

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCE
SCHOOL OF ALLIED HEALTH SCIENCES
DEPARTMENT OF NURSING AND MIDWIFERY

**ASSESSMENT OF FACTORS AFFECTING UTILIZATION OF FOCUSED
ANTENATAL CARE AMONG WOMEN IN GIBE WEREDA, HADIYA ZONE,
SNNPR ETHIOPIA, 2015**

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This Thesis by _____ is accepted in its present form by the Board of Examiners as satisfying thesis requirement for the degree of Masters of Science in maternity nursing and reproductive health.

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Acronomy

ANC	Antenatal Care
DCF	Data collection facilitator
EDHS	Ethiopia Demographic and Health Survey
FANC	Focused Antenatal Care
FMOH	Federal Ministry of Health
LMIC	Lower Middle Income Country
MDG	Millennium Development Goal
MIC	Middle Income Country
PI	Principal Investigator
PPS	Proportion to Population Size
SNNPR	Southern Nation Nationality People's Region
Sup	Supervisor
UNFPA	United Nation Population Fund Agency
UMIC	Upper-Middle Income Countries
WHO	World health organization

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ABSTRACT

BACKGROUND: Focused antenatal care (FANC) is one of the important factors in dropping maternal morbidity and mortality; meanwhile, many women in Ethiopia do not receive such care. However, little is known about determinants factor of FANC service utilization in Ethiopia and particularly in Gibe Wereda.

OBJECTIVES: To determine focused antenatal care status and associated factors among mothers who gave birth within 3 month preceding the study in Gibe Wereda.

METHOD: A community based cross sectional study was conducted using quantitative methods from April, 2015 in Gibe Wereda, on 287 women who gave birth 3 month preceding the study. To select study participant in the Wereda, 8 out of 22 Kebeles were selected randomly. A study participant or mothers were selected by simple random sampling method from the sampling frame. Data was entered by Epidata 3.1 and analyzed using SPSS version 16.0, and ethical clearance, consent letter and informed consent was obtained from Addis Ababa ethical review committee, Gibe Wereda administration and study participant respectively.

RESULT: Majority the respondents 166 (58.7%) were between 25-34 age group with mean age of 29.14years. In this study the overall coverage for Antenatal care utilization was 242 (85.5%). Among 283 interviewed mothers 114 (40.3%) followed four and above times ante natal care visit during their last pregnancy and 169 (59.7%) mothers followed less than four times. Mother's educational status, travel time, knowledge of danger signs, plan for last pregnancy and knowledge on starting ANC were found to be predictors of focused antenatal care utilization.

Conclusion and recommendation: Even if there was relatively high antenatal care utilization among the study participants but focused antenatal care utilization was low in the study area. Women's education status, teaching month's of starting ANC and educating about obstetric danger signs is an important factor for utilization of FANC service in the study area suggesting that educating girls will have a great impact on improving future utilization of FANC in the area. Availing health infrastructure is crucial in reducing time travel to reach health facility will enhance women to follow FANC.

CHAPTER ONE: INTRODUCTION

1.1 Background

Globally, an estimated 211 million pregnancies and 136 million births occur every year [1]. In the world, pregnancy and childbirth is a perilous journey [2] and more than 40% women may experience sudden and unpredictable acute obstetric problems during pregnancy, child birth and post-partum period or 800 women around the world die unnecessarily during pregnancy or childbirth each day [3, 4, 5]. Maternal and newborn mortality cost the world economy estimated \$15 Billion in lost productivity each year [5].

Antenatal care (ANC) is one of the important factors in dropping maternal morbidity and mortality; meanwhile, many women in developing countries do not receive such care [6]. Antenatal care is more beneficial in preventing adverse pregnancy outcomes when received early in the pregnancy and continued through delivery [7,8].

World Health Organization (WHO) recommends that a woman without complications should have at least four antenatal care visits, the first of which should take place during the first trimester [8]. Focused antenatal care (FANC) is personalized care provided to a pregnant woman which emphasizes on the women's overall health, her preparation for child birth and readiness for complications (emergency preparedness) or it is timely, friendly, simple safe services to pregnant women [8, 9].

One of the strategies aimed at addressing maternal mortality in developing countries is the implementation of focused antenatal care (FANC), which is the care a woman receives throughout her pregnancy [10]. Trials conducted in Argentina, Cuba, Saudi Arabia, and Thailand proved that FANC was safe and was a more sustainable, comprehensive, and effective antenatal care (ANC) model [10].

Early detection of problems in pregnancy leads to more timely referrals for women in high risk categories or with complications; this is particularly true in Ethiopia, where three-quarters of the population live in rural areas and where physical barriers pose a challenge to providing health care [7].

1.2 Statement of the problem

Globally in 2010 World Health Organization (WHO) estimates that 287,000 maternal deaths occurred as result of pregnancy and childbirth-related complications each year, with 99% of these deaths occurring in developing countries and in sub-Saharan Africa, the estimated maternal mortality ratio is 500 per 100,000 live births. More than 60% of all maternal deaths were contributed by ten countries, Ethiopia is one of them. [11].

In Ethiopia, according to EDHS 2011 report maternal mortality ratio is estimated about 676 deaths per 100,000 life birth which is higher than sub Saharan Africa and maternal deaths represent 30 % of all deaths to women age 15-49 years [7]. Globally antenatal care coverage is 72%, in developing countries 68%, and industrialized countries 98% [(12)].

According to the 2011 Ethiopia demographic and health survey (DHS) Only 43% of mothers who have had a live birth in the five years received prenatal care from health professionals. but 2014 EDHS report showed that 57.5% of women received prenatal care from health professionals. This showed that there is change from time to time in utilizing antenatal care [7, 13].

Thirty-two percent of women with a live birth in the five years before the survey made four or more ANC visits during the length of their pregnancy, a marked improvement from 19 percent reported in the 2011 EDHS [7, 13]. Similarly according to EDHS 2014 Ethiopia Urban women are more likely than rural women to have made four or more visits (68 percent versus 27 percent) [13].

It is known that ANC helps to reduce the occurrence of maternal morbidity and mortality by providing chances for health promotion and information about danger signs, birth preparedness and where to seek care for pregnancy complications [8]. However, this maternity care utilization in Ethiopia is very low as compared to developed and most of developing countries. Little is known about determinants factor of FANC service utilization in Ethiopia and particularly in Gibe Wereda.

1.3 Significance of the study

Ethiopia is committed to achieve MDG five to reduce the maternal mortality ratio by three quarters between 1990 and 2015; following the commitment with the goal Ethiopia is expected to reduce maternal mortality in 2015 to 267 maternal deaths per 100,000 livebirths. While, the maternal mortality ratio is still high.[14].

Focused antenatal care is one of strategy to reduce maternal and newborn morbidity and mortality but factors affecting FANC utilization is vary in different situations and places. Therefore, this study is intended to assess factors affecting FANC utilization among women who gave birth in Gibe Wereda, south Ethiopia.

The study will benefit Gibe Wereda health office for improvement and effective interventions of maternal health services for Wereda population and findings will be relevant and useful for reproductive health planners and implementers of the program. This study will assist in giving inputs to policies and strategies makers use it as a base line for their future interventions and activities.

It is the first study in the area so;it will be benefit as a base line for future researcher.

CHAPTER TWO: LITERATURE REVIEW

2.1. Proportion of Focused Antenatal Care

Antenatal care (ANC) coverage provides a measure of access to the health system and is critical to identify maternal risks and improve health outcomes for the mother and the newborn or most important intervention in reducing maternal mortality and one of the MDG indicators to track national effort towards safe motherhood [15]. Globally antenatal care coverage is 72%, in developing countries 68%, and industrialized countries 98% [12].

According to the 2014 Ethiopia demographic and health survey (DHS) Only 31.6% of mothers who have had a live birth in the five years received four and more prenatal care from health professionals [13].

Proportion of focused antenatal care different in different study a study conducted in Yem special Woreda, southwestern Ethiopia 28.5% of women received ANC at least once but, the majority (71.5%) reported that they did not attend ANC for their last pregnancy. Out of those who utilized ANC services, (49.2%) of them made their first visit in their second, trimester of pregnancy and (29.1 %) had four or more visits during their last pregnancy [16].

Also another study in Hadiya Zone antenatal care service utilization was 86.3%. However, from those who attended antenatal care services (68.2%) started antenatal care visit during the second trimester of pregnancy and significant proportion (42%) had less than four visits [17]. Another study in Kham district about (64.3%), had visited less than four times during their previous pregnancies, whereas only 51 (35.7%) had visited four times or more [18].

A study conducted in Dembecha District, Northwest Ethiopia about 60% pregnant women received at least one ANC visit by skilled health professionals. From 60% pregnant women received ANC visit more than 80% had four or more antenatal care visits. The major segment of mothers visited health facilities during the second trimester [19].

Another study also conducted in Debre Berhan health institutions about (26.2%) pregnant mothers started their first ANC visit early while the rest, (73.8%) started ANC late [20].

Similar study conducted in Ayder Kebele Mekelle city 2013 about 88.9% of the women had at least one antenatal visit during their recent pregnancy. Almost half of the antenatal care (44.2%) attendants made their first visit during their second and third trimester of pregnancy. Among antenatal care users around 84.8% had four and above antenatal care contacts [21]. ANC is a critical element for reducing maternal mortality, and for providing pregnant women with a broad range of health promotion and preventive health services [22].

2.2. Factors Affecting Focused Ante Natal Care Utilization

Different study revealed that utilization of focused antenatal care was affected by different factors. A study conducted in Ibadan, Nigeria on 2010 Women who were 25 years or more were more likely to attend ANC clinic than women who were less than 25 years. Also Married women were more likely to attend ANC clinic compared to women who were single, separated or divorced. Educational status also showed a significant association with respondents having an education of secondary school and above attending ANC clinic more compared to women who had an education of primary school and below. The husband education also showed a significant association with those whose husband had an education of secondary school and above attending ANC clinic more compared to respondents whose husband had an education of secondary school education and respondents' husband occupational status also showed significance as the respondents whose husbands were professionals (lower, middle and higher) were most likely to attend ANC clinic compared to those whose husband were skilled and unskilled. Women who were Muslims or other religions were more than 2 times likely to attend ANC clinic than women who were Christians [23].

According to EDHS, 2011 report antenatal care from a skilled provider is more common among women age 34 and younger (34-36 %) than among women age 35-49 (27 %). Women are almost twice as likely to receive antenatal care from a skilled provider for first births (46 percent) than for birth orders six and higher (23 %). The proportion of women who did not receive any antenatal care increases with the child's birth order. There is a direct relationship between a woman's education level and whether she is likely to receive

ANC from a skilled provider. For example, 91% of women with more than secondary education received ANC from a skilled provider compared with 25 percent of women with no education. Similarly, the proportion of women who received ANC is greatest among those in the highest wealth quintile (75%), and decreases with each wealth quintile to a low of 17 percent among women in the lowest wealth quintile [7].

Another study also conducted in Hadiya Zone, SNNPRS, revealed that ANC service utilization is significantly influenced by maternal age and Mothers who are in the age group of 25-29 years were less likely to utilize ANC service than women who are 35 years and older. Positive husband attitude towards ANC was significantly related to antenatal care service utilization. Moreover, in this study the use of antenatal care was found to be related to mother's level of education. Mothers with primary educational level were more likely to attend ANC than women who are unable to read and write. It was also observed that availability of women's time is important. Family size was a strong determinant of antenatal care service utilization. Mothers who live within a household size less than three people were eight times more likely to utilize ANC than those living in a household size greater than five. Furthermore, maternal education and age, husband attitude, family size and perceived With regard to the determinants of ANC morbidity were major predictors of ANC service utilization [17].

A systematic review of the literature Journal of Advanced Nursing 2008 study conducted the major factors that can affect the uptake of antenatal care services in developing countries are maternal education, husband's education, marital status, availability, cost, household income, women's employment, media exposure and having a history of obstetric complications [24].

A Study conducted in Yem special Woreda, southwestern Ethiopia educational status, residence, knowledge about danger signs of pregnancy and age at first pregnancy were some of the predisposing factors that showed a statistically significant association with antenatal care utilization. Among the enabling factors, husband approval and distance showed a

Statistically significant association with antenatal care utilization. Besides, perceived susceptibility to pregnancy related illness in future pregnancies, planned pregnancy and illness experienced in past pregnancy were some of the need factors that showed a statistically significant association with antenatal care utilization [16].

Another study in Kham district in 2008 levels of education and knowledge were the most important predictors of ANC utilization in the Kham District. Educated women were 6.8 times (95% CI = 2.7–16.8) more likely to receive ANC services than those who had no education, and women who were highly knowledgeable were 6.5 times (95% CI = 2.4–17.6) more likely to do so than those who were deficient in knowledge. Moreover, family income proved to be one of the most significant predictors of ANC service utilization. Women who had high incomes were 2.6 times (95% CI = 1.2–5.7) more likely to have obtained ANC services than women with low incomes. Women who lived nearby were 2.9 times (95% CI = 1.1–7.6) more likely to frequent an ANC than those who lived far away [18].

Similarly another study conducted in Dembecha District, Northwest Ethiopia mothers aged less than 20 years, illiterate, and lived in a household whose annual income was less than 6000 Birr were less likely to utilize antenatal care.

Those mothers aged between 20 to 40 years, with education attainment of primary and above, and lived in a house hold whose monthly income more than 6000 Birr per annum were 1.5 to 3 times more likely to utilize antenatal care than those who were younger than 20 years, illiterate and whose household earned less than 6000 Birr per annum. This study revealed also that single, divorced, widowed or separated women were less likely to utilize antenatal care than married ones [19].

A study conducted in Debre Berhan In 2012 pregnant mothers who had good knowledge on timing of the first ANC were about three times more likely to start their first ANC visit early as compared to their counterparts. Mothers with planned pregnancy were 1.66 times more likely to start first ANC visit early as compared to those who had unplanned pregnancy.

Nulliparous mothers were 3.65 times more likely to start first ANC visit early as compared to those who had at least one history of birth. However, educational status, pregnancy-related complications for current pregnancy, history of abortion and still birth, previous utilization of service, monthly income, number of children alive, and means of approving pregnancy were not significantly associated with early ANC visit [20].

A study conducted in Ayder Kebelle Mekelle city in 2012/2013 63.4% of study participants were in the age group of 25 to 34 years and Most of the respondents (86.6%) were orthodox Christian by religion. A significant number (76.3%) of the respondents did attend formal education. Also 85.3% of respondents were married currently. From the total respondents (54%) were unemployed or house wife and majority of the study participants (49.6%) had zero parity [21].

Similar study conducted 2011 in Pakistan was husband's attitude towards ANC utilization: 41% said that their husbands were supportive in giving permission for ANC. 35% said that their husbands were against it. Regarding ante natal care (ANC) utilization, 41 % of the women did not receive ANC because of lack of financial support 33% said their family did not support the decision to get ANC.13% said transportation was an issue .knowledge of benefits of ANC: only 29% were aware of the benefits of ANC [25].

A Study conducted in rural West Sumatra, Indonesia in 2010 Nearly 80% (77.9%) of respondents received ANC more than four times and 22.1% received ANC less than four times. Women aged 21 to 34 were more likely to receive less than four ANC visit (87.5%) compared to those who were over 35 years old. As a group primiparous received less than four ANC visits, which was statistically significant compared to multiparous ($p = 0.001$). Women who finished basic education tended to receive fewer than four ANC visits compared to women who finished secondary education ($p = 0.07$) [26].

A study conducted in Addis Ababa in 2008 mother who made their first ANC visit within the recommended time is (40.2%) while those who booked late were (59.8%). Respondents who received advice on recommended time of booking, their pregnancy was planned and first pregnancy, were more likely to book timely compared to others [27]

Conceptual frame work

This conceptual frame work has three main factors which may affect focused ante natal care. According to the diagram shown below socio economic, demographic and Husband Factor affect the utilization of focused antenatal care directly or indirectly. Likewise the other group of variables reproductive history of mother and access to health service affects the use of focused antenatal care directly or indirectly. This conceptual frame work is adapted from previous study conducted. Diagrammatically it is shown as follows [15 - 21].

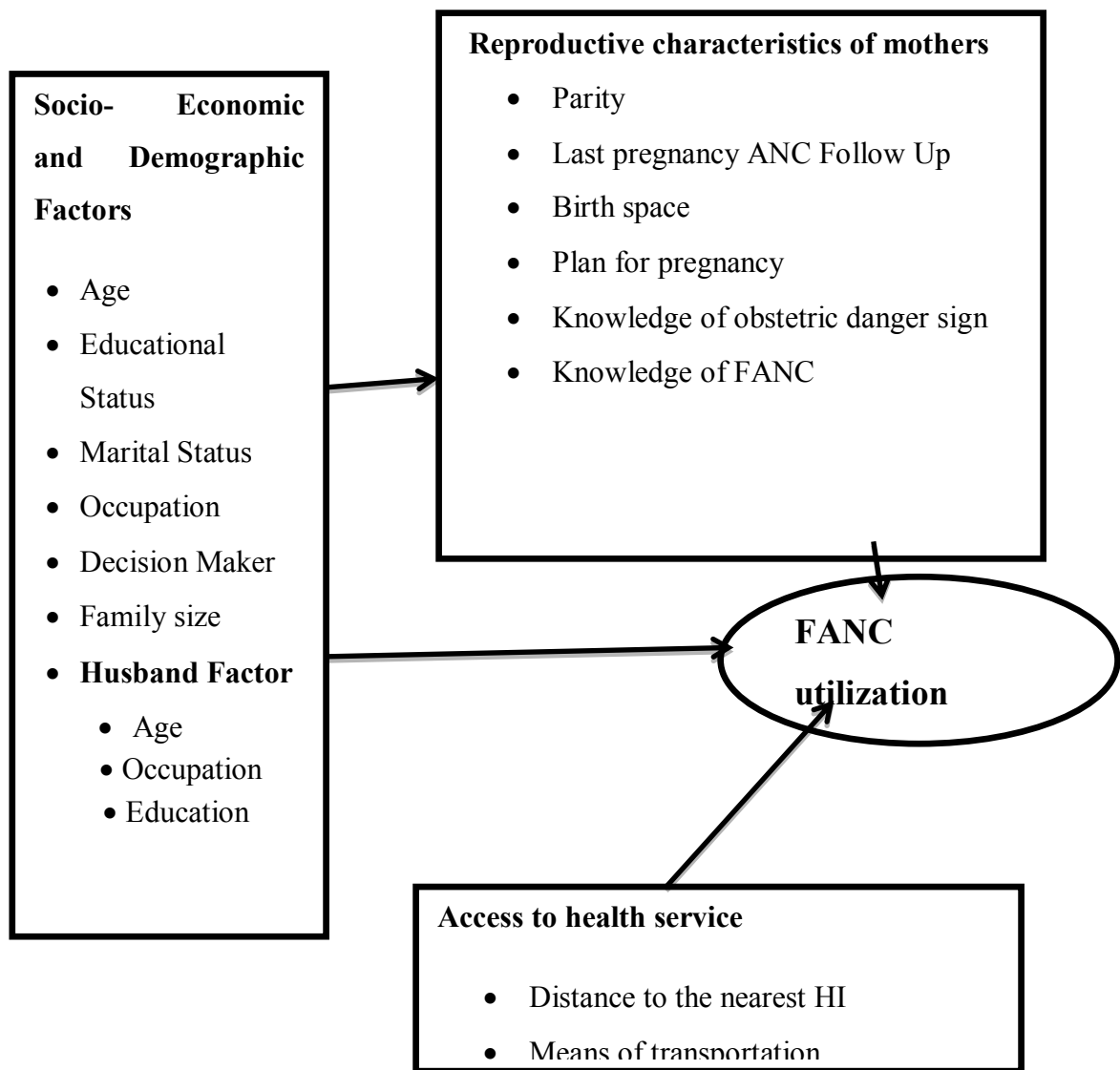


Figure 1 Conceptual framework adapted different studies [15 -21]

CHAPTER THREE: OBJECTIVES

3.1 General objective

To determine focused antenatal care status and associated factors among mothers who gave birth within 3 month preceding the study in Gibe Wereda April 2015,

3.2 Specific objective

1. To assess focused antenatal care status of mothers who gave birth within 3 month preceding the study in Gibe Wereda April 2015,
2. To identify factors associated with focused antenatal care birth within 3 month preceding the study in Gibe Wereda April 2015,

CHAPTER FOUR: METHOD AND MATERIAL

4.1 Study Area

The study was conducted in Gibe Wereda, South Ethiopia. Gibe Wereda is found in Hadiya Zone, in SNNPR, 262 K.M. away from the capital city, Addis Ababa and there are 22 rural Kebeles. According to SNNPR statistical office, the projected population was 133, 443; of which 67, 179 (50.34%) were females among this 31, 092 were women in reproductive age group and 4, 350 deliveries annually and there are four public health centers and 22 health posts in the Wereda.

4.2 Study Period

The study was conducted in Gibe Wereda from 15-30, April, 2015.

4.3 Study Design

Community based cross sectional study was conducted using quantitative methods in the selected Kebeles in Gibe Wereda, South Ethiopia.

4.4 Source Population

All mothers who gave birth in the last 3 months prior to the study in Gibe Wereda.

4.5 Study Population

Sampled mothers who gave birth in the last 3 months prior to the study

4.6 Inclusion and Exclusion Criteria

4.6.1 Inclusion Criteria

- Mothers who gave live and still birth during the last 3 months in the study during data collection period.
- Mothers who are volunteers to participate in the study during data collection period.

4.6.2 Exclusion Criteria

- Mothers who are mentally and physically incapable for interview during data collection period will be excluded.
- Mothers who are not volunteers to participate in the study during data collection period will be excluded.

4.7 Sample Size Determination

4.6.1 Sample Size

Sample size was determined by using single population proportion formula.

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

According to 2014, EDHS report proportion of mothers who visited ANC four and more times is 31.6% (13). Then after, based on the following assumption the sample size is calculated:-

Where:

$Z_{\alpha/2}$ = critical value = 1.96 for 95% CI

p = proportion of mother visited ANC four and more times = 31.6%

d = degree of precision (margin of error) = 0.05 or 5%

$$n = \frac{(1.96)^2 \cdot 0.316(1-0.316)}{(0.05)^2} = \underline{\underline{333}}$$

The above sample was taken from a relatively small population (N = 1200) then, the required minimum sample was obtained from the above estimate by using correction formula.

$$n_f = \frac{n}{\frac{n+1}{N}} =$$

Where n_f = desired sample size

n = calculated sample size

N = total population

$$n_f = \frac{n}{\frac{n+1}{N}} = \frac{333}{\frac{333+1200}{1200}} = 260.6 = 261$$

By considering non response rate of 10%

$$N = 261 * 0.1 = 26.1 = 27$$

$$n_f = 261 + 26.1 = \underline{\underline{287.1}} \text{ Therefore the final sample size was } = \underline{\underline{288}}$$

4.8 Sampling procedure

To select the study subjects, 8 Kebeles was selected out of 22 Kebeles in the Wereda randomly by lottery method. To select study participant from selected 8 Kebeles, first sampling frame was generated from family folder found at health post from each Kebeles. All women who gave birth in the last 3 months prior to the study were registered then sample was allocated to each Kebeles by proportional allocation to their population size. Finally the study participant or mothers were selected by simple random sampling method from the sampling frame.

4.8.1 Proportional allocation

Sample size selected from sampling frame of Kebeles is calculated according to proportional to population size:

$$n_i = N_i * n$$

N

Where;

n_i = Number of women selected from each sampling frame

N_i = Sampling frame of each Kebeles

N = Total sampling frame ($N_i + N_i + N_i + N_i + N_i + N_i + N_i$)

n = Total sample size

N = 440 Total Number of women in 8 Kebeles

1. Homecho $\frac{52 \times 288}{440} = 34$

2. Amboro $\frac{40 \times 288}{440} = 26$

3. Hadiye $\frac{36 \times 288}{440} = 24$

4. Megacho $\frac{88 \times 288}{440} = 58$

5. HPA $\frac{42 \times 288}{440} = 28$

6. Hamola $\frac{90 \times 288}{440} = 59$

7. Haleliche $\frac{58 \times 288}{440} = 38$

8. Astea $\frac{34 \times 288}{440} = 23$

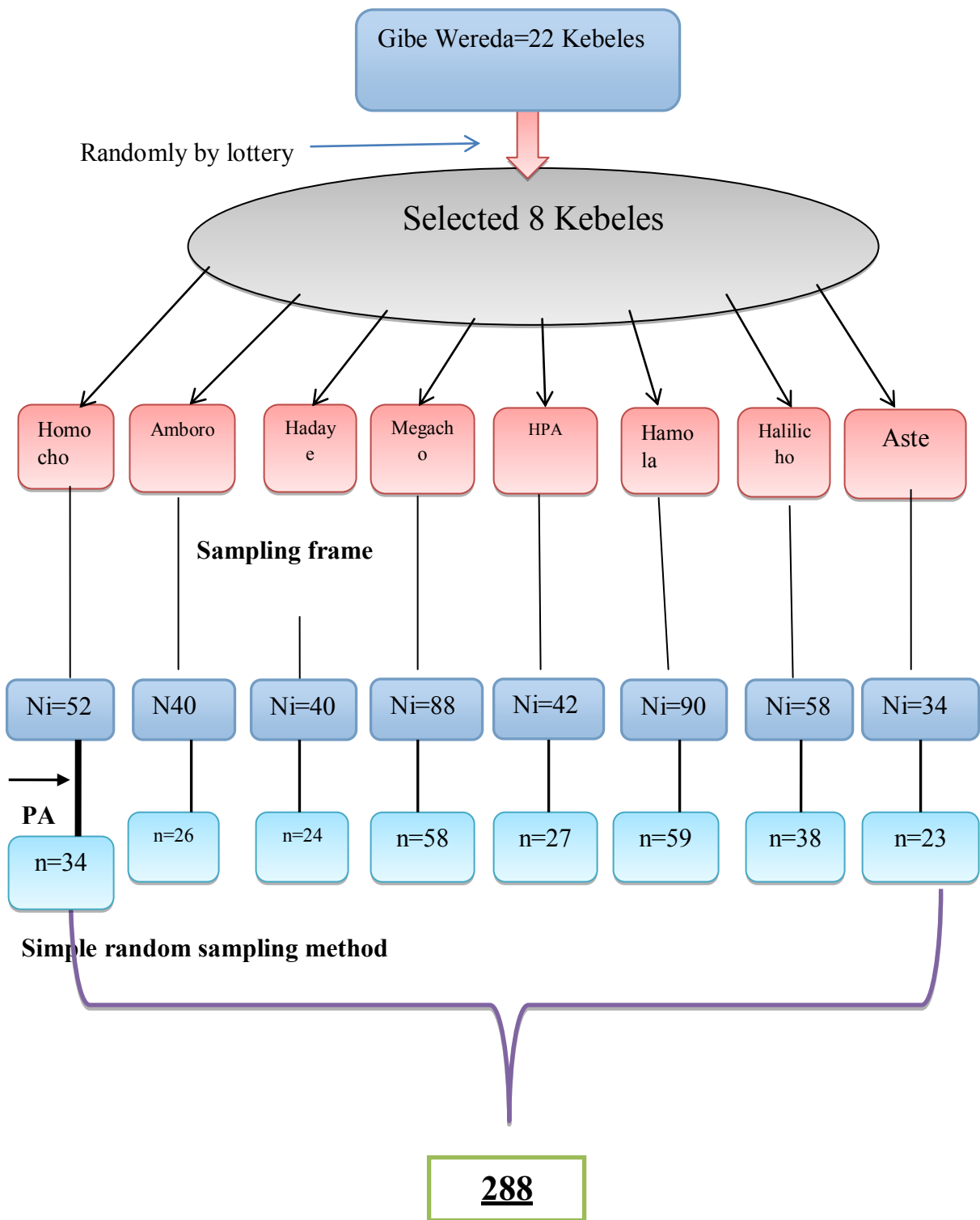


Figure 2 Schematic Representation of the Sampling Procedure

4.9 Methods of Data Collection

4.9.1 Data Collection Instrument

A structured questionnaire was adapted from different study (15, 17, 18, 22). The English version of the questionnaire was adapted in such a way that it includes all the relevant variables to meet the objectives of the study. Then it was translated into Hadiyisa and Amharic version by individuals who had knowledge of these languages and other individuals with similar ability also back translate the Hadiyisa and Amharic versions to English version to check for its originality.

4.10 Pre test

Questionnaire was pre-tested on 10% of sample size 5 days before the actual data collection in Gibe Wereda in Kebeles not included in the study to check wording, logic and skip order of the questionnaire in sensible way of the respondents' and to insure respondent understanding the questionnaire. Findings and experiences from the pre-test was utilized to modify the tools.

4. 11. Data Collection Procedure

The outcome variables focused ante natal care was measured by structured questionnaire whether they attend focused ante natal care for their last pregnancy. Independent variables socio demographic, reproductive characteristics of mothers and access to health facility were measured by using structured questionnaire from mothers by face to face interview.

Five diploma graduates, two professional Nurses and two health extensions, who can speak both Amharic and Hadiyisa language, were recruited as data collectors, supervisors and home indicator respectively. The training was provided by the principal investigator for one day and ten days before the actual data collection time. They were retrained on their responsibilities for describing the purpose of the study, informing respondents on the importance of honest and sincere response. Data was collected by face to face interview after informed consent was obtained from respondents. The collected data was checked by the supervisors daily for completeness and finally the principal investigator monitored the overall quality of data collection procedures.

4.12. Data Quality Control

The training was given for the data collectors, supervisors and home indicator ten days before data collection from the study participants. As a result of the pretest necessary corrections were made as per its requirement to some of the questionnaires. Moreover, during data collection supervisors checked in the field how the data collectors do their task. The principal investigators also closely supervised the field activity on daily basis. At the end of each data collection day the principal investigator also checked the completeness of filled questionnaires and whether recorded information was made sense to ensure the quality of data collected. Besides this, the principal investigator carefully entered and thoroughly cleaned the data before the commencement of the analysis.

4.13 Study Variables

4.13.1 Dependent variables

Focused ante natal care

4.13.2 Independent variables

Socio-demographic

Age , Occupation of women, Decision maker ,Husband age, Husband occupation , Husband Education, family size, Ethnicity , Marital status, Religion, Residence

Reproductive characteristics of mothers

Knowledge of FANC, Birth space,Parity, Plan for the pregnancy, Knowledge of obstetric danger signs

Access to health service

Distance to the nearest health institution, Means of transportation

4.14. Operational Definitions

Focused antenatal care: In this study Focused antenatal care was considered as if a mother received at least four antenatal care visits and more during pregnancy period by health professional.

Knowledge of obstetric danger sign: Women considered as good knowledgeable about obstetric danger signs related to pregnancy and childbirth if they scored equal and above the mean (above 3) from 5 knowledge questions and if less than mean considered as poor knowledgeable.

Knowledge of focused Antenatal care: refers to the level of understanding of mothers' about Focused Antenatal care. If the mother answer four and above Women considered as knowledgeable or not.

4.15. Data Analysis Procedure

Data was entered Epidata version 3.1 and cleaned and analyzed using SPSS version 16.0 statistical Software. Description of data was made using tables, percentage, and graph. Binary logistic regression analysis was used to assess association between dependent and independent variables. The strength of statistical association was assessed by adjusted odds ratios and 95% confidence intervals and statistical significance was considered at $P < 0.05$.

4.16. Ethical Clearance

Ethical clearance was obtained from Addis Ababa University Ethical Review Board. Written permission letter was requested from Gibe Wereda Administration, Gibe Wereda health office. Clients were provided with information sheet about the objective of the study, privacy and confidentiality then verbal informed consent was obtained from participants.

4.17. Dissemination and Utilization of Results

Result of the study will be presented to Addis Ababa university department of nursing and midwifery as partial fulfillment of master's degree in maternity. It will be disseminated to Gibe Wereda health office and will be communicated to concerned institution. The findings will be presented in different seminars, meetings and workshops and will be published in a scientific journal. Hard and soft copy will be available in the library of Addis Ababa University and department of nursing and midwifery for graduate students as well as for other concerned readers and the result will be utilized Gibe Wereda health office and policy maker or further investigation and it will be disseminated to Ethiopian Ministry of Health and the respective health institutions and sectors, as well as, other interested and concerned organizations.

CHAPTER FIVE: RESULT

5.1. Socio demographic characteristics of mothers

Out of the sample 287 mothers who gave birth in the last three month prior to the study period, 283 (98.6%) were participated in the study. Five mothers refused to participate in the study. Out of 283 mothers, majority 166 (58.7%) were between 25-34 age group with mean age of 29.14 and standard deviation of 5.9 years (table 1).

Large majority study participants 279 (98.6%), 244 (86.2%) and 240 (84.8%) were married, flowed protestant religion, and house wife respectively; and similarly 269 (95.1%) are ethnically Hadiya (table 1). Regarding mothers occupation about 240 (84.8%) of mothers were house wife and 43 (15.2%), were additional work. Concerning mothers educational status, less than half of 70 (24.7%) not attended formal education, 139 (49.1%) attended primary and 48 (17.0%) attended secondary 26 (9.2%) diploma and above education.

Majority of respondents husbands age between 31-45 years 156 (56.7%), ≤ 30 years 99 (36%), >45 years 20 (7.3%). Regarding respondent's husbands educational status, 77 (27.6%) not attended formal education, 133(47.7%) primary education and 41 (14.7%) secondary, whereas 28 (10.0%) diploma and above education. With respect to respondent's husbands occupation 182 (65.2%), 23 (8.2%), 28 (10.0 %) and 46 (16.5%) were farmers, daily laborers, government employees and merchants respectively (table1).

About 149 (52.7%) of the respondents had a family size greater than five person and 134 (47.3%) less than five family size. Majority of respondents 212(74.9%) travel greater than two hour to reach the nearest health center (with minimum 15 minute and maximum 4:00 hour). Regarding means of transportation almost all respondents 273 (96.5%) travel on foot (table 1).

Table 1 Socio demographic characteristics of mothers Gibe Wereda, South Ethiopia, April, 2015.

Variables	Category	Number	Percent
Age group of mothers	15-24 years	62	21.9
	25-34 years	166	58.7
	≥35 years	55	19.4
	Total	283	100.0
	Mean age =29.14		
Marital status of mothers	Married	279	98.6
	Widowed	3	1.1
	Divorced	1	.4
	Total	283	100.0
Religion of mothers	Orthodox	33	11.7
	Catholic	6	2.1
	Protestant	244	86.2
	Total	283	100.0
Ethnicity of mothers	Hadiya	269	95.1
	Gurage	7	2.5
	Kembata	3	1.1
	Amhara	4	1.4
	Total	283	100.0
Occupation of mothers	Housewife	240	84.8
	Additional work	43	15.2
	Total	283	100.0
Educational status of mothers	No formal	70	24.7
	Primary	139	49.1
	Secondary	48	17.0
	Diploma & above	26	9.2
	Total	283	100.0
Husband age	≤30 years	99	36.0
	31-45 years	156	56.7
	>45 years	20	7.3
	Total	275*	100.0
Occupation of husband	Farmer	182	65.2
	Daily laborer	23	8.2
	Govt. employee	28	10.0
	Merchant	46	16.5

	Total	279**	100.0
Educational status of husband	No formal	77	27.6
	Primary	133	47.7
	Secondary	41	14.7
	Diploma & above	28	10.0
	Total	279	100.0
Family size	≤5	134	47.3
	>5	149	52.7
	Total	283	100.0
Time to reach health inst.	> 2 hour	212	74.9
	≤ 2hour	71	25.1
	Total	283	100.0
Means of transportation	Feet	273	96.5
	Animals	10	3.5
	Total	283	100.0

*missing and nonresponse

**missing

5.2 Reproductive characteristics of mothers

As shown in the table -2 below regarding mothers about number of pregnancy or parity, 29 (10.2%), 97 (34.3%), 197 (34.3%), and 60 (21.2%) had 1, 2-3, 4-5, and >5 times pregnancies respectively. Regarding birth space 152 (59.8%) of mothers were two and less years of birth interval between previous and last child pregnancy.

More than half 182 (64.3%) of mothers planned their last child pregnancy, the rest 101 (35.7%) did not planned. Regarding the decision making for ANC visit, 129 (53.3 %), 28 (16.9%) and 85 (11.6%), of mothers decided by themselves, herself and her husband together and husband only respectively.

Majority of mother 111(45.9%) came to health institution were for vaccination reason, 93 (38.4%) for medication reason and other 38 (15.7%).

Table 2 Reproductive characteristics of mothers in Gibe Wereda, South Ethiopia, April, 2015.

Variables		Number	Percent (%)
Parity	1	29	10.2
	2-3	97	34.3
	4-5	97	34.3
	>5	60	21.2
	Total	283	100.0
Birth space	<=2	152	59.8
	>2	102	40.2
	Total	254**	100.0
Intended pregnancy	Yes	182	64.3
	No	101	35.7
	Total	283	100.0
Decision making for ANC visit	Mine only	129	53.3
	Mine & my husband	28	11.6
	My husband only	85	35.1
	Total	242**	100.0
Reason for ANC visit	Vaccination	111	45.9
	Medical check up	93	38.4
	Other reasons	38	15.7
	Total	242	100.0

** Missing and non response

5.3. Knowledge on obstetric danger signs,number and starting month of ante natal care visits

As shows in the below Table 3 knowledge on danger signs on pregnancy more than half 179 (63.3%) of the mothers were not knowledgeable about danger signs that occur during pregnancy. they scored below the mean score for knowledge questions, considered as poor knowledgeable and 104 (36.7%) mothers were scored above mean score for knowledge questions, considered as good knowledgeable.

less than half 132 (46.6%) of mother were knowledgeable on number of visits for ANC with no problem ,where as 151 (53.4%) of mother were not knowledgeable on number of visits for ANC with no problem . One hundred thirty four (47.3%) of mother were knowledgeable on number of visits for ANC with problem ,where as 149 (52.7%) of mother were not knowledgeable on number of visits for ANC with problem .

Regarding to Knowledge of month/weeks on starting ANC; 95 (33.6%) of mother were knowledgeable and more than half of 188 (66.4%) were not knowledgeable on time at initiation FANC (table 3).

Table 3 Knowledge of mothers on danger signs and month and number of ante natal care visits Gibe Wereda, South Ethiopia, April, 2015.

Variables	Not knowledgeable N (%)	Knowledgeable N (%)
Knowledge of danger signs during pregnancy		
Persistent vomiting	212 (74.9)	71 (25.1)
Vaginal bleeding	93 (32.9)	190 (67.1)
Severe headache	158 (55.8)	125 (44.2)
Hypertension	197 (69.6)	86 (30.4)
Face hand and fits swelling	182 (64.3)	101 (35.7)
Over all knowledge on danger signs during pregnancy	179 (63.3)	104 (36.7)
Knowledge on numbers of visits for ANC with no problem	151(53.4)	132(46.6)
Knowledge on numbers of visits for ANC with problem	149(52.7)	134(47.3)
Knowledge of month/weeks on starting ANC	188(66.4)	95(33.6)

5.4. Proportion of focused ante natal care

Among 283 interviewed mothers majority 242 (85.5%) attended antenatal visits, out of these 19 (6.7 %), 58 (20.5%), 51 (18.0%), 92 (32.5 %), 18(6.4%) and 4(1.4%) attended one, two, three, four, five and six times antenatal visits respectively, but 41(14.5%) were not attend antenatal care.

Among 283 interviewed mothers 114 (40.3%) mothers followed focused ante natal care four and above times during their last pregnancy and 169 (59.7%) mothers did not follow focused ante natal care.

Table 4 Proportion of focused ante natal care and antenatal care visits in Gibe Wereda, South Ethiopia, April, 2015

ANC visit	No	41	14.5
	One time	19	6.7
	Two times	58	20.5
	Three times	51	18.0
	Four times	92	32.5
	Five times	18	6.4
	Six times	4	1.4
	Total	283	100
FANC	Yes	114	40.3
	No	169	59.7
	Total	283	100

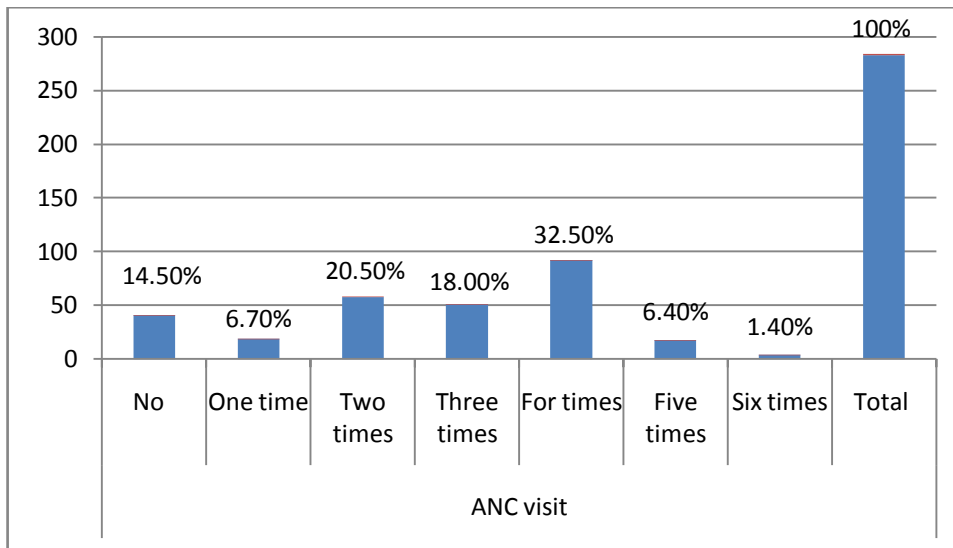


Figure 3 antenatal care visits in Gibe Wereda, South Ethiopia, April, 2015.

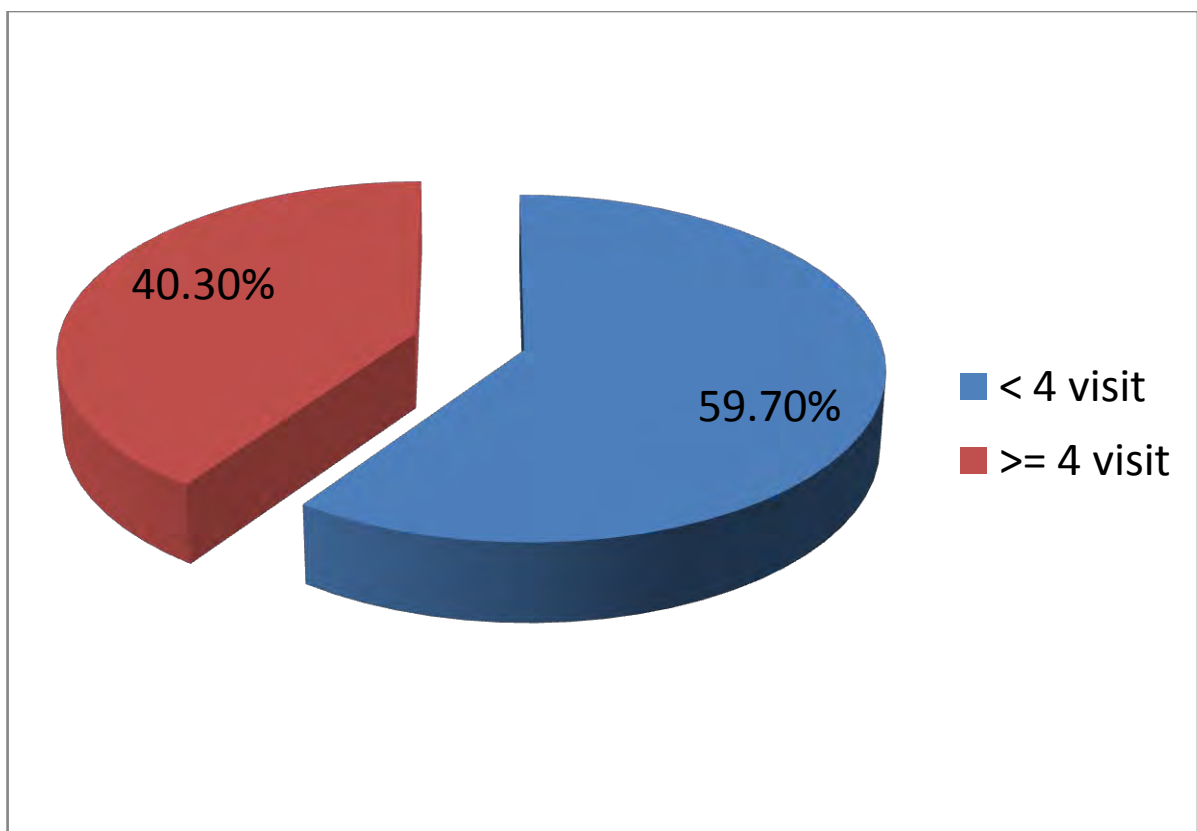


Figure 4 Proportion of focused ante natal care in Gibe Wereda, South Ethiopia, April, 2015.

5.5. Factors associated with focused ante natal care visits of mothers

Bivariate and multivariate logistic regression analysis was done using inter method to analyze factors associated with focused ante natal care utilization.

Bivariate analysis was conducted to select candidate variable for multivariate analysis. P value 0.2 was used as cut off point and variables with P-value less than 0.2 were selected for the final model.

On the bivariate analysis variables like age of the mothers, education, husband age, education and occupation , parity, time to reach the HI, family size, knowledge of danger sign during pregnancy, knowledge of starting month for ANC visits, intend the pregnancy are significant and selected for multivariate analysis .

Variables like occupation of the mothers, decision making for ANC visits, reason for ANC visits are not significant and their p value is greater than 0.2 and variables like knowledge of mothers about number ANC visits during no problem and with problem are not included in multivariate analysis because of does not fit the assumption of chi square they have cell value less than 5 count.

As shown in table 5 below mothers educational status was found statistically significant; mothers whose educational primary, secondary and diploma and higher were 5.4, 14 and 17 times more likely to follow focused ante natal care than no formal educational level of mothers [AOR=5.4(1.5-19.8), 13.9 (3.1-61.7) and 17.7(2.8-112.1)]respectively.

Similarly mothers who traveled ≤ 2 hours from their home to health center were 7.6 times more likely to follow focused ante natal care than those who travelled more than two hours to reach the nearest health institution[AOR=7.6 (2.4 -24.5)]

Mothers who planned their last pregnancy were two times more likely to follow focused ante natal care than those who didn't planned their last pregnancy [AOR=1.9 (1.02 -4.5).

Knowledge of mothers about month's starting ANC visits was found statistically significant on following focused ante natal care; mothers who know the appropriate time for initiating ANC visits were 2.4 times more likely to follow FANC than mothers who didn't know the appropriate for starting ANC visits[AOR= 2.4 (1.1 -5.5)].

Knowledge of danger signs during pregnancy was found statistically significant; mothers who were knowledge about danger signs during pregnancy were 3 times more likely follow FANC than mothers poor knowledge about danger signs during pregnancy [AOR=3.1 (1.3-7.0)].

Table 4 Logistic regression of factors associated with focused ante natal care visits in Gibe Wereda, South Ethiopia, April, 2015.

Variables	FANC		ODDS RATIO		P value
	YES N (%)	NO N (%)	COR (95%)	AOR (95%)	
Age of mothers (n=283)					
<i>15-24 years</i>	32 (11.3%)	30 (10.6%)	4.8(2.1-11.2)	0.6(0.13-3.2)	0.582
<i>25-34 years</i>	72 (25.4%)	94 (33.2%)	3.4(1.6-7.3)	1.6(0.5-5.6)	0.449
<i>≥35 years</i>	10 (3.5%)	45 (15.9%)	1.00	1.00	
Educational status of the mothers (n=283)					
<i>No formal</i>	6 (2.1)	64 (22.6)	1.00	1.00	
<i>Primary</i>	56 (19.8)	83 (29.3)	7.2(2.9-17.8)	5.4(1.5-19.8)	0.011
<i>Secondary</i>	33 (11.7)	15 (5.3)	23.4 (8.3-66.1)	13.9(3.1-61.7)	0.001
<i>Dip. & above</i>	19 (6.7)	7 (2.5)	28.9(6.7-96.6)	17.7(2.8-112.1)	0.002
Husband age (n=275)					
<i>≤30 years</i>	51(18.5)	48 (17.5)	9.6(2.1-43.4)	0.7(0.1-7.0)	0.763
<i>31-45 years</i>	60 (21.8)	98 (34.9)	5.6(1.3-25.1)	0.5(0.1-3.9)	0.472
<i>>45 years</i>	2 (7)	18 (6.5)	1.00	1.00	
Educational status of husband(n=279)					
<i>No formal</i>	15 (5.4)	62 (22.2)	1.00	1.00	
<i>Primary</i>	55 (19.7)	78 (28.0)	2.9(1.5-5.6)	0.4(0.4=2.9)	1.022
<i>Secondary</i>	25 (9.0)	16 (5.7)	6.5(2.8-15.0)	1.8(0.2-3.7)	0.933
<i>Dip. & above</i>	19 (6.8)	9 (3.2)	8.7(3.3-23.1)	0.9(0.001-2.7)	0.287

Husband occupation (n=279)					
<i>Farmer</i>	60 (21.5)	122 (43.7)	1.00	1.00	
<i>Daily laborer</i>	9 (3.2)	14 (5.0)	1.3(0.52-3.2)	0.4 (0.1- 1.8)	0.235
<i>Govt. employee</i>	18 (6.5)	10 (3.6)	3.7(1.6-8.4)	1.8 (0.3 -11.6)	0.529
<i>Merchant</i>	27 (9.7)	19 (6.8)	2.9(1.5-5.6)	0.9 (0.1 -2.4)	0.900
Family size(n=283)					
≤ 5	72 (25.4)	62 (21.9)	3.0(1.8-4.8)	1.5 (0.5 -4.9)	0.498
> 5	42 (14.8)	107 (37.8)	1.00	1.00	
Time to reach health inst. (n=283)					
≤ 2 hour	107 (32.8)	105 (37.1)	9.3(4.1-21.3)	7.6 (2.4 -24.5)	.001
> 2 hour	7 (2.)	64 (22.6)	1.00	1.00	
Parity (n=283)					
<i>1</i>	18 (6.4)	11 (3.9)	10.6(3.7-30.6)	1.6 (0.4 -5.7)	0.612
<i>2-3</i>	53(18.7)	44 (15.5)	7.8(3.4-18.2)	1.2 (0.2 -6.1)	0.858
<i>4-5</i>	35(12.4)	62 (21.9)	3.7(1.5-8.6)	1.7 (0.5 -5.8)	0.382
> 5	8 (2.8)	52 (18.4)	1.00	1.00	
Birth space (n=254)					
≤ 2	49 (19.3)	103 (40.6)	1.00	1.00	
> 2	47 (18.5)	55 (21.7)	1.8(1.1-3.0)	0.7 (0.3 -1.6)	0.447
Intended pregnancy (n=283)					
<i>Yes</i>	94 (33.2)	88 (31.1)	4.3(2.2-6.2)	1.9 (1.02 -4.5)	0.042
<i>No</i>	20 (7.1)	81 (28.6)	1.00	1.00	
knowledge on danger signs during pregnancy (n=283)					
<i>Knowledgeable</i>	74 (26.1)	30 (10.6)	8.6(4.9-14.9)	3.1 (1.3-7.0)	.008
<i>Not knowledgeable</i>	40 (14.1)	139 (49.1)	1.00	1.00	
knowledge of month/weeks on starting ANC visit (n=283)					
<i>Knowledgeable</i>	58 (20.5)	37 (13.1)	3.7()	2.4 (1.1 -5.5)	.033
<i>Not knowledgeable</i>	56 (19.8)	132 (46.6)	1.00	1.00	

CHAPTER SIX: DISCUSSION

6.1. Proportion of Focused Antenatal Care

This community based cross-sectional study tried to assess focused antenatal care utilization among child bearing mothers in Hadiya zone, Gibe Wereda. Among 283 interviewed mothers 114 (40.3%) followed ante natal care visit four and above times during their last pregnancy and 169 (59.7%) mothers did not follow focused ante natal care. This result was higher than Ethiopia demographic and health survey conducted in 2014 about 31.6% of mothers who have had a live birth in the five years received four and more prenatal care from health professionals this difference might be due to time difference and EDHS encompasses remote areas of the region [13].

Similarly this study also higher than study conducted in 2009 in Yem special Woreda, southwestern Ethiopia only 28.5% of women had effective antenatal care services during their last pregnancy [16], this might be due to time difference, since 2009 a lot of health reform, construction of health infrastructure, and health promotion probably done.

But this study lower than in a study conducted in 2014 in Ayder Kebele Mekelle city around 84.8% had four and above antenatal care contacts [21] and also lower than a study conducted in rural West Sumatra, Indonesia in 2010 which is 80% of respondents received ANC more than four times; this discrepancy might be due to this study is conducted in rural area but this two were in urban setting there is difference between in educational status between urban and rural people and access and means of transportation to health facility also affect mothers not visit and to visit FANC.

6.2. Factors Affecting Focused Antenatal Care Utilization

Mothers' educational status was found statistically significant with focused antenatal care. Mothers whose educational primary, secondary and diploma and higher were more likely to follow focused ante natal care than no formal educational level of mothers. Similarly a study conducted in *Ibadan, Nigeria* on 2010. Educational status also showed a significant association with respondents having an education of secondary school and above attending ANC clinic more compared to women who had an education of primary school and below [23]. Also in EDHS, 2011 report there is a direct relationship between a woman's education level and whether she is likely to receive ANC from a skilled provider. For example, 91% of women with more than secondary education received ANC from a skilled provider compared with 25% of women with no education [7]. Another study in Kham district levels of education were the most important predictors of ANC utilization educated women were more likely to receive ANC services than those who had no education [18]. Similarly a Study conducted in rural West Sumatra, Indonesia Women who finished basic education tended to receive fewer than four ANC visits compared to women who finished secondary education [26]. This might be due to education is likely to enhance females' autonomy so that women develop greater confidence and capability to make decisions about their own health and educated mothers more likely to understand education given about health and danger signs and educated mothers are more likely to seek health care than less educated.

Time to reach the nearest health facility significantly determine FANC utilization mothers who traveled ≤ 2 hours from their home to health center were 7.6 times more likely to follow focused ante natal care than those who travelled more than two hours to reach the nearest health institution. These findings are consistent with other study in Kham district Women who lived nearby were 2.9 times more likely to frequent visit ANC than those who lived far away [18]. Longer time to reach the nearest health facility discourages mothers to follow FANC because of when reach 3 and 4 trimester they are weak to travel long distance in the case of rural area where no transport access in contrary physical proximity of health

Institution was determining factor in case of this study were most of study participants 96.5% was travel on foot. Mothers living in closer proximity to modern health services were more likely to receive services from health personnel for the treatment of life-threatening and high-risk conditions and frequent ANC visit during the pregnancy period.

In this study mothers who planned their last pregnancy were two times more likely to follow focused ante natal care than those who didn't planned their last pregnancy. This Study is consistent with study conducted in Yem special Woreda, southwestern Ethiopia[16] and Debre Berhan In 2012 [20], planned pregnancy were factors that showed a statistically significant association with antenatal care utilization. The possible explanation could be those mothers who had planned pregnancy might be more educated and it is believed that, wanted pregnancies are more cared and worry to healthy child this leads mothers to follow recommended ANC visit than women not planned.

Another predictor of focused antenatal care was Knowledge of month/weeks on starting ANC. Mothers who know the appropriate time for initiating ANC visits were 2.4 times more likely to follow FANC than mothers who didn't know the appropriate time for starting ANC visits. This finding was in line with study conducted in Debre Berhan In 2012 [20]. This might be due to when mothers started ANC visit very soon the probability of reaching four and above ANC will be high but if mother started late they will get delivery before reaching four visits and if their first ANC visit early and providers inform and advise the pregnancy danger signs and services she will receive that also enhance mothers to get FANC service.

Knowledge of danger signs during pregnancy was found to be significantly associated with Focused Antenatal Care. This finding was consistent study conducted in Yem special Woreda, southwestern Ethiopia[16]. This may be due to mothers who had knowledge on danger signs there may be aware of the possible adverse event happened during pregnancy period that leads mothers follow to FANC than mothers with poor knowledge of danger signs.

6.3. Limitation of this study

- This study does not show cause and effect relationship.

6.4. Strength of this study

- To minimize the possible recall bias women's who gave birth in last three month prior to study was selected.

CHAPTER SEVEN: CONCLUSION

There was relatively high antenatal care utilization among the study participants but this study confirmed that focused antenatal care utilization was low in the study area. this study also confirmed that among 283 interviewed mothers 114 (40.3%) mothers followed focused ante natal care four and above times during their last pregnancy and 169 (59.7%) mothers did not follow focused ante natal care more than half of participant attend less than four visit.

This study also identified that educational level, time to initiate ANC visit, knowledge of danger signs during pregnancy, intended pregnancy and time to reach to health facility of mothers were the main factor influencing women who received less than four ANC during pregnancy.

CHAPTER EIGHT: RECOMMENDATION

Based on the above findings of the study the following recommendations were suggested:

To Health Sector, Regional Health Bureau and Educational Sector

- Women's education status is an important factor for utilization of FANC service in the study area suggesting that educating girls will have a great impact on improving future utilization of ANC in the area.
- Ministry of health and regional health bureau have to accessing health infrastructure to the community nearby this will reduce time to reach health institution and encourage pregnant women to fully utilize FANC services.
- Educational sector has to plan adult learning program; for those who do not attend formal education.

To Wereda Health Office, Health Center and Health Post

- Have to increase awareness of mothers on the danger signs of pregnancy and time to initiate ANC visit
- Have to advise mother to have planned pregnancy and hence, key action should be taken in availing, advising mothers to take contraceptive that enable mothers to find a suitable & more effective method to reduce unplanned pregnancy.

To Researchers

- Researchers have to continue conducting research on knowledge, attitude and quality of service provision of health professional towards Focused Antenatal Care utilization.

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ANNEXES

Annex I English Version Information Sheet for Study

I temporarily represent Addis Ababa University College of Health Science Department of nursing and midwifery. This study will be conducted to determine factor affecting utilization of focused antenatal care among women who gave birth 3 month preceding the study in Gibe Wereda SNNPR Ethiopia. The study is directly related to women who gave birth, you are one of the women who have been selected systematically to participate in this study. Therefore, you are kindly requested to participate in this study and provide the information required from you. The interview will last approximately 20 minutes. Your responses will be kept confidential and there will be no way of linking your individual identifier responses to the final results of the study findings.

Objective: To determine focused antenatal care status and associated factors among mothers who gave birth within 3 month preceding the study in Gibe Wereda SNNOR Ethiopia.

Duration: The study will be conducted in Gibe Wereda from 15-30, March, 2015

Benefits: I would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful in the planning and implementation of intervention activities to prevent delays and improve maternal and neonatal survival.

Consent: You may end the interview at any time and also refuse to participate in the study entirely. Your refusal will not restrict you from obtaining the required medical care when you need. Are you voluntary to respond to the questions?

Yes; -----

No; -----

Name of principal investigator - Tigist Bekele

Address – Mobile Number 0913537599

E- Mail - tigestbekele325@yahoo.com

Date ----- Signature -----

Annex I Amharic Version Information Sheet For Study

በአዲስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ዲፓርትመንት ነርሲንግ እና ሚድኤል ስራ ትምህርት ክፍል የሁለተኛ ዲግሪ ተማሪ በሚሰራው ጥናት ላይ መረጃ ሰብሳቢ ቡድን አባል ነኝ። ጥናቱ የሚያተኩረው በእናቶች የቅድመ ወሊድ ዝግጅት ሁኔታና ክብካቤ ላይ ነው። እርስዎን የተወሰኑ ጥያቄዎች ለመጠየቅ እንፈልጋለን፣ መጠይቁ ከ--20-----ደቂቃ በላይ አይወስድም እርሶ የሚሰጡኝ መልስ ሚስጢራዊነቱ የተጠበቀ ሲሆን ከጥናት ግልጋሎት በዘለለ በእርሶ ላይ ምንም አይነት ጉዳት አያደርስም ስለዚህም ስሞትን አንይዝም ፡፡

ጥቅም(Benefits):- የሚሰጡት ምላሽ ለዚህ ጥናት ከፍተኛ ጥቅም ከመስጠቱም ባሻገር በችግሩ ዙሪያ ለሚሰሩ መንግስታዊ እና መንግስታዊ ላልሆኑ ድርጅቶች አንደ አንደ ግብዓት ያገለግላል። ከዚህም ባሻገር ለእቅድ ትግበራ፣ የእናቶችናየህፃናትንሞትከመከላከልአንፃርከፍተኛሚናይጫወታል፡፡

የጥናቱጊዜ:-ጥናቱ የሚካሄድበት ጊዜ በጊዜ ወረዳ የተመረጡ ቀበሌዎች ከመጋቢት 15 እስከ 30/2015 ዓ.ም ይሆናል

ፍቃድ(Concent) :-

በሚጠየቁ ወቅት መመለስ የማይፈለጉት ጥያቄ ካለ ያለመመለስ እንዲሁም መጠይቁ ከተጀመረ በኋላም መቋረጥ ይችላሉ። ስለዚህ እርስዎ በዚህ ጥናት ውስጥ ለተጠየቁት መጠይቆች መልስ እንዲሰጡን በትህትና እጠይቃለሁ። በጥናቱ ላይ ለመሳተፍ ተስማምተዋል?

አዎ _____

አልስማማሁም _____

የጥናቱባለቤት :- ትግስት በቀለ ከበደ

አድራሻ:- ሲቁ 0913537599

ኢ.ሜይል - tigestbekele325@yahoo.com

ቀን ----- ፊርማ -----

Annex- II English version questioner for interview

Addis Ababa University School Of Allied Health Science Department Of Nursing And Midwifery.

Questioner On Assessment Of Factor Affecting Utilization Of Focused Ante Natal Care In Gibe Wereda, South Ethiopia, March, 2015

Identification Information

001. Code No. _____

002. Kebele _____

003. Got _____

Instruction for interviewer: For each of the following questions, please circle the number of the alternative or fill the blank space that fit the response of the respondent.

Section--1: Socio-demographic Information of mothers

1.01. What is your age in completed years? In year: -----

1.02. What is your marital status?

01. Single

02. Married

03. Widowed

04. Divorced

1.03. What is your religion?

01. Orthodox

02. Catholic

03. Protestant

04. Muslim

99. Other (Specify) _____

1.04. What is your ethnicity?

01. Hadiya

02. Gurage

03. Kembata

04. Amhara

05. Other (Specify) _____

1.05 What is your occupation?

01. Housewife

02. Govt. employee

03. Farmer

04. Daily laborer

05. Merchant

06. Other (Specify) _____

1.06 What is your educational status?

01. Illiterate

03. Secondary

02. Primary

04. Diploma & above

1.07. What is your husband's age in completed years? In year: -----

1.08. What is your husband's educational status?

01. Illiterate

02. Primary

03. Secondary

04. Diploma and above,

1.09 What is your husband's occupation?

01. Farmer

02. Daily laborer

03. Govt. employee

04. Merchant

99. Other (Specify) _____

1.10 What is your family size? (In number) _____

1.11. How many hours did the health institution far to reach? (In hours) _____

1.12. What are the means to reach health institution or transportation? (Multiple answers is possible)

01. Feet

02. Animal

03. Car

04. Bicycle or motor bicycle

05. Other (Specify) _____

Section-2: Reproductive history of women

2.01. How many times in total you became pregnant? (In numbers) _____

2.02. Did you follow antenatal care for your last pregnancy?

01. Yes 02. No

2.03. How many times did you visit ANC for the last pregnancy? (In number) _____

2.04. How many antenatal care visits is a pregnant woman supposed to make during the whole pregnancy period? (In Number)

01. When there is no problem _____

02. When there are problems _____

2.05. Do you have any specific reasons why you started antenatal care at that period?

.....

.....

2.06. At which month of the pregnancy did you start antenatal care?

01. 0 – 3 months (0-12 Weeks)

02. 4 – 6 months (13-24 Weeks)

03. 7 – 9 months (25-36 weeks)

04. Don't Know

2.07. From whom did you ask for permission or discuss to attend antenatal care clinics?

01. mine only

02. Mine & my husband

03. My husband only

04. Other (Specify).....

2.08. Did you intend the last pregnancy?

01. Yes 02. No

2.09. What was the birth space between previous and last child? (In year)_____

2.10. Did you know danger signs related to pregnancy?

210.1. Persistent vomiting

01. Yes, I know

2. I don't know

210.2. Vaginal bleeding

01. Yes, I know

2. I don't know

210.3. Severe headache

01. Yes, I know

2. I don't know

210.4. Hypertension

01. Yes, I know

2. I don't know

210.5. Face hand and feet swelling

01. Yes, I know

2. I don't know

210.6. Others (specify) _____

This is the end of the interview. THANK YOU!

Date of data collection _____

Name of data collector _____

Signature _____

Name of supervisor _____

Signature _____

Annex III Amharic Version Questionnaires for Interview

አዲስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ዲፓርትመንት ነርሲንግ እና ሚድ አይፈሪ ትምህርት ክፍል

በጊቤ ወረዳ ከወለዱ3 ከወር ቦታች ለሆኑት እናቶች ላይ ለሚሰራ ጥናት የተዘጋጀ መጠይቅ

የመለያ መረጃ

001. የመጠይቁ መለያ ቁጥር_____

002. ቀበሌ_____

003. ጎጥ_____

መመሪያ ለጠያቂው፡- እባክዎን ለያንዳንዱ ጥያቄ የተጠያቂውን ምላሽ ከአማራጮቹ ውስጥ ያክብቡ ወይም በባዶው ቦታ ምላሹን ይጻፉ፡፡

ክፍል -1 ፡ስነ ህዝብና ማህበራዊ ጉዳዮች

1.01 እድሜዎት ስንት ነው(በቁጥር)-----

1.02የጋብቻዎት ሁኔታ እንዴት ነው?

01. ያገቡ

02. ያላገቡ

03.ባል የሞተባቸው

04.የፈቱ

1.03የሚከተሉት ሐይማኖትዎት ምንድን ነው?

01. ኦርቶዶክስ

02. ካቶሊክ

03.ፕሮስቴስታንት

04.ሙስሊም

05. ሌላ ከሆነ ይጠቀስ

1.04ብሄርዎት ምንድን ነው?

01. ሃዲያ

02. ጉራጌ

03.ከምናታ

04.አማራ

05. ሌላ ከሆነ ይጠቀስ-----

1.05ስራዎትአይነትምንድን ነው?

01. የቤት እመቤት

02. የመንግስት ሰራተኛ

03.ግብርና

04.የንግድ/ሥራ

05. ሌላ ከሆነ ይጠቀስ-----

1.06የትምህርት ደረጃዎትእንዴት ነው?

01. ያልተማሩ

02. አንደኛ ደረጃ

03. ሁለተኛ ደረጃ

04. ዲፕሎማና ከዚያ በላይ

1.07 የባለቤትዎ እድሜ ስንት ነው?_____

1.08 የባለቤቶች የትምህርት ሁኔታ እንዴት ነው?

- 01. ያልተማሩ 02. አንደኛ ደረጃ
- 03. ሁለተኛ ደረጃ 04. ዲፕሎማና ከዚያ በላይ

1.09. የባለቤትዎ ስራ ምንድን ነው?

- 01. ገበሬ 02. የቀን ሰራተኛ 03. የመንግስት ሰራተኛ 04. ነጋዴ
- 05. ሌላ ከሆነ ይጠቀስ _____

1.10 የቤተሰቦች ብዛት ስንት ነው? (በቁጥር) _____

1.11. ወደ ጤና ተቋሙ ለመድረስ ምን ያህል ሰዓት ይወስድበታል? (በሰዓት) _____

1.12. ወደ ጤና ተቋሙ ለመድረስ በምን አይነት የማጓጓዣ ዘዴ ይጠቀማሉ?

- 01. በእግር 02. በጋማ እንሰሳ
- 03. በመኪና 04. በባይስክል
- 05. ሌላ ከሆነ ይጠቀስ _____

ክፍል - 2: የእርግዝና እና የወሊድ ሁኔታ

2.01. በአጠቃላይ ምን ያህል ጊዜ እርጉዝ ሆያው ያውቃሉ? (በቁጥር) _____

2.02. የመጨረሻው ልጆች እርግዝና ጊዜ የቅድመ ወሊዲ ክብካቤ አድርገው ነበር?

- 01. አዎ 02. አይደለም

2.03. ለምን ያህል ጊዜ ነው የቅድመ ወሊዲ ክብካቤ ያደረጉት? (በቁጥር) _____

2.04 አንዲት ነፈስ ጡር እናት በሙሉ እርግዝና ጊዜዋ ምን ያህል ጊዜ የእርግዝና ክትትል ታደርጋለች?

204 ችግር ሲያጋጥማት _____

204 ምንም ችግር ሳይኖር _____

2.05 የእርግዝና ክትትል ለመጀመር የተለየ ምክንያት የሆኑትን ይጥቀሱ?

2.06 በየትኛው ወር የእርግዝና ክትትል መጀመር አለበት?

- 01. 0 – 3 ወር (0-12 ሳምንት)
- 02. 4 – 6 ወር (13-24 ሳምንት)
- 03. 7 – 9 ወር (25-36 ሳምንት)
- 04. አላውቅም

2.07 የእርግዝና ከትትል ለማድረግ ከማን ጋር ተማከርሽ/ወሰንሽ

01. በራሴ

02. እኔና ባለቤቴ

03. ባለቤቴ ብቻ

04. ሌላ ከሆነ ይጠቀስ _____

2.08 የመጨረሻውን ልጆትን አቅደው ነው ያረዝቱት?

01. አዎ

02. አይደለም

2.09. የአሁኑና የቀድሞ ልጆት ያለው የጊዜ ርቀት ምን ያህልነው? (በቁጥር) _____

2.10. በእርግዝና ወቅት ያሉትን አደገኛ የጤና ችግር ያውቃሉ?

210.1. ማስመለሥ

01. አውቃለሁ

02. አላውቅም

210.2. በብልት ደም መፍሰስ

01. አውቃለሁ

02. አላውቅም

210.3. ከፍተኛ የራስ ምታት

01. አውቃለሁ

02. አላውቅም

210.4. የደም ግፊት

01. አውቃለሁ

02. አላውቅም

210.5. የፊት እግርና እጅ ማበጥ

01. አውቃለሁ

02. አላውቅም

210.6. ሌሎችም ካሉ ይጥቀሱ _____

ቃለ መጠይቁ ተጠናቋል

እጅግ በጣም አመሰግናለሁ !!

የቃለ መጠይቁ ቀን -----

የጠያቂው ስም-----

ፊርማ-----

የተቆጣጣሪው ስም-----

ፊርማ-----

Annex- IV Hadiyisa Version Questionnaire for Interview

Addis Ababa universitee Minadabfeya' o omaasayinskollegi

Nursingamidwiferylessanchiqodoo

Gibeworadanneseseworonyooammoii fayyaa' ombaxxbikkinabaxxakaminaqashingudisakoxa
michuwwa

Qabalee

Mine xiggo_____

Xemanchiksumm_____

Supelvayzeleksumm_____

La'isisa

Hundim

ammo

witamdabachinekenettinesidamukmarajainneasheremakkoanne. Matmatxamichuwoddimillag
koduwwamakkohanne. Ebikindabachuwqanana imhasissoyyo. Ammakdabachdenamissmacess
ekkalassagekitabimhassissokko. Ammo'iichikamihukamak sum kitabamoyyo.

Section--1: Hundimammo'iichammanxamakamannee.

1.01. Ki ummurme'o? hinchine: -----

1.02. Min isakamogora?

1. Bajamee
2. Min isitoik
3. Bubesancho
4. Manchilehukoki

1.03. Haymanota?

1. Amnano
2. Orthodox
3. Islam
4. Katolik
5. Mulekyolass

1.04. Zara?

1. Hadiya
2. Kembata
3. Wolayita
4. Halaba
5. Mulekyollas

1.05. Ki lossangabalame'o?

1. Temattobe'ek
2. 1-8
3. 9-12
4. Koleginshanan

1.06. Ki baxxogor?

1. Min ammatte
2. Abulanchi
3. Dederanchi
4. Gag dirjitbaxanchotte
5. Addilbexanchotte
6. Belbexanchotte
7. Mulekyolass

1.07 Min anichikummurme'o? hinchine: -----

1.08. Minanichiklossangaballa?

1. Temattobe'ek
2. 1-8
3. 9-12
4. Koleginshanan

1.09. Min anichikbaxxoogor?

1. Bulanchi
2. Dederanchi
3. Gag dirjitbaxanchotte
4. Addilbexanchotte
5. Belbexanchotte

1.10. Abarrosxiggo? (xigginne) _____

1.11. Kin minninnxennaxabbaffebee'emariminmee'eammanmassokko?

01. ≤ 2 hour 02. > 2 hour

1.12. Mahinnetxennaxanmattakammokk? (Multiple answers is possible)

01. Lokkinne
02. Faraddinne
03. Kame'inne
04. Csaykillinnete'immotorinne

Qooxo 2: Xoochamaninagudobaxuwa

2.01. Lasaanch cilia qatitamanelitokaeligagenmee'otee?xiigine_____

2.02. kaa'eelagenqattitikicillinefsaxurkititilaissakainne?

01. Ooyya 02. Aa'ee

2.03. mee'exuraane fsaxurkititilaissakaa? xiigine_____

2.04. matnefsaxurammoo'imee'egizenene fsaxurkititila

Yoo hawwiya'okkikxiigine_____

Yoo hawwibeelaasxiigine_____

2.05. .Lasaanchqachchamanegooqitaakiogoramahinda'eihukisaaxarasitaa?

.....
.....

2.06.lasaanchqachiamanexiigauwoomanagudisaahelito?

01. 01. 0 – 3 hincho (0-12 santa)
02. 4 – 6 hincho (13-24 santa)
03. 7 – 9 hincho (25-36 santa)
04. laquummoyyoo

2.07 nasturaneekititilaissakyyiayyanattekikkiorrammane?

01. attattenee
02. attinamanchonatte
03. manchoxaaltee
04. yoo'o les kure_____

2.08. Lasaanch cilia qatitiamaneichiaqadakaqatoyyonee ?

01. Ooyya 02. . Aa'ee

2.09. mee'ehinchoottekaeligencilliqatta'aaffollobbanee? _____

2.10. Xuuchchiamanebadisoomare'elaqoo?

2.10.1. Qeeraa'lananxuuchchi(12iihanaan)

01. Ooyya 2. Aa'ee

2.10.2. firoo'lafuurimma

01. Ooyya 2. Aa'ee

2.10.3. Landioorachinekee'maalxiigdilimi

01. Ooyya 2. Aa'ee

2.10.4. Xiiggafechi

01. Ooyya 2. Aa'ee

2.10.5. Mullikeen

01. Ooyya 2. Aa'

2.10.6. 05. Mulibeyo (caakkise)_____

Kuklasaanchixammichcha.

Galaxxoommo!

Balli _____

Xammichaxammumanchi summa _____

Mare'e _____

Supervisorisumm _____

Mare'e _____

Annex V Assurance of Principal Investigator

I, the undersigned, agree to accept responsibility for the scientific, ethical and technical conduct of the research project and provision of the required progress as per terms and conditions of the research and publication office in an effect of time grant is forwarded as the result of this application. I will provide timely progress report to my advisor and seek the necessary advice and will communicate timely with my advisor.

Name of student: Tigistbekele

Signature: _____ Date _____

Advisor: S/r AkilHailu (BSc, MSc,)

Signature _____ Date _____