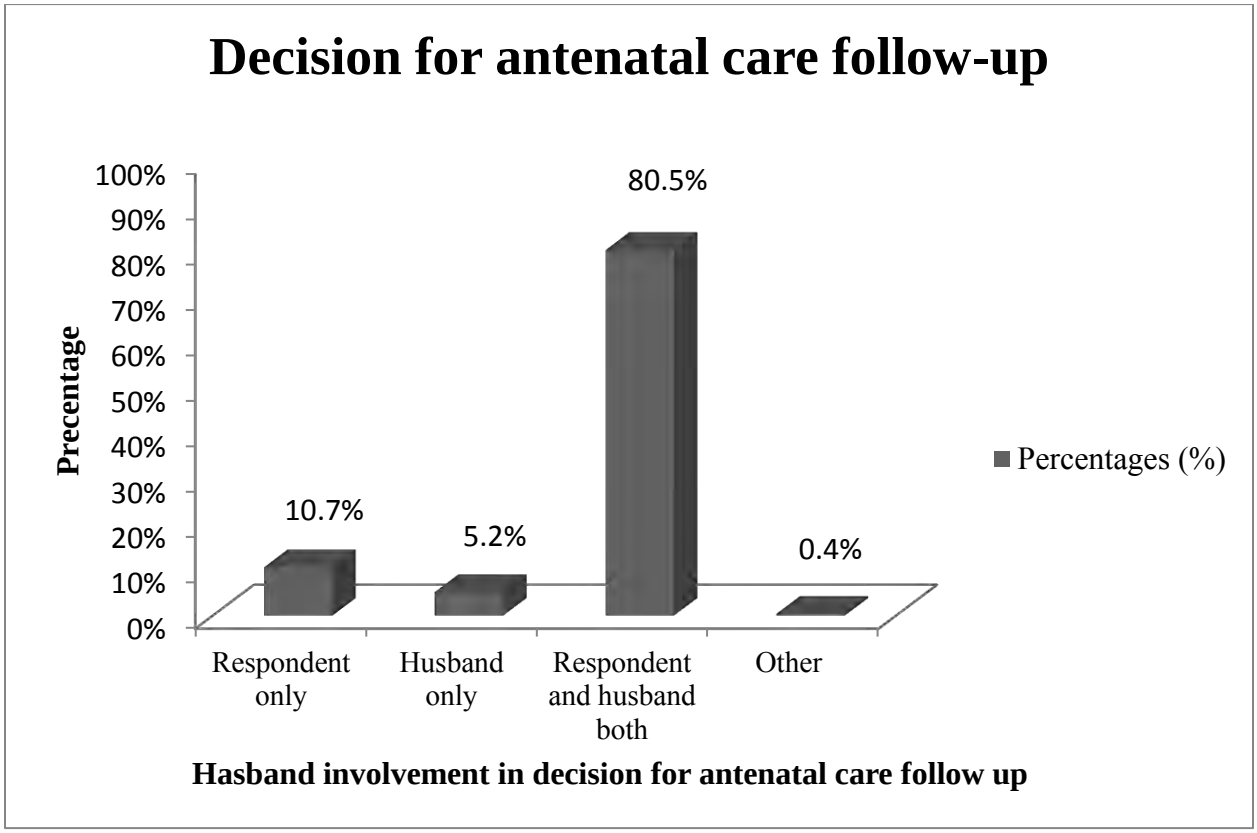

Figure 3 Level of husband involvement in decision for antenatal care follow up in Wolaita Zone Sodo Town, 2017

6.5. Reason for referral

Among the reason for referral 69(29.6%) were referred due to obstructed or prolonged labor followed by 34(14.6%) fetal distress, 27(11.6%) Malpresentation, 20(8.6%) Previous caesarean section, 16(6.9%) Multiple pregnancy, 16(6.9%) Postpartum hemorrhage, 16(6.9%) Anemia, 14(6%) hemorrhage, 13(5.6%) Poor obstetric history, 10(4.3%) Ruptured uterus, 9(3.9%) Eclampsia, 7(3%) Preeclampsia, and 5(2.1%) Preterm labour respectively. From the women referred to hospital majority of 189(81.1%) respondent were reached hospital by ambulance and 23(9.9%) respondent were reached hospital by privet car or transportation. 126(54.1%) respondent and husband both made final decision about whether or not to seek for assistance and one hundred and sixty two (69.5%) respondent accompanied to seek care by husband.

118(50.6%) respondents were seen midwife/nurse for assistance during health problem followed by 114(48.9%) respondent were seen doctor.

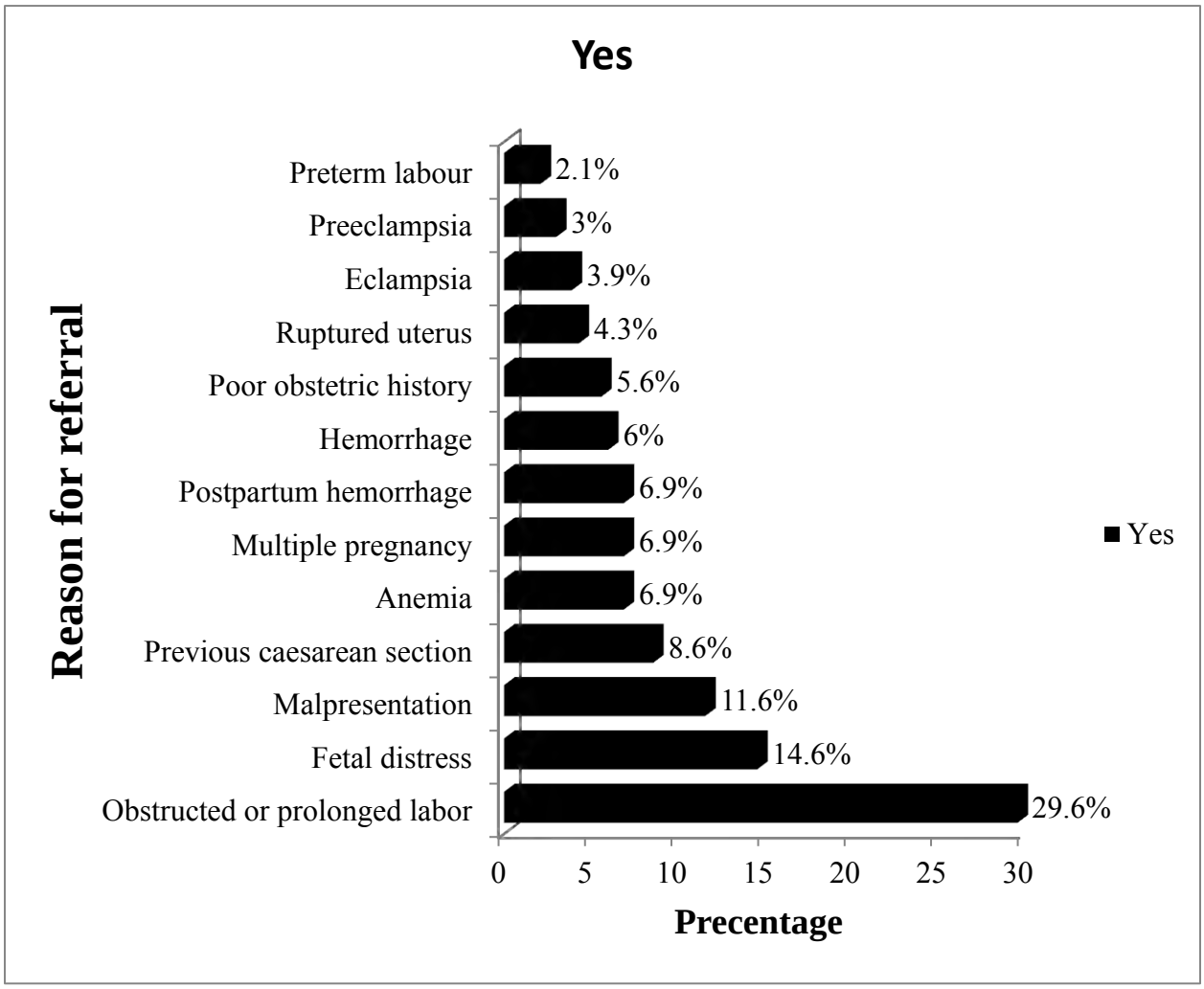

Figure 4 Reason for obstetric emergency referral in Wolaita Zone Sodo Town, 2017

5.6. Husband accompanied to deliver place

Among respondent referred to hospital one hundred and fifty sixe (67%) respondents were accompanied to deliver place by other member of the family and 75(32.2%) respondent were accompanied to deliver place by male partner.

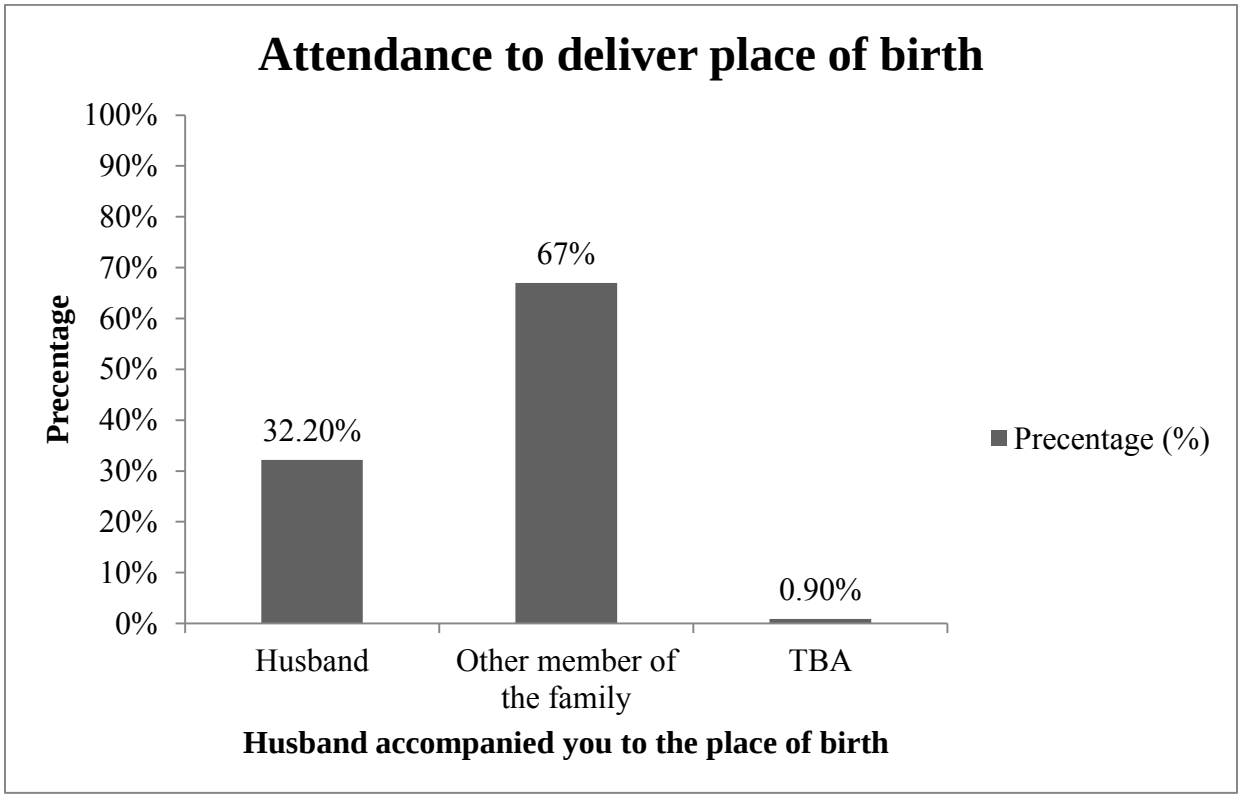

Figure 4 Level of husband attendance to place of birth in Wolaita Zone Sodo Town 2017

Table 4: Husband involvement in decision making for health care seeking in Wolaita zone Sodo town, 2017(N=233)

Variables	Category	Frequency	Percentages (%)
How did you go to the health facility	Ambulance	189	81.1%
	Privet car	23	9.9%
	Taxi/bus	21	.9%
Who accompanied you to the place where you gave birth	Husband	75	32.2%
	Other member of the family	156	67%
	TBA	2	.9%

Distance from health facility	>5 km	184	79%
	<5km	49	21%
Who made the final decision about whether or not you would go somewhere for assistance	Respondent only	16	6.9%
	Respondent and husband both	126	54.1%
	Husband only	83	35.6%
	Other	1	.4%
Who accompanied you to seek care	Husband	162	69.5%
	Friends/neighbors	14	6%
	Other member of respondent fam	56	24%
	Other	1	.4%
Whom did you see for assistance for this health problem	Doctor	114	48.9%
	Nurse or midwife	118	50.6%
	HEW	1	.4%

5.7. Factors influencing male involvement in birth preparedness and complication readiness for obstetric referral

In the bivariate analysis significant association was observed between the occupation of respondent, occupation of husband, educational status of respondent and husband, Distance of health facility, having ANC follow-up and experience of obstetric complication with male partner's involvement in birth preparedness and complication readiness for obstetric referral.

Respondent who's education states were primary and below were 0.23 times less likely husband involved in birth preparedness and complication readiness for obstetric referral when compared to respondents who's educational states were secondary and above (COR=0.232 (95%CI=0.085, 0.0638)).

Male partners educational states were primary and below were 1.60 more likely involved in birth preparedness and complication readiness for obstetric referral than those who had educational states secondary and above (COR =1.60 (95%CI=1.070, 2.611)).

Women who were formally employed were 1.86 times more likely male involved in in birth preparedness and complication readiness for obstetric referral than those who were informal employment (95%CI=0.507,7.527).

Male partners who were formally employed were 0.089 times less involved in birth preparedness and complication readiness for obstetric referral than those who were informal employment (COR =0.089 (95%CI=0.011, 0.734).

After adjusting for the effect of confounding variables using logistic regression, variables like distance of health facility, having ANC follow-up and experience of obstetric complication have statistically significant association with male partner's involvement in birth preparedness and complication readiness for obstetric referral, while the rest are not statistically significant $p<0.05$.

Distance to the nearest health facility less than 5 km had lower odds of husband involvement in birth preparedness and complication readiness for obstetric referral compared to more than 5km (AOR=0.288, 95%CI=0.116,0.719 , P=.008).

Women who had any experience of pregnancy complications were significantly associated with male partner's involvement in birth preparedness and complication readiness for obstetric referral. Respondent who had any experience of pregnancy complications were 1.8 times more likely male participated in birth preparedness and complication readiness for obstetric referral as compared to those who were no experienced pregnancy complications(AOR=1.8, 95%CI=1.059,3.040)).

Women who had received ANC follow up at list one time were 2.9 times higher male partner involvement in birth preparedness and complication readiness for obstetric referral than those who had not received ANC at list once(AOR=2.9, 95%CI=1.521,5.510)). (Table 5)

Table 5: Bivariate and Multivariate analysis for factors associated with male involvement during birth preparedness and complication readiness for obstetric referral in Wolaita zone Sodo town, 2017

Variables	Male involvement		COR (95%CI)	AOR (95% CI)	P-value
	Yes	No			
Respondent Educational					
Primary and below	26(20.3%)	102(79.68%)	0.232 (0.085-0.638%)	0.937 (0.243-3.611)	.924
Secondary and above	55(52.38%)	50(47.61%)	1.00	1.00	
Husband education					
Primary and below	89(51.44%)	84(48.55%)	1.60 (1.070-2.611)	1.088(0.433-2.737)	.858
Secondary and above	24(40%)	36(60%)	1.00	1.00	
Respondent Occupation					
Formal employment	48(85.71%)	8(14.28%)	1.86 (0.507- 7.527)	2.482(0.569-10.828)	.227
Informal employment	135(76.3%)	42(23.72%)	1.00	1.00	
Husbands occupation					
Formal employment	13(16.3%)	67(83.75%)	0.089 (0.011-0.734)	0.086(0.007-1.040)	.054
Informal employment	105(68.6%)	48(31.37%)	1.00	1.00	
Distance of HF					
Less than 5km	10(14.5%)	59(85.5%)	.233 (.107-.558)	**0.28(0.116-0.719**)*	.008
More than 5 km	69(15.76%)	95(84.2%)	1.00	1.00	
ANC at least once					
Yes	105(46.6%)	120(53.33%)	2.62(1.521- 4.740)	**2.9(1.521-5.510**)*	.001
No	2(25%)	6(75%)	1.00	1.00	
Experience of complication					
Yes	16(7.54%)	196(92.5%)	1.63 (1.073- 2.639)	**1.8(1.059-3.0 40**)*	0.030
No	1(4.76%)	20(95.2%)	1.00	1.00	

Statistically significant at*= p-value<0.05 1=reference point

CHAPTER SIX

6. Discussion

The aim of this study was to assess male partners' involvement in in birth preparedness and complication readiness for obstetric referral of a spouse and its associated factors among women admitted at MCH department due to obstetric referral at Wolaita zone, Sodo town, Southern Ethiopia.

In this study prevalence of male partners' involvements' in birth preparedness and complication readiness for obstetric referral was 30.9. Women who had any experience of pregnancy complications were 1.8 times and those who received ANC follow up at list one time were 2.9 times more likely male participate in birth preparedness and complication readiness for obstetric referral whereas women's who walked less than 5 km distance to the nearest health facility had lower odds of husband involvement in birth preparedness and complication readiness for obstetric referral compared to those who walked more than 5km.

The study finding revealed that the prevalence of male partners' involvements' in birth preparedness and complication readiness for obstetric referral was 30.9% which is lower than study done in Tigray region, Ethiopia (60.4%) and Ambo Town (50.8%) (25,34). The possible explanation for such low involvement might be due to educational and occupational states variation. However, the finding was higher than study done in Gamo Gofa Zone of southern Ethiopia (9.4%)(13). The reason why this finding is higher might be educational and occupational states variation.

Using bivariate analysis those participants husband who attend secondary and higher level of school had more involvement in birth preparedness and complication readiness for obstetric referral. This finding was supported by the study done in northern Nigeria, Uganda and Rwanda and Ambo (8,20,24,34). The possible explanation is that education enhances male knowledge on birth preparedness and complication readiness for obstetric referral.

Respondents education states primary and below were 0.23 times less likely male involved in birth preparedness and complication readiness for obstetric referral when compared to

respondents who's educational states were Secondary and above (COR=0.232(95%CI=0.085, 0.0638)). This was similar with other study done in Japan and Uganda (20,27).

Respondent's occupation was one of the significant factors in promoting male partners' involvement in in birth preparedness and complication readiness for obstetric referral. Male partners whose wife were formally employed were1.86 times more likely to involved in in birth preparedness and complication readiness for obstetric referral than those who were Informal employment (95%CI=0.507,7.527). This was similar with other study done in Nepal (5).

By using multivariate analysis having ANC follow-up at list once was significant predictor for male partners' involvement in birth preparedness and complication readiness for obstetric referral. Respondent who had ANC follow-up at list once were 2.9 times more likely male involve in birth preparedness and complication readiness for obstetric referral than those had no ANC follow up. The finding was consistent with other study done in Haiti, Ambo and Addis Ababa (7,26,34). Having ANC follow-up at list once could influence male partner's involvement in birth preparedness and complication readiness for obstetric referral.

Respondent who walk to nearest health facility that provide obstetric care, delivery and PNC services are located more than 5km from home, were 0.28 time highly accompanied by husbands compared to those living less than 5km. The finding was consistent with other study done Addis Ababa (26).

Our study also showed that women who had any experience of pregnancy complications were more likely male involve in birth preparedness and complication readiness for obstetric referral than those who didn't have any signs. The finding was consistent with other study done in Uganda(20). This may be due to spouses might have been worried more than those whose spouses had not any signs of pregnancy complications.

7. Strengths and Limitation of the study

7.1 Strengths of the study

The study was based on a standardized questionnaire on similar topic

High response rate

7.2 Limitation of the study

Limitation of the study was unlike most other researches, this study didn't include husbands in the sample. Generalizations about husband involvement were made based on wives report. The study was cross sectional.

8. Conclusion

Male involvement in birth preparedness and complication readiness for obstetric referral is low. Male involvements on making plane for deliver were relatively higher during pregnancy. whereas husbands participation in joint decision on where to attend ANC follow up and making final decision about where to go for assistance and accompanied to seek care moderate, and level of husband accompanied to deliver place is low.

Factors that were significantly associated with male involve in birth preparedness and complication readiness for obstetric referral were respondent educational states, husband educational states, respondent occupational stats, husband occupational states, distance of health facility, having ANC follow up at list ones and experience of obstetric complication during pregnancy.

9. Recommendations

- The government and other responsible bodies should make efforts to increase community based health education, awareness creation and improve male partner's involvement in birth preparedness and complication readiness for obstetric referral.
- Communities should be empowered economically and socially i.e. Education, Employment.
- Programmes should give emphasis on raising awareness thought couple based education about maternal complications to increase male accompany emergency obstetric care and delivery.
- Encourage women to come with her husband for the first ANC visit early in pregnancy and for adequate frequency of ANC visits.
- Till now, few researches have been conducted on similar topics in this country. For best understanding and maintaining and improving maternal and child health, more researches should be conducted in the future for the purpose of planning and implementing and evaluating reproductive health care.

ANNEXE 1: Reference

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ANEEXE 2: Questioner

Addis Ababa University
School of nursing and midwifery
Department of RH and maternity

TITLE OF THE STUDY: Assessment of male involvement in birth preparedness and complication redness for emergency referral at Wolaita Zone, Sodo Town, SNNPR, Ethiopia, 2017

Consent form

My name is _____. We are conducting a study on assessment of male involvement in birth preparedness and complication redness for emergency referral. We are interested on the experiences of women who had emergency referral and given births in the Sodo teaching and referral hospital MCH ward. You may be eligible to participate in the study. The result of the study will help to understand how to plan health services and to set strategies on how to involve men in the reproductive health care of the women as a whole. We have some questions and will not take much of your time. The information you will give us will be kept confidential i.e. it will not be disclosed to anyone other than the study team. You will not be asked your name. You don't have to be in the study but we hope you will agree to answer the questions since your views are important. There is no right or wrong answers. If I ask you any question that make you feel uncomfortable just let me know and I will go to the next question or you can stop the interview at any time. It is very important that you answer every question truthfully. The principal investigator for the study is KEBREAB PAULOS, RH and maternity student at Addis Ababa University and I am part of the study team. For further information, you can call to the principal investigator by Mobile phone No. +251 912281104

Do you have any questions?

May I continue the interview now?
If you agree, please sign in the space below.
Signature of the participant _____ Date _____
Signature of the interviewer _____ Date _____

SECTION1: BACKGROUND CHARACTERSTICS OF THE RESPONDENT			
No	QUESTIONS	CODING CATEGORIES	SKIP
1.	Age?	_____	
2.	Religion?	Orthodox ……..……..…1 Muslim…….2 Catholic……3 Protestant……...4 Other (specify)_____	
3.	Ethnicity?	Amhara …….1 Oromo…….2 Tigre …….....3 Guragie……4 Siltie……..5 Wolaita …….6 Other (specify) _____	
4.	Educational level?	No formal Education……..1 Primary (1-8) ……...2 Secondary (9-12)…….3 Tertiary (above 12)……..…...4	
5.	Occupation?	Gov. org. Employed……...1 NGO or Private Org. employed ….2 Merchant …….3 Daily laborer ……4 House wife……5 Other (Specify) _____	
6.	What is your marital status now?	Single……1 Married……..2 Widowed……3 Divorced…….4 Separated……5	

SECTION 2: BACKGROUND CHARACTERSTICS OF THE HUSBAND			
No	QUESTIONS	CODING CATEGORIES	SKIP
7	Your Husband's Age?	_____	
8	Your Husband's religion?	Orthodox ……..…1 Muslim…….2 Catholic……3 Protestant……...4 Other (specify)_____	
9	Your Husband's ethnicity?	Amhara ……..1 Oromo……..2 Tigre …….....3 Guragie…….4 Siltie……..5 Wolaita …….6 Other (specify) _____	
10	What is your husband's educational level?	No formal Education……..1 Primary (1-8) ……...2 Secondary (9-12)……..3 Tertiary (above 12)……..…...4	
11	What is your husband's occupation?	Gov. org. Employed……...1 NGO or Private Org. employed …….2 Merchant …….3 Daily laborer ……..4 Other (Specify) _____	

SECTION3: Knowledge of obstetric complication and Sours of information			
No	QUESTIONS	CODING CATEGORIES	SKIP
12	In your opinion, what are some serious health problems that can occur during pregnancy that could endanger the life of a pregnant woman?	Bleedings……1 Severe headache……..2 Blurred vision……..3 Convulsion……4 High fever……..5 Loss of consciousness……6 Other (Specify) _____	
13	In your opinion, could a woman die from [this problem] any of these problems?	Yes……1 No…….2	
14.	In your opinion, what are some serious health problems that can occur during labor and childbirth that could endanger the life of a pregnant woman?	Severe Bleeding……1 Severe headache……..2 Blurred vision……..3 Convulsion……4 High fever……..5 Loss of consciousness……6 Labor lasting >12 hr……7 Placenta not delivered……..8 Other (Specify) _____	
15.	In your opinion, could a woman die from [this problem] any of these problems?	Yes……1 No…….2	
16.	In your opinion, what are some serious health problems that can occur during the first 2 days after birth that could endanger the life of the woman	Bleedings……1 Severe headache……..2 Blurred vision……..3 Convulsion……4 High fever……..5 Loss of consciousness……6 Other (Specify) _____	
17.	In your opinion, could a woman die from [this problem] any of these problems?	Yes……1 No…….2	
18	Have you seen, heard or read any information related to	Yes……1 No…….2	

	birth preparedness in the past six months?		
19.	From which source(s) did you see, hear, or read about birth preparedness?	Radio……1 Tv ……2 Written sours……..3 Interpersonal sours……4 Other (Specify) _____	

SECTION4. INFORMATION ON MALE INVOLVMENT IN BIRTH PREPAREDNESS AND HEALTH SEEKING BEHAVIORS			
No	QUESTIONS	CODING CATEGORIES	SKIP
20	Did you or your husband have made a plan of where to deliver from?	Yes……..……1 No ……..……2	
21	Who have made the plan of where to deliver from?	Respondent only ……..1 Respondent and husband both……2 Husband only…….3	
22.	Where did you give birth to the recent baby?	Home ……1 Health facility……..…2 Other (Specify)_____	
23.	If home, why didn't you deliver in a health facility?	Cost too much…….1 Facility not open……..2 Too far……..3 No transportation……4 Quality service……5 Husband did not allow……..6 Other (Specify)_____	
24.	Who paid for the cost of transport to reach to the place of birth during labor?	Respondent only ……1 Respondent and husband both…….2 Husband only……..3 Relatives…….4 Others (Specify)_____	
25.	Who have paid the cost for health facility care during labor?	Respondent only ……1 Respondent and husband both…….2 Husband only……..3 Relatives…….4 Not paid……..……..5 Others (Specify)_____	
26.	Who assisted with the delivery of the baby?	Doctor……..1 Nurse or midwife……..2	

		Health officer……..3 HEW……4 Others (Specify)_____	
27.	Who have saved money in case of emergency?	Respondent only ……1 Respondent and husband both…….2 Husband only……..3 Others (Specify)_____	
28.	Did you have antenatal care check-up at least once during your pregnancy?	Yes……..……1 No ……..……2	
29.	If yes, who made decided where you should attend ANC?	Respondent……1 Husband……..2 Make a decision as a couple…….....3 Others (Specify)_____	
30.	During this pregnancy, did you experience any serious health problems related to the pregnancy?	Yes……..……1 No ……..……2	
31.	What problems did you experience?	Bleedings……1 Severe headache……..2 Blurred vision……..3 Convulsion……4 High fever……..5 Loss of consciousness…….6 Other (Specify) _____	
32.	Which one of these problems was the most severe?	Bleedings……1 Severe headache……..2 Blurred vision……..3 Convulsion……4 High fever……..5 Loss of consciousness…….6 Other (Specify) _____	
33.	Did you seek assistance for this problem?	Yes……..……1 No ……..……2	
34.	IF NOT, Why did you not seek assistance for this problem?	Husband disproval ……1 Facility too far……2 No transportation……3	

		Didn't know where to go……4 Other (Specify) _____	
35.	Who made the final decision about whether or not to seek assistance for this problem?	Respondent only ……..1 Respondent and husband both……2 Husband only…….3 Other (Specify) _____	
36.	Do you seek health care during problem and complications?	Yes……..……1 No ……..……2	
37.	Whom did you see for assistance for this problem?	Doctor…….1 Nurse or midwife……2 Health officer……..3 HEW…….4 Other (Specify) _____	
38.	Who made the final decision about where you would give birth?	Respondent only ……..1 Respondent and husband both……2 Husband only…….3 Other (Specify) _____	
39.	DO you give birth in facility?	Yes……..……1 No ……..……2	
40.	Can you tell me the reasons for your referral?	Anemia…….1 Eclampsia……..2 Fetal distress……..3 Hemorrhage……4 Obstructed or prolonged labor……5 Poor obstetric history……6 Malpresentation……7 Multiple pregnancy……8 Previous caesarean section…….9 Ruptured uterus……10 Preterm labour……..11 Postpartum hemorrhage……12	
41.	How did you go to the health facility?	Ambulance……..1 Privet car…….2 Taxi/bus……3 Cart…….4 Other (Specify) _____	
42.	Who accompanied you to the place where you gave birth?	Husband……1 Other member of the family…….2 TBA……3	

		Other (Specify) _____	
43.	How long did it take to reach the health facility?	>5 km……..1 <5km…….2	
44.	Who made the final decision about whether or not you would go somewhere for assistance?	Respondent only ……..1 Respondent and husband both……2 Husband only…….3 Other (Specify) _____	
45.	Who accompanied you to seek care?	Husband……1 Friends/neighbors……2 Other member of respondent fam……3 Other (Specify) _____	
46.	Whom did you see for assistance for this health problem?	Doctor……1 Nurse or midwife…….2 Health officer…….3 HEW……..4 Other (Specify) _____	

አዱስ አበባ ዩኒቨርሲቲ

የጤና ሳንስ ኮሌጅ ነርስንግ ና ሚድዋይፈር ት/ቤት

የስምምነት መግለጫ ቅጽ

ጤና ይስጥሌኝ ስሜ ---------- ይባሳል፡፡ ባል በእርግዝና እና በወሉዴ ጊዜ የሚኖውን ተሳትፎ መገምገሚያ ጥናት እያሄዴን እንገኛሇን፡፡ በወሊይታ ዞን ሶዶ ከተማ የሚኖሩና ባለትዲር ሴቶች ሊይ በወሌድ ወቅት በምገጥማቸዉ ችግር ምክንያት በሪፈረ ሆስፍታል በመጡ ሰቶች የነበራቸውን ገጠመኝ ሇማወቅ ፍሊጎት አለን፡፡ እርሰዎም በጥናቱ ሊይ ሇመሳተፍ መስፈርቱን ያሟለ ሉሆኑ ይችሊለ፡፡ ከጥናቱ የሚገኘው ውጤት የጤና አገሌግልት እቅዴ እንዳት ማውጣትና ባጠቃሊይም ወንድች በሴቶች የስነ ተዋሌድ ጤና እንክብካቤ እንዳት መሳተፍ እንዯሚችለ ስሌቶችን ሇማስቀመጥ ይረዲሌ፡፡ ትንሽ ቁጥር ያሊቸው ጥያቄዎች አለን ብዙ ጊዜዎትንም አንወስዴብዎትም፡፡ የሚሰጡን መረጃ ምስጢሩ የተጠበቀ ይሆናሌ ይህም ማለት ከጥናቱ ቡድን አባሳት ውጭ ሇማንም ሰው የሚገሇፅ አይሆንም፡፡ ስምዎትንም አይጠየቁም፡፡ በጥናቱ ውስጥ የግድ መካተት አይኖርብዎትም ነገር ግን የሚሰጡን አስተያየት ጠቃሚ ስለሆነ ጥያቄዎቹን ሇመመለስ ፈቃደኛ እንደሚሆኑ ተስፋ እናደርጋለን፡፡ ትክክለኛና የተሳሳተ መልስ የሚባል የለም፡፡ ሇስሜትዎ የማይመች ጥያቄ ከጠየኩኝ እንዲውቅ ብቻ ያድርጉ ወደሚቀጥለው ጥያቄ እሄዲለሁ ወይም ቃለ መጠይቁን በማንኛውም ጊዜ ማቆም ይችሊለ፡፡ እያንዲንደን ጥያቄ በሃቀኝነት ቢመሌሱ ጠቃሚ ይሆናሌ፡፡

የጥናቱ ዋና ተመራማሪ ክብረአብ ጳዉልሎስ በአዱስ አበባ ዩኒቨርሲቲ በነርስግ ትምርት ክፍል የስነ ተዋልዶ ጤና የሁለተኛ ዱግሪ ተማሪ ሲሆን እኔ ደግሞ የጥናቱ ቡዴን አባሌ ነኝ፡፡

ሇተጨማሪ መረጃ ሞባይሌ ስሌክ ቁጥር 0912281104 መደወል ይችሊለ፡፡

ጥያቄ ይኖርዎታሌ?

ክፍል 1፡- የመሌስ ሰጭ እናት የመደብ ባህሪያት የሚመለከቱ ጥያቄዎች ?

ተ.ቁ	ጥያቄዎች	ማስታወሻ ክፍልች	መዝለያ
1	ዕድሜ ?		
2	ሃይማኖት ?	ፕሮቴስታንት……..ሀ ኦርቶድክስ…….ለ ሙስሉም…….ሐ ካቶሉክ ……መ ለላ (ይጥቀሱ)_____	
3	ብሔር ?	ወሊይታ……..ሀ ጋሞ……..ለ ጉራጌ ……ሐ ስሌጤ……መ አማራ ……ሠ ኦሮሞ……ረ ላሊ(ይጥቀሱ)…….	
4	የትምህርት ደረጃ ?	መጥበኛ ትምህርት ያሌተማረ አንዯኛ ዯረጃ (1-8) . ሁሇተኛ ዯረጃ (9-12) ሦስተኛ ዯረጃ (ከ12 በሊይ)	
5	ሥራ ?	የመንግስት ዴርጅት ተቀጣሪ …..ሀ መንግስታዊ ያሌሆነ ወይም የግሌ ዴርጅት ተቀጣሪ ……..ለ ነጋዳ …….. …….ሐ የቀን ሰራተኛ ……መ የቤት እመቤት ……ሠ ለላ(ይጥቀሱ)_____	
6	የሚያገኙት ወርሃዊ ገቢ አለዎት?	አዎ……..……1 የለም…-……2	
7	የጋብቻ ሁኔታ	ያሊገባች ያገባች የተፈታች ባል በሞት ያጣች	

ክፍል -2 ፡- የባል የመደብ ባህሪያትን የሚመለከቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	ማስታዎሻ ክፍልች	
8	የባለቤትዎ ዕዴሜ		
9	ሃይማኖት	ፕሮቴስታንት……..ሀ ኦርቶድክስ…….ለ ሙስሉም…….ሐ ካቶሉክ ……መ ለላ (ይጥቀሱ)_____	
10.	የባለቤትዎ ብሔር	ወሊይታ……..ሀ ጋሞ……..ለ ጉራጌ ……ሐ ስሌጤ……መ አማራ ……ሠ ኦሮሞ……ረ ላሊ(ይጥቀሱ)…….	
11.	የባለቤትዎ የትምህርት ደረጃ?	የመንግስት ዴርጅት ተቀጣሪ …..ሀ መንግስታዊ ያሌሆነ ወይም የግሌ ዴርጅት ተቀጣሪ	

		……..ለ ነጋዳ …….. ……ሐ የቀን ሰራተኛ ……መ ገበረ……ሠ ለላ(ይጥቀሱ)_____	
ክፍል 3 በእርግዝና ወቅት የምያጋጥሙ ችግሮች እዉቀት እና የመረጃ ምንጮች			
12	በእረግዝና ወቅት ከምያጋጥሙ የጠና ችግሮች ምታዉቋትን ጥቀሱ	የደም መፍሰስ ከግተኛ ራስምታት ብዝታ መንቀጥቀጠ ከግተኛ ትኩሳት ራስን መሳት ለላ(ይጥቀሱ)_____	
13	ከላይ የጠቀሳችሁት ምክንያቶእ እናቶእን ለሞት ይዳርጋሉ	አዎ---------- አይደለም	
14	በወልድ ወቅት ከምያጋጥሙ የጠና ችግሮች ምታዉቋትን ጥቀሱ	ከፍተኛ የደም መፍሰስ ከግተኛ ራስምታት ብዝታ መንቀጥቀጠ ከግተኛ ትኩሳት ራስን መሳት ከ 12 ሰዐት በይ ምጥ ላይ መቆየት የእንግደ ልጅ መቅረት ለላ(ይጥቀሱ)_____	
15	ከላይ የጠቀሳችሁት ምክንያቶእ እናቶእን ለሞት ይዳርጋሉ	አዎ---------- አይደለም	
16	ከወልድ ወቅት በሁዋላ ከምያጋጥሙ የጠና ችግሮች ምታዉቋትን ጥቀሱ	የደም መፍሰስ ከግተኛ ራስምታት ብዝታ መንቀጥቀጠ ከግተኛ ትኩሳት ራስን መሳት ለላ(ይጥቀሱ)_____	
17	ከላይ የጠቀሳችሁት ምክንያቶእ እናቶእን ለሞት ይዳርጋሉ	አዎ---------- አይደለም	
19	ሰለ እርግዝና ና ተጉዋዳኝ ሁነታዎች ባለፉት 6 ወራት ሰምተዉ አይተዉ ወየም አንብበዉ ያዉቃሉ	አዎ---------- አይደለም	
20	ከየትኛዉ መረጃ ምንጭ ሰለ እርግዝና ና ተጉዋዳ ኝ ሁነታዎች ሰሙት ያዩት ያነበቡት	ራዱዮ ቴላቪዥን ከተጻፉ የመረጃ ምንጮች ከሰዎች በማዉራት ለላ(ይጥቀሱ)_____	
ክፍል 4 የ ወንዶች ተሳትፎ በየቅዱመ ወሉዱ ፣ በወሉዱና በዱህረ ወሉዱ አገሌግልት እና ጠናን መጠበቅን ነተመለከተ			
21	አንች ወየም ባልሽ በጠና ተቁዋም የመዉለድ	አዎ---------- አይደለም	

	እቅድ ነበራችዉ		
22	ማንዉ በጠና ተቁዋም እንድት ወልጅ ያቀደልሽ	መሌስ ሰጪ ……ሀ መሌስሰጪ እና ባሌ በጋራ ……ለ ባሌ ብቻ	
23	በቅርቡ ከዝህ በፍት የት ነዉ የወለድሽዉ	በት በጠና ተቁዋም ለላ(ይጥቀሱ)_____	
24	በት የወለድሽ ከሆነ ምክንየቱ ምንድ ነዉ	ክፍያ ስለተወደደ ጠና ተቁዋም ዝግ ስለሆነ ጠና ተቁዋም በጣም ሩቅ ስለሆነ ተራንስፎርት ስላጣዉ አገልግሎቱ ጥራት ስለምንል ባለ ሰላልፈቀደ ለላ(ይጥቀሱ)____	
25	በምጥ ጊዜ የሚወሌደበት ቦታ ለመዴረስ የመጓጓጥ ወጪ የከፈለ ማን ነበር ?	መሌስ ሰጪ ……ሀ መሌስሰጪ እና ባሌ በጋራ ባሌ ብቻ ዘመድ ለላ(ይጥቀሱ)____	
26	በምጥ ጊዜ በጤና ተቋም የጤና እክብካቤ አገሌግልት ወጪ የከፈለው ማን ነበር ?	መሌስ ሰጪ እናት ብቻ ……ሀ መሌስሰጪ እናት እና ባሌ በጋራ ……ሇ ባሌ ብቻ……..ሐ ዘመዴ…… አልተከፈለም ላሊ (ይጥቀሱ)	
27	የማዋለዴ አገሌግልት የሰጠዎት ማን ነበር	ሀኪም ነርስ ፣ወይስ አዋሊጅ ነርስ ጤና መኮንን ጤና እክስቴንሽን ባሇሙያ ለላ(ይጥቀሱ)____	
28	በእርግዝናዎ ጊዜ ለዴንገተኛ ጊዜ የሚሆን ገንዘብ የቆጥበው ማነበር ?	መሌስ ሰጪ እናት ብቻ ……ሀ መሌስሰጪ እናት እና ባሌ በጋራ ……ሇ ባሌብቻ ለላ(ይጥቀሱ)____	
29	በእርግዝናዎ ጊዜ የቅድመ ወሉዴ አገሌግልት ቢያንስ ለ1 ጊዜ አግኝተው ነበር ?	አዎ----------1 አይደለም	
30	የቅድመ ወሊደድ አገሌግልት የት ማግኘት እንዯሚገባዎት የወሰነው ማን ነበር ?	መሌስ ሰጭ እናት ……ሀ ባሌ ……ሇ መሌስ ሰጭ እናት እና ባሌ በጋራ……ሐ ላሊ (ይጥቀሱ)_____	
32	በዝህ እርግዝና ጋረ በተያያዘ የጠና ችግር አጋጥሞ ሽ ያዉቃል	አዎ----------1 አይደለም	
33	ምን የጠና ችግር አጋጥሞሽ ነበር	የደም መፍሰስ ከግተኛ ራስምታት ብዝታ መንቀጥቀጠ ከግተኛ ትኩሳት	

		ራስን መሳት ለላ(ይጥቀሱ)_____	
34	ከላይ ከጠቀሱት ችግሮች ተገኛዉ ነዉ የበልጥ ከባዱ	የደም መፍሰስ ከግተኛ ራስምታት ብዝታ መንቀጥቀጠ ከግተኛ ትኩሳት ራስን መሳት ለላ(ይጥቀሱ)_____	
35	በዝህ ችግር ምክንያት ወደ ጠና ተቁዋም ህደዉ ነበር	አዎ----------1 አይደለም	
36	ወደ ጠና ተቁዋም ካልሃዱ በምን ምክንያት ነበር ያለህዱት	ባል ስላልፈቀደ በርቀት ምክንያት ትራንስፎርት በማታት ምክድበትን ስለማላዉቅ ለላ(ይጥቀሱ)_____	
37	ማን ነዉ ባጋጠመሽ የጠና ችግር ወደጠና ተቁዋም እነደትሄጂ የምወስነዉ	መሌስ ሰጪ ……ህ መሌስሰጪ እና ባሌ በጋራ ባሌ ብቻ ለላ(ይጥቀሱ)_____	
38	የጠና እክል እና ችግሮች ስደርሱ ወደ ጠና ተቁዋም ትሄጅያለሽ	አዎ----------1 አይደለም	
39	የህክምና አገሌግልት የሰጠዎት ማን ነበር	ህኪም ነርስ ፣ወይስ አዋሊጅ ነርስ ጤና መኮንን ጤና እክስቴንሽን ባለሙያ ለላ(ይጥቀሱ)_____	
40	የት እንደምትወልጅ ምወስነዉ ማነዉ	መሌስሰጪ እና ባሌ በጋራ ባሌ ብቻ ለላ(ይጥቀሱ)_____	
41	በጠና ተቁዋም ነዉ የወለድሽዉ	አዎ----------1 አይደለም	
42	ርፍረ የረጉሽምክንያት ምንድነዉ	ደም ማነስ አክላምሽያ ፍርአክላምሽያ የሽል መታፈን ደም መፍሰስ የማጸን ጥበት ከዝህ በፍት ከወሊድ ጋር ተያያዝ ችግሮች የአቀማመጥ ችግር መንታ እርግዝና የበፍት ቀዶ ጥገና የማጸን መቀደድ ያለግዘ ምጥ ከወሊድ ብሁዋላ የደም መፍሰስ	
43	በምን ተጉዘሽ ወደ ጠና ተቁዋም ደረሽ	አንቡላንስ የግል መኪና ታኪስ ለላ(ይጥቀሱ)_____	
44	ማን ነዉ አብረዉሽ ወደ ምትወልጅበት ባታ	ባሌ ሌላ የበተሰብ አባል	

	ሽኝቶሽ የሄደዉ	የልምድ አዋላጅ ለላ(ይጥቀሱ)____	
45	የጠና አገሌግልት የሚሰጥ በአቅራቢያዎ የሚገኝ የጤና ተቋም ከመኖሪያ ቤትዎ ያሇው ርቀት ?	ከ5 ኪ.ሜ ያንሳሌ ……*ሀ* ከ5 ኪ.ሜ ይበሌጣሌ ……ሇ	
46	የጠና ህክምናና እርዳታ ሇማግኘት ምተሄጅበትን ምወስነዉ ማነዉ	መሌስ ሰጪ እናት ብቻ ……*ሀ* መሌስሰጪ እናት እና ባሌ በጋራ ……ሇ ባሌብቻ ለላ(ይጥቀሱ)____	
47	የጠና ህክምናና እርዳታ ሇማግኘት በምተሄጅበት ወቅት ማነዉ አብረዉሽ የምሄዱ	በሌ ጉዋደኞቸ/ጎረቤቶቸ ለላ የቤተሰባቸ አባል ለላ(ይጥቀሱ)____	
48	የጠና ህክምናና እርዳታ ማነዉ የሰጠሽ	ሀኪም ነርስ ፣ወይስ አዋሊጅ ነርስ ጤና መኮንን ጤና እክስቴንሽን ባለሙያ ለላ(ይጥቀሱ)____	

ANEEXE 3 :Declaration

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

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This research has been submitted for examination with our approval as a University advisor.

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