ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF NURSING AND MIDWIFERY

ASSESSMENT OF FACTORS AFFECTING UTILIZATION OF INSTITUTIONAL DELIVERY SERVICES AMONG CHILD BEARING AGE WOMEN IN HADIYYA ZONE, SNNPR, ETHIOPIA.

By: TADESSE LELAGO (BscN)

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES,

ADDIS ABABA UNIVERSITY FOR PARTIAL FULFILMENT OF REQUIRMENT FOR MASTER DEGREE IN REPRODUCTIVE AND MATERNITY HEALTH NURSING.

ADDIS ABABA

ETHIOPIA

MAY 2012

ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF NURSING AND MIDWIFERY

A THESIS ON ASSESSMENT OF FACTORS AFFECTING UTILIZATION OF INSTITUTIONAL DELIVERY AMONG CHILD BEARING AGE WOMEN IN HADIYYA ZONE, SNNPR, ETHIOPIA BY TADESSE LELAGO HAS BEEN ACCEPTED AND APPROVED BY EXAMINING BOARD

ADIVOSER: ATO BERHANU DESSALEGN (Bsc, MPH) _____

_____ _____

EXAMINER

Acknowledgement

First and for most I would like to express my deepest gratitude to my advisor Ato Berhanu Dessalegn for his unreserved all support and enriching comment throughout the study period.

I will extend my thanks to Addis Ababa University for sponsoring this thesis project. My appreciations also go to all staffs of Department of Nursing for their unreserved support throughout the course and thesis works.

I thank also staffs of Hadiyya Zone Health Department and Woreda Health Offices in the zone, who facilitated the data collection process.

My special thanks also go to my parents, friends and classmates for their continuous encouragement and material support throughout my academic life.

Last but not least I would like to thank the data collectors, supervisors and all research participants who took part in the study

Above all my heartfelt thanks and glory extends to almighty God for His uncountable help and support throughout my life as well in this work.

Table of content

.

List of Figures

List of Tables

Annexes

List of Acronyms

AAU	Addis Ababa University
ANC	Antenatal Care
CBAW	Child Bearing Age Women
CI	Confidence Interval
95%CI	Ninety five percent confidence interval
EDHS	Ethiopian Demographic and Health Survey
Epinfo	Epidemiological information
GOE	Government of Ethiopia
HC	Health Center
HD	Home Delivery
HEW	Health Extension Worker
HF	Health Facility
HH	House Hold
HP	Health Post
ID	Institutional Delivery
PNC	Post natal Care
L10K	Last Ten Kilometers Project
MDG	Millennium Development Goal
MDG-5	Millennium Development Goal-5
MOH	Ministry Of Health
PI	Principal Investigator
PAD	professional assisted delivery
SNNPR	Southern Nation, Nationalities and Peoples Region
SPSS	Statistical Package for Social Studies
TBA	Traditional Birth Attendant
WHO	World Health Organization

Abstract

Background: A women's health is critical to her own life, and to the well-being of her family and the economy of her community and her country. About 99% of maternal deaths occur in developing countries. Yet, most of these deaths could be avoided, if preventive measures were taken and adequate care was made.

Objective: To assess factors affecting utilization of institutional delivery service among child bearing age women in Hadiyya zone SNNPR.

Methodology: A cross sectional quantitative study was conducted among women who gave birth with in the last three years preceding the survey in Hadiyya zone, SNNPR. Concerning to sampling procedure a cluster sampling method was used to reach the eligible women in the randomly selected study area. Data was collected by interview administered semi-structured questionnaire by trained HEWs who able to speak local language. Data was entered at Epinfo version 3.4 software and exported to SPSS software version 16 for analyses.

Result: A total of 414 women who had given at least one birth in the preceding three years before the survey were interviewed giving response rate of 98.8%. Even though majority of the mothers (86.2%) received ANC, only 24.6% of them delivered at health facilities and the rest (76.4%) delivered at home with the help of relatives or TBAs which revealed gap between ANC and delivery care utilization. The multivariate analysis revealed that women's residences, educational status, age, knowledge of danger signs, ANC frequency, and satisfactory attitude to institutional delivery were the major factors that affect maternal utilization of institutional delivery.

Conclusion and recommendation: Findings of this study demonstrated that utilization of institutional delivery care among child bearing age women in Hadiyya zone is low. So promotion of maternal education, antenatal care, information education and communication on obstetric risks and general health service expansion were recommended

Chapter one

1. Introduction

1.1 Background

Pregnancy is a normal process that results in a series of both physiological and psychological changes in expectant mothers. However, normal pregnancy may be accompanied by some problems and complications which are potentially life threatening to the mother and / or the fetus (1). In 1987 the World Bank, in collaboration with World Health Organization (WHO) and United Nations Population Fund (UNFPA) launched the Safe Motherhood Initiative (SMI) which aimed at reducing maternal morbidity and mortality by one half by the year 2000. SMI is to ensure that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. Safe Motherhood embodies the philosophy that women and infants should not die or be harmed during pregnancy and childbirth (2).

The term 'Skilled Birth Attendance' has been defined as the process by which a woman is provided with adequate care during labor, delivery and the early postpartum period. This requires skilled personnel to attend the delivery and an enabling environment, including adequate supplies, equipment, drugs as well as effective communication and referral systems. A skilled birth attendant is 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 pregnancy, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns(3)

Skilled delivery care is considered a crucial function within the health care system for saving the lives of mothers and newborns and represents an important indicator for monitoring MDG 5 (4, 5). All women need maternity care in pregnancy, childbirth and after delivery to ensure optimal pregnancy outcomes. However, around the world, one third of births take place at home without the assistance of a skilled attendant. WHO strongly advocates for "skilled care at every birth" to reduce the global burden of 536 000 maternal deaths in 2005 (5). Countries measure the proportion of deliveries assisted by skilled attendants frequently since it is one of the indicators of progress towards millennium development goal 5 (MDG-5), which aims to improve maternal health.

1.2 Statement of the problem

Each year, out of an estimated 120 million pregnancies that occur worldwide: more than half a million women die from the complications of pregnancy and childbirth; more than 50 million women suffer from a serious pregnancy-related illness or disability; at least 1.2 million newborn infants die from complications during delivery. Skilled care during childbirth and immediately afterward can make a critical contribution to preventing these maternal and newborn deaths and disabilities. An estimated 15% of pregnant women will experience a life-threatening complication during pregnancy or childbirth. Clinical experience indicates that skilled birth attendants, properly equipped and supported, can prevent or manage many of these complications (6).

According to the recent review of the millennium development goals (MDG), little progress has been made with respect to MDG 5 on improving maternal health (7). The global burden of maternal death in 2005 was 536 000 (5). The most recent estimates show that 358,000 maternal

deaths occurred worldwide in 2008, with 99% of maternal deaths occurring in developing countries as a whole, and 87% in Sub-Saharan Africa and south Asia yearly (8).

More than one in four maternal deaths in developing countries occurs during labor and delivery and in the 24 hours post-delivery. This rate of death is higher than for any other 36-48 hour period during the nine-months of pregnancy and 42-days postpartum. Two in four maternal deaths occur from the onset of labor to the end of the first week post-delivery. Most of the deaths during this short period are due to hemorrhage and eclampsia while septic deaths usually occur after seven days postpartum (9).Proper care during pregnancy and delivery is important for the health of both the mother and the baby, and is the fifth millennium development goal (MDG). Federal Ministry of Health of Ethiopia has a goal of reducing maternal mortality by 75% by 2015 which has been adopted as an international development target as part of the MDG. The challenge now is on identifying and implementing effective and affordable interventions so that progress towards the goal becomes a reality (10).

In Ethiopia, antenatal care (ANC) from a trained provider is important to monitor the pregnancy, reduce morbidity and mortality risks for the mother and child during pregnancy and delivery. The 2011EDHS preliminary results showed that 34% of women who gave birth in the five years preceding the survey received antenatal care from a trained health professional at least once for their last birth (11). Antenatal care from a trained health professional has increased by 6 percent since the 2005 EDHS estimated as 28%. Skilled birth according to 2011EDHS preliminary report has been doubled that of EDHS of 2005 which is only 5%. According to 2011 EDHS health facility delivery is highest in Addis Ababa about 82.3% and the lowest in SNNPR about 6.2%. In other regions Afar, Somalia and Amhara is a little better than SNNPR as 6.8%, 7.6% and 8.0% respectively as compared to 27.5%, and 32.4% in Gambela and Harari. These data indicate that

the utilization of skilled delivery care is very low in the country and varies by residence and region. Maternal mortality in Ethiopia according to 2005 EDHS is about 673 per 100,000 births which is one of the worse in Sub-Saharan countries (12, 13)

Women must have access to comprehensive health care to improve their overall health and mortality outcomes as envisaged by the MDGs. This comprehensive care requires health systems that can and do make high-quality services accessible, available, and affordable at both the primary care and referral levels. The geographic coverage of health facilities, usually reported as distance or time required to reach the nearest health center is an important barrier for large segments of societies in most countries, particularly in rural areas and urban slums. Women in rural areas often walk more than an hour to the nearest health facility. Poor road infrastructure and lack of reliable public transport or access to emergency transportation make access difficult, especially when obstetric complications occur. As a result, women are obliged to seek health care from less-trained providers who are more accessible but who are neither competent nor equipped to deal with pregnancy complications (14).

Access to and demand for services is affected by geographical, financial and cultural barriers and poor care seeking behaviors. Although the Government of Ethiopia (GOE) has made tremendous progress in developing state-of-the-art health policies and expanding both its physical infrastructure and availability of HEWs in rural areas, utilization of key quality services such as antenatal care, prevention of mother to child transmission, labor and skilled delivery remains particularly low (4)

Institutional delivery Service Utilization in SNNPR region is low as many other parts in the country, 6.2% of the deliveries in the region were within the health facility while 93.8% took place at home (13). Even though underutilization of the existing health service was a major problem in Ethiopia, studies on the determinants of institutional delivery service use are scarce and mainly focused on institutional based. However, few studies have been conducted so far in community setting of different parts of the country. Assessment about the status of delivery service utilization in the zone was not carried out. That is why the study to be important to identify those factors affecting utilization of institutional delivery service in the studying area. Therefore the purpose of this study will be to explore and describe factors affecting utilization of institutional delivery service in Hadiyya zone SNNPR.

1.3 Significance of study

Enhancing the care-seeking behavior of pregnant women is required in addition to increasing service provision. Ensuring healthy pregnancies and a safe delivery is an essential component of reproductive health. This study will provide valuable information on the magnitude of institutional delivery in the study area for government program managers, stakeholders. In addition to this it helps programme managers and implementers to address the gaps in maternal health problems concerning to utilization of institutional delivery through provision of valuable recommendation so that to achieve the millennium development goal and reducing the high rates of maternal mortality. It will also be used as baseline study for those who will like to conduct further research on similar title.

Chapter two

2. Literature review

Shifting births to health facilities has generally been a reliable strategy for reducing maternal deaths. The high level of maternal mortality in developing countries is partly due to the non-availability of services, and partly to the poor utilization of these services when they are available. There are several reasons behind the low use of skilled delivery care services (15)

2.1 Proportion of birth attended in health institution

Proportion of births attended by skilled health personnel around 2007 in the world wide, developing regions, Sub-Saharan Africa was 64%, 61%, 44% respectively(16).Worldwide, 34% of deliveries had not skilled attendant. This means 45 million births occurring at home without skilled health personnel each year. Skilled attendants assist in more than 99% of births in more developed countries versus 62% in developing countries (17). Although the proportion of births assisted by skilled attendants has been steadily rising from 47% in 1990 to 64% in 2007 (18)

A number of study showed that the proportion of birth attended by health professional was low, however proportion of birth attended by traditional birth attendants, relatives and with no assistance was high. A community based cross sectional study on safe delivery service utilization among women of childbearing age in North Gondar Zone, North West Ethiopia showed that home delivery account about 86.5% while institutional delivery account only 13.5% (19). A cross sectional community based study in Arsi zone, South-East Ethiopia revealed that only 4.3% of rural and 40.4% of urban women delivered in health institution (20). The rest of deliveries were attended at home by traditional birth attendants, relatives and no assistance at all.

Other studies illustrated that the majority of births were took place at home. Traditional birth attendants (TBAs), relatives or others and not any type of assistance at all were birth attendents (21,22). 51% of births to urban mothers were attended by a health professional and 50% were delivered in a health facility, compared with 5% and 4% respectively, of births to rural women. Mothers residing in Addis Ababa are the most likely to be attended at delivery by a health professional (84 percent) and the most likely to deliver in a health facility (82 %) compared with mothers of other regions (13).

The Last Ten Kilometers Project (L10K) in four regions showed the vast majority of the deliveries (91%) took place at home. Professionally assisted delivery could be considered very low in all the four regions at 8%—24 % in Tigray, 9% in Oromiya and SNNP, and as low as 4% in Amhara. The HEWs reported to have attended only 4% of the deliveries in the four regions. Trained traditional birth attendants assisted 8% of the deliveries, the untrained TBAs 12% of deliveries and 63% reported to have been assisted by families/friends/neighbors and 5% of the women in the four regions reported self-assisted delivery; this was as high as 10% in Oromiya (23).

2.2 Factors affecting utilization of institutional delivery service

2.2.1 Socio demographic factors

A number of socio demographic factors were found to have a significant influence on use of skilled care at delivery. They include women‘s age, education level, marital status and income. Study in Tanzania revealed that young women are just starting child bearing and are told to be in high risk group, they tend to fear home deliveries. It is also possible that the new generation with the higher proportion of women who have formal education have different perspectives in delivery care when comparing to older generation (24). A community based survey on use of

antenatal services and delivery care among women in rural western Kenya revealed that factors associated with delivery outside a health facility included maternal age ≥ 30 years, < 8years of education, and > 1 hour walking distance from the hospital (25)

Women who had more schooling years were having higher proportion of deliveries attended by skilled personnel compared to those with fewer years of schooling or those who did not go to formal schooling. This study also revealed that family size, monthly income, husband education, and having possess radio were important factors which determine the utilization of institutional delivery (26)

EDHS 2011 showed that 51% of births to urban mothers were attended by a health professional and 50% were delivered in a health facility, compared with 5% and 4% respectively of births to rural women. Mothers residing in Addis Ababa were the most likely to be attended at delivery by a health professional (84%) and the most likely to deliver in a health facility (82%) compared with mothers of other regions. Mothers' educational status is highly correlated with whether delivery assisted by a health professional and whether the birth is delivered in a health facility. Five percent of births to mothers with no education were attended by a health professional and delivered in a health facility compared with between 70% and 72% of births to mothers with some secondary education (13). Study in North Gondor zone showed mothers whose educational status was secondary school and above, were eleven times more likely to give birth at health institutions than women with other level of education (27).

2.2.2 Obstetrics factors

Studies carried out in different parts of the world concerning maternal health care utilization had identified some factors related to pregnancy and child birth. Particularly, for safe delivery service utilization it was indicated that mothers who had lower age at first pregnancy, more than one previous pregnancies, birth order of more than one, received ANC service, birth complications in previous and immediate pregnancies, Previous use of professionally assisted delivery (PAD) were commonly found to be significantly associated with safe delivery service utilization (28, 29). Women in Undra Pradesh, India are more likely to get care for their first delivery than others that follow. This is associated with factors like fear of the unknown or excitement that is probably associated with the first child birth (30).

Maternal parity is an independent predictor of utilization of delivery care services in rural Ethiopia. Women with 2-4 and 5+ children are 60% and 50 % less likely, respectively, to receive delivery care than para one women (31). A community based study in Gonder indicated women who did not have any booking of antenatal visit was less likely to give birth at health facilities than those received antenatal care. Moreover, mothers who have had past history of intrapartum complication were more likely to seek safe delivery care than those with no such history (27).

Women gravidity, ANC use, ANC frequency, encountered problem during pregnancy, labor and delivery, birth order and ever use of delivery service were significantly associated with preference to place of delivery. As gravidity and birth order increases the likelihood to use safe delivery service decreases. Women who had encountered problem during pregnancy and labor were two times higher to utilize health facility delivery service. Mothers who gave birth at health facility before the last birth were more likely to utilize delivery service for the next births (26)

2.2.3 Health service factors

Factors preventing women in developing countries from seeking life-saving health care services include: transportation problem and road condition, inadequacy of primary health care facilities, shortage of trained health worker, lack of supplies, distance from health facilities, cost (direct service fees as well as the fees associated with transportation, drugs and supplies (32,33).

Accessibility of health services have been shown to be an important determinant of utilization of health services in developing countries. In most areas in Africa, one in three women lives more than five kilometers from the nearest health facility (34). The scarcity of vehicles especially in remote areas cost of transport, poor road conditions and the difficulty of walking for hours to the nearest health facility may also pose problems for pregnant women (35). Fees reduce women‘s use of maternal health care services and keep millions of women from seeking care even when complications arise. Even when formal fees are low or non-existent; there may be informal fees or other costs that pose significant barriers to women‘s use of services. These may include costs of transportation, drugs, food, or lodging for the women or for family members who help care for her in the hospital (33, 36).

Approximately half (51.2%) of women consulted their husbands, 44.5% consulted family members such as their mother-in-law or sister-in-law and 3% consulted neighbors and friends. Women who earned money through self-employment or credit used the small amount of money they earned to pay for health care, but most women would only seek care on their own accord if services were free (38). A facility based Study in Uganda showed that the higher proportion of women delivered their infant in their home with no trained assistance. Of these home deliveries; 34 % stated that this was due to financial limitations; transport problem accounted for 23 % and

27% were due to other reason like delivery occurring to quickly or late at night to attend the in health facility (38).

2.2.4 Maternal knowledge and attitudes on utilization of institutional delivery service.

The dynamics become urgent when a life-threatening obstetric emergency occurs. Recognizing danger signs and deciding to seek care are influenced by a woman‘s knowledge of pregnancy-related health risks (39).Several studies showed that women who knew risks of pregnancy, warning signs of pregnancy and labor, life threatening birth complications, existence of delivery service at health facilities, and who had positive attitudes towards health facility delivery care had higher probability of using modern health facilities for child birth (29).

Study in Tanzania showed that the proportion of women with skilled care at delivery increased with knowledge of danger sign from 39% among women who did not mention any to 68 percent among who did mentioned four almost or more danger signs ($P < 0.005$) (41). A study in a semi-urban community of Nigeria found that women and their birth attendants did not seek help promptly because they lacked knowledge of warning signs, believed that supernatural forces caused complications, faced transportation difficulties, and believed that hospitals provided poor care (42).

Studies conducted in Ethiopia had showed that knowledge of mothers about maternal and child health care was significantly lower for women who wanted to deliver at home compared to those who wanted to deliver at health institutions. The reported reasons for home delivery were absence of health problems, short duration of labor, preferring the attention of relatives and more trust on traditional birth attendants or relatives than health professionals (28, 42). Respondents’ overall attitudes towards danger health problem related to childbirth and safe delivery utilization

has significant association with service utilization. Those women who have favorable attitude utilized the service three times more than those who have unfavorable attitude (20)

2.3. Conceptual Framework

This study has used a comprehensive conceptual framework adapted from one developed for analyses of reproductive health outcomes (39, 42). The details of the framework displayed in figure below. The arrows in the diagram show interactions between the variables most of the factors are interrelated to each other. As depicted in the diagram safe delivery service utilization is affected by governmental policies and regulations on health and related sectors. Furthermore, it is affected by community and house hold factors those influence the individual level factors.

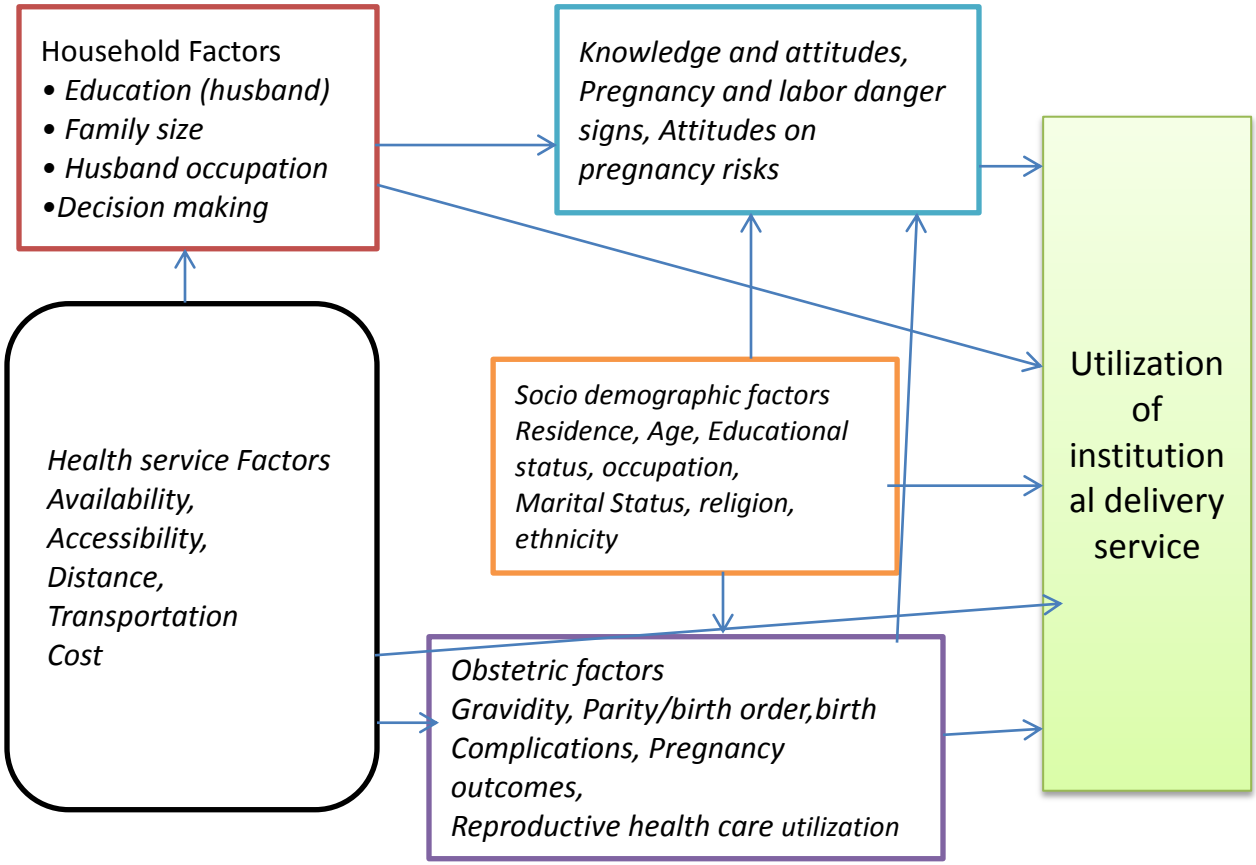


Table 1: Partial adapted conceptual framework from one developed for analyses of reproductive health outcomes.

Chapter three

3. Objectives

4.1 General objectives

- To assess factors affecting utilization of institutional delivery in Hadiyya zone, SNNPR, Ethiopia

4.2 Specific objective

- To determine the magnitude of institutional delivery service
- To describe obstetric factors associated with institutional delivery service
- To assess knowledge of mothers toward institutional delivery service
- To describe attitude of mothers towards institutional delivery service
- To identify health system factors influencing utilization of institutional delivery service

Chapter four

4. Methods and materials

4.1 Study area and study period

Hadiyy zone was established in 1985 E.C. it is located to the south west of the Ethiopia in area of 3542.66 sq km with population density of 92 people/sq km. The capital of the zone, Hossaina is 230 Km far from Addis Ababa and 194 Km far from Hawassa (regional city). Hadiyya zone is bordered by :Gurage zone in the north, Silte zone in the east, Kembata Alaba zone in the south,Yem Special Woreda & Omo river in the west. Major ethnic group in Hadiyya zone is Hadiyya and major religions include protestant, orthodox and Muslim. The climatic condition is distributed as high land (24%), mid land (65%) and low land (11%).

Administrative organization of Hadiyya zone is structured into 10 woredas and one town administration and then to 329 kebeles. A total of 291,761(4.9%) households are found in the zone. The population status in the zone in year 2003 E.C based on 2007/8 housing census projection was estimated to 1,429,631. The population proportion distributed as male 707,238 (49.47%), female 722,393 (50.53%). The population reside to rural is 1,276,660 (89.3%) and urban is152, 971 (10.7 %). Child bearing age women (CBAW) estimated 23.3% out of this 3.9 % are expectant pregnant women and 3.5%, 8.31% and 15.6% children are under1, 3 and 5 respectively.

Regard health facilities within the zone there are one zonal hospital, 55 health centres, 287 health posts, 67 private clinics and 23 private pharmacies. Concerning health professional, there are 12 physicians, 47 health officers, 419 nurses (all types) and 646 health extension workers were

working since 2003 E.C. Health service coverage in the zone estimated to be 96.2% and health service utilization is 46% (43).

4.1 Study period - This study was conducted from September 2011 to May 2012.

4.3 Study design

A community based cross-sectional quantitative study design was employed to assess factors affecting utilization of institutional delivery services in hadiyya zone.

4.4 Population

4.4.1 Source population

The source populations for this study were all women in a child bearing age who have at least one birth experience in the previous three years before the survey.

4.4.2 Study population

Samples of women in the child bearing age who have had at least one birth experience in randomly selected woredas of the study area.

4.5 Inclusion and exclusion criteria

Inclusion criteria

- Women who gave at least one birth with in the 3 years preceding the survey.

- Women who were mentally and physically capable of being interviewed.

-women who gave birth in the study area

Exclusion criteria

-Women who did not have any birth experience within the last three years preceding the survey

-Women who were sick or mentally incapable at the time of interview

4.6 Sample size determination and sampling procedure

A single population proportion formula is used to calculate the sample size:-

n= (z α/2)2 x P (1-p)/d2 to estimate the sample size of the participants to be interviewed.

Where n=number of the study subjects

Z=is the standardized normal distribution curve value for the 95% confidence interval (1.96)

P= Favorable attitude (22) = 22.3%

d=the desired precision of the estimate (the margin of error between the sample and population)

5%

Non-response rate as 5% the sample was calculated as follows and a design effect of 1.5.

$$n = \frac{(Z_{1/2})^2 P(1-P)}{d^2}$$

$$= \frac{(1.96)^2(0.223)(1-0.223)}{(0.05)^2} = 266.25$$

= ((0.05x266.25) +295.64) x1.5= 419

Sampling procedures

Sampling technique- Probability, cluster sampling technique was used. Firstly a simple random sampling was performed to select two woredas for logistic and financial reasons. Secondly from the list of kebeles (clusters) in the two woredas, eight kebeles (clusters) was randomly selected. Three rural kebeles and one semi-urban kebele (woreda town administration) from each woreds were randomly selected. Population proportion sample allocation was determined based on size of households in each randomly selected kebeles. All households having the target women (women with at least one birth experience within the last three years) in the kebele was interviewed. One eligible woman was expected from each household. One woman having recent delivery was selected in the event where a household had two or more eligible women. Households with no eligible women were excluded from the study. The point to start household interview was selected first then the house to the right of reference point with eligible woman was the first to start interviewing. After a successful interview of each household the interviewer continue to the right side of the next household until the required sample size were achieved from that specific kebele. In case the required samples were not achieved within specific kebele, data collection will be continued to the next kebele since the consecutive kebels did not include.

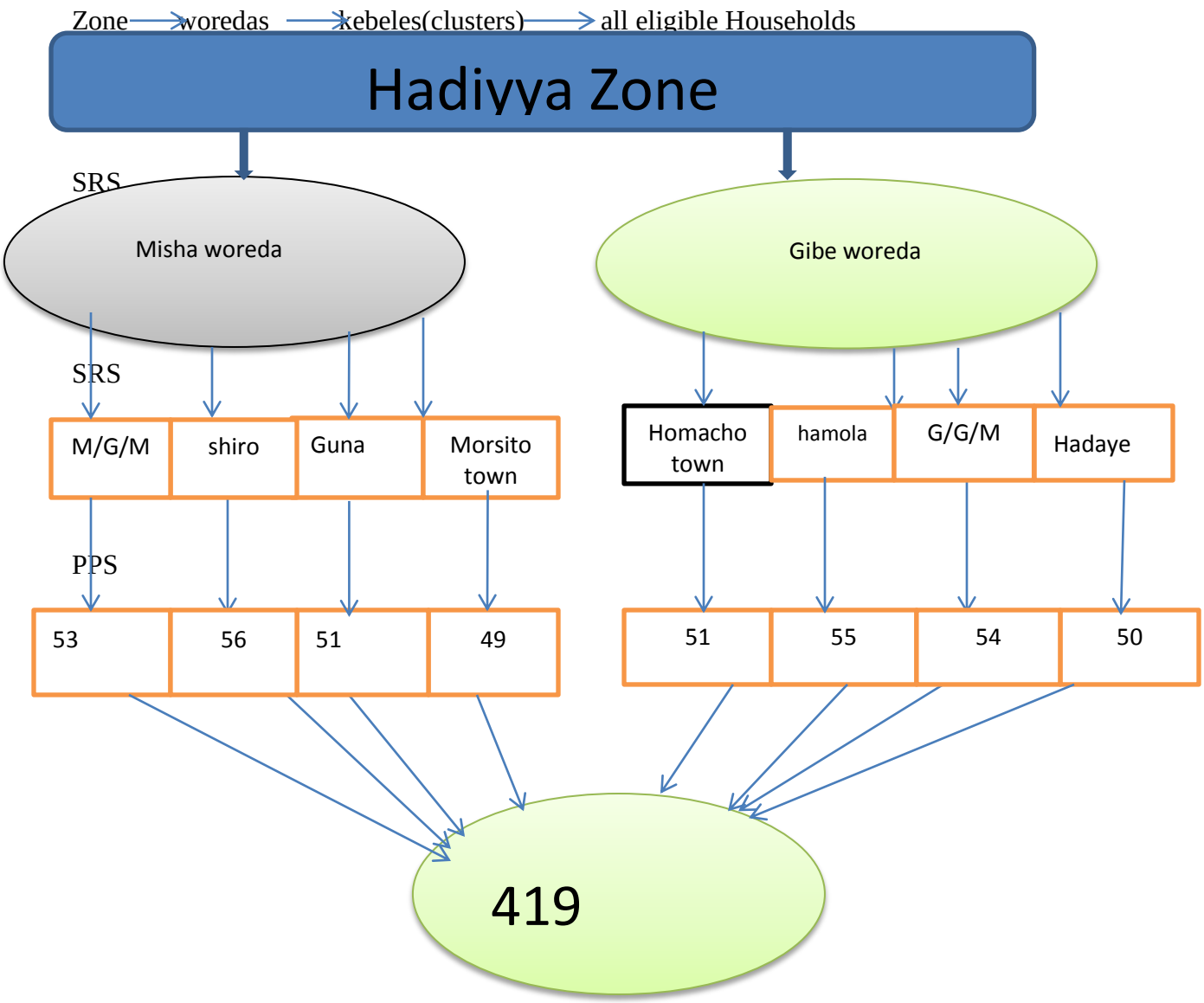


Figure 2: Schematic representation of sampling procedure

4.8 Variables

Dependent variable

- Utilization of institutional delivery service

Independent variable

- Socio-demographic variables (age of mother, religion, ethnicity, marital status, occupation, education, monthly income)
- Obstetric history (gravidity, parity, history of prolonged labor, ANC follow up
- Health service factors (cost of health service, distance, transportation).
- Knowledge and attitude factors- pregnancy and labor danger sign, knowledge about pregnancy risk, attitude on health facility.

4.9 Operational Definitions

Institutional delivery service utilization:- Giving birth at a setup where safe delivery service is being provided, at health facilities.

Child bearing age women:- women whose age lies within reproductive age range (15-49 years)

Home delivery:-delivery took place at locations other than health facility without assistance of a trained professional.

Birth in the last three years:- all births within 3years including live birth, still birth or death after live birth.

Know danger signs of pregnancy:- at least three of the accepted danger signs mentioned

Know danger signs of labor:- at least three of the accepted danger signs mentioned.

Satisfactory attitude:- women were considered as having satisfactory attitude towards utilization of institutional delivery service if they scored above the mean value 0.5 on 11 attitude questions and unsatisfactory if otherwise. A total of 11 attitude questions, which have got three

choices agree, disagree and indifferent. For positive statement those who chose agree were given 1 point and those who chose indifferent and disagree were given zero. The overall attitude was calculated by summing scores to get the mean value.

4.10 Data collection

4.10.1 Data collection Tools

Interview based semi-structured questionnaire was used to conduct the data. The questionnaire was adapted from DHS and related thesis works after reviewing relevant literature (23,43). The English version of the questionnaire was translated in to Amharic language for better understanding by the data collectors and respondents. Consistency was checked by translating the Amharic version back to English by another individual fluent in both languages.

4.10.2 Data collectors

Data collectors were eight female HEWs, two Bsc Nurses for supervision activities. The training was given for data collectors and supervisor for half day on method of extracting the needed information through interviewing the mothers, how to fill the information on a structured questionnaire and the ethical aspect in approaching the mothers. They were approach the mothers in a polite and respectful manner. The interviewer collected the information based on the given guide line using a structured questionnaire. The supervisor monitored the data collection process of the interviewer and if any problem happens he would try to solve or contact the principal investigator.

4.11 Data quality control

To ensure the quality of data, only trained HEWs was involved. The Pre-test was carried out on 7 % women who were not included in study subject and modification was taken according to the findings. On the days of data collection, the principal investigator and supervisor monitored the data collection process by checking completeness of the data and if any problem correction has been taken at data collection site. Data was checked again for its completeness before data entry and the cleaning process was done by running simple frequency after data entry for its consistency. If data were not consistent, it was checked referring the hard copy questionnaire. Finally data analysis was performed.

4.12 Data processing and analysis

After data collection, each questionnaire checked visually for completeness and coding was given at the right margin of the questionnaire followed by almost all variables in the questionnaire. The template scheme for data entry was developed and pre-tested for skipping patterns and allowed comment values by entering about 30 questionnaires. After this validation the principal investigator entered the data using EPI INFO version 3.4 and exported to SPSS version 16.0 statistical software packages for data cleaning and analysis. Frequencies, percentage, p-value, odds ratio and 95% confidence interval were used to compute data. Graphs and tables were used to display the computed results. The degree of association between independent and dependent variables were assessed using crude odds ratio with 95% confidence interval and with the respective p-value. Consecutively multiple logistic regression analysis was performed to control the potential confounding variables under the study to identify the independent determinant factors.

4.13 Ethical consideration

Ethical approval was obtained from the Research and Publications Committee of Department of Nursing and Midwifery, College of Health Sciences, Addis Ababa University. A formal letter for permission and support was written to the Hadiyya Zone Health Department and then the Zone was written a letter to respective Woredas. The purpose of the study was clearly explained to concerned bodies. All the study participants were informed about the purpose of the study, their right to refuse and informed verbal consent was obtained prior to the interview. The women were also told that the information obtained from them treated with complete confidentiality and did not cause any harm on them.

4.14 Dissemination of result

This thesis will be presented as requirement for partial fulfillment of master degree in maternity and reproductive health nursing at the Department of Nursing and Midwifery, Addis Ababa University. It will be presented or submitted for Hadiyya Zone Health Department. Presentations at professional, local, national and international meetings and publication in peer reviewed national and international journals will be attempted.

Chapter five

5. Results

A total of 414 women who had given at least one birth in the preceding three years before the survey were interviewed giving response rate of 98.8%.

5.1 Socio-demographic characteristics of the respondents

Three hundred nineteen (77.1%) of the respondents were reside in rural and 95 (22.9%) were urban. The majority of women's age was between 20-34yrs with mean age of 30.8 and SD of ± 5.5. Hadiyya was the major ethnic groups with 93.2%. The dominant religion is protestant with 82.6 %, followed by orthodox which was 15.2%. Regarding to marital status of the respondents the majority 384(92.8%) was married.

Educational level of the respondents, those who reported secondary and above accounted 97(23.4%) and not able to read &write and primary school level accounted 197 (47.6%) and 120 (29.0%) respectively. Three hundred twenty six (78.8%) of the women were housewives whereas 23(5.6%) were government employee. The rest of women were daily laborer, merchant & house maid. One hundred forty eight(35.8%) of the head of house of the respondents were attended secondary and above whereas134 (32.4%) were not attended formal education. Regard to access to mass media more than half 236(57%) did not have radio and/ or television in their home while 178(47%) of respondents had reported they had radio and/or television. See the details of socio demographic factors in the following table.

Table 1: Socio demographic characteristics of the respondents, Hadiyya Zone, SNNPR Ethiopia, May 2012

Variables	Frequency	Percent
Residence		
rural	319	77.1
urban	95	22.9
Age of Respondents		
15-19	19	4.6
20-34	266	64.3
35-49	129	31.2
Religion		
protestant	342	82.6
orthodox	63	15.2
others*	9	2.2
Ethnicity		
hadiyya	386	93.2
others**	28	6.8
Marital status of respondents		
married	384	92.8
divorced	14	3.4
widowed	15	3.6
Educational status of respondents		
no formal educated	197	47.6
primary school level	120	29.0
secondary & above	97	23.4
Occupational status of respondents		
housewives		
daily laborer	326	78.7
merchant	27	6.5
gov't employee	30	7.2
others***	23	5.6
Educational status of	8	1.9
the house hold head (n=384)		
not read & write	134	32.4
primary school	132	31.9
secondary & above	148	35.7
Radio or TV		
yes	178	43.0
no	236	57.0

Others* Muslim, catholic,joova witness others** Amhara, kembata, silte gurage Others***

student, house maid

5.2 Obstetric characteristics of the respondents

The delivery profile of the respondents has been reported as 63(15.2%) of women had at least one delivery and 120(29.0%) of the respondents had five and more deliveries. Two hundred thirty one (55.8%) of the women's delivery history was between two to four births. Out of the respondents, 111 (26.8%) said their most recent pregnancy was not planned while the rest 303(73.2%) said it is planned. Regarding the utilization of ANC service 357(86.2%) of the respondents were attended for the last pregnancy. Out of those155 (37.4%) were followed three or more times. About 51% of them attended in health posts whereas 48% attended in the health centers. See fig .3

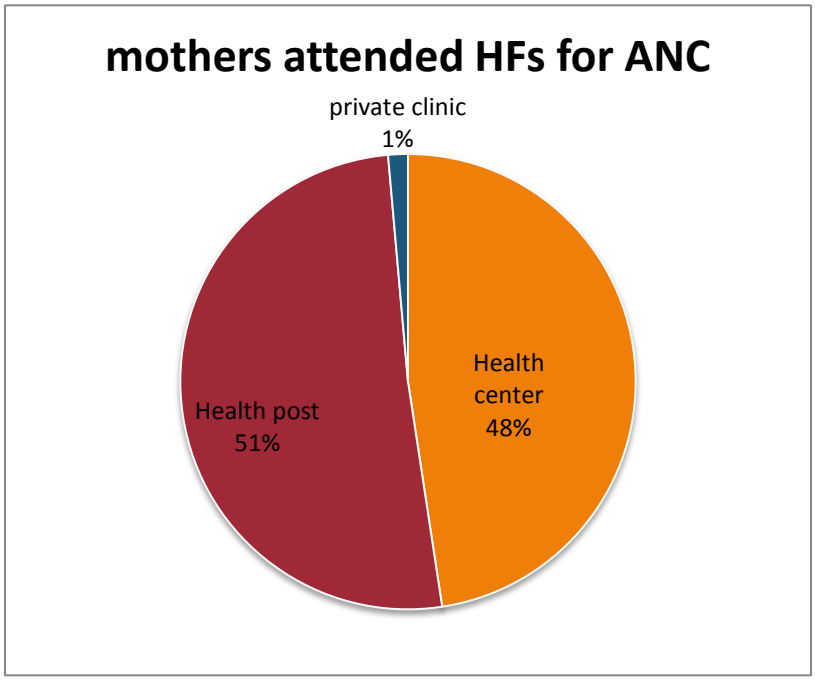


Figure 3: Health facilities attended for ANC follow up by respondents in their last pregnancy in Hadiyya zone, SNNPR, Ethiopia, May 2012.

Utilization of delivery services among the respondents at any of before last pregnancies delivery were 110(26.3%), out of these one fourth had two or more times and three fourth had one times gave birth at institution respectively. About 9% of the women said they encountered problems during delivery before the recent delivery. Regarding the delivery history of the respondents for most recent delivery within the last three years about 311(75.6%) of the respondents gave birth at home while nearly 101 (24.4%) gave at institutions. Out of the respondents 50(12.1%) reported they had one or more history of abortion. Fifteen (3.6%), 6(1.4%) and14 (3.4%) of the women had history of stillbirth, neonatal and infant death respectively. See table 2 for obstetric history of respondents.

Table 2: Obstetrics characteristics of the respondents in Hadiyya Zone, SNNPR, Ethiopia, May 2012

Variables	Frequency	percent
Para		
1	63	15.2
2-4	231	55.8
5+	120	29.0
Was it planned pregnancy		
yes	303	73.2
no	111	26.8
According to your birth order, last child is		
1	61	14.7
2-3	150	36.2
4+	203	49
Received ANC		
yes	357	86.2
no	57	13.8
Number of ANC follow up (n=357)		
1&2	202	48.8
3+	155	37.4
Advised to delivery in HI(n=357)		
yes	245	59.2
no	11	27.1
History of institution delivery before last delivery	110	26.3
yes	304	73.7
no		
Delivery Complication before last pregnancy	39	9.4
yes	375	90.6
no		
History of abortion	50	12.1
yes	364	87.9
no		
History of still birth	15	3.6
yes	399	96.4
no		
History of neonatal death	6	1.4
yes	408	98.6
no		
History of infant death	14	3.4
yes	400	96.6
no		

Most delivery 313(75.6%), among the respondents in the last three years preceding the survey were attended at home. Only 101(24.4%) of the respondents were given delivery at health facilities. Concerning the delivery place, health centers were the primary site for institutional delivery. About 61(15.7%) of deliveries were attended at health centers. About 21(5%) of the deliveries were attended in hospital. (Fig 4)

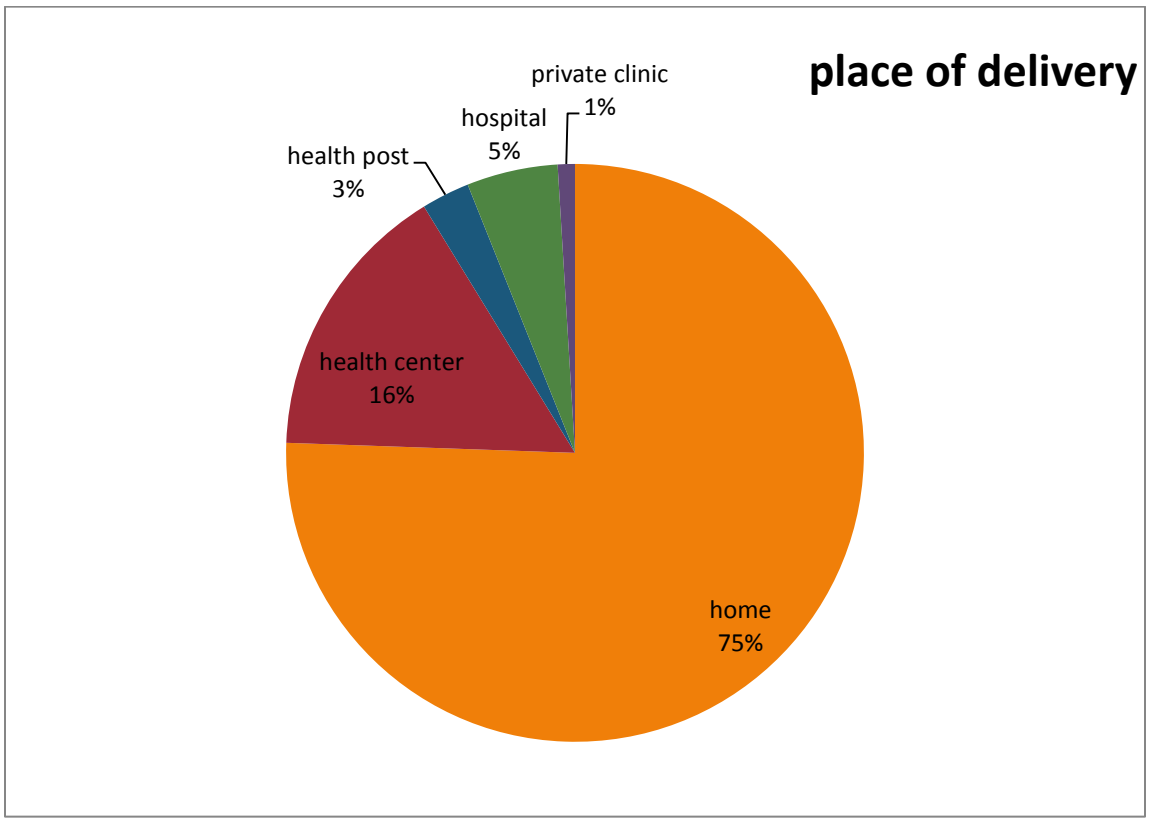


Figure 4: Place of delivery attended by respondents for the recent delivery within the last three years in hadiyya zone, SNNPR, Ethiopia, May 2012

Among the birth attendants, traditional birth attendants were attended most delivery about 28.5% and health professionals 21.5% while HEWs attended only 8.0 % of deliveries. This data indicates that some of the home deliveries about 5% were attended by health professionals even though they were categorized under home delivery. See the details in figure below

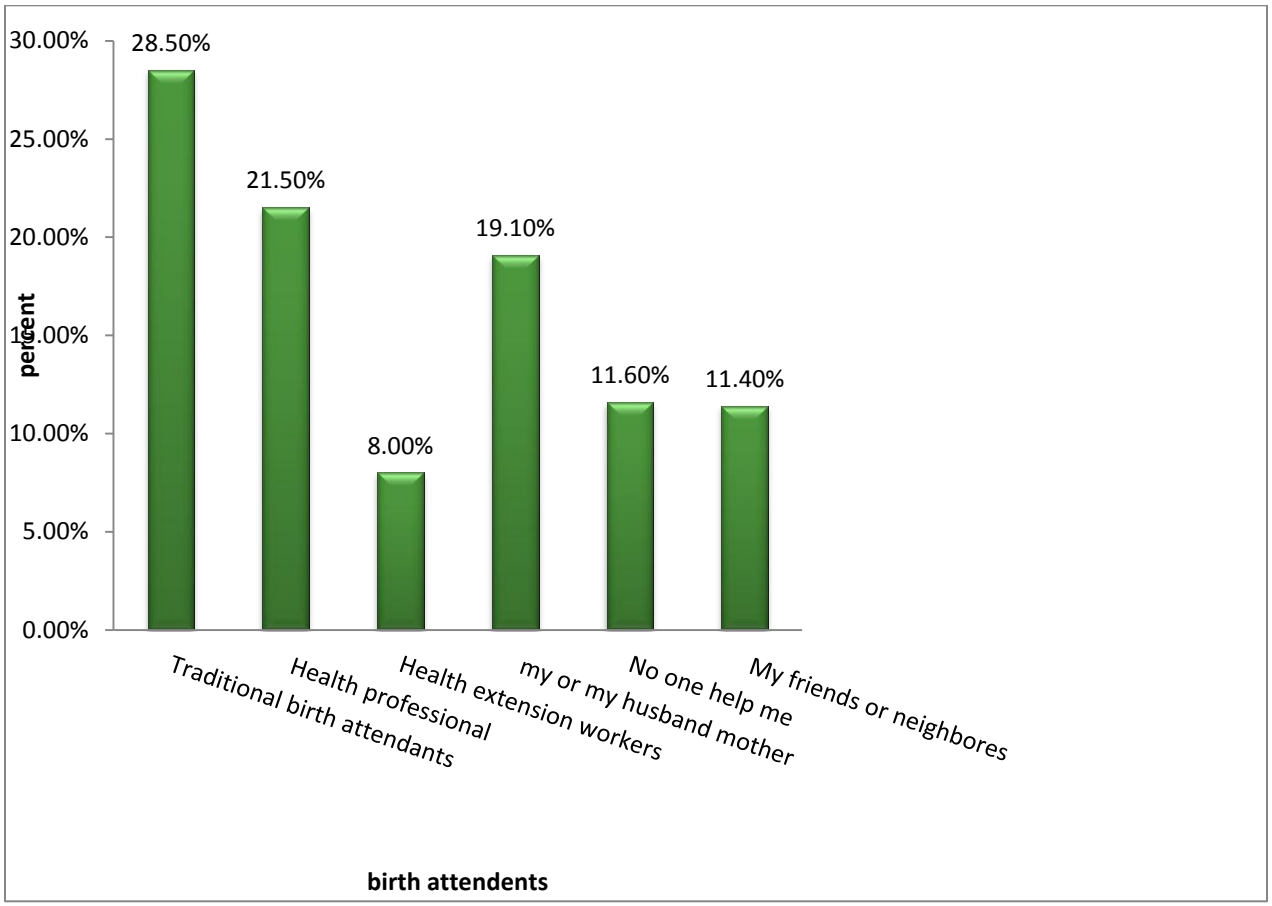


Figure 5: Delivery attendants for the last birth in hadiyya zone SNNPR, Ethiopia, May 2012. *Health professionals*=nurse, midwifery, health officers and doctors

Women reported one or more different reasons for the selection of delivery place. As explained above majority of the women gave birth at home. Among the reasons presence of TBA (34.1%), smooth & short duration of labor (34.8%) and women like with their relatives (34.4%) were the major factors those enhance home delivery. Distance, told no problem in pregnancy, no abnormality before the last pregnancy in home delivery, roads & transportation were also commonly mentioned factors. See detail in fig 5.

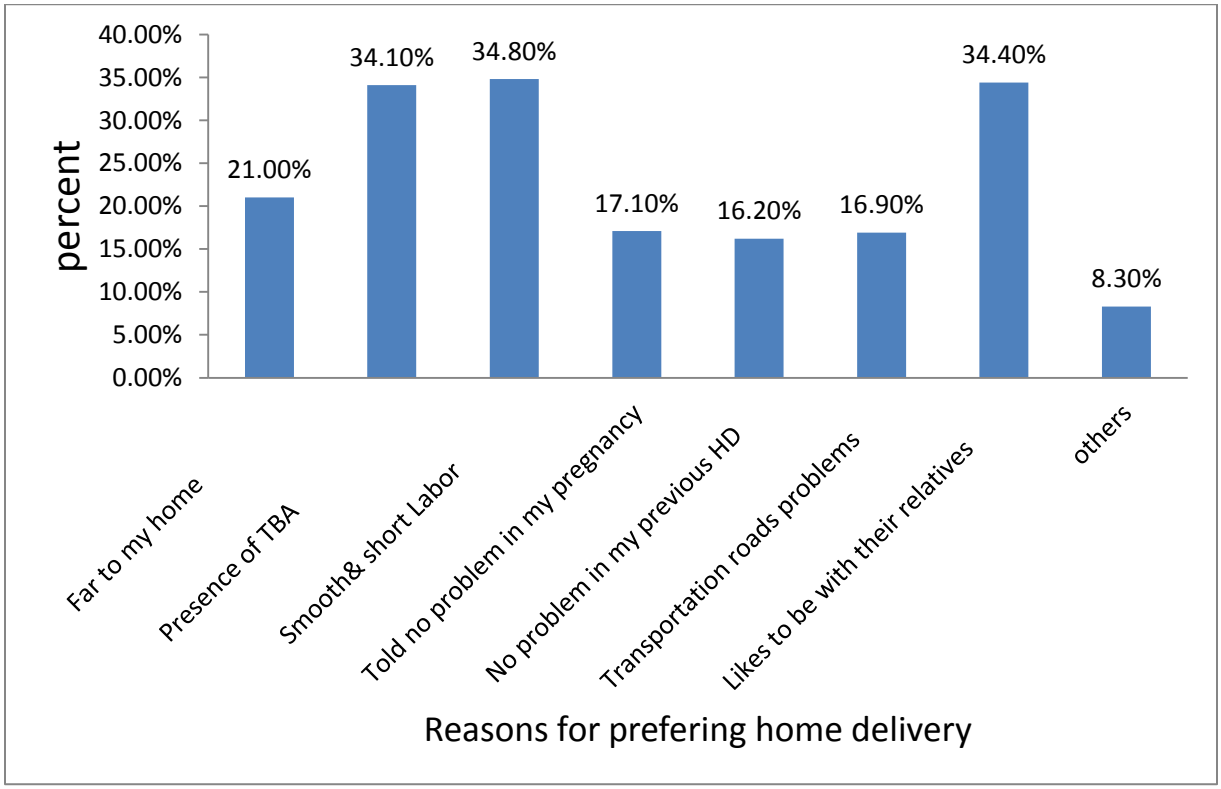


Figure 6: Respondents reasons for choice to give birth at home by respondents in hadiyya Zone SNNPR, Ethiopia, May 2012

- *Others* =cost, husband will not allow, HF not open regularly, unwelcome approach of professionals
- *Note that the percent sum up not equal to 100% due to multiple response*

Some reasons why mothers gave birth at health facilities were illustrated in the following figure. The most commonly mentioned reasons were to get better care and previously informed to give birth in health facility when they followed ANC. To get better care and advised to give birth at HFs accounts 66.3% and 67.3% respectively. To get better outcome, difficult labor, & bad outcome in previous HD were other repeatedly mentioned factors. See fig 7

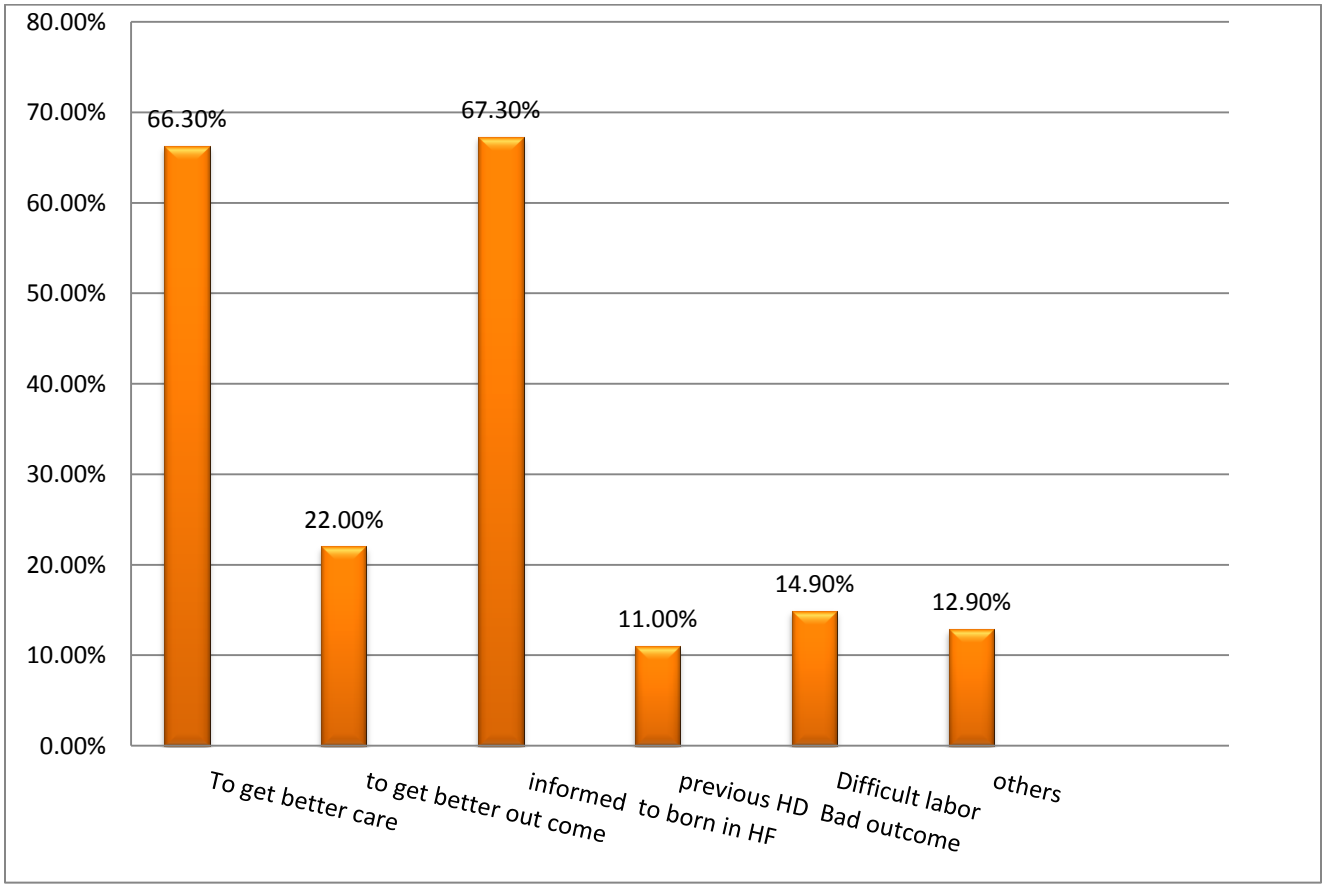
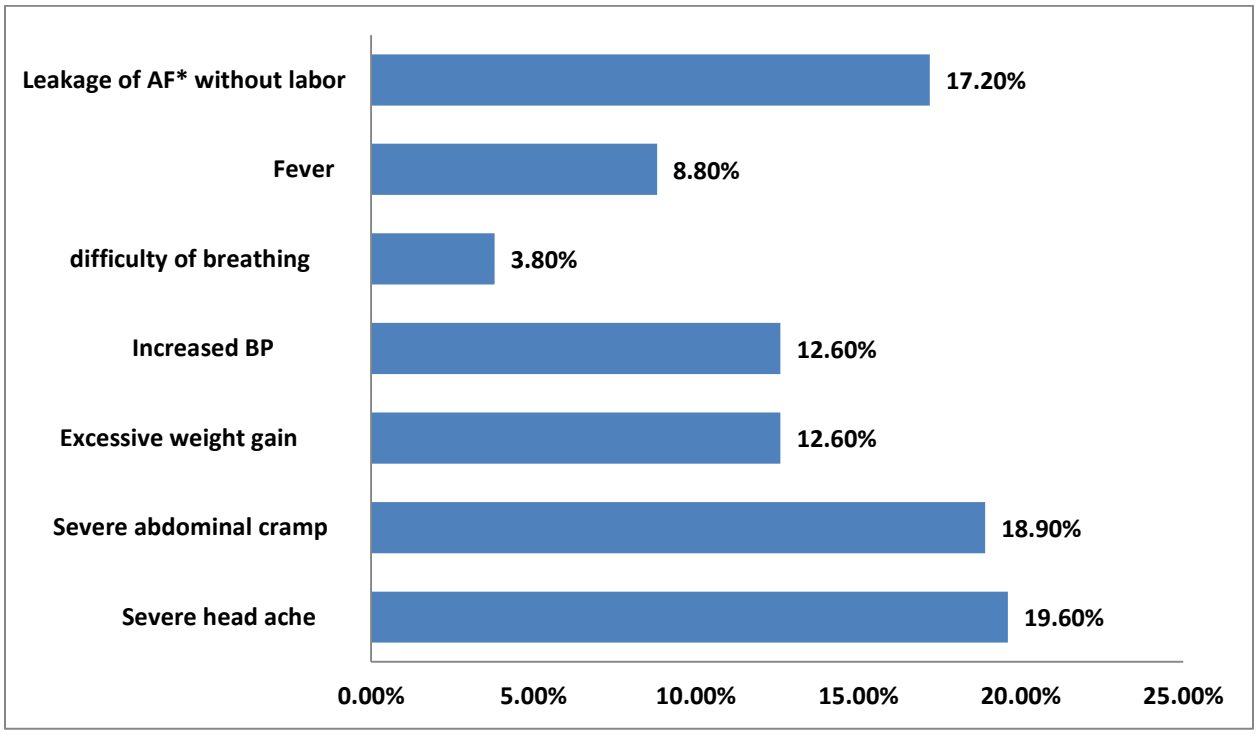


Figure 7: Respondents reasons for choice to give birth at HF for their last delivery in hadiyya zone, SNNPR, Ethiopia, May 2012

- *Others* =I was sick during my pregnancy, my husband encourage me, HF near to my home.
- *Note that the percent sum up not equal to 100% due to multiple response*

5.3 Knowledge and attitude factors related to utilization of institutional delivery

Two hundred fifty five (61.6%) of the respondents knew at least one of the pregnancy related risk. Most of them mentioned pregnancy related disease and fetal death. Only 50 (12.1%) of the women mentioned maternal death as pregnancy related risks. Two hundred eighty five (68.8%) of the women knew at least one danger signs of pregnancy. Severe headache, severe abdominal cramp and leakage of amniotic fluid without labor were the most mentioned danger signs. See detail in fig.7



AF* amniotic fluid

Figure 8: Pregnancy danger signs mentioned by respondents in Hadiyya zone, SNNPR, Ethiopia, May 2012

Three hundred four (73.4%) the respondents knew at least one of the risks of home delivery while 317 (76.6%) reported at least one benefits of health institution delivery despite their low utilization of institutional delivery. Among the listed risk of HD (n=304) fetal distress is the most mentioned 101(24.45%) followed by maternal death (18.8%) and maternal exhaustion (13.5%). On the other hand the most mentioned benefits of ID were early detection of problems 118(28.5%) followed by on time solving of problems and minimizing of harmful traditional practices 81(19.6%) and 50(12.1%) respectively. The following graph summarizes Danger signs of labor mentioned by respondents.

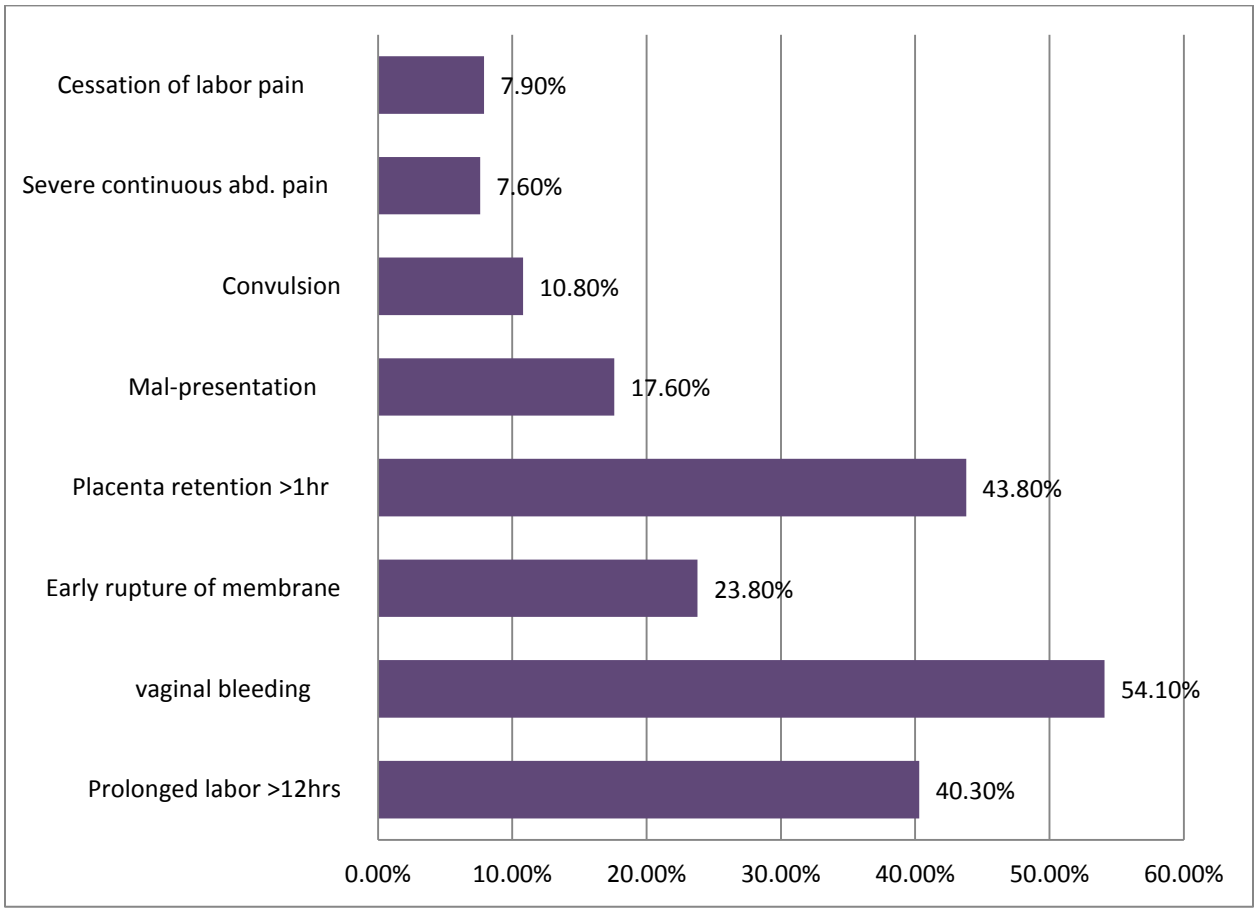


Figure 9: Danger signs of labor mentioned by respondents in Hadiyya zone, SNNPR, Ethiopia, May 2012

- *Note that the percent sum up not equal to 100% due to multiple response*

Two hundred ninety (70%) of women mentioned at least one danger signs of labor. The most commonly listed danger signs were vaginal bleeding, placental retention and prolonged labor with 54.1%, 43.8% & 40.3% respectively. See detail in the fig 10

Table 3: Frequency table on knowledge and attitudes of respondents towards pregnancy, labor and delivery service, Hadiyya Zone, SNNPR, Ethiopia, May 2012

Variables	frequency	percent
Know risk of pregnancy		
yes	255	61.6
no	159	38.4
Know at least one pregnancy danger signs		
yes	285	68.8
no	129	31.2
Know three or more pregnancy danger signs		
yes	98	23.7
no	316	76.3
Know at least one labor danger signs		
yes	290	70.0
no	124	30.0
Know at least three or more labor danger signs		
yes	97	23.4
no	317	76.6
Know risk of Home Delivery		
yes	304	73.4
no	110	26.6
Know Benefits of Health Institution Delivery		
yes	317	76.6
no	97	23.4
Attitude of respondents		
satisfactory	141	34.1
not satisfactory	273	65.9

Attitude is an important determinant factor which affect mothers utilization of institutional delivery even if there is availability of health facilities. In this study overall attitude 141(34.1%) of women had satisfactory attitude toward institutional delivery. Among those 94(66.7%) gave birth at HF for the last delivery and one –third (33.3%) gave birth at home. More than half of the respondents 266(65.9%) had not satisfactory attitude toward institutional delivery. Among these only 7(2.6%) of women gave birth at HFs. This magnitude may show that attitude is one of the important determinant factors. The detail of attitude statements and response are seen in table 4.

Table 4: Percentage distribution of respondents on attitude statements towards utilization of institutional delivery in hadiyya Zone, SNNPR, May 2012

Variables	agree	percent	disagree or in different	percent
Most complications of labor are preventable.	215	51.9	199	48.1
Most complications of Labor are treatable	199	48.1	215	51.9
Any pregnant women are exposed to complication of delivery	145	35.0	269	65.0
Delivery complications can be severe & may be hazardous to my Well-being.	161	38.9	253	61.1
Delivery complications can be severe and may be hazardous to the newborn	238	57.5	176	42.5
Being attended by a skilled delivery attendant may be beneficial to my wellbeing	224	54.1	190	45.9
Being attended by a skilled delivery attendant may be beneficial to the newborn‘s wellbeing.	184	44.4	230	55.5
Health professionals at HFs are skilled enough to detect and treat or refer delivery complications.	200	48.3	214	51.7
Health facilities in nearby are adequately equipped to provide delivery service.	199	48.1	215	51.9
Health facilities in nearby are staffed with skilled professionals to provide delivery service.	236	57.0	178	43.0
Women do not go to health facility for delivery because the health worker do not treat them respectfully	149	36.0	265	64.0

5.4 Health service factors related utilization of institutional delivery

One hundred sixty three (39.4%) of women took more than one hour to reach the nearest health facility by walking and 251 (60.9%) of the respondents reported that it took less than one hour to reach nearby health facility. Two hundred seventy three (65.9%) of the respondents reported in their vicinity there is health post then followed by health center 118(28.2%) and private clinics 24(5.8%). Three hundred sixty three (89.4%) of the respondents were aware of that the nearby health institution provides delivery care. One hundred fifty eight (38.2%) of the women had given birth at near health institution in the last and/or before last pregnancy. Respondents' opinion (n=158) regarding to payment for their delivery care, 106 (67.1%) of respondents said they got the service free while about 40(25.3%) of the women said it was medium. Concerning to service used from nearby health facilities, respondents used different services. Most respondents used ANC (69.8%). PNC is the least used one. See details in the fig 10.

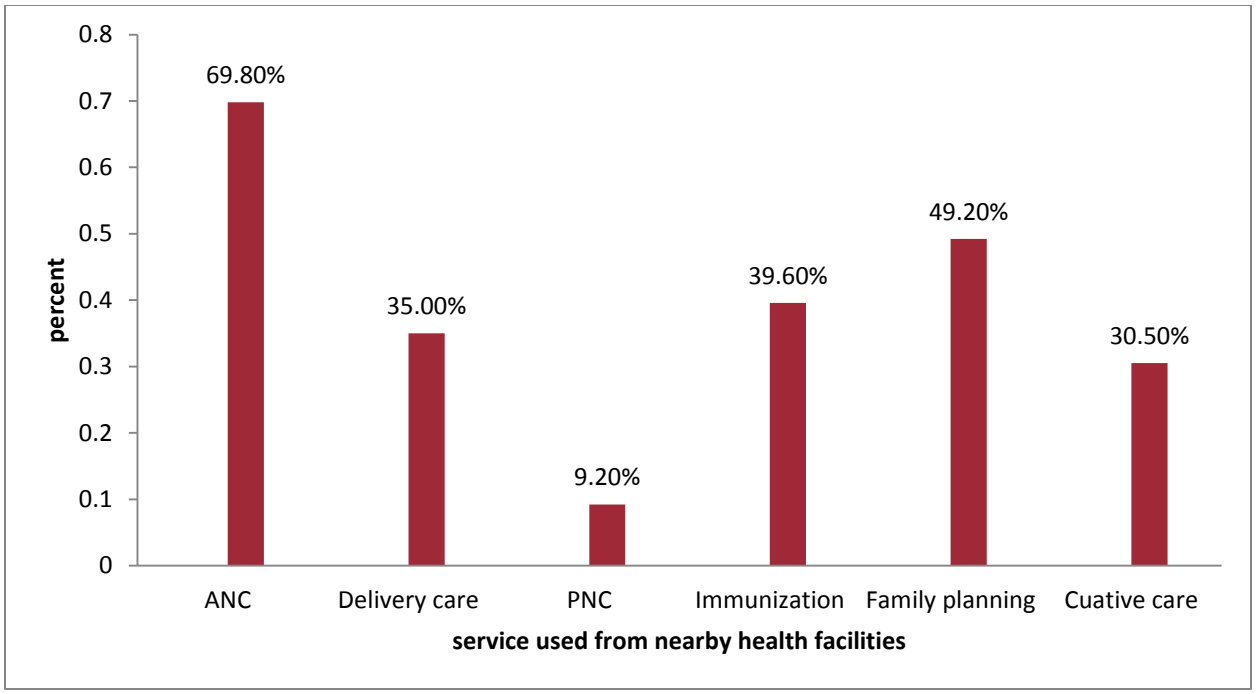


Figure 10: Health services used by respondents in nearby health facilities in Hadiyya zone SNNPR, Ethiopia, May 2012

- *Note that the percent sum up not equal to 100% due to multiple response*

Three hundred thirteen (75.6%) women reported that they decided their health service utilization. Similarly 311(75.1%) of the women decide delivery place by themselves. One hundred one (24.9%) seeks help of others for the decision of their delivery place. See table 5

Table 5: Health service factors and women decision making, Hadiyya Zone, SNNPR, May 2012

Variables	frequency	percent
Walking hrs. to nearest HF		
<1hr	251	60.9
>=2hr	161	39.1
Know health facility provide delivery care		
yes	363	87.7
no	51	12.3
ever given births at that health facilities		
yes	158	38.2
no	256	61.8
Opinion on the payment(n=158)		
free	106	67.1
medium	40	25.3
others**	12	7.5
Decision maker for health service utilization		
self	313	75.6
Other than self	101	24.4
Decision maker for place of delivery		
self	311	75.1
Others**	103	24.9

*costy, no comment ** husband, both husband &wife, relatives

5.5 Determinants of institutional delivery service

Crude analysis of socio-demographic variables on binary logistic regression showed that residence, maternal age, education status were all significantly associated with health facility delivery at $p<0.05$. On the other hand, marital status, ethnic group and religion of the respondents did not show statistical association with HF delivery utilization.

Those mothers who reside in urban area were about forty two times higher to give birth at health institution than the rural counter parts (COR 42.2 95%CI= 22.4-79.8). Women with higher age tended to utilize institutional delivery less likely. Mothers who were older than thirty four and twenty to thirty four years were less likely to give birth at health institution than the younger one with [COR 0.16, 95%CI=0.06-0.45] and [AOR 0.02, 95%CI=0.01-0.07] . Women who had more schooling years were having higher proportion of deliveries attended institutional delivery compared to those with fewer years of schooling or those who did not go to formal schooling with(COR 31.4 95%CI=16.6-59.4

Among the obstetric factors ANC frequency, parity and ever use of institutional delivery service were significantly associated with preference to place of delivery [$p<0.05$]. women with three and above ANC visit were more than ten times more likely to use the health facility delivery service compared to women with 1 & 2 ANC visits[COR 10.9, 95%CI=5.9-19.8]. As parity of mothers lowered, the tendency to use institutional delivery increased. Women who had one para were more likely than two to four para then to grad para to give birth at health facilities with [COR 37.4, 95%CI=13.3,104.6] and [COR 7.5,95%CI=2.9-19.4]. Also previous exposure of delivery service was significantly associated with place of delivery. Mothers who gave birth at

health facility before the last delivery were more likely to utilize delivery service for the next births [COR 3.1, 95%CI=1.9, 5.1].

Mother who did know at least three danger signs of pregnancy and labor, were significantly associated with utilization of institutional delivery [COR 22.1, 95%CI=11.9-37.2] and [COR 18, 95%CI=10.6-32.5] respectively. Mothers having satisfactory attitude to pregnancy and delivery risks were more likely to utilize the healthy delivery service [COR 76.0 95%CI=33.2-173.9] than those with no satisfactory attitude. Regarding to health service factors, distance is another important factor that affects the utilization of institutional delivery. Mothers walk less than one hour to reach nearby health facilities were more utilize the institutional delivery. Mother lived from HF which takes less than an hour by walking were eight times higher to utilize the institutional delivery than those walk more than or equal to an hour with [COR 8.5 , 95%CI=4.3-17.1].

A multi logistic regression approach was applied to determine which factors best explained and predict utilization of institutional delivery service. Consequently a number of independent variables like, place of residence, respondent education, age of respondent, ANC frequency more than or equal to three, know danger signs of pregnancy and labor, and attitude were found to be significant on multivariate analysis. The details are summarized on the table 6.

Mothers who lived in urban were more likely to deliver at HFs. Mothers who reside in urban were more than seven times likely to give birth at health facility than the rural counterparts [AOR 7.4, 95%CI=1.7-22.9]. Years spent in school did show a significant association with seeking of skilled care during delivery. Mothers with secondary and above year of schooling

were significantly associated with utilization of health facility delivery service than primary and below. secondary and above years of schooling mothers were nearly six times more likely to give birth at health institution than those with primary and below[AOR 5.7, 95% CI=1.7- 19.3]. Maternal age did show significant association. As maternal age increase, the utilization of institutional delivery was less likely. Maternal age greater than thirty four years and twenty to thirty four years were significantly associated than whose age less than twenty with [AOR 0.078, 95%CI=0.008,-0.79] and [AOR 0.02 95%CI=0.001-0.34]

ANC frequency did show significant association with utilization of institutional delivery. women attended three or more times prenatal clinic were nearly four times likely to use institution to give birth than those attended one or two times[AOR 3.9, 95%CI=1.3-11.6]. Parity and ever use of health institution delivery before last delivery were not showed significant association with place of delivery (table 6). Ever use of institutional delivery did not reveal significant association with institutional delivery [AOR 1.9, 95%CI=0.58- 6.2].

Mothers knew at least three or more danger signs of pregnancy and labor were showed statistically significant association. Mothers knew at least three danger signs of pregnancy were more than six times likely to give birth in health institution than those did not knew [AOR 6.2, 95%CI=1.9-20.7] and mothers knew at least three danger signs of labor were six times tend to give birth in health institution [AOR 6.3, 95%CI=2.0-19.9]. Mothers' satisfactory attitude toward institutional delivery showed significant association than those did not have satisfactory attitude. Mothers who showed satisfactory attitude were more than eleven times more likely to give birth at health institution than those not[AOR 11.9, 95%CI=3.8-37.2]. Distance to the nearest health facility for women did not show significant association [AOR 2.0, 95%CI=0.54-7.5].

Table 6; Determinants of institutional delivery service utilization among the child bearing age women, Hadiyya Zone, SNNPR, Ethiopia, May 2012

variables	Place of delivery		COR 95%CI	AOR 95%CI
	HD	ID		
Residence				
rural	293[91.8%]	26[8.2%]	1.00	1.0
urban	20[21.1%]	75[78.9%	**42.260 [22.4,79.8]****	**7.4[1.7, 22.9]****
Age of Respondents				
15-19	5[26.3%]	14[73.7%]	1.0	1.0
20-34	185[69.5%]	81[30.5%]	**0.16[0.06,0.45]****	**0.078[0.008, 0.79]**
35-49	123[95.3%]	6[4.7%]	**0.02[0.01,0.07]****	**0.02[0.001, 0.34]****
Educational status of respondents	296[89.2%]	36[10.8]	1.00	1.0
Primary & below	17[20.7%]	65[793%]	**31.4 [16.6, 59.4]****	**5.7[1.7, 19.3]****
secondary & above				
No. of ANC follow up(n=357)				
1-2	190[94.1%]	12[5.9%]	1.0	1.0
3+	69[44.5%]	86[55.5%]	**10.880[5.9, 19.8**]**	**3.9[1.3, 11.6]****
Parity				
1	24[38.1%]	39[61.9%]	**37.4[13.3, 104.6]****	0.85[0.18, 3.9]
2-4	174[75.1%]	57[24.7%]	**7.5[2.9, 19.4]****	0.68[0.08 ,5.7]
5+	115[95.8%]	5[4.2%]	1.0	1.0
History of Institutional delivery	64[58.7%]	45[41.3%]	**3.1[1.9, 5.1]****	1.9[0.58, 6.2]
yes	249[81.6%]	56[18.4%]	1.0	1.0
no				
Know danger signs of pregnancy	29[29.6%]	69[70.4%]	**21.1[11.9, 37.2]****	**6.2[1.9, 20.7]****
yes	284[89.9%]	32[10.1%]	1.0	1.0
no				
Knows danger signs of labor				
yes	30[30.9%]	67[69.1%]	**18.6[10.6,32.5]****	**6.3[2.0, 19.9]****
no	283[89.3%]	34[10.7%]	1.0	1.0
Attitude of respondents				
satisfactory	47[33.3%]	94[66.7%]	**76.0[33.2, 173.9**]**	**11.9[3.8,37.2]****
not satisfactory	266[97.4%]	7[2.6%]	1.0	1.0
Time took by walking				
<1hr	160[63.7%]	93[4.3.3%]	**8.5[4.3, 17.1]****	2.0[0.54, 7.5]
>=1hr	151[93.8%]	10[6.2%]	1.0	1.0

****p<0.05**, AOR 95%CI –adjusted for 95% confidence interval

Chapter six

6. Discussion

Findings in this study agree with many others studies. Home delivery accounts high percentage (76.6%) while institutional delivery accounts about (24.4%). Home delivery shows a decrease compared to other studies conducted in rural community in different corner of the country (19, 20, and 21). This may implies a progress in maternal care service utilization. It could be increasing access and affordability of health institution to the community. It may be also through health promotion by health extension workers.

Respondents major reasons regarding to the preference of home delivery were availability of TBA (34.1%), smooth & short duration of labor (34.8%) and likes to be with their relatives which is in line with(19,22,41). These reasons may be interrelated. These may imply that mother trust more on TBA and they seek PAD when the labor is not short as well smooth. It may also be, women may develop fear to give birth at HFs. This may show women may fear the procedures and/or health professionals than attending delivery by their relatives or TBA at home.

Regarding to major reasons why women selected institutional delivery, to get better care and informed to give birth at HF were the common ones (66.3% & 67.3%) respectively. These are very interesting things that mothers utilized prior information to give birth in institution. Seek better care may implies that women may be better educated or utilize information given when they attend ANC which should be encourageable. Previous home delivery, bad outcome and difficult labor or prolonged labor also were important factors that enhance mothers to seek professional support during delivery. These are the fact that mothers know better care is given at

health institution than home but they do not like to utilize unless they face one or more abnormalities.

In line with other studies socio demographic characteristics such as place of residence, educational status of the respondent and age of the respondent were the common influencing factors for facility delivery service utilization in study area. Urban women were more than seven times more likely to give birth at health facility than the rural counter parts. This finding is consistent with a number of the studies (2, 20, 22, and 26). This may plausibly be explained that urban women tend to benefit from increased knowledge and access to delivery service compared to the rural counterparts. It is also likely health facilities are more accessible in urban areas and the various health promotion programs by large are accessible for urban women. Urban women may also get more access for education so that they are more aware of health problems. Moreover, rural women are more readily influenced by traditional practices that are contrary to the modern health care. Rural women may have also less access to the health facilities and lack of awareness when compared to urban.

Education is one of the major socio demographic factors that influence an individual behavior and attitude. The finding in this study is consistent with the findings in, EDHS, North Gonder, Tanzania, and many others (12, 24, 27, and 31). Maternal educational status showed statistically significant association with the utilization of the institutional delivery services. Women having secondary and above educational level were nearly six times more likely to give birth in the health institution than primary and below educational level. The possible explanation for why education is a key determinant could be that the more a woman go up through education level,

the more knowledgeable she will be about the use of health facility and also it is likely to enhance female power so that women develop greater confidence and capability to make decision about their own health need.

Age of the respondents has showed a significant association with institutional delivery. As maternal age increase, the like hood to delivery at HFs is less likely. This is consistent with studies done in Tanzania and as well EDHS 2005(11, 24). A study in Tanzania suggested that the new generation younger women could have formal education and have different perspectives on delivery care compared to the older generations (24). EDHS 2005 also indicated that mothers younger than 35years are more likely to utilize delivery care than the older (11). This may possibly be the older women, because of previous experience of home delivery; they do not need to go to give birth at health facilities. The younger age seek institutional delivery since more of them may be educated so that they easily accepted advice from health professionals and they may not trust unprofessional delivery assistant, thus they likely to delivery at HFs to get professional assisted care. It also may be the younger develop fear since duration of labor may probably long particularly in first pregnancy, so that they were look for professional assistance.

Women received ANC were about 86.2% but only 24.4% attended institutional delivery from the total of respondents. This shows there is a wide gap between ANC bookings and attending institutional delivery, however, one aim of providing ANC is to promote institutional delivery. This implies the need for further investigation on the huge gap between ANC and delivery care utilization which should be linked to each other. This is plausibly the wide distribution of health posts and HEWs may increase ANC booking by initiating expectant women to follow ANC but

still further community mobilization and service accessibility will be required to increase women awareness regard to importance of institutional delivery services.

Women who were more antenatal visit showed a significant association than those have one or two visit which is in line (20, 28, and 29). This reveals that the women may be familiar to the HFs & get awareness; therefore, women's health care need is increased. It may also be because of contact with skilled care provider during pregnancies gives chance for the women to know more about the importance of skilled attendant during childbirth and she may utilize the advice get during the ANC visit.

Women who ever had given birth at HF before the immediate birth were not significantly associated with institutional delivery which is inconsistent with study done in North shoe (26). This may indicate mothers' may utilize HFs not consistently. The possible reason for this may be that mothers gave delivery when they face problem during delivery such as prolonged labor. It may also imply that behavioral consistency of maternal care utilization might not increase by mothers. It reveals that mother may not probably satisfied by previous care which may not encourage them to health service utilization again.

The dynamics become urgent when a life-threatening obstetric emergency occurs. Recognizing danger signs and deciding to seek care are influenced by a woman's knowledge of pregnancy-related health risks (39). On the present study women knowledge on pregnancy& labor danger signs showed significant association which is in line with a number of studies done in Tanzania, Nigeria and others (29, 41 and 42). Women who knew at least three or more accepted danger signs of pregnancy were about six times likely to give birth at health institution than those who did not know. This may imply those mothers who are able to recognize danger signs could have

greater fear of the possible outcomes of the signs so that they would be encouraged to deliver at HFs. Moreover, maternal awareness of danger signs, during pregnancy and labor encourage timely decision to utilize HFs.

Attitude is also another determinant factor that enhances or discourages mothers toward the utilization of institutional delivery since merely presence of HFs does not determine health care utilization. In this study, mothers who had satisfactory attitude were twelve times likely to give birth at health institution than those had not satisfactory attitude which consists with study done Arsi, south east Ethiopia(20). Knowledge and attitude are important determinant factors that influence an individual towards the utilization delivery and other health care service. The more positive attitude a women have, the better decide to seek health care. The more a woman has the satisfactory attitude to institutional delivery, the better like hood to deliver at institution.

Many studies did show the availability, accessibility and affordability of health facilities were strong predictors of general health care utilization and child birth care in particular (32, 33). In most areas in Africa, one in three women lives more than five kilometers from the nearest health facility (34). The scarcity of vehicles especially in remote areas, cost of transport, poor road conditions and the difficulty of walking for hours to the nearest health facility may also pose problems for pregnant women (35). Inconsistent with this studies (35), the present study revealed that distance to nearby HFs were not associated with use of institutional delivery. This could be due to sampled women being taken from those accessible kebeles. Moreover, it is obvious that mere presence of facilities do not assure utilization of services. It could be also wide distribution of health posts to the kebeles nearer to the rural women since more than two third (65.5%) of the

women reported that there is health posts in their vicinity but delivery in health post is as low to 3% from the total delivery.

Chapter seven

7. Strength and Limitations

7.1 Strength

- Data collectors being HEWs reduce both selection and information biases since they know all the localities of their respective kebeles, well known, live with them, speaks local languages and of the same sex with study subjects.
- Selection bias was also minimized since it was community- based study with probability sampling technique.
- High response rate.

7.2 Limitation

- For time and logistic reasons the study was conducted on accessible kebeles so that it might not be generalizable to all women in the Zone but could work for areas with similar setting.
- There could be recall bias since the women were asked for events within the last three years prior to the survey. However, the most recent births were considered and local events were utilized to remind them.

Chapter eight

8. Conclusion and Recommendation

8.1 Conclusion

- In conclusion, this study demonstrated that utilization of institutional delivery service is low, as clearly indicated by the major maternal health service indicators (delivery services) during the period of three year preceding the survey.
- Even though majority of the mothers were received ANC, only 24.6% of them delivered at health facilities and the rest (76.4%) majority delivered at home with help of relatives TBAs & others which revealed big gap between ANC and delivery care maternal service utilization.
- Presence of TBA, short labor and likes to be with relatives or family were the commonly mentioned reasons to prefer home delivery.
- To get better care & information to give birth at health institution were commonly mentioned reasons to prefer institutional delivery.
- Health centers and health post were the most attended institution for ANC follows up.
- Health centers were the primary site for institutional delivery
- Urban residence, educational status, satisfactory attitude & more ANC frequency were independent determinants of institutional delivery service utilization.
- As maternal age increase, the utilization of institutional delivery is less likely

8.2. Recommendation

Based on the findings of the study, the following areas were identified and specific recommendations were made.

Generally

- Women‘s education should be promoted to at least beyond the primary level.

To health care providers

- Health care providers should provide information on risks of pregnancy, risks of home delivery, benefits of giving birth at health facilities, danger signs during pregnancy and labor to mothers, family members and the community.
- Antenatal care should be promoted and linked with delivery care to minimize the gap between them.
- Health care providers should stimulate mothers by warm and welcome approach to increase positive at attitude to maternal service utilization.

To local health sector officials

- Health facilities need to be equipped with basic supplies and equipment
- Referral linkage between HPs and HCs and hospitals should be strengthened
- Health workers should encourage mothers when they attend ANC to link with institutional delivery services utilization
- Community education about pregnancy, child birth and postpartum, particularly, the danger sign of pregnancy, labour and delivery and the actions ensuing complication need to get particular attention. So that information, education and communication should be ensured through different means.

References

1. Fraser M, Cooper A. Myles Textbook for Midwives. 4th ed., Churchill Livingston, Edinburgh, 2003.
2. White Ribbon Alliance for Safe Motherhood. Awareness, Mobilization and Action for Safe Motherhood: A Field Guide. White Ribbon Alliance for Safe Motherhood, Washington, D.C., 2000
3. National Primary Health Care Development Agency-Midwives Service Scheme and PRRINN-MNCH collaboration Increasing. Skilled Birth Attendance in Nigeria, 2010
4. UN. Millennium Declaration, 2000. Washington.
5. WHO. Make every mother and child count, 2005. Geneva,
6. Mia MacDonald. Ann Starrs. Family Care International, Inc. New York, NY 10012 USA, 2002. (http://www.safemotherhood.org)
7. UNICEF. Tracking progress in maternal, newborn & child survival. 2008 Geneva.
8. WHO, UNICEF, UNFPA, and World Bank. Trends in maternal mortality from1990-2008. Estimates developed by WHO, UNICEF, UNFPA and the World Bank, 2010. Geneva.
9. Koblinsky M. Issues in Programming for Safe Motherhood, Mother Care Arlington, VA: John Snow Inc. 2000.
10. Family Health Department. Ministry of Health. Facility based rapid need assessment for the making pregnancy safer initiative: Implementation of four pilot regions in Ethiopia, March 2002.
11. Central statistic Authority Ethiopia: Demographic & Health Survey 2005. September 2006.

12. Central statistical agency Ethiopia; Ethiopia Demographic and Health Survey 2011 Preliminary Report, September 11,2011; Addis Ababa, Ethiopia
13. Rashid SF Afsana K. Discoursing birthing cares: experiences from Bangladesh, Dhaka: University Press Limited, 2001, p.128.
14. UNFPA. Regional workshop on skilled birth attendants in South and West Asia, Islamabad, 2004.
15. World Health Organization. Proportion of births attended by a Skilled health worker, 2008; Geneva.
16. United Nations. The Millennium Development Goals report Statistical Annex. New York, 2007. (http://www.un.org/millenniumgoals, accessed 14 August 2008).
17. WHO. Proportion of birth attended by a skilled health worker; 2008, Geneva.
18. WHO, UNICEF, UNFPA and the World Bank. Estimates developed of Maternal mortality in 2005: Geneva, 2007. (http://www.who.int/reproductive-health/publications/maternal_mortality_2005/index.html, accessed 14 August 2008).
19. Mesfin N. et al .Assessment of safe delivery service utilization among women of childbearing age in north Gondar Zone,North West *Ethiop.J.Health Dev.* 2004;18(3):145-152
20. Mulumebet A. et al. Predictors of safe delivery service utilization in Arsi zone, south-east

    Ethiopia. Ethiop J Health Sci. 2011. Vol. 21, Special Issue.
21. Yared M. Patterns of maternity care service utilization in Southern Ethiopia: Evidence from a community & family survey. Ethiopian Journal of Health Development, 2003; 17(1):27-33.

22. Yalem Tsegay. Determinants of Antenatal Care, Institutional Delivery and Skilled Birth Attendant Utilization in Samre Saharti District, Tigray, Ethiopia. A thesis Submitted to Epidemiology and Global Health, Sweden University, 2010. (Unpublished)

23. The Last Ten Kilometers Project. 2009. Baseline Household Health Survey: Amhara,Oromiya, SNNPR. (unpublished)

24. Rose NM, Mpembeni, j., et al. Use pattern of maternal health services and determinants of skilled care during delivery in southern Tanzania: Implications for achievement of MDG- 5 targets, BMC pregnancy and child birth; 2007.7(29):978-81.

25. Anna M van Eijk. Use of antenatal services and delivery care among women in rural western Kenya: a community based survey, Reproductive Health 2006, 3:2;154-158 http://www.reproductive-health-journal.com/content/3/1/2

26. Frewein G. Assessment of factors for safe delivery service utilization among women of childbearing age in ephratanagidim district, north shoa zone, amhara regional state, Ethiopia. A thesis presents to Addis Ababa University, Ethiopia, 2009.(unpublished)

27. Nigussie M. Assessment of safe delivery service utilization among women of child bearing age in North Gondar Zone, North West Ethiopia. Ethiop J. Heath Dev; 2004. 18(3): 145-152.

28. Amardeep T., Amir M., Kaberi B., Fred H. Where to deliver? Analysis of choice of delivery location from a national survey in India. BMC Public Health; 2008. 8(29):89- 95.

29. Bolam A., et al. Factors affecting home delivery in Katmandu Valley, Nepal. Health Policy and Planning; 1999. 3(2):152-8.

30. Balaji R,Dilip TR, Dujjal R. Utilization of and expenditure on delivery care services: some observation from Nashik District, Regional Health, 2004.

31. Mekonnen, Y and Mekonnen, A. Utilization of maternal health care services in Ethiopia: Calverton,Maryland, USA. Ethiopian Health and Nutrition Research Institute, Addis Ababa, Ethiopia; 2002.

32. World Bank. Population and reproductive health; World bank 2002.

33. World Bank. Understanding the access, demand and utilization of health services by rural women in Nepal and their constraints, South Asian Region. June 25, 2001..

34. WHO. Maternal and child health regional estimates of perinatal mortality weekly epidemiological record, 1993; Geneva.

35. Yuster EA. Rethinking the role of the risk approach and antenatal care in maternal mortality reduction, International Journal of Gynecology and Obstetric,1995.

36. Mahler H. The Safe motherhood initiative; A call action. Lancet.; 1997. 1:668-670

37. Tann J.et al. Use of antenatal services and delivery care in Entebbe; a community survey. BMC Pregnancy and Child Birth, 2007. 7: (1)23-26.

38. Elizabeth L., Nandini Ooman, Joanne Epp, et al. Achieving the Millennium Development Goal of Improving Maternal Health: Determinants, Interventions and Challenges. HNP Discussion paper. Washington, DC: The International Bank for Reconstruction and Development / The World Bank, 2005 .

39. Rose NM, Mpembeni, j et al. Use pattern of maternal health services and determinants of skilled care during delivery in southern Tanzania: Implications for achievement of MDG- 5 targets, BMC pregnancy and child birth; 2007. 7(29):978-81.

40. Okolocha C. et al. Socio-cultural factors in maternal morbidity and mortality: a study of a semi-urban community in Southern Nigeria. Journal of Epidemiology and Community health; 1998. 52:293-7.

41. Abyot A., assessment of factors associated with safe delivery service utilization among women of childbearing age in sheka zone, SNNPR, south west ethiopia ; a thesis submitted to the school of graduate studies of Addis Ababa University, july 2008.(unpublished)

42. Fantahun M., Olwit G, Shamebo D. Determinants of ANC attendance and preference to place of delivery in Gulele district. Eth J Health Development. 1992; 6(2):17-22

43. Hadiyya Zone Health Department. Population demography and health survey Hossana, SNNPR Ethiopia,2003.

Annex 1: Information sheet for participants

Here, I the undersigned, at Addis Ababa University College of Health Sciences Department of Nursing Graduate studies Program, currently I will be undertaking research on a topic entitled assessment of factors affecting utilization of institutional delivery service among child bearing age women in Hadiyya zone SNNPR Ethiopia. For this study, you will be selected as a participant and before getting your consent or permission of your participation, you need to know all necessary information related to the study. Thus, this information will be detailed as;

- Objective: To assess of factors affecting utilization of of institutional delivery among child bearing age women in Hadiyya zone SNNPR Ethiopia
- Significance of the study: There is no research done on this topic in the study area. So it is believed that it can be used as reference for those who are interested to perform a research on the similar topics. Finding out which factors determines for low utilization of institutional delivery is important for policy makers, stakeholders and program implementers to improve utilization institutional delivery.

Participants to be included: Samples of women in the child bearing age who have had at least one birth experience in selected woredas of the study area..

- Confidentiality: All information you give will be kept confidential and will not be accessible to any third party. Your name will not be registered on the question sheet so that you will not be identified.
- Risks and Benefits of the study

  Risks: The study will be carried out simply by interviewing you, the already prepared and structured questions. The procedure doesn't bear any physical or psychological trauma. Furthermore, you will not be forced to respond to the information you do not know.
- Benefits: your participation in the study no payment will be granted or has no any special privilege to you. But, participating in the study and giving your information to questions asked will have great input in efforts to improve utilization of institutional delivery.
- Consent: Your participation in the study will be totally based on your willingness. You have the right not to participate from the beginning, or stop any time after starting participation. You will not be forced to respond to the information you do not know.
- Time: the time to complete this interview may take from 25-30 minutes.

Annex 2: consent form English version

Verbal informed Consent form that certify the respondents' agreement before the interview

Good morning, Good afternoon (According to its convenience). My name is _____. I am Nurse professionally and now I am collecting data from women who gave birth in the last three years preceding the survey for the research being conducted to assess factors affecting utilization of institutional delivery by Mr. Tadesse Lelago who is the degree in master of Maternity and Reproductive Health Nursing student in Addis Ababa University . You are selected to be one of the participants in the study by chance. The study will be conducted through interview. Your name and other personal identifiers will not be recorded on data collection format and the information that you give us will be kept confidential and will also be used for this study purpose alone. A code number will identify every participant and no names will be used. If a report of the result is published, only summarized information of the total group will appear. The interview takes 30 minutes and is voluntary and you have the right to participate, or not to participate or to refuse at any time during the interview. You will not face any problem if you do not agree to the information to be asked and you will not be also denied of getting any medical services from the health institution. Your participation on this study helps to identify factors affecting the utilization institutional delivery in Hadiyya zone. If you have any questions about this study you may ask me or the principal investigator

- Are you willing to participate in the study? 1. Yes 2. No
- Interviewer who certified that the informed consent has been given verbally from the respondents

Name_____ signature_____ Date_____

- Checked by:

  Name _____ signature_____ Date_____

Annex 3: English questionnaire version

Households Identification

2. Questionnaire code_____

2. Woreda _____ Kebele_____

Instruction –Circle the responses for questions with alternatives and write for open ended questions on the space provided.
Part One: Respondents Socio Demographic Factors

Serial no.	Questions	Option/alternative	
101	What is your age in completed years?	_____	
102	Marital status	1. Married 2. Single 3. Divorced 4. Separated 5. Widowed 6. Other, specify----------	
103	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Other, specify----------	
104	Educational status of the respondent	1. Illiterate 2. Only read & write 3. primary school (1-8) 4. 2ndary high school(9-12) 5. 12+ 6. Other, specify----------	
105	Ethnicity	1. Hadiyya	

		2. Kembata 3. Guragea 4. Other specify-------	
106	Occupation	1. House wife 2. Farmer 3. Gov't employee 4. Private employee 5. Merchant 6. Housemaid 7. Student 8. Other, Specify-----	
107	Do you have monthly income	1. Yes 2. No 3. I don't want to tell	2,3,skip to 109
108	If yes toQ107,monthly income in Birr	_____birr	
109	Who is the head of the house hold	1. My husband 2. My self 3. My father 4. My mother 5. The father of my husband 6. The mother of my husband 7. Other, specify----------	
100	Educational status of the head of the household (if other than her self	1. Illiterate 2. Only read & write 3.primary (1-8) 4. 2ndary high school(9-12) 5. 12+ 6.Other, specify	
111	Do you have radio	1. Yes 2. No	
Part II: Obstetrics history factors			

201	How many times you have been pregnant in your life?(Probe for abortions, still births and current conception)	_____	
202	How old were you at your last pregnancy?	_____	
203	What were the outcomes of the pregnancies? (Ask for each item and put numbers on the space provided.)	1. Total live birth------- 2. Abortion ---- 3. Still birth-------- 4. Died within seven days-- 5.Died b/n 7days & birthday---------- 6. Live birth survived to>1yr-- 7. Other specify------	
204	Was the pregnancy planned?	1. Yes 2.No	
205	Did you receive antenatal care for the pregnancy?	1. Yes 2. No	If 2, skip to 210
206	Where did you follow your ANC visit?	1. hospital 2. health center 3. health post 4. home	
207	How many times did you visit for the care till delivery?	----------	
208	Where did you deliver your last baby in the past three years?	1. home 2. Hospital 3. Health center 4. Private clinic 5. Health post 6. Other, specify	
209	Why did you prefer to deliver at home? (Ask for those delivered at	1. much cost of HFs 2. Facility not open regularly	

	home only.) More than one response is possible	3. Facility too far 4. Poor quality service of HFs 5. No female provider at HFs 6. Husband will not allow 7. Need to be with relatives 8. Unwelcoming approach of health workers 9. Presence of TBAs 10. Labour was smooth and short 11. Previous HDs was normal 12. Lack of accompanies 13. I was told my pregnancy is normal 14. Lack of transport 15. Other(specify)-----	
210	Why did you prefer to deliver at Health facility? Ask for those delivered at health institutions.	1. HF is near to me 2. Need Better service 3. Previous better out come with delivering at HF 4. I was told to deliver at health facilities 5. Difficult labor 6. Bad outcome with previous HD 7. Other, specify-----	
211	Who assisted your last child birth?	1. health professional 4. Health extension workers 5. TTBA 6. TBA 7. Community Health agent	

		8. Mother 9. Husband 10. Mother in law 11. No one 12. Other (specify)----	
212	Did you encounter any health problems during labor, delivery and immediately after birth during your last delivery?	1. Yes 2. No 3. I don't remember	If 2,skip to 219
213	If yes Q216, what were the problems?	1. Excessive Vaginal bleeding 2. Prolonged labor(>12 hrs) 3. Retained placenta (>1hr) 4. Inability to control urine/faces/both 5. Mal-presentation 6. Fetal death 7. Early rupture of membrane 8. Loss of consciousness 9. Other, specify…	
215	According to your birth order, where does the last baby belong?	1. First 2. Second 3. Fourth 4. Fifth and above	
216	Did you encounter any health problems during labor, delivery and immediately after birth immediate next to your last delivery?	1. Yes 2. No 3. I don't remember	If 2&3, skip to 222
217	If yes, what were the problems?	1. Excessive Vaginal bleeding 2. Prolonged labor(>12 hrs) 3. Retained placenta (>1hr) 4. Inability to control	

		urine/faces/both 5. Mal-presentation 6. Fetal death 7. Early rupture of membrane 8. Loss of consciousness 9. Other, specify……	
218	Have you ever given birth at HFs before your last birth?	1. Yes 2. No 3. I do not know	
Part: III Women knowledge and Attitudes factors			
301	Are you aware of any health risks a woman might experience during pregnancy?	1. Yes 2. No	If 2, skip to 303
302	If yes what are the risks?	1. Pregnancy related disease 2. Maternal death 3. Fetal death 4. Other specify	
303	Did you know any danger signs of pregnancy	1. Yes 2. No	If 2,skip 307
304	If yes, what are the danger signs? Circle the mentioned responses.	1. Swelling of leg/face 2. Vaginal bleeding 3. Reduced/absence of fetal movement 4. Severe head ache 5. Severe abdominal cramp 6. Excessive weight gain 7. Increased BP 8. Severe difficulty of breathing 9. Leakage of amniotic fluid without labor	

		10. Fever 11. Blurring of vision 12. Other specify-----	
305	Did you experience any of the danger signs during your last pregnancy?	1. Yes 2. No 3 I do not know	
306	Do you know any danger signs of labour?	1. Yes 2. No	
307	If yes, what are the danger signs do you know? Multiple responses are possible.	1. Prolonged labor >12hrs 2. Early rupture of membrane 3. vaginal bleeding 4. Placenta retention >1hr 5. Mal-presentation 6. Increased BP 7. Convulsion 8. Cessation of labor pain 9. Severe continuous abdominal pain 10. Other, specify----	
308	Do you think giving birth at home has risks?	1. Yes 2. No	
309	If yes, what risks do you know?	1. Maternal exhaustion 2. Fetal distress 3. Maternal deaths 4. Fetal/neonatal death 5. Disease transmission from attendants 6. Higher postpartum morbidity 7. other specify------	
310	Do you know any benefits of giving birth at HFs?	1. Yes 2. No	If 2,skip 313

311	If yes, what benefits do you know?	1. Early detection of problems 2. Timely solving problems 3. Lower maternal exhaustion 4. Better new born care 5.Lower maternal postpartum morbidity 7. Other specify--------	
312	Most complications of labour are preventable.	1. Agree 2. Disagree 3.In different	
313	Most complications of Labour are treatable.	1. Agree 2. Disagree 3.In different	
315	Delivery complications can be severe & may be hazardous to my well-being.	1. Agree 2. Disagree 3.In different	
316	Delivery complications can be severe and may be hazardous to the newborn.	1. Agree 2. Disagree 3.In different	
317	Being attended by a skilled delivery attendant may be beneficial to my wellbeing.	Agree 2. Disagree 3.In different	
318	Being attended by a skilled delivery attendant may be beneficial to the newborn's wellbeing.	1. Agree 2. Disagree 3.In different	
319	Health professionals at HFs are skilled enough to detect and treat or refer delivery complications.	1. Agree 2. Disagree 3.In different	
320	Health facilities in nearby are adequately equipped to provide delivery service.	1. Agree 2. Disagree 3.In different	

321	Health facilities in nearby are staffed with skilled professionals to provide delivery service.	1. Agree 2. Disagree 3.In different	
322	Women do not go to health facility for delivery because the health worker do not treat them respectfully	1. Agree 2. Disagree 3.In different	
Part IV Women health service utilization			
401	Is there health facility in your vicinity?	1.Yes 2.No	If 2, skip to 405
402	If yes, how far is it?	_____walking hours _____ km	
403	What type of health facility is it?	1. Health post 2. Health center 3. Hospital 4. Private clinic 5. other specify	
404	Does the health facility provide delivery care?	1.Yes 2.No 3. I do not know	
405	Have you ever used any modern health facility?	1.Yes 2.No 3. I do not know	If 2, skip To 407
406	If yes, what services did you get so far?	1. ANC 2. Delivery 3. PNC 4. Immunization 5. Family planning 6. Curative services 7. Other specify	
407	If no, what are the reasons?	1. Facility too far 2. Not seriously ill 3. High cost of facilities 4. Presence of traditional	

		healers 5. Too busy with HHs chores 6. Others specify….	
408	Have you ever given births at HFs?	1. Yes 2.No	2,skip to 412
409	If yes, how did you receive the service?	1. Free of charge 2. On payment basis 3. I do not remember	
410	If you received on payment, how much did you pay during your most recent HF delivery service?	--------Birr	
411	What was your opinion on the payment?	1. Unaffordable 2. Fair 3. Cheap 4. I do not have suggestions	
412	Who decides your health service utilization?	1. Self 2. Husband 3. Relatives 4. Religious leader 5. Other specify	
413	Who decides place for your child birth?	1. Self 2. Husband 3. Relatives 4. Religious leader 5. Other specify….	
414	Who decides about whom would attend your delivery?	1. Self 2. Husband 3. Religious leader 4. Cultural leader 5. Other specify….	

Annex 4: የጥናቱ መረጃ ቅጽ በአማርኛ

ከዝህ በታች እንደተገለፀዉ በአዲስ አበባ ዩኒቨርስቲ የጤና ሳይንስ ኮሌጅ ነርስ ና ሚድዋፈሪ ት/ክፍል የድህር ምረቃ መረሃ ግብረ በአሁኑ ወቅት" እናቶች በጤና ተቋም እንደይወልዱ ተጽኖ የምያደርጉ ምክንያቶችን ማወቅ' በሚላዉ በሀድያ ዞን በሚገኙ ወረደዎች የምደረግ ጥናት እያከሄድኩ ነዉ።

የዚህ ጥናት ተሳታፍ ለመሆን እርሶዎ ተመርጠዋል። በጥናቱ ላይ ለመሳተፍ ፍቃደኝነትዎ ከመጠየቅ በፊት ጥናቱን በተመለከተ አስፈላጊ የሆኑ መረጃዎችን ማግኘት ያስፋልጎታል። ስለዝህ በጥናቱ ላይ ለመሳተፍም ሆነ ላለመሳተፍ መጀመረያ ማወቅ የሚገባዎትን መረጃ እንደሚከተለዉ እናቀርብሎታለን።

ሀ. የጥናቱ አላማ ፡ የምርምሩ አላማ እናቶች በጤና ተቋም እንደይወልዱ ተጽኖ የምያደርጉ ምክንያቶችን ለይቶ ለማወቅ ነዉ።

ለ. በጥናቱ የሚካተቱ ተሳታፊዎች ፡መረጃዉ በሚሰበሰብበት ግዜ በለፉት ሦስት ዓመት ዉስጥ የወለዱ እናቶች በጥናቱ ይካተታሉ።

ሐ. የጥናቱ ጥቅምና ጉዳት

ጥናቱ የሚካሄዳዉ ቀደም ብሎ ለዝሁ ጥናት ታስቦ የተዘጋጀዉን ጥያቄ በመጠየቅ ነዉ። ሆኖም በጥናቱ ተሳታፊዎች አካል ላይም ሆነ አእምሮ ለይ ፊጽሞ ጉዳት አይኖርም። ያልገባዎትን መረጃ ለመመለስ አይገደዱም። በጥናቱ በመሳተፎ የሚከፈልዎት ክፍያ ወይም የተለየ ጥቅም አይኖርም።በሌላ በኩል በጥንቱ በመሳተፎና ለጥያቄ ተገቢዉን መረጃ መስጠትዎ እናቶች በጤና ተቋም እንደይወልዱ ተጽኖ የምያደርጉ ምክንያቶችን ለማወቅ ከፍተኛ እገዛ ያደርጋል።

መ. የጥናቱ ምስጥራዊነት፡ እርሶዎ የሚሰጡት መረጃ በሚስጥር ይጠበቃል እንድሁም ለሶስተኛ ወገን ተላልፎ አይሰጥም። ከማንኛዉም መረጃ ጋር ሰምዎ አይመዘገብም።

ረ.ፍቃደኝነትዎን በተመለከተ፡ በጥናቱ ላይ መሳተፈዎ ሙሉ በሙሉ የሚመሰረተዉ በራሶዎ ፍላጎትና ፈቃደኝነት ለይ ነዉ።ከመጀመረያዉ በጥናቱ ላይ ለመሳተፍም ሆነ ላለመሳተፍ ይችላሉ።ካልተስማማዎት በመሀል የማቋረጥ መብትዎ ሙሉ በሙሉ የተጠበቀ ነዉ።ያልገባዎትን መረጃ ለመመለስ አይገደድም።

6.ጥያቄዉ የሚወስደዉ ጊዜ ቢበዛ ሰላሳ ከ25-30 ደቂቃዎች ብቻ ነዉ።በመጨረሻም ለሰጡኝ መረጃዎች ከልብ ላመሰግንዎት እወዳለዉ።

Annex 5: የስምምነት ቅጽ በአማርኛ

ጉደዩ፡ የእናቶችን ወሊድ አገልግሎት አጠቃቀም ለይ ተጽኖ የሚያደርጉ ነገሮችን ለማጥናት የተዘጋጀ መጠይቅ፣

<u>የሚሰጥር አጠባበቅና የጥናቱ ጥቅም</u>

ጤና ይስጥልኝ፤

እኔ----------እባላለሁ በአዲስ አበባ ዩንቨርሲቲ የነርስግ ና ሚድዋፈሪ ትምህርት ቤት ሁለተኛ ዓመት ተማሪ አቶ ታደሰ ለላጎ በሚያከሄደዉ የጥናት ቡድን አባል ነኝ:: ጥናቱ በዕጣ በተመረጡ ቀበሌዎችና ቤቶች ላይ የሚከሄድ ነዉ:: የጥናቱ ዓላማ እናቶች የወሊድ አገልግሎ ትን በበቅ ሁኔታ እዳይጠቀሙ የሚያግዱትን ጉዳዮች ለይቶ የመፍትሄ መንገዶችን መጠቆም ነዉ::

ለዚሁ ዓላማ የርስዎን ማህበራዊና ስነ ህዝባዊ በእርግዝናና ወሊድ ጊዜ ችግሮች ላይ ያለዎትን ግንዛቤና አመለካከት መረጃዎች

እንሰበስባለን:: ስለሆናም የሚሰጡን መረጃ መንግስትና ሌሎች ጉዳዩ የሚመለከታቸዉ አካላት የእናቶችን ወሊድ አገልግሎት አጠቃቀም ለማሻሻል የመፍትሄ መንገዶችን እንዲቀይሱ ይረዳቸዋል፡፡

ያለባለሙያ እገዛ ወይም ከጤና ተም ዉጭ የሚወለዱ እናቶችና የሚወልዳቸዉ ህጻናት በከፍተኛ ሁኔታ እስከሞት ለሚያደርሱ ጉዳቶች ይጋለጣሉ:: በጥናቱ ላይ የሚሳተፉት በፍላጎትዎ ሲሆን በሙሉም ሆኔ በከፊል ያለመሳተፍ መብትዎ የተጠበቀ ነዉ:: ጥናቱ ላይ ያለመሳተፍ ዉሳነዎ የተከበረ ከመሆኑም በላይ የጤና አገልግሎት አጠቃቀሞት ላይ ምንም ዓይነት ችግር አይከሰትም:: በሚንሰበስባቸዉ መረጃዎች ላይ ስምዎት ስለማይመዘገብና ሌሎችም መለያ መረጃዎች በሚስጥር ተጠበቀዉ ከጥናቱ ቦኃላ ስለሚቃጠሉ ምስጥሮቹ ለማንም እንደማይሰጥ እርግጠኛ ይሁኑ፡፡

ቃለ መጠይቁ 25-30 ደቂቃዎች ያህል የሚወስድ ሲሆን በማንኛዉም ጊዜ ማቆም ይችላሉ:: እስካሁን በተነጋገርናቸዉ ጉዳዮች ላይ ያልገባዎትና ግልፅ ያለሆነ ነገር ካለ መጠየቅ ይችላሉ፡፡ አሁን በጥናቱ ላይ ለመሳተፍ ተስማምተዋል?በማመስገን ወደ ቀጣዩ ቤት ሂጂ/ህድ::

አዎን ---------- አይለም ---------- ፈቃደኛ ካለሆኑ ዉሳነያቸዉን አክብረሽ/አክብረ

የተስማሙ ከሆኑ ቃለ መጠይቁን ቀጥይ/ቀጥል

ቃለ መጠይቁን ያደረገችዉ /ያደረገዉ ስም---------- ፊርማ-------- ቀን----------

የተቆጣጣሪዉ ስም----------ፊርማ---------ቀን----------

Annex 6: መጠይቆች በአማርኛ

ክፍል አንድ፤ የተጠያቂዉ አጠቃላይ የማህበራዊና እኮኖሚያዊ መረጃ የተመለከተ መጠይቅ

	ጥያቄዎች	ምርጫዎች	
101	ይህ ቃለ መጠይቅ ሲደረግልዎ እድሜዎ ስንት ነዉ (በዓመት)	----------	
102	የጋብቻ ሁኔታ	1. ያገባች አብረዉ የሚኖሩ 2. ያላገባች 3. አግብታ የፈታች 4. አግብታ ተለያይተዉ የሚኖሩ 5. ባልዋ የሞተባት 6. ሌላ (ይጠቀስ)------	
103	ሐይማኖት	1.አርቶዶክስ 2. እስላም 3. ፕሮቴስታንት 4. ካቶሊክ 6. ሌላ (ይጠቀስ)-------	
104	የትምህርት ደረጃዎ	1. ምንም አልታመርኩም 2. ማንበብና መጻፍ ብቻ 3. ከ1-6ኛ ክፍል 4. ከ7-12ኛ ክፍል 5. ከ12ኛ ክፍል በላይ 6.ሌላ (ይጠቀስ)	
105	ብሔር	1.ሀድያ 2. ከምባተ 3. ጉራጌ 4. ሌለ ይጥቀሱ	
106	የስራ ድርሻዎ	1.የቤት እመቤት 2. ግብርና 3. የመንግስት ሰራተኛ 4. የቀን ሰራተኛ 5. ነጋዴ 6. የሰዉ ቤት ሰራተኛ 7. ምንም ስራ የለኝም 8. ተማሪ 9. ሌላ (ይጠቀስ) ------	
107	የወር ገቢ አልዎት?	1. አዎ 2. የለኝም 3. ለመናገር ፍቃድኛ አይደለሁም	
108	የወር ገቢ በወር ሲሰላ?	_____	
109	የቤተሰቡ ሃላፊ ማን ነዉ?	1. ባለቤቴ 2. እኔ 3. አባቴ 4. እናቴ 5. የባለቤቴ እባት 6. የባለቤቴ እናት 7.ሌላ (ይጠቀስ) ------	
110	የቤተሰቡ ሃላፊ ትምህርት ደረጃ(ከእርስዎ ሌላ ከሆነ)	1. ያልተማረ 2. ማንበብና መጻፍ የሚችል 3. ከ1- 6ኛ ክፍል 4. ከ7 - 12ኛ ክፍል 5. አስራ ሁለተኛ ክፍል	

		6. አላውቅም	
111	ሬድዬን አለዎት?	1. አለኝ 2. የለኝም	

ክፍል ሁለት፡ ባለፈዉ ሶስት አመተት ያለዉን የእርግዝናና የወሊድ ሁኔታን በተመለከተ መጠይቅ

	ጥያቄዎች	አማራጭ መልሶች	
201	በአጠቃላይ በእድሜዎ ለምን ያህ ጊዜ ነፍሰጡር ሆነዉ ያዉቃሉ?	----------	
202	በመጀመሪያ እርግዝናዎ እድሜዎ ስንት ነበር?	_____	
203	በመጨረሻ እርግዝናዎ ወቅት እድሜዎ ስንት ነበር?	_____	
204	የእርግዝናዎ ዉጤት ምን ነበር? (በእያንዳንዱን አማራጭ መልሶች መሰረት ከፍት ቦታዉ ይሞላ)	1. በህይወት የተወለዱ------- 2. ዉርጃ ---------- 3. ሞተዉ የተወለዱ -------- 4. በህይወት ተወልደዉ በሰባት ቀን ዉስጥ የሞቱ---------- 5. በህይወት ተወልደዉ በሰባት ቀንና በአንድ አመት መካከል የሞቱ--------- 6.ሌላ ካለ ይጠቀስ	
205	እርግዝናዎ የታቀደ ነበር?	1.አዎ 2. አይደለም	
206	ቅድማወልድ ክትትል/ምርመራ/ አድርገዉ ያዉቃሉ?	1. አዎ 2. አላዉቅም	2 ወደ 211
207	የነፍሰጡር ምርመራ ካደረጉ ምርመራዉን የተከተታሉት ዬት ነበር?	1.ጤና ጣቢያ 2.ጤና ኬላ 3.ሆስፒተል 5. የግል ክልንክ	
208	የነፍሰጡር ምርመራ ካደረጉ ምርመራዉን የደረገልዎት ባለሞያ ማን ነዉ?	1. ጤና ባለሙያ 5. ጤና ኤክስቴንሽን ሠረተኛ 6. በሰለጠነ የልምድ አዋላጅ 7. ባልሰለጠነ የልምድ ዋላጅ	
209	እስከወልዱ ድረስ ስንት ጊዜ ክትትል አደረጉ?	_____	
210	የእርግዝና ክትትል ስታደርግ በጤና ተቋም መዉለድ ያለዉን ጥቅም ተነግሮሽ ነበር	1.አዎ 2. አይደለም 3.አለስተዉስም	
211	የት ነበር የወለዱት?	1.የራሴ ቤት 2.ሆስፒታል 3. ጤና ጣቢያ 4. ጤና ኬላ 5.መንገድ ለይ 6. የግል ክልንክ	በጤና ተቋም ከሆነ ወደ ጥያቄ 213

212	ለምን ነበር ቤት የወለዱት?	1. የጤና ተቋማት ክፍያ ብዙ ስለሆነ 2. ጤና ተቋማት ሁልጊዜ ክፍት ስለማይሆኑ 3. ጤና ተቋም ሩቅ ስለሆነ 4. የጤና ተቋማት ጥራት አነስታኛ ስለሆነ 5. ሴት ባለሙያዎች ስለማይኖሩ 6. ባለበቴ ጤና ተsም እንዲሄድ ስላልፈቀደ 7.ዘመዶቼ ባሉበት መወለድ ስለፈለኩ 8. የጤና ባለሙያዎች አቀራረብ ጥሩ ሥለልሆነ 9. የልምድ አዋላጆች ስለነበሩ 10.የምጥ ጊዜ አጭር ስለነበሩ 11.ካአሁን በፊት ቤት ወልጄ ችግር ስላልገጠመኝ 12.የሚወስደኝ ስለልነበር 13. እርግዝናዬ ችግር እንደሌለበት ስለተነገረኝ 14. የመንገድ´/ የትራፖርት/የገንዘብ/ ችግር 15. ሌላ ይጥቀሱ	
213	በጤና ማዕካል የወለዱት ዋነኛ ምክንያት ምንድነዉ?	1.ከምኖርባት ቦታ ቅርብ ስለሆነ 2. የተሸለ እንክብካቤ ለማገኘት 3.ከዚህ በፊት ጤና ማዕካል ወልጄ ጥሩ ነገር ስለገጠማኝ 4.በጤና በላሙያ ስለተነገረኝ 6.ከዚህ በፊት ቤት ወልጄ ችግር ስለገጠማኝ 7. የወልድ ችግር ስለገጠማኝ 8. ሌላ ምክንያት ከሎዎት ይጥቃሱ-----	

214	የመጨረሻ ወሊድዎትን ያዋለድዎት ማን ነበር?	1. ጤና ባለሙያ 2. የጤና ኤክስቴሽን ሠረተኛ 3. የሰለጠነች የልምድ አዋለጅ 4. ያልሰለጠነች የልምድ አዋለጅ 5. እነቴ/የበለቤት እነት 6.ባለቤቴ 7.ማንም አለገዘኝም 8. ሌለ ይጥቀሱ----------	
215	በመጨረሻዉ እዝርግዝነዎት ወሊድ ጊዜ የጤና ችግር ገጥሞት ነበር	1. አዎ 2. አይደለም 3. አለስታዉስ	2፣3 ወደ 220
216	ከገጠሞት ምን ነበር	1. ካመጠን ያለፈ ደም መፍሰስ 2. የምጥ መዘግየት(12ሰዓት) 3. እንግዴ ልጅ መዘግየት/ካ1 ሳዓት ባለይ 4. ሽንትና ኣይነ ምድር መቆጣጠር አለመቸል 5. የፅነስ አመጣጥ ትክክለኛ አለመሆን 6. የሽል ሞት 7. የሽርት ዉሃ ያለጊዜዉ መፍሰስ 8. ራስ መሳት 9. ሌለ ይጠቀስ----------	
217	ለችግሮቹ ምን መፍትሔ ነበር የወሳዱት	1.ወደ ጤና ተቋም ሄድኩ 2.የልምድ አዋለጅ አማከርኩ 3.ምንም አለደረኩም 4.ሌለ ይጥወሱ----------	
218	በወልድዎት ቅደም ተከተል መሰረት የመጨረሻዉ ስንተኛ ልጅ ነበር	1. 1ኛ 2. 2ኛ 4. 3ኛ 4. 4ኛ 5.አምስትና ከዚ በለይ	
219	ከመጨረሻ በፊት በነበረዉ እርግዝናዎት በወሊድ ግዜ የጤና ችግር ገጥሞት ነበር	1. አዎ 2. አይደለም 3. አለስተዉሰም	2፣3 ወደ 223
220	ምን ምን ችግሮች ነበሩ የገጠሞት?	1. ካመጠን ያለፈ ደም መፍሰስ 2. የምጥ መዘግየት 3. እንግዴ ልጅ መዘግየት/ካ1 ሳዓት ባለይ	

		4. ሽንትና ኣይነ ምድር መቆጣጠር አለመቸል 5. የፅነስ አመጣጥ ትክክለኛ አለመሆን 6. የሽል ሞት 7. የሽርት ዉሃ ያለጊዜዉ መፍሰስ 8. ራስ መሳት 9. ሌለ ይጠቀስ----------	
221	ከመጨረሻዉ ወሊድዎት በፊት ጤና ማዕከል ወልደዉ ያዉቃሉ?	1. አዎ 2. አይደለም 3. አለስተዉሰም	
222	ወልደዉ ከሆነ ስንት ጊዜ ነበር የወልዱት?	_____	

ክፍል ሦስት፤ የእናቶች ግንዛቤና አመለካከት ጥያቄዎች

301	ከእርግዝና ጋር በተያያዛ ሊመጣ የምችል የጤና ችግር ያዉቀሉ?	1. አዎን 2. አለዉቅም	2 ወደ 303
302	የሚያዉቁ ከሆነ ችገሮቹ ምን ምን ናቸዉ?	1.ከእርግዝና ጋር የተያያዙ በሽታዎች 2.የእናቶች ሞት 3.የህፃናት ሞት 4. ሌለ ይጥቀሱ----------	
303	በእርግዝና ጊዜ የሚከሰቱ አደገኛ ምልክቶች ያዉቃሉ?	1. አዎን 2. አለዉቅም	2 ወደ 307
304	አደገኛ ምልክቶቹ ምን ምን ናቸዉ/ ከአንድ በላይ ምላሽ ሊሰጥ ይችላል?	1.የፊት ወይም እግር እብጠት 2. ካማሕፀን ደም መፍሳስ 3. የፅንስ እንቅስቃሴ መቀነስ/መጥፋት 4. ከፍታኛ ራስ ምታት 5. ከፍተኛ የሆድ ህመም /ቁርጠት 6. ከመጠን በላይ ክብደት መጨመር 7. የደም ግፊት መጨመር 8. ከፍተኛ የመተንፈስ ችግር 9. ከፍታኛ ትኩሳት 10. ያለ ምጥ ያሻርት ወሃ መፍሳስ 11. የዓይን ብ»ታ 12.ሌለ የጥቀሱ----------	

305	በመጨረሻዉ እርግዝና ጊዜሽ እነኝህን ምልክቶቸ ገጥሞዎተል?	1. አዎን 2. አይደለም 3.አለስተዉሰም	2፣3 ወደ 307
306	በወልድ ጊዜ የሚከሰቱ አደገኛ ምልክቶች ያዉቃሉ?	1. አዎን 2. አለዉቅምም	2 ወደ 309
307	የሚያዉቁ ከሆነ ምልክቶቹ እነማን ናቸዉ? ከአንድ በለይ መልስ ይቸለል	1. የምጥ መዘግየት(ከ12 ሣዓት በለይ) 2. ያለጊዜዉ የሽርት ዉሃ መፍሰስ 3. ደም መፍሰስ 4. እንግዴ ልጅ መዘግየት 5. ትክክል ያልሆነ የጽንስ አመጣጥ 6. የደም ግፊት መጨመር 7. መንቀጥቀጥ እንደሚጥል በሽታ ማድረግ 8. የምጥ ህመም ማቆም 9. የማያርጥ ከፍተኛ የሆድ ቁርጠት 10. ሌላ ካለ ይጥቀሱ----------	
308	በቤት መዉለድ አስግነዉ ብሎ ያስበሉ	1. አዎን 2. አይደለም	2 ወደ 311
309	አዎ ከሉ ስገቶቹ ምንምን ነቸዉ?	1. የእናቶች ድካም ያስከትላል 2.የፅንስ መታፈን 3.የእናቶች ሞት 4.ከአወለጆች በሽታ መተላለፍ 5.ጎጅ ልማደዊ ድርግቶች ሰለበ መሆን 6.የፅንስ ጨቅላ ህፃን ሞት 7. በአራስ ቤት ህመም ይጨመራል 8.ሌላ ካለ ይጥቀሱ	
310	በጤና ተቋም መዉለድ ጥቅም አለዉ ?	1. አዎን 2. አይደለም	2 ወደ 313
312	ጥቅም አለ ከሉ፣ምን ምነ ጥቅሞች አሉት?	1.ችግሮች በጊዜዉ ይለያሉ 2.ችግሮች በጊዜዉ ይታከማሉ 3. የእናቶች ድካም ይቀንሳል 4. የተሻለ ህፃን እንክብካቤ ይኖራል 5. ጎጂ ልማዳዊ ድርጊቶች አይኖሩም	

		6. እናቶች አራስ ቤት ህመም ይቀንሳል 7. ሌላ ካለ ይጥቀሱ	
313	አብዛኝዎችን የምጥ ችግሮችን መከላከል ይቻለል ።	1.እስማማለሁ 2. አልስማማለሁ 3. ምንም አስተያየት የለኝም	
	አብዘኞቹን የምጥ ችግሮች/ጉደቶች/ መታከም ይቻለል ።	1.እስማማለሁ 2. አልስማማለሁ 3. ምንም አስተያየት የለኝም	
314	ማንኛዉም እርጉዝ ሴት በወልድ ምክንያት ለሚመጡ የጤና ችግር የተጋለጠች ነች::	1.እስማማለሁ 2. አልስማማለሁ 3. ምንም አስተያየት የለኝም	
315	በወልድ ምክንያትየሚመጡ የጤና ችግሮች በጤናዬ ላይ አስካፊ ዉጤትን ሊያስከትል ይችለል።	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	
316	በወልድ ምክንያት የሚመጡ የጤና ችግር በሚወለደዉ ልጅ ጤና ላይ አስካፊ ዉጤትን ሊስከትል ይችለል።	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	
317	በወልድ ወቅት በሰለጠነ የጤና ባለሙያ ታግዘ ሚወለድ የተሸለ ጤና እንዲኖረኝ ይረዳል።	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	
318	በወልድ ወቅት በሰለጠነ የጤና ባለሙያ ታግዘ ሚወለድዉ ሂፃን የተሸለ ጤና እንዲኖሮ ይረዳዋል::	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	
319	በጤና ባለሙያዎች የወሊድ ችግሮችን ለመለየት ለማከምና ከአቅማቸዉ በላይ ከሆነ ለመላክ ብቁ ናቸዉ	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	
320	በአቅራቢዎት ያሉት ጤና ተቋማት በበቂ መሳሪየዎችና ቁሰቁሶች የተሞሉ ናቸዉ።።	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	
321	በአቅራቢዎት ያሉት ጤና ተቋማት ባለሞያዎች የወሊድ አገልግሎት ለመስጠት ብቁ ናቸዉ።።	1.እስማማለሁ 2. እልማማለሁ 3. ምንም አስተያየት የለኝም	
322	ሴቶች በጤና ተቋም መዉለድ የለበቸዉም ምክንያቱም የጤና በለሙያዎች በእንክብከቤ ስለማያክሙ።።	1.እስማማለሁ 2. እልስማማለሁ 3. ምንም አስተያየት የለኝም	

ክፍል አራት፤ የጤና አገልገሎት አጠቃቀምና ዉሳኔ ሰጪነት

401	በቅአራቢያዎት ጤና ተቋም አለ?	1. አዎን 2. አይደለም	
402	ይህ ጤና ተቋም ምን ያህል ይርቀል?	-----ክሜ/---------ሳዓት (በእግር ጉዞ)	
403	ምን ዓይነት ጤና ተቋም ነዉ?	1. ጤና ከላ 2. የግል ክልንክ 3.ጤና ጣቢያ 4. ሆስፒታል	
404	የጤና ማዕከሉ የወሊድ አገልግሎት ይሰጣል?	1.አዎን 2. አለዉቅም	
405	ዛመናዊ ህክምና ተቋም ተጠቅመዉ ያዉቃሉ?	1.አዎን 2. አለዉቅም	2 ወደ407
406	ተጠቅመዉ ከሆነ ምን ምን አገልግሎቶችን አግኝተዋል?	1.ቅድመ ወልድ ክትትል 2.የወልድ አገልግሎት 3.የድህረ ወልድ አገልግሎት 4.ክትበት 5.የቤተሰብ ምጠኔ አገልግሎት 6.የፈዉስ ህክምና አገልግሎት 7.ልለ ይጥቀሱ----------	
407	ተጠቅመዉ የማያዉቁ ከሆኑ ለምን ነበር ያልተጣቀሙ?	1.በጣም ስለራቀኝ 2. በጣም ስለልተመምኩ 3. በጣም ዉድ ስለሆነ 4.የበህል ህክሞች ስለሉ 5. በቤት ስራ በተሌ ስለሆንኩኝ 6.ሌለ የጥቀሱ----------	
408	ጤና ማዕከል ወልደዉ ያዉቃሉ?	1.አዎን 2. አላውቅም	2 ወደ212
409	የወለድ አገልግሎቱን አግኝተዉ ከሆነ እንዴት ነበር ያገኙት?	1. በነፃ 2. በክፍያ 3. አላስታዉስም	
410	ከከፈሉ ምንያህል ነበር የከፈሉት?	----------ብር	
411	በክፍያዉ ላይ ምን አስተያየት አለዎት?	1. ዉድ ነዉ 2. መካከለኛ ነዉ 3. ርካሽ ነዉ 4. አስተያየት የለኝም	
412	የጤና አገልግሎት አጠቃቀምዎትን	1.ራሴ 2. ባለቤቴ 3.የህይመኖት መሪ 4.ዘመዶቼ	

	የሚወስነዉ ማን ነዉ?	5. ሌለ ይጥቀሱ----------	
413	በወሊድ ወቅት የትመዉለድ እንደለብዎት ዉሰኔዉን ሚሰጠዉ ማነዉ?	1.ራሴ 2. ባለቤቴ 3.የሀይመኖት መሪ 4. ዘመዶቼ 5. ሌለ ይጥቀሱ----------	
414	ወልድ ጊዜ የምከታተለዉን ሰዉ ማንነዉ የሚወስነዉ	1.ራሴ 2. ባለቤቴ 3.የሀይመኖት መሪ 4. ዘመዶቼ 5. ሌለ ይጥቀሱ----------	

Annex 8: Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in this or another university and that all sources of materials used for this thesis have been fully acknowledged.

Name: Tadesse Lelago

Signature: _____

Date: _____

This thesis work has been submitted for examination with my approval as university advisor.

Name: Ato Berhanu Dessalegn (Bsc, MPH)

Signature: _____

Date: _____