

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH



Patterns of admission of laboring mothers and the association between birth preparedness and delayed presentation during labor in public health centers of Addis Ababa, Ethiopia, 2017

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Advisors:-

- **Meselech Assegid (MPH)**
- **Professor Yifru Berhan (Obstetrician and Gynecologist)**

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**A THESIS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH FOR THE
PARTIAL FULFILLMENT OF THE REQUIREMENT FOR MASTER'S DEGREE IN
PUBLIC HEALTH, ADDIS ABABA UNIVERSITY.**

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Acknowledgement

First and for most I would like to thank God without whom I couldn't even think of doing anything. My second gratitude goes to Addis Ababa University for giving me this chance to learn in this school. I would also like to thank my advisors Mrs. Meselech Assegid and Professor Yifru Berhan for their continuous support and constructive comments and also Dr. Mitike Mola for her advice and support. I would like to thank UNFPA for funding my thesis work. I would also like to give appreciation for my data collectors, supervisors, and respondents. Last but not the least I would like to thank my family and friends for being there for me.

List of Abbreviation and Acronyms

AAU- Addis Ababa University

AARHB- Addis Ababa Regional Health Bureau

ANC- Ante Natal Care

EDHS- Ethiopian Health and Demographic Surveillance

ERC- Ethical Review Committee

HC- Health Center

K/K- Kolfe Keraniyo Sub-city

N/L- Nifas Lafto Sub-city

MMR- Maternal Mortality Ratio

NICU- Neonatal Intensive Care Unit

REC- Research Ethics Committee

SRS- Simple Random Sampling

WHO- World Health Organization

Abstract

Background: In 2015 an estimated 303,000 women died from maternal causes globally and developing countries account for 99% of these deaths. Delay in seeking care during labor is a recognized contributor for these adverse pregnancy outcomes. Birth preparedness and complication readiness plan is one of the crucial elements of Safe motherhood for a woman to get timely care during pregnancy and childbirth to avoid these adverse outcomes.

Objective: This study aimed to see the patterns of admission of laboring mothers and the association between Birth preparedness and delayed presentation in public health centers of Addis Ababa, Ethiopia, 2017

Method: This was a facility based cross-sectional study done in 10 public health centers of Addis Ababa from Mar-Apr, 2017. Multistage sampling technique was used to identify the sample health centers then systematic random sampling was used to select the study participants. Data was collected using a pretested structured questionnaire. Tables and charts were used to present descriptive results. OR was used to measure association and 95% CI and P-Value<0.05 were used as predictors of significant association. Bi-variate and Multi-variate analysis was done to see the independent effect of each variable on the outcome variable.

Result: Women who came delayed during labor were found to be 47%. Twenty and 13.6% of mothers came in latent first stage and second stage of labor respectively whereas the remaining 32.6% came during early active and 33.4% on late active first stage of labor. Four hundred fifty nine (74.2%) participants were found to be well prepared for birth and mothers who were not well prepared were 1.63(AOR=1.63:1.04, 2.55) times more likely to come delayed during labor. Women at older age (AOR=6.76:1.41, 32.35), multigravida women (AOR=2.14:1.36, 3.36), women having less visits than the recommended number of antenatal visits (AOR=1.8:1.17, 2.80), and aware of danger symptoms of post-partum (2.1:1.28, 2.54) were also the one who were more likely to come delayed.

Conclusion: Delayed presentation during labor was found to be high and found to have an inverse relationship with level of birth preparedness. Focus on counseling women that every pregnancy is at risk, on birth preparedness and on the recommended number of antenatal visits is recommended.

1. Introduction

1.1 Background

Labor is a natural process of expelling a viable fetus (≥ 28 weeks gestation) from the uterine cavity. There are three stages of labor: the first, second and third stage. The first stage of labor is the time from the onset of true labor to full dilatation of the cervix, 100% effacement and with adequate uterine contraction. It has three stages (the latent stage up to 3cm and fully effaced, early active first stage 4-5cm, and late active first stage 6-9cm). The second stage of labor is the time from full dilatation of the cervix till the delivery of the fetus while third stage is the time from the delivery of the fetus to expulsion of the placenta (1).

In 2015, an estimated 303,000 women died from pregnancy related causes globally and developing countries account for 99% of these deaths with Sub-Saharan Africa alone accounting for roughly 66%, followed by Southern Asia (2). Three main direct obstetric causes were responsible for this higher maternal deaths. These are hemorrhage, hypertensive disorders of pregnancy, and infection/sepsis (3).

The risks of maternal and neonatal mortality and morbidity are higher at birth and in the immediate post-natal period (4). There are an estimated 2.6 million still births a year globally. These deaths are common on late preterm and term fetuses. And 98% of these deaths occur in low and middle-income countries particularly in south Asia and Sub-Saharan Africa. Around 70% of these deaths happen in the time of labor or child birth and mostly associated with obstetric emergencies (5).

Reducing maternal mortality to 70/100,000 live births and no country having more than 140/100,000 live births is one goal in the sustainable development goal (6).

Addressing inequities in access to and quality sexual, reproductive, maternal and newborn health care services is one of the five strategic objectives for ending preventable maternal mortality by World Health Organization (WHO). The first strategy to meet this objective is women empowerment which gives women autonomy to decide for their own reproductive health including decision to seek and access maternal health care services(7).

USAID's program in Ethiopia currently focuses on supporting government's national interventions on birth preparedness and maternity services; treatment of obstetric complications and disabilities, including fistula; newborn care and treatment of child illnesses. (8)

1.2 Statement of the problem

In low and middle income countries 11-17% of mothers die while giving birth and obstetric complications during labor accounts for 58% of still births and newborn deaths (9). Delay in seeking medical care during labor and delivery is the main contributor for these higher maternal and neonatal deaths. It is also accountable for higher risk of developing obstetric complications and poor fetal or neonatal outcome (10-12). Delay in accessing hospital care is one of the independent predictors of perinatal mortality in Low-income countries (13).

Delayed presentation during labor and obstetric emergencies is also associated with severe maternal morbidity or near miss. Hypertensive disorder and post-partum hemorrhage are responsible for this events (14).

The magnitude of delayed presentation during labor was 20% in two teaching hospitals of Addis Ababa and this delayed presentation is associated with adverse fetal and maternal outcomes like uterine rupture/ obstructed labor, prolonged rupture of membrane, admission of neonate in Neonatal Intensive Care Unit (NICU) and perinatal mortality (12).

Birth preparedness and complication readiness plan (BPCR) is one of the crucial elements of safe motherhood for mothers to get timely care during pregnancy, delivery, and post-partum based on the argument that preparing for birth and being ready for complications reduces all three phases of delays in receiving these services. Birth preparedness and complication readiness plan includes deciding where to give birth, identifying a skilled health care provider, arranging transport, knowing about danger signs of pregnancy, and preparing for urgent action during emergency (15).

The government of Ethiopia started implementing BPCR package as one component of Focused Antenatal Care since 2007 to enable pregnant women get timely care during childbirth and in case of emergency (16).

1.3 Rationale

Women in reproductive age group account for 43.3% of the total population in Ethiopia (17). It is known that women and children are vulnerable group of a society in many ways. One of these is that a woman who is in the reproductive age group in Sub-Saharan Africa had a 1 in 36 life time risk of maternal death because this is the time when a woman could get pregnant (2). Accessing timely skilled care during childbirth is one of the key strategies to minimize this risk and prevent maternal deaths in our country (18).

According to the Ethiopian Demographic and Health Surveillance 2016 report, 97% of deliveries in Addis Ababa take place in health facility with the presence of skilled care provider (19). But there is lack of evidence on the time of presentation of mothers during labor in Addis Ababa. And also previous study conducted in Addis (12) classifies mothers who only came in the second stage of labor as delayed but this study included mothers who came during late active first stage or second stage of labor in the delayed category, as presence of skilled provider during labor is a key intervention to minimize fetal death or maternal and neonatal morbidity and mortality it will be helpful if mothers come at early stage of labor to get proper and close follow otherwise complications cannot be detected and managed early.

Federal Ministry of Health in Ethiopia is implementing birth preparedness plan for mothers to get timely care during delivery and a number of studies were done on the status of birth preparedness and complication readiness and its associated factors in our country and in Addis also (20-27). But little is known about the effect of birth preparedness on time of presentation during labor. So this study aimed to see the pattern of admission of laboring mothers and the association between birth preparedness and delayed presentation during labor in public health centers of Addis Ababa.

1.4 Significance of the study

The finding from this particular study will be used by policy makers and programmers to give solution for the identified problems. And it will address the knowledge gap on role of birth preparedness in reducing delay during labor. It will also help the public health centers of Addis Ababa to implement evidence based intervention.

2. Literature Review

Delay in seeking obstetric care is one of the contributing factors for maternal and neonatal morbidity and mortality worldwide as time of labor and delivery is the risky period for both the mother and the fetus where unpredictable obstetric complications could occur (9).

Studies from Africa showed a significant reduction in maternal, fetal, and neonatal mortality when delivery is attended by skilled health personnel with midwifery skill (28). So having a health worker with midwifery skills present during labor and child birth is one of the most important interventions to reduce maternal, fetal, and neonatal morbidity and mortality (29).

2.1 Magnitude and factors associated with delay in accessing obstetric care during labor

A study conducted in University hospital of Benin, Nigeria on causes and consequences of late arrival during labor revealed that 7.9% women arrive late during labour. This late arrival to the labour ward was significantly associated with high parity, low educational status, and poor antenatal attendance(30). There was also another study conducted again in another university hospital in Nigeria and reported that 25.3% of women were admitted in second stage of labor. The reasons for late arrival were transportation difficulties, fast progress of labor, and husband not around. Multi gravidity was also associated with late arrival (31).

Another study conducted in Ogun state, Nigeria on health care seeking behaviors of pregnant woman reported that there was a great concern on cost in accessing health care service. Economic factors were found to be associated with delay in seeking care (32).

A case control study done in 1993 in two teaching hospitals of Addis Ababa revealed that 20% of mothers came in second stage of labor and problems related to referral, decision-making, transport, money and delay within hospitals were associated with delayed presentation during labor (12).

A study on factors influencing delay in arrival to maternity hospital in Kathmandu reported that age, multi parity, and educational status were associated with late arrival during delivery (33).

There was a qualitative study conducted in rural India. All women included in the study reported that they tried to access delivery care service. But many factors delayed them from getting the appropriate care. Not understanding the severity of complication, thinking there is low quality of delivery service and gender inequality were some of the reasons that delayed decision to seek

care. The other factors which delayed the women from reaching the appropriate facility were transportation problem and not knowing the actual place that they could get the care they need or visiting different facilities (34).

A cross-sectional study done in 27 referral hospitals in Brazil revealed that any type of delay was observed in 53.8% of the cases (maternal death or near miss): delay because of problem in decision to seek care accounts 10.2% and in 34.6% of cases delays were associated with accessibility of health care services and 25.7% were related to quality of care (10).

A qualitative study was conducted in Makwanpur district Nepal to explore the first delay in accessing delivery care service. Most women were aware of the benefits of institutional delivery but there were many barriers that keep them away from getting the service. Woman's status at home, wishing not to disappoint family by going out of their will, being ashamed to show their body in health institution were some of the reasons. Problem in accessing transportation was also a contributor for the delay in seeking care (35). There was also another qualitative study done on staff's perspective of barriers to accessing delivery care service found that lack of awareness about the availability of the service, poor quality services, women being too busy to attend, humiliation, financial issues were among the reasons the first delay while Giving birth on the way before reaching health facility and preference of higher facility were reasons for the second delay (36).

A cross-sectional study done in Songkhal province of southern Thailand revealed that 99% of deliveries happened in hospital. Low educational status, refusal to seek care, out of pocket payment, fear of cost, transportation problem, low expectation of getting good care or perception of being treated badly were associated with delay in accessing delivery care (37).

A qualitative study done in Nicaragua on utilization of maternal health care services showed that inadequate access to care and economic factors were not the only factors associated with decision to seek care. Knowledge about and giving recognition to maternal services, partner support, prior experience and communication with other woman health care workers were also associated with decision to seek care (38).

Another qualitative study done in Malindi district, Kenya indicated women face problem in making decision to seek care and getting to the appropriate health care services. Reasons for first

delay were lack of birth preparedness, having problem in identifying a place for delivery. The second delay was also because of long distance and transportation problem (39).

A cross-sectional study done in Bahir dar on maternal delay in utilizing delivery service revealed that 37% of the mothers reported having problem in decision making to seek care. Age, occupation, educational status, income, knowledge about ante natal care, decision making autonomy, problems in previous and current pregnancy were associated with delay in seeking care. 31.7% mothers also reported that they had a problem with transportation. Unemployment and low educational level were also significantly associated with the second delay (40).

Another study conducted on the role of male partner in reducing delay to seek emergency obstetric care in hospitals of north showa, Amhara showed 69% of decision to seek care was made by husband. Male educational status and having life-threatening condition were significantly associated with reduction of delay in seeking care (41).

2.2 Magnitude of birth preparedness and complication readiness

A study conducted in a tertiary hospital in India revealed that 67% of women fulfilled at least one component of BPCR. But women who were well prepared were only 23.7%. Having complication during pregnancy was positively associated with birth preparedness. Well prepared mothers were less likely to develop complications (42).

A facility based study done in Kenya on women attending Ante Natal Care (ANC) revealed that 70.5% of women were prepared for birth and 90.6% said they were prepared for obstetric emergency. In this study 87.9% of the study participants ascertain a place to deliver but only 4.7% of the women knew at least two obstetric danger signs. Vaginal bleeding was the most stated danger sign in all phases (43).

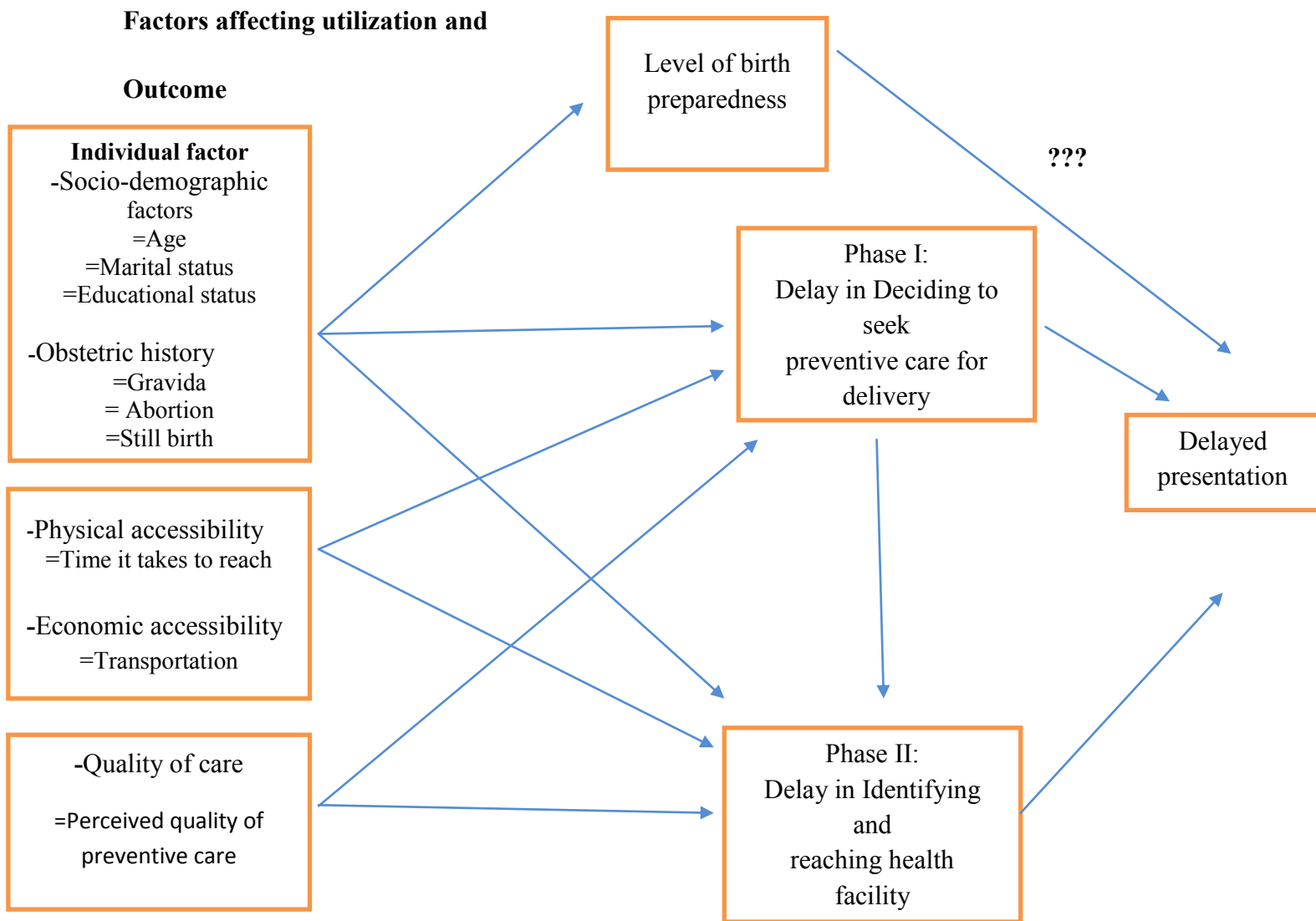
Another study done in a teaching hospital of Accra showed that 99% of the respondents had ANC follow up and almost 99.8% of them delivered in a health facility. 75% of the women were counseled on birth preparedness and complication readiness but 62% were prepared and 74% of the women had a good knowledge about obstetric danger signs. The most mentioned danger signs were hemorrhage (60.7%), excessive vomiting (33.1%), and swelling of face, hands and feet (28.8%) (20).

There was a community based cross-sectional done in Tanzania on women who delivered within the last two years before the study period. Many of the mothers (86.2%) identify where to give birth, a skilled birth attendant, and a person to accompany during labor and who will take care of the remaining family at home. The study revealed that only 14.8 of the woman had knowledge about at least three danger signs (21).

There was a study conducted on awareness of BPCR in Federal Police Hospital Addis Ababa. In this study 67.8%, 62.1%, 52.2% of pregnant women were knowledgeable about important danger signs during pregnancy, delivery, and postpartum, respectively. And almost half (56.3%) of the mothers found to be prepared for birth and its complications (22). Another facility based study done in Adama concluded 29.1% of pregnant women visiting government facilities found to be prepared. Knowledge about obstetric danger signs was also found to be low. Educational status, previous obstetric history and being counseled on BPCR were among the factors found to significantly associated with preparedness (23).

An institution based cross-sectional study done in Dilchora referral hospital of Dire dawa town on determinants of BPCR revealed that 54.7% of mothers were well prepared and higher educational status and knowledge about obstetric danger signs were associated with it (24).

There were another three community based cross-sectional studies conducted in different parts of Ethiopia. These were in Adigrat, Jimma, and Basolin districtin Amhara region. In these studies 22%, 23.3%, and 26.9% of mothers were found to be well prepared respectively. Socio-economic characteristics, parity, previous obstetric history, being counseled on BPCR, antenatal care utilization, and place of residence were associated with BPCR (25-27).



Source: adapted from Thaddeus & Maine, 1994 and modified with literature review

Figure 1: Conceptual framework for factors associated with delayed presentation of laboring mothers in public health centers of Addis Ababa, Ethiopia, 2017

3. Objective

3.1 General objective

-To assess Patterns of admission of laboring mothers and the association between birth preparedness and delayed presentation in public health centers of Addis Ababa, Ethiopia, 2016/2017

3.2 Specific objective

- To determine the time of presentation of laboring mothers during labor in public health centers of Addis Ababa, 2017
- To assess the magnitude of birth preparedness among laboring mothers in public health centers of Addis Ababa, 2017
- To measure the association between birth preparedness and delayed presentation of laboring mothers in public health centers of Addis Ababa, 2017

4. Method

4.1 Study setting and period

The study was conducted from Sep 2016-June 2017 in Addis Ababa which is the capital city of Ethiopia. According to Addis Ababa city administration integrated land information center report Addis Ababa covers an area of 530.14 square kilometers with projected 2017 total population of 3,435,030 (44). The overall health care activity of the city is coordinated by Addis Ababa regional health bureau. There are 52 hospitals: 11 government, 41 private and 90 health centers. From these 6 of the government hospitals and all of the health centers are under Addis Ababa regional health bureau. One public health center is estimated to give service to 40,000 population. Annual number of expected pregnant women is 35,449.

As this study aimed to look at the time of presentation of mothers to health facility during labor, Addis Ababa is selected as a study site because almost all deliveries happen in health facilities (97%).

4.2 Study design

This particular study was conducted using an institution based cross-sectional study design.

4.3 Source population

The source populations for this particular study were all pregnant women in Addis Ababa.

4.4 Study population

The study populations were all pregnant women who came to deliver in public health centers of Addis Ababa.

4.5 Sample size determination

Sample size: was determined using single population proportion formula. It was first calculated for the outcome variable and then for the factors associated with it.

1. $n = \frac{(Z_{\alpha/2})^2 P(1-P) * \text{design effect}}{d^2}$

Where

$$Z_{\alpha/2}=1.96$$

P = 0.2, Magnitude of delayed presentation (12)

95%CI	p	d	Design effect	Sample size
1.96	0.2	0.02	1.5	2304
1.96	0.2	0.03	1.5	1024
1.96	0.2	0.04	1.5	576

Because of resource limitation the third sample size was chosen. When 10% non- response is added, $576 \times 10/100 = 57.6$ the sample size became **634**

$$2. \quad n = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2} \times \text{design effect}$$

Where

$$\alpha = 0.05 \text{ or } Z_{\alpha/2} = 1.96$$

P = 0.56, percentage of mothers who reported were well prepared for birth (23)

$$d = 0.05$$

$$n = \frac{(3.84)(0.56)(1-0.56)}{(0.05)^2} \times 1.5$$

$$n = 567 + 58(\text{NRR})$$

$$n = \mathbf{625}$$

So the larger sample size was taken which is **634**.

Average delivery in one public health center of Addis Ababa was 36 per month and the data collection period was two months so the number of health centers needed to get the sample size were 9 ($634/72 = 8.8 \sim 9$).

4.5 Sampling procedures

Multi-stage sampling was used to find the selected health centers. First five sub-cities were selected from the 10 sub-cities using Simple Random Sampling (SRS) lottery method. Then 10 health centers (HCs) were selected using SRS (lottery method). Nine health centers were enough to get the needed sample size but to make the allocation proportional 2 health center from each sub-city were selected. Sample size for each health centers was calculated using proportion to size calculation based on the number of average deliveries attended per month then systematic random sampling (where the K^{th} interval is 2) was used to get the sample subjects. Average delivery of the three consecutive months before the data collection period was used as a sampling frame to calculate the k value for the systematic random sampling. Health centers with less than 30 deliveries per month were excluded from the study because of logistic limitation.

Kolfe Keraniyo (K/K) Sub-city

AB HC: $n = \frac{634 * 134}{632} = 135$

632

W11 HC: $n = \frac{634 * 74}{632} = 74$

632

Nifas Silk Lafto (N/L) Sub-city

W 2: $n = \frac{634 * 86}{632} = 87$

632

W12: $n = \frac{634 * 48}{632} = 48$

632

Bole Sub-city

Dilfre: $n = \frac{634 * 47}{632} = 47$

632

W17: $n = \frac{634 * 55}{632} = 55$

632

Addis Ketema (AD/K)

AD/K HC: $n = \frac{634 * 60}{632} = 60$

632

W7 HC: $n = \frac{634 * 36}{632} = 36$

632

Gulele Sub-city

Selam HC: $n=\underline{634*53}= 53$

632

Addisu Gebeya (AD/G) HC: $n=\underline{634*39}= 39$

632

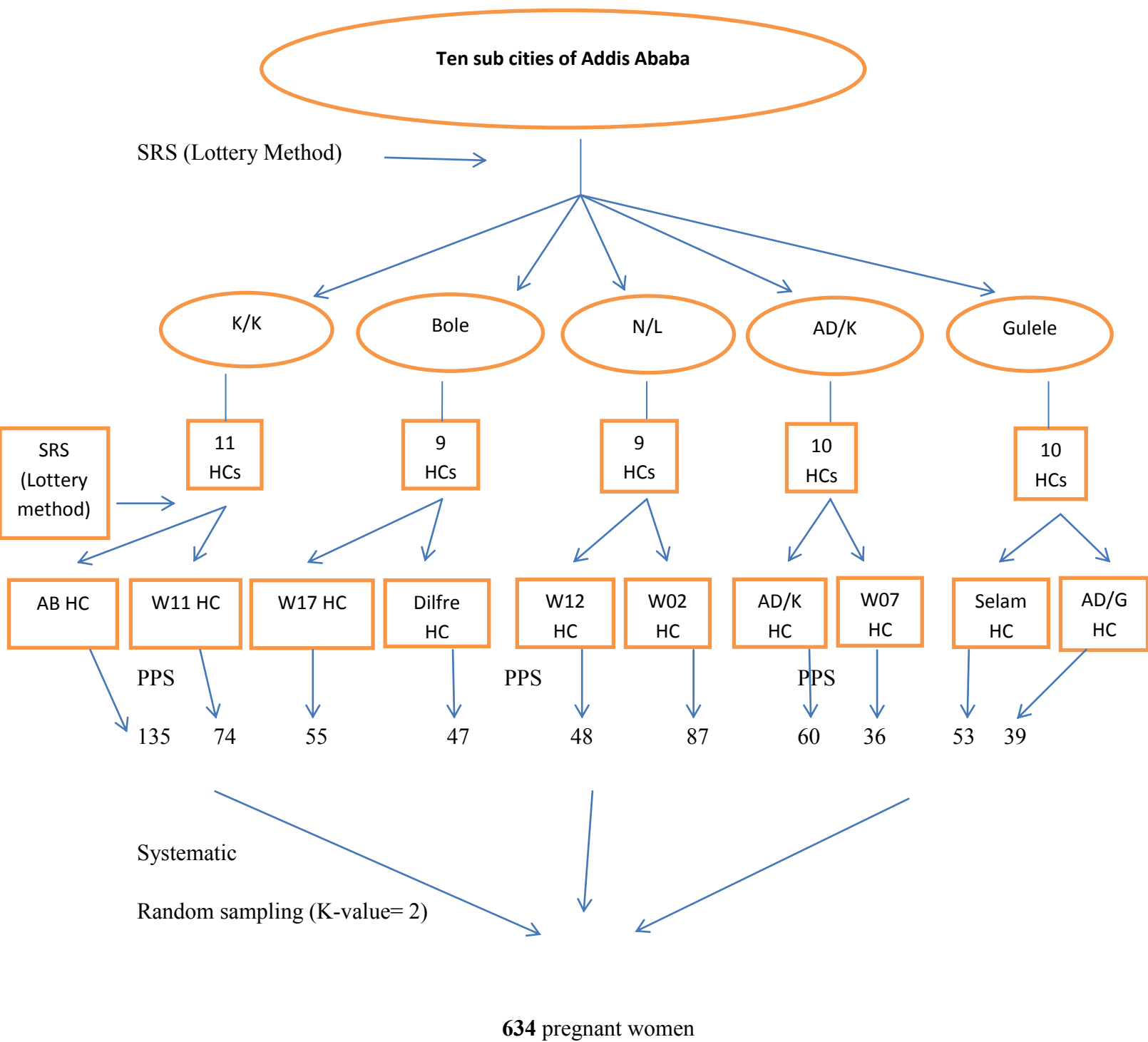


Figure2: Schematic presentation of the sampling procedure used in the study

4.6 Data collection

4.6.1 Data collection tools

Structured questionnaire was used to obtain data from laboring mothers during the study period in the selected health centers of Addis Ababa. Data on socio-demographic characteristics, economic status, obstetric history, perception on maternal health care services, accessibility of delivery service, and status of birth preparedness was collected using an adopted structured questionnaire.

4.6.2 Data collection procedures

The questionnaire was first developed in English and then translated in to Amharic, which was the common language of the study participants. Ten data collectors and 10 supervisors were selected (1 data collector and 1 supervisor) from each health center. One day training was given for all the data collectors and supervisors. The questionnaire was pre-tested among 5% of laboring mothers of the sample size on three of the selected HCs (AB, W11, and W2) in Addis Ababa. Finally, data was collected after correction is done on the questionnaire according to result of the pretest after the women gave birth based on their willingness. The principal investigator went every week to the sampled health centers to check for the progress and to give feedbacks.

Operational definition

- **Delayed presentation:** presentation of laboring mothers to health center during the late active first stage and second stage of labor.
- **Well prepared mothers:** mothers who were prepared for at least four out of the six components of birth preparedness plan used in this study.
- **Not well prepared mothers:** mothers who were not prepared for any one of birth preparedness plan components or prepared for less than or equal to 3 components.
- **Knowledgeable about obstetric danger symptoms:** women who mentioned spontaneously at least two danger symptoms during pregnancy, delivery, and post-partum.

4.7 Data quality assurance

Data quality was assured by using adopted and pretested questionnaire. Pretest was conducted on 5% of the sample population. Data collectors were Midwives working in labor ward having at least 3 years' experience and the supervisors were heads of labor wards of each health centers and checked for data completeness and consistency every day. Furthermore one day training on the purpose of the study, the tool to be used, and data collection procedure was given to the data collectors and supervisors. The supervisors call the principal investigator when they faced a problem or for any misunderstanding. Principal investigator went to the health centers every week to check data completeness and consistency.

4.8 Data analysis

Data editing was carried out regularly through the course of the survey. The collected data was entered in to a computer using EPI data software version 3.1. Then the data was exported to STATA 14 software program for cleaning and analysis.

First cleaning was made by doing frequency tables including missing data. Missing data was recoded if there is a value in the questionnaire. Descriptive results like percentage and frequency distribution of all variables were presented using tables and charts. The dependent variable (delayed presentation during labor) was created by categorizing each woman depending on stage of labor at arrival to the health facility. Women who came during late active first stage and second stage of labor were classified in the delayed category and who came in the latent and early active first stage of labor were classified under early category.

Binary logistic regression model was used to determine the association of each independent variable with the dependent one. 95%CI was used to conclude whether there is statistically significant association between the independent and dependent variable. P-value was used to differentiate variables to be included in the multiple regressions Model. Variables with p-value<0.2 were included in the multiple logistic regression model. Finally the adjusted effect of each independent variable on the dependent variable is presented using odds ratio.

Dependent Variables

- Delayed presentation of laboring mothers

Independent variable

- Birth preparedness

- Socio-demographic/economic characteristics of the woman
- Knowledge about obstetric danger sign and symptoms
- ANC service utilization
- Accessibility of delivery service
- Obstetric history
- perceived quality of Antenatal and delivery care

4.9 Ethical consideration

Final proposal was submitted to School of Public Health Research and Ethics Committee (REC) of Addis Ababa University (AAU) for ethical clearance. After ethical clearance from REC of AAU is secured a formal letter was issued from AARHB and the selected sub-cities to selected health centers to start the data collection. The potential risk and benefit of the study was discussed with the participants and they were included based on their willingness after Verbal informed consent is obtained from each. The participants were clear that they could discontinue the interview at any time and all the information they gave will be kept confidential as names will not be recorded on the form.

4.10 Dissemination of results

The result of this study will be disseminated to College of Health Science School of Public Health of Addis Ababa University, Addis Ababa regional health bureau, and to Federal Ministry of Health. Strong effort will be made to publish the result on peer reviewed journals.

5. Result

5.1 Socio-demographic characteristics

A total of 621 with response rate of 98% laboring mothers were participated in the study. Among all participants 459 (74.2%) mothers were well prepared for birth while 160 (25.8%) were not well prepared. Five hundred thirty (85.5%) and 59(9.5%) of the study participants were in the age group 20-34 years and greater than 35 years respectively. The mean age of respondents was 26.7 years with standard deviation ± 5.15 . Of the well prepared mothers 397 (86.5%) and 47 (10.2%) of them were in the age group 20-34 years and greater than 35 years respectively whereas 131 (82%) and 13 (8%) mothers who were not well prepared were in the age group 20-34 years and more than 35 years. Concerning current marital status, 432 (94.1%) well prepared participants were married while 133 (83.6%) not well prepared mothers were married. Sixty nine (15.0%) participants from the well prepared mothers had attended higher education while 24 (15.1%) not well prepared mothers attended higher education. Three hundred seventy six (81.92%) well prepared respondents and 115 (71.9%) not well prepared mothers decide together with their husband regarding health issues while 36 (7.84%) well prepared mothers and 25 (15.6%) not well prepared mothers decide for themselves.

Table 1. Socio-demographic characteristics of mothers who came to deliver in 10 selected public health centers of Addis Ababa, 2017

characteristics	Well-prepared		X ² (p-value)	
	Yes (n, %)	No (n, %)		
Mother's age (years)				
	< 20	15 (3.3)	16 (10.0)	0.003
	20-34	397 (86.5)	131 (82.0)	
	>35	47 (10.2)	13 (8.0)	
Current Marital Status				
	Married	432 (94.1)	133 (83.6)	0.001
	Unmarried	27 (5.9)	26 (16.4)	
Religion				
	Orthodox Christian	215 (47.1)	81 (51.6)	0.49
	Muslim	182 (39.8)	60 (38.2)	
	Protestant	60 (13.1)	16 (10.2)	
Ethnicity				
	Amhara	121 (26.4)	51 (32.1)	0.23
	Oromo	104 (22.6)	41 (25.8)	
	Tigray	42 (9.2)	17 (10.6)	

	Guraghe	158 (34.4)	40 (25.2)	
	*Others	34 (7.4)	10 (6.3)	
Mother's education				
	No formal education	82 (17.8)	34 (21.4)	0.63
	Primary school	193 (42.1)	68 (42.8)	
	Secondary school	115 (25.1)	33 (20.7)	
	Higher education	69 (15.0)	24 (15.1)	
Mother's occupation				
	Daily laborer	25 (5.5)	22 (13.8)	0.001
	Merchant	84 (18.3)	21 (13.2)	
	Housewife	244 (53.2)	75 (47.2)	
	Employed	102 (22.2)	32 (20.1)	
	**Others	4 (0.8)	9 (5.7)	
Decision maker				
	Woman	36 (7.84)	25 (15.6)	0.009
	Woman and her husband	376 (81.92)	115 (71.9)	
	Others	47 (10.24)	20 (12.5)	

*Others = Silte, Hadiya, Wolayta, and Gamo

**Others = students and no occupation

5.2 Past obstetric history

Out of 621 respondents, 126 (27.5%) well prepared and 56 (35.0%) not well prepared mothers were pregnant for the first time. One hundred three (22.4%) participants from the well prepared mothers and 39 (24.4%) from the non -prepared mothers reported that they had previous history of abortion while 36 (7.8%) well prepared and 11(6.9%) not prepared mothers had a previous history of one or more stillbirth.

Table 2. Past obstetric history of mothers who came to deliver in 10 selected public health centers of Addis Ababa, 2017

Variable	Well-prepared		X ² (p-value)	
	Yes (n, %)	No (n, %)		
Number of pregnancy				
	1	126 (27.5)	56 (35.0)	0.07
	>1	333 (72.5)	104 (65.0)	
Previous history of abortion				
	Yes	103 (22.4)	39 (24.4)	0.61
	No	356 (77.6)	121 (75.6)	
Previous history of stillbirth				
	Yes	36 (7.8)	11(6.9)	0.69
	No	423 (92.2)	149 (93.1)	

5.3 Time of presentation during labor

Out of all participants, 125 (20.4%) came in the latent first stage of labor while 84 (13.6%) came in the second stage. Two hundred ninety (47.1%) mothers were late/delayed to come during labor while 326 (52.9%) came early.

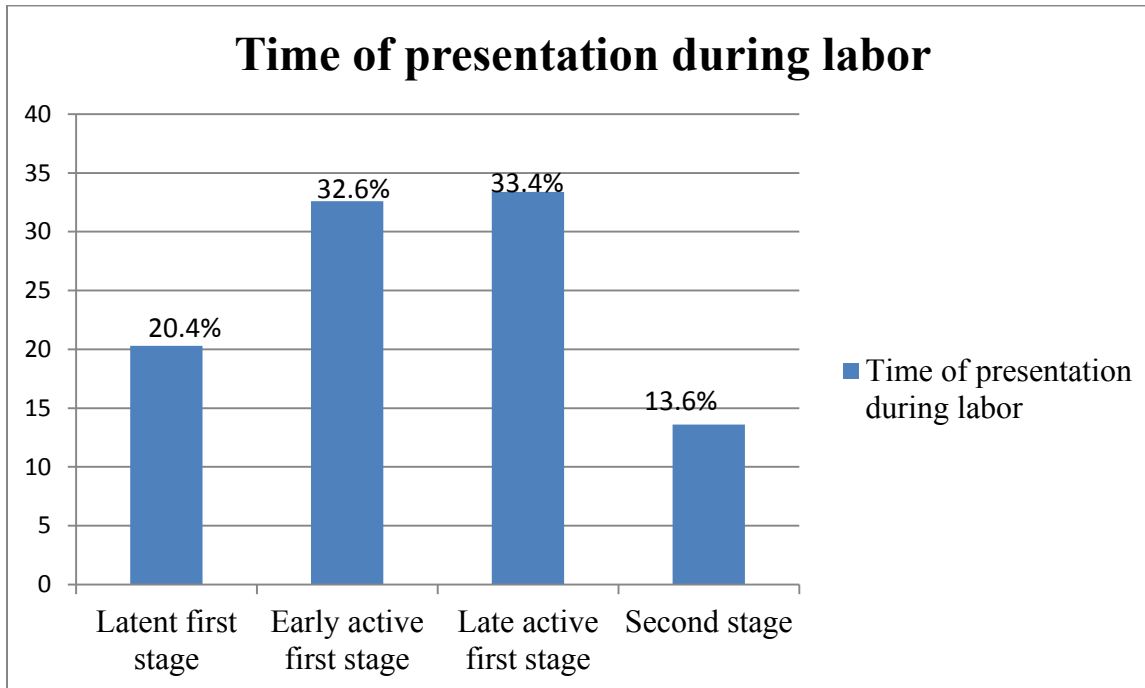


Figure 3. Time of presentation of mothers during labor in 10 selected public health centers of Addis Ababa, 2017

5.4 Experience in current pregnancy

Among well prepared mothers 452 (98.5%) have attended antenatal clinic at least once while it was 130 (81.3%) respondents from mothers who were not well prepared. One hundred sixty eight (37.3%) and 150 (33.3%) well prepared mothers had their first antenatal visit during first trimester and had less than four antenatal visits respectively. Concerning counseling during antenatal visits, 427 (95.7%) well prepared and 109 (86.5%) not well prepared mothers were counseled on place of delivery, 432 (96.4%) well prepared and 89 (68.5%) not well prepared mothers on the benefit of institutional delivery while 428 (95.5%) well prepared and 108 (83.1%) not well prepared mothers were counseled on signs and symptoms of true labor. Among all participants, 347 (76.8%) respondents from well prepared mothers and 84 (64.6%) respondents from not well prepared mothers were satisfied with the care they received during their antenatal visits.

Table 3. Experience of mothers in current pregnancy who delivered in 10 selected public health centers of Addis Ababa, 2017

Variable	Well-prepared		X ² (p-value)	
	Yes (n, %)	No (n, %)		
Antenatal care				
	Yes	452 (98.5)	130 (81.3)	0.001
	No	7 (1.5)	30 (18.7)	
Gestational age at first antenatal care visit (Trimester)				
	First	168 (37.3)	43 (33.1)	0.21
	Second	246 (54.5)	70 (53.8)	
	Third	37 (8.2)	17 (13.1)	
Number of visits				
	<4	150 (33.3)	45 (34.9)	0.74
	>=4	300 (66.7)	84 (65.1)	
Counseling on delivery place				
	Yes	427 (95.7)	109 (86.5)	0.001
	No	19 (4.3)	17 (13.5)	
Counseling on benefit of institutional delivery				
	Yes	432 (96.4)	89 (68.5)	0.001
	No	13 (2.9)	22 (16.9)	
	Don't remember	3 (0.7)	19 (14.6)	
counseling on how to reach health institution during labor				
	Yes	404 (90.2)	72 (55.4)	0.001
	No	18 (4.0)	35 (26.9)	
	Don't remember	26 (5.8)	23 (17.7)	
counseling on danger symptoms of pregnancy				
	Yes	369 (82.4)	98 (75.4)	0.08
	No	39 (8.7)	20 (15.4)	
	Don't remember	40 (8.9)	12 (9.2)	
counseling on signs of true labor				
	Yes	428 (95.5)	108 (83.1)	0.001
	No	12 (2.7)	14 (10.7)	
	Don't remember	8 (1.8)	8 (6.2)	
Perceived quality of ANC				
	Yes	347 (76.8)	84 (64.6)	0.005
	No	105 (23.2)	46 (35.4)	

5.5 Awareness about obstetric danger symptoms

Among all respondents who have ever heard of danger symptoms during pregnancy well prepared mothers account for 385 (83.9%) while not well prepared mothers account for 112 (70%) respondents. Regarding danger symptoms during delivery and post-partum 318 (69.3%) and 321 (69.9%) well prepared mothers were aware respectively.

Table 4. Awareness about obstetric danger symptoms of mothers who delivered in 10 selected public health centers of Addis Ababa, 2017

Variable	Well-prepared		X ² (p-value)
	Yes (n, %)	No (n, %)	
Awareness about danger symptoms during pregnancy	Yes	385 (83.9)	0.001
	No	74 (16.1)	
Awareness about danger symptoms during labor and delivery	Yes	318 (69.3)	0.001
	No	141 (30.7)	
Awareness about danger symptoms during post-partum	Yes	321 (69.9)	0.001
	No	138 (30.1)	
Knowledge about obstetric danger sign	Knowledgeable	236 (58.4)	0.007
	Not knowledgeable	168 (41.6)	

5.5 Experience in current labor and delivery

Among all participants 298 (48%) of them were satisfied with the care they received during their current delivery. Well prepared mothers who were satisfied with the delivery care they received were 254 (55.3%) while only 44 (27.5%) not well prepared mothers were satisfied. Seventy (15.3%) and 406 (89%) well prepared mothers came on foot during labor and it took them less than 30mins to reach to the health facility respectively.

Table 5. Experience in current labor and delivery of mothers who delivered in 10 selected public health centers of Addis Ababa, 2017

Variable	Well-prepared		X ² (p-value)
	Yes (n, %)	No (n, %)	
Perceived quality of delivery care			
Yes	254 (55.3)	44 (27.5)	0.001
No	205 (44.7)	116 (72.5)	
Transport during labor			
By foot	70 (15.3)	34 (21.4)	0.14
Car (paid)	298 (65.1)	91(57.2)	
Car (free)	90 (19.6)	34 (21.4)	
Time			
≤30min	406 (89.0)	139 (89.1)	0.98
>30	50 (11.0)	17 (10.9)	

Among all well prepared mothers 206 (45.3%) of them come late/delayed during labor whereas 84 (52.8%) mothers who were not well prepared come delayed.

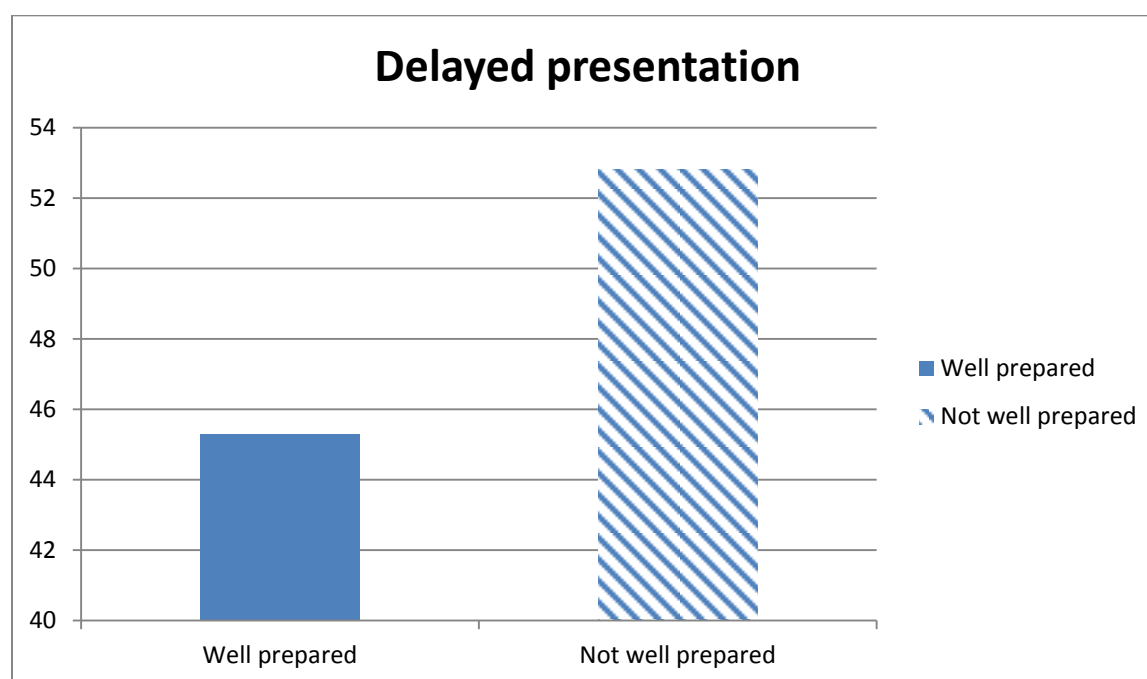


Figure 4. Time of presentation during labor and level of birth preparedness of mothers who delivered in 10 selected public health centers of Addis Ababa

5.6 Bivariate and Multivariate analysis

Binary logistic regression was done to see the association of each independent variable with the outcome variable. Age group of 20-34years (COR= 3.65:1.47, 9.03) and more than 35years (COR=8.12:2.87, 23.02) were found to be associated with the outcome variable. Moreover number of pregnancy (COR=2.54:1.76, 3.66), having previous history of still birth (OR=2.32:1.24, 4.33), first antenatal care visit in second trimester (COR=1.51:1.06, 2.15) and third (COR=3.06:1.63, 5.74), having antenatal care visits less than four times (OR=2.09:1.47, 2.97) , being not satisfied with antenatal care (COR=1.84:1.26, 2.68), and awareness about danger symptoms of post-partum (COR=1.8:1.26, 2.68) were found to be associated with the outcome variable.

Variables having p-value<0.2 and found to be important factors in other literatures were included in the multiple logistic regression model. After the regression model is done variables which have significant association with delayed presentation were age, number of pregnancy, awareness about danger symptoms of post-partum, number of antenatal visits. The multiple regression analysis also revealed that Birth preparedness has significant association with delayed presentation.

Mothers who were in the age group 20-34years (AOR=6.76:1.41,32.36) and above 35 (AOR=11.47:2.13,61) were 6.76 and 11.47 times more likely to come delayed during labor when compared to mothers less than 20 years of age. Mothers who were pregnant at least for their second time were 2.14 times more likely to come delayed (AOR=2.14:1.36, 3.36) compared to mothers pregnant for their first time. Delayed presentation during labor was also higher in mothers who had less than four antenatal visits (AOR=1.8:1.15, 2.78) when compared to mothers who had four or more. Mothers who were aware of post-partum danger symptoms were 2.1 (AOR=2.1:1.28, 2.54) times more likely to come delayed compared to mothers who have never heard of it. Women who were not well prepared were 1.63 (AOR=1.63: 1.04, 2.56) times more likely to come delayed than women who were well prepared.

Table 6. Bivariate and multivariate analysis of independent and dependent variables included in the study

characteristics	Delayed presentation		COR(95%CI)	AOR(95%CI)
	Yes (n, %)	No (n, %)		
Mother's age (years)				
< 20 years	6 (19.35)	25 (80.65)	1.0	
20-34 years	245 (46.67)	280 (53.33)	3.65[1.47,9.03]	6.76 [1.41,32.36]
>35years	39(66.1)	20 (33.9)	8.12[2.87,23.02]	11.47[2.13,61]
Current Marital Status				
married	266 (47.33)	296 (52.38)	1.0	
unmarried	24(45.28)	29 (52.67)	0.92[0.52,1.62]	1.33 [0.29,5.92]
Ethnicity				
Amhara	76 (44.19)	96 (55.81)	1.0	
Oromo	57 (39.58)	87 (60.42)	0.83[0.53,1.29]	0.69[0.41,1.16]
Tigray	32 (53.33)	28 (46.67)	1.44[0.80,2.60]	1.09[0.56,2.14]
Guraghe	101 (51.53)	95 (48.47)	1.34[0.89,2.03]	1.04[0.63,1.72]
others	24 (55.81)	19 (44.19)	1.59[0.81,3.13]	1.32[0.54,3.22]
Mother's education				
illiterate	60 (52.17)	55 (47.83)	1.32[0.76,2.29]	1.2[0.59,2.43]
Primary school	123 (47.49)	136 (52.51)	1.09[0.68,1.77]	1.05[0.59,1.85]
secondary school	65 (43.92)	83 (56.08)	0.95[0.56,1.60]	0.88[0.48,1.61]
Higher education	42 (45.16)	51 (54.84)	1.0	
Decision maker				
Woman	27 (44.26)	34 (55.74)	1.0	
Woman and my husband	223 (45.79)	264 (54.21)	1.06[0.62,1.82]	0.99[0.25, 3.83]
others	40 (58.82)	28 (41.18)	1.79[0.89,3.62]	2.5[0.59,10.74]
Number of pregnancy				
1	57 (31.32)	125 (68.68)	1.0	
>1	233 (53.69)	201 (46.31)	2.54[1.76,3.66]	2.14[1.36,3.36]

Gestational age at first antenatal visit					
	First trimester	83 (39.52)	127 (60.48)	1.0	
	Second trimester	156 (49.68)	158 (50.32)	1.51[1.06,2.15]	1.26[0.83,1.90]
	Third trimester	36(66.67)	18 (33.33)	3.06 [1.63,5.74]	1.46[0.67,3.18]
Number of visits					
	<4	116 (59.49)	79 (40.51)	2.09[1.47,2.97]	1.8[1.17,2.80]
	>=4	157 (41.21)	224 (58.79)	1.0	
Perceived quality of ANC					
	Yes	187 (43.59)	242 (56.41)	1.0	
	No	88 (58.67)	62 (41.33)	1.84[1.26,2.68]	1.39 [0.91,2.13]
Awareness about danger symptoms during delivery					
	Yes	201 (50.5)	197 (49.5)	1.0	
	No	89 (40.83)	129 (59.17)	0.68[0.48,0.95]	1.16[0.71,1.09]
Awareness about danger symptoms during post-partum					
	Yes	212 (51.96)	196 (48.04)	11.8[1.28, 2.54]	2.1[1.28,2.54]
	No	78 (37.5)	130 (62.5)	1.0	
Birth preparedness					
	Well prepared	147 (43.75)	189 (56.25)	1.0	
	Not well prepared	143 (51.44)	135 (48.56)	1.35[0.94,1.94]	1.63[1.04,2.56]

6. Discussion

This study revealed that 47% of women came delayed to health facility during labor. This delayed presentation was found to have significant association with age of the woman, number of pregnancies, number of antenatal visits, and awareness about danger symptoms of post-partum. Significant association was also found between birth preparedness and delayed presentation.

Nearly half of the studied women delayed in this study and this finding is inconsistent with results reported from case control studies in Nigeria 7.9% (cases=150 controls=300) and 25.3% (both cases and controls=140) (30, 31) and even the 20% reported from a case control (148 cases and 296 controls) study in two teaching hospitals of Addis Ababa (12). This difference is may be due to the difference in classification because in this study mothers who came during late active first stage or second stage of labor were considered as delayed while the other studies classified mothers as delayed if they presented only during second stage of labor.

In this study, about three fourth of mothers were well prepared. This finding is almost similar with a finding from a cross-sectional study from Kenya (n=149) (43) but much higher when compared to findings from cross-sectional studies in Federal Police Hospital Addis Ababa (56.3%, n=224), Adama (29.1%,n=642), and Diredawa (54.7%, n=391) (22-24). The finding from this study was also more than three times higher from three community based cross-sectional studies conducted in different parts of Ethiopia. These were in Adigrat, Jimma, and Basolin district in Amhara region. In these studies 22%, 23.3%, and 26.9% of mothers were found to be well prepared respectively. This difference could be attributed to the fact that this study is conducted in the center of the country where access to healthcare is better and might be due to difference in the study setting.

Birth preparedness is found to have an association with delayed presentation during labor in this study. This is women who were not well prepared were more likely to come delayed compared to well-prepared women. This finding is similar with finding in Kenya from a qualitative study that lack of birth preparedness was one reason for delayed presentation during labor (39).

This implies that being prepared for birth will help a mother to come early during labor because she planned how to overcome the common challenges that could pullback a woman from

accessing timely care. So working on strengthening birth preparedness counseling and ensuring that a woman is prepared for birth will be a crucial thing to minimize late presentation during labor.

Multigravida mothers were found to be more likely to come delayed compared to primigravida women. This finding is consistent with studies done at Benin City in Nigeria and also a maternity hospital in Kathmandu (30, 33). This delay could be contributed by the thought that they are experienced so can take their time home and come when the labor progress. Age was also found to be significantly associated with delayed presentation during labor. This is woman in the age group 20-34 and above 35 years were more likely to come delayed during labor than women at early age group (<20yrs). This might occur because majority of the older women in this study were pregnant for their second time and more. And this result is consistent with a study conducted in Bahar dar, Ethiopia where women in the age group 20-34 and above 35 years were more likely to come delayed compared to women less than 20 years (40).

Concerning the relationship between number of antenatal visits and delayed presentation during labor this study revealed that women who had less antenatal visits (<4) were more likely to come delayed in labor. This result is consistent with a finding from a maternity hospital in Kathmandu (33). This indicates poor antenatal attendance may therefore predict late arrival in labour. So having the recommended number of antenatal visits might enable woman to come early as the women could have a better chance to get counseling service.

Mothers who are aware of danger symptoms of post- partum were more likely to come delayed during labor when compared to woman who have never heard of it. This could be due to the fact that women who were aware of post -partum danger symptoms were more of (76%) in the multigravida category in this study who did not consider themselves risk for having complication.

Perceived quality of delivery care is one of the reasons that hinder women from seeking timely care during labor and delivery (10, 36). In this study it is found that less than half of the participants were found to have good perception on the delivery care they got from the facility they currently gave birth. Most of the women were satisfied with the structure and cleanliness of the overall environment but their problem was mostly on staff's attitude and inadequacy of the

information they got during labor about labor condition, procedures to be done, and pain management. This might have an implication that there will be a chance that a woman prefers to stay at home till the labor progresses well because there is a better environment at home where there could be many others who feel her pain and treat her with empathy. So these women may have a greater chance to come delayed during their future pregnancy.

Limitation of the study

- Estimation of cervical dilation is done with different individuals as this study is conducted in a number of health centers. The estimated dilatation could differ from person to person. But we tried to select the data collectors and supervisors which have more experiences working in labor ward and made the data collectors and supervisors to evaluate the woman on her arrival if they are available at the time.
- The data collectors and supervisors were health care providers working in labor wards of the studied health centers. So they could introduce information bias.
- As this study is a facility based it could not be generalized to the general population.
- The other thing is woman who gave birth in private clinics were also not included in this study.

7. Conclusion

Delayed presentation during labor was found to be high where nearly half of the study participants came delayed. Twenty and 13.6% of mothers came in latent first stage and second stage of labor respectively. Concerning birth preparedness three fourth of the participants were well prepared. Women at older age, multigravida women, women having less than the recommended number of antenatal visits, and aware of danger symptoms of post-partum were the one who were more likely to come late during labor. Birth preparedness was also found to have an independent effect on the time of presentation of mothers during labor. This is women who were well prepared were more likely to come delayed.

8. Recommendations

- The health care providers working in Antenatal department of public health centers of Addis Ababa should focus on counseling all pregnant women attending their antenatal care visits in public health centers on the benefit of early presentation during labor and the consequences of being delayed.
- The health care providers working in Antenatal department should focus on counseling every woman particularly multigravida with emphasis that complication could occur any time especially during labor and delivery. Should also counsel and encourage women to have at least the recommended number of antenatal visits.
- Health care providers working on maternal health departments in public health centers of Addis Ababa should strengthen counseling on birth preparedness.
- Further studies are recommended including women referred to hospitals because of obstetric complication and delivering in private clinics. Also other studies are recommended to look on the consequences of delayed presentation with respect to the level of birth preparedness.

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Annex 1: English version

PARTICIPANT INFORMATION SHEET

Dear Participants

My name isI am here on the behalf of Retina Mamo who is a masters student in Addis Ababa university school of public health in department of Reproductive health. She is working her thesis on Patterns of admission of laboring mothers and the effect of birth preparedness and complication readiness on delayed presentation during labor in public health centers of Addis Ababa. Prior to this I will be explaining information about the study and requesting you to participate in the study.

Purpose: To assess the Patterns of admission of laboring mothers and the effect of birth preparedness and complication readiness on delayed presentation during labor.

Benefit: This study will benefit all pregnant women and their families in terms of getting evidence based intervention and the result of this study will be used by policy makers.

Harm: This study will take some of your time and may not be easy for you to answer because the interview will take place within few hours after your delivery.

Confidentiality and right of participant: Without permission from you and legal body, any part of this study will not be disclosed to third person. You are not expected to give your name. Your participation in this research is voluntary. You have full right to refuse to a question that you don't want to answer and withdraw from the participation at any time if you don't wish to continue. There will not be any negative consequence and benefit because of participating and not participating on the study. However your participation on this study is very important for achievement of the study. We hope you will participate in the study for the sake of the benefit of the research result.

Duration of the interview – This interview will take approximately 15 – 20 minutes.

Are you willing to participate on the study? Yes----- No-----

Address: Cell phone +251919264517 Email: retimamo@gmail.com

Questionnaire for assessment of Patterns of admission of laboring mothers and the effect of birth preparedness and complication readiness on delayed presentation in public health centers of Addis Ababa.

Part I. Socio- demographic characteristics

S. No	Questions	Coding categories	Skip to	Remark
101	Age in completed years?	_____		Write in numbers
102	What is your current marital status?	1. Married 2. Cohabiting 3. Divorced/Separated 4. Widowed 5. Never married		
103	What is your ethnicity?	1. Amhara 2. Oromo 3. Tigray 4. Guraghe 5. Other (Specify)_____		
104	What is your religion?	1. Orthodox 2. Muslim 3. Protestant 4. Other(Specify) _____		
105	What is the highest level of education you have attended?	1. Illiterate 2. Primary (1-8 grades) 3. Secondary (9-12 grades) 4. Higher education		
106	What is the highest level of education your husband has attended?	1. Illiterate 2. Primary(1-8 grades)		

		3.Secondary (9-12 grades) 4. Higher education		
107	What is your occupation?	1. Daily laborer 2. Merchant 3. Housewife 4. Employed 5.Other(specify) _____		
108	What is your husband's occupation?	1. Daily laborer 2. Merchant 3. Employed 4.Other(specify) _____		
109	About how much is your family average income per month in monetary terms (Household)?	_____		Write in numbers
110	Who decides about health issues in your house?	1. My husband 2. Me 3. We decide together 4. My family 5. His family		
Part II. Past Obstetric History				
201	Number of total pregnancies in lifetime? (includes Abortion, still birth, live birth)	-----		Write in numbers
202	How many times have you given birth in your life time?	-----		A pregnancy which reached 7 months or more will be regarded as a delivery
203	Number of children alive now?	-----		Write in numbers

204	Do you have any history of abortion?	1. Yes 2. No		
205	Do you have any history of stillbirth?	1. Yes 2. No		
Part III. Experience In Current Pregnancy and perceived quality of ANC				
Instruction: now I am going to ask you about your perception on the ANC you get from this facility, please be free to answer whatever you feel about the service and you have to know that the care that you will get from now on will not depend on your answer.				
301	Cervical dilatation on admission	-----		Write in cm
302	Stage of labor	1. Latent first stage(up to 3cm) 2. Early active (3-5cm) 3. Late active (6-9cm) 4. Second stage		It is considered early active if the following criteria are fulfilled -cervix is 3-5cm dilated, -100% effaced and -contraction comes 3-5 times per 10 min and each lasts for at least 40 seconds
303	Did you attend antenatal clinic during this pregnancy?	1. Yes 2. No	If No go to part 4	
304	How many times did you attend clinic during this			Write in

	pregnancy?	-----		numbers
305	In any of those ANC visits did you get an opportunity to be advised/ counseled on the following:			
	i. Where to deliver	1. Yes 2. No 3. Don't remember		
	ii. Benefits of delivering at the health facility/hospital	1. Yes 2. No 3. Don't remember		
	iii. How to reach the health facility when labor starts	1. Yes 2. No 3. Don't remember		
	v. Danger symptoms during pregnancy	1. Yes 2. No 3. Don't remember		
	vi. Signs of true labor	1. Yes 2. No 3. Don't remember		
306	During the ANC visits were you alerted by health care providers that you have a danger signs of pregnancy?	1. Yes 2. No	If No go to Q 309	
307	Which signs were you alerted that you have?	_____		Write in names
308	Did your health care provider tell you that you had a medical problem during your pregnancy?	1. Yes 2. No	If No go to Q 311	
309	What was the medical problem he told you that you had?	-----		Write in names
310	Do you think the entire information you get during your ANC visits was adequate?	1. Yes 2. No		

311	Did the health professional seem willing to answer any questions you may have had?	1. Yes 2. No		
312	How long did you usually have to wait before seeing your provider?	1. Less than 15 minutes 2. 15-30 min 3. 30min-1hr 4. More than 1hr		
313	Were you satisfied with the time you usually had to wait to be seen?	1. Yes 2. No		
314	Were you satisfied with the amount of privacy and confidentiality you were offered during your visits?	1. Yes 2. No		
315	Did any staff or attendant speak to you in a way that upset you? (e.g. shouting, using abusive language etc)	1. Yes 2. No		
316	Did you feel comfortable/free to discuss all your concerns with your attendant?	1. Yes 2. No		
Part IV. Knowledge On Obstetric Danger Signs				
401	Have you ever heard about danger symptoms during pregnancy?	1. Yes 2. No	If No go to Q 403	
402	What danger symptoms do you know that occur during pregnancy? (multiple answer is possible)			First ask the woman to answer spontaneously Then read the alternatives for her
	I. Woman mentioned spontaneously	1. Vaginal bleeding 2. Convulsions 3. Headache with blurred vision 4. Abdominal pain 5. Reduced fetal		

		<p>movement</p> <p>6. Fever and Too weak to get out of bed</p> <p>7. Fast or difficulty in breathing</p> <p>8.Swellingof fingers, face and legs</p> <p>9. Leakage of fluid per vagina</p> <p>10. Woman mentioned none of the above</p>		
	<p>II. Woman mentioned after options are read for her</p>	<p>1. Vaginal bleeding</p> <p>2. Convulsions</p> <p>3.Headache with blurred vision</p> <p>4. Abdominal pain</p> <p>5.Reduced fetal movement</p> <p>6. Fever and Too weak to get out of bed</p> <p>7. Fast or difficulty in breathing</p> <p>8.Swellingof fingers, face and legs</p> <p>9. Leakage of fluid per vagina</p> <p>10. Woman know none of the above</p>		
403	<p>Have you ever heard about danger symptoms during child birth?</p>	<p>1. Yes</p> <p>2. No</p>	<p>If No go to</p>	

			Q 405	
404	What danger symptoms do you know that occur during child birth?(multiple answer is possible)			First ask the woman to answer spontaneously Then read the alternatives for her
	I. Woman mentioned spontaneously	1. Severe vaginal bleeding 2. Waters break and not in labour after 6 hours 3. Placenta not expelled 1 hour after birth of the baby 4. Prolonged (>12 hours) labor 5. Woman mentioned none of the above		
	II. Woman mentioned after options are read for her	1. Severe vaginal bleeding 2. Waters break and not in labour after 6 hours 3. Placenta not expelled 1 hour after birth of the baby 4. Prolonged (>12 hours) labor 5. Woman know none of the above		
405	Have you ever heard about danger symptoms after child birth?	1. Yes 2. No	If No go to part 5	

406	What danger symptoms do you know that occur after child birth? (multiple answer is possible)			First ask the woman to answer spontaneously Then read the alternatives for her
	I. Woman mentioned spontaneously	<ul style="list-style-type: none"> 1. Heavy/severe vaginal bleeding 2. Headache with blurred vision. 3. Fast or difficult breathing. 3.Bad smelling vaginal discharge 4. Fever and too weak to get out of bed. 5. Painful urination 6. Hot, swollen, painful breasts 7. Woman mentioned none of the above 		
	II. Woman mentioned after options are read for her	<ul style="list-style-type: none"> 1. Heavy/severe vaginal bleeding 2. Headache with blurred vision. 3. Fast or difficult breathing. 3.Bad smelling vaginal discharge 4. Fever and too weak to 		

		get out of bed. 5. Painful urination 6. Hot, swollen, painful breasts 7. Woman know none of the above		
--	--	--	--	--

Part V. Birth preparedness and complication readiness

501	Were you prepared for the following components during this pregnancy:			
	i. Identified place of delivery	1. Yes 2. No		
	ii. Identified birth attendant	1. Yes 2. No		
	iii. Arranged transportation	1. Yes 2. No		
	iv. Saved money	1. Yes 2. No		
	v. Have a person accompanying during labor	1. Yes 2. No		
	Vi. Arrange a person who could take care of the house and children while the mother is away	1. Yes 2. No		

Part VI. Perceived quality of Delivery Service

Instruction: now I am going to ask you about your perception on the delivery service you get from this facility, please be free to answer whatever you feel about the service and you have to know that the care that you will get from now on will not depend on your answer.

601	Do you think the structure of the facility is well maintained (Delivery Room)?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
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602	Are toilets clean for patient use?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
603	Is there a clean bed and delivery table in the labor/delivery room?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
604	Were you made to feel comfortable by all the staff or attendant who was attending your delivery?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
605	Did your birth attendant communicate with you about:			
	i. Progress of your labor?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
	ii. Procedures he/she needed to do?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
	iii. Pain management?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		

606	Do you think the entire information was adequate to your needs?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
607	Was your birth attendant or other staffs willing to answer your questions?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
608	Were you satisfied with the amount of privacy you were offered?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
609	Did any staff or attendant speak to you in a way that upset you? (e.g. shouting, using abusive language etc)	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
610	Did you feel comfortable/free to discuss all your concerns with your attendant?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		
611	Do you think the staff/birth attendant spend enough time with you during your labor?	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree		

Part VII. Accessibility of the health facility

701	How did you get to this facility when your labor starts	1. On foot 2. By vehicle (paid) 3. By vehicle (free)		
702	How long did it take you to reach this facility?	----- min		

Thank you for your participation

Checked by:

Supervisor name -----signature-----date-----

Annex 2: Amharic Version

አዲስ አበባ ዩኒቨርሲቲ

ህክምና እና ጤና ሳይንስ ኮሌጅ

የማህበረሰብ ጤና ትምህርት ቤት

የጥናቱ መግለጫ የአማርኛ ቅፅ

መግቢያ:- ጤና ይስጥልኝ እንደምን አሉ? እኔ..... እባላለሁ:: እዚህ የመጣሁት ይህንን ጥናት የሚያካሄድ የአዲስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ የሕብረተሰብ ጤና ትምህርት ቤት የስነ ተዋልዶ ትምህርት ክፍል የድህረ ምረቃ ተማሪ የሆነችውን ረቲና ማምን ወክዬ ነው :: ጥናቱ ወላድ እናቶች በወሊድ ሰአት የሚመጡበት ጊዜ እና ቅድመ ወሊድ ዝግጅት በወሊድ ወቅት ዘግይቶ መምጣት ላይ ያለው ተጽእኖ ላይ ሲሆን በጥናቱ ላይ ተሳትፎ ለማድረግ ወይም ላለማድረግ እንዲወስኑ በቅድሚያ የተወሰነ መረጃ እንሰጥታለን ::

የጥናቱ አላማ : ወላድ እናቶች በወሊድ ሰአት የሚመጡበት ጊዜና እና ቅድመ ወሊድ ዝግጅት በወሊድ ወቅት ዘግይቶ መምጣት ላይ ያለውን ተጽእኖ ማወቅ

የጥናቱ ጥቅም : ወላድ እናቶች በመረጃ ላይ የተደገፈ አገልግሎት እንዲያገኙ በተጨማሪም ከዚህ ጥናት የሚገኘው ውጤት ለፖሊሲ አርቃቂዎች ይጠቅማል

የጥናቱ ጉዳት: ቃለ መጠይቁ የተሳታፈውን ጥቂት ጊዜ የሚወስድ ሲሆን በተጨማሪም ቃለ መጠይቁ የሚደረገው ከወለዱ በ 6 ሰአታት ውስጥ ስለሆነ ተሳታፊዎን ጥቂት ምቹት ሊነሳ ይችላል:: ግን ተሳታፊው በጥናቱ የሚደርስባቸው ምንም ዓይነት ጉዳት የለም::

ሚስጥራዊነት እና የተሳታፊዎች መብት: ያለ ተሳታፊው እና ያለ ህግ ፈቃድ ማንኛውም መረጃ ለሶስተኛ ወገን አይተላለፍም:: ተሳታፊዎች ስማቸውን እንዲጠቅሱ አይጠበቅም::

ተሳታፊው በዚህ ጥናት ላይ የመሳተፍ ወይም ያለመሳተፍ መብቱ የተጠበቀ ነው:: በመሳተፍ ላይ እያሉ ቃለመጠይቁን በማንኛውም ሰዓት ማቋረጥ ወይም ከጥያቄዎቹ ውስጥ ለመመለስ የማይፈልጉትን ጥያቄ አለመመለስ ይችላሉ::

ተሳታፊው ተሳታፊ በመሆናቸው እና ባለመሆናቸው በቀጥታ የሚያገኙት ጥቅምም ሆነ ጉዳት የለም:: ነገር ግን በእዚህ ጥናት ላይ መሳተፍዎ ለጥናቱ ስኬታማነት ያገለግላል:: ለጥናቱ ውጤታማነት ሲባል በጥናቱ ላይ እንደሚሳተፉ ተስፋ እናደርጋለን::

ቃለ-መጠይቁ የሚወስደው ጊዜ:- ቃለ-መጠይቁ በአማካይ 15-20 ደቂቃ ይወስዳል ::

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት?

አዎ----- አይደለሁም -----

አድራሻ: ስልክ ቁጥር : + 251919264517

ድህረ ገጽ: retimamo@gmail.com

ቃለ መጠይቁን ያረጋገጠው ሱፐርቫይዘር:-

ስም -----

ፊርማ ----- ቀን -----

እናቶች በወሊድ ሰአት የሚመጡበትን ጊዜና ቅድመ ወሊድ ዝግጅት በወሊድ ወቅት ዘግይቶ ከመምጣት ጋር ያለውን ግንኙነት ለማጥናት የተዘጋጀ መጠይቅ

ተ.ቁ	ጥያቄ	ኮድ	ዕለፍ	አስተያየት
1. ተሳታፊዎን የተመለከተ ጥያቄ				
101	ዕድሜ	-----		በቁጥር
102	የጋብቻ ሁኔታ	<ol style="list-style-type: none"> 1. ያገባች 2. ያለጋብቻ አብራ የምትኖር 3. የተፋታች/የተለያየች 4. የሞተባት 5. እስከ አሁን ያላገባች 		
103	ዘር	<ol style="list-style-type: none"> 1. አማራ 2. አሮሞ 3. ትግሬ 4. ጉራጌ 5. ሌላ(ይጠቀስ)----- 		
104	ሀይማኖት	<ol style="list-style-type: none"> 1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ሌላ(ይጠቀስ)----- 		
105	የትምህርት ደረጃ	<ol style="list-style-type: none"> 1. ያልተማረች 2. የመጀመሪያ ደረጃ ት/ት 3. ሁለተኛ ደረጃ ት/ት 4. ከፍተኛ ደረጃ ት/ት 		
106	የባል የትምህርት ደረጃ	<ol style="list-style-type: none"> 1. ያልተማረ 2. የመጀመሪያ ደረጃ 		

		3. ሁለተኛ ደረጃ 4. ከፍተኛ ደረጃ		
107	የስራ ሁኔታ	1. የቀን ስራተኛ 2. ነጋዴ 3. የቤት እመቤት 4. ተቀጣሪ 5. ሌላ(ይጠቀስ)-----		
108	የባል የስራ ሁኔታ	1. የቀን ስራተኛ 2. ነጋዴ 3. ተቀጣሪ 4. ሌላ(ይጠቀስ)		
109	አጠቃላይ የቤተሰብሽ ገቢ በብር ስንት ነው	-----		በቁጥር
110	በቤታችሁ ውስጥ የጤና ጉዳይ በተመለከተ የሚወስነው ማነው?	1. ባሌ 2. እኔ 3. ባሌና እኔ በጋራ 4. የኔ ቤተሰብ 5. የሱ ቤተሰብ		
2. ስነ-ተዋልዶን የተመለከቱ ጥያቄዎች				
201	በአጠቃላይ ስንት ጊዜ አርግዘሻል(በህይወት፣ ሞቶ የተወለደና ውርጃንም ያካትታል)	-----		በቁጥር ይጻፍ
202	በአጠቃላይ ስንት ጊዜ ወልደሻል? (በህይወት፣ ሞቶ የተወለደ)	-----		7 ወርና ከዚያ በላይ የሆነው እርግዝና እንደወሊድ ይቆጠራል
203	አሁን በህይወት ያሉ ልጆች ብዛት	-----		
204	ከዚህ በፊት ውርጃ አጋጥሞሽ ያውቃል?	1. አዎ 2. የለም		

205	ከዚህ በፊት በማህፀንሽ ውስጥ ሞቶ(ጠፍቶ) የተወለደ ህፃን ነበር?	1. አዎ 2. የለም		እርግዝናው 7 ወርና ከዚያ በላይ መሆን አለበት
<p>3. የአሁኑን ዕርግዝና የተመለከቱ ጥያቄዎች</p> <p>አሁን በዚህ እርግዝና ወቅት ባገኘሽው የእርግዝና ክትትል ላይ ያለሽን አመለካከት ጠይቅሻለሁ:: የሚሰማሽን በነጻነት መመለስ ትችያለሽ መልስሽ እዚህ በምታገኘው አገልግሎት ላይ የሚያመጣው ጥሩም ሆነ መጥፎ ተጽዕኖ የለም::</p>				
301	የማህጸን በር ክፍተት	----- ሴ.ሜ		
302	የምጥ ደረጃ	1 ላተንት (እስከ 3ሴ.ሜ) 2 አክቲቭ(3-5 ሴ.ሜ) 3 ሌት አክቲቭ (6-9 ሴ.ሜ) 4 ሰከንድ ስቴጅ		It is considered early active if the following criteria are fulfilled -cervix is 3-5cm dilated, -100% effaced and -contraction comes 3-5 times per 10 min and each lasts for at least 40 seconds
303	በዚህ እርግዝና ወቅት የእርግዝና ክትትል አድርገሽ ነበር?	1. አዎ 2. የለም	መልሱ የለም ከሆነ ወደ ምእራፍ 4 ይሂዱ	
304	ክትትል ስትጀምሪ እርግዝናው ስንት ወር ነበር?	-----		
305	ለክትትል ስንት ጊዜ ወደ ጤና ተቋም ሄደሻል?	-----		በቁጥር ይጻፍ

306	በማናቸውም ለክትትል በሄድሽባቸው ጊዜያት ስለሚከተሉት ጉዳዮች ምክር አግንተሽ ነበር?			
	i. የወሊድ ቦታ	1. አዎ 2. የለም 3. አላስታውስም		
	ii. የጤና ተቋም መወሊድ ያለውን ጥቅም	1. አዎ 2. የለም 3. አላስታውስም		
	iii. ምጥ ሲጅምርሽ ወደ ጤና ተቋም እንዴት መድረስ እንደሚቻል	1. አዎ 2. የለም 3. አላስታውስም		
	iv. በእርግዝና ጊዜ ስለሚከሰቱ አደገኛ ምልክቶች	1. አዎ 2. የለም 3. አላስታውስም		
	v. የእውነተኛ ምጥ ምልክቶች	1. አዎ 2. የለም 3. አላስታውስም		
307	በክትትል ጊዜ የጤና ባለሙያ በእርግዝና ጊዜ የሚከሰት የአደጋ ምልክት አለብሽ ብሎሽ ያውቃል?	1. አዎ 2. የለም	መልሱ የለም ከሆነ ወደ ጥያቄ 309 ይሂዱ	
308	አለብሽ ያለሽ ምልክት ምን ነበር?	-----		
309	በክትትል ጊዜ የጤና ባለሙያ የውስጥ ደቄ ችግር አለብሽ ብሎሽ ነበር?	1. አዎ 2. የለም	መልሱ የለም	

			ከሆነ ወደ ጥያቄ 311 ይሂዱ	
310	አለብሽ ያለሽ ችግር ምን ነበር?	-----		
311	በከትትል ጊዜ ያገኘሽው መረጃ በቂ ነው ብለሽ ታስቢያለሽ?	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም 		
312	ይከታተልሽ የነበረው ጤና ባለሙያ ያሉሽን ጥያቄዎች ለመመለስ ፍቃደኛ ነበር ብለሽ ታስቢያለሽ?	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም 		
313	ለከትትል ስትሄጁ ባለሙያ ለማየት ቢያንስ ለምን ያህል ጊዜ ትጠብቁያለሽ?	<ol style="list-style-type: none"> 1. ከ15 ደቂቃ ያነሰ 2. 15-30 ደቂቃ 3. 30-1 ሰዓት 4. ከ1 ሰዓት በላይ 		
314	ለመታየት በምትቆይው ሰዓት ደስተኛ ነበርሽ?	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም 		
315	በከትትል ጊዜ በምታገኘው ለብቻ የመታየት ነፃነትና ምስጢር ጠባቂነት ደስተኛ ነበርሽ?	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም 		

316	በከትትል ወቅት አንቺን በሚያበሳጭ ወይም በሚያንቋሽሽ መልኩ ተናግሮሽ የሚያውቅ ጤና ባለሙያ አለ?	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም 		
317	የሚሰማሽን ሁሉ ከሚከታተልሽ ጤና ባለሙያ ጋር ለማውራት ይቸግሮሽ ነበር?	<ol style="list-style-type: none"> 1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም 		
4. በእርግዝና፤ ወሊድና ከወሊድ በኋላ ስለሚከሰቱ አደገኛ ምልክቶች ዕውቀት በተመለከተ				
401	ከዚህ በፊት በእርግዝና ጊዜ ስለሚከሰቱ አደገኛ ምልክቶች ሰምተሽ ታውቄያለሽ?	<ol style="list-style-type: none"> 1. አዎ 2. የለም 	መልሱ የለም ከሆነ ወደ ጥያቄ 403 ይለፉ	
402	እነዚህ አደገኛ ምልክቶች ምንምን ናቸው?			በመጀመሪያ ምርጫው ሳይነበብላት የምታውቀውን ትመልስ ከዛ ቀጥሎ ደግሞ ምርጫው ተነበላት የመረጠችው ይሞላል
	I. እናቲቱ በግል የጠቀሰችው	<ol style="list-style-type: none"> 1. ከማህፀን ደም መፍሰስ 2. ማንቀጥቀጥ 3. ራስ ምታትና ብሽታ 4. የሆድ ህመም 5. የልጅ እንቅስቃሴ መቀነስ 6. ቶሎ ቶሎ መተንፈስ ወይም ለመተንፈስ መቸገር 7. ትኩሳትና ከአልጋ ለመነሳት መቸገር 8. የፊት፣የእጅና እግር ማበጥ 		

		<p>9. ከማህፀን ቀጭን ፈሳሽ መፍሰስ (የእንሽርት ውሃ)</p> <p>10. የትኛውንም ምልክት አልጠቀሰችም</p>		
	II. እናቲቱ ምርጫው ተነባላት የጠቀሰችው	<p>1. ከማህፀን ደም መፍሰስ</p> <p>2. ማንቀጥቀጥ</p> <p>3. ራስ ምታትና ብሽጥታ</p> <p>4. የሆድ ህመም</p> <p>5. የልጅ እንቅስቃሴ መቀነስ</p> <p>6. ቶሎ ቶሎ መተንፈስ ወይም ለመተንፈስ መቸገር</p> <p>7. ትኩሳትና ከአልጋ ለመነሳት መቸገር</p> <p>8. የፊት፣የእጅና እግር ማበጥ</p> <p>9. ከማህፀን ቀጭን ፈሳሽ መፍሰስ (የእንሽርት ውሃ)</p> <p>10. የትኛውንም ምልክት አልጠቀሰችም</p>		
403	ከዚህ በፊት በወሊድ ጊዜ ስለሚከሰቱ አደገኛ ምልክቶች ስምተሽ ታውቋል?	<p>1. አዎ</p> <p>2. የለም</p>	<p>መልሱ የለም ከሆነ ወደ ጥያቄ 405 ይለጁ</p>	
404	እነዚህ አደገኛ ምልክቶች ምንምን ናቸው?			<p>በመጀመሪያ ምርጫው ሳይነበብላት የምታውቀውን ትመልስ ከዛ ቀጥሎ ደግሞ ምርጫው ተነባላት የመረጠችው ይሞላል</p>
	I. እናቲቱ በግል የጠቀሰችው	<p>1. ብዛት ያለው ደም ከማህፀን መፍሰስ</p> <p>2. የእንሽርት ውሃ ከፈሰሰ በኋላ በ 6 ሰአት ውስጥ ምጥ አለመጀመር</p>		

		3. የእንግዶ ልጅ ከወሊድ በኋላ በአንድ ሰአት ውስጥ አለመውጣት 4. የምጥ መርዘም (ከ12 ሰዓት በላይ) 5. የትኛውንም ምልክት አልጠቀሰችም		
	II. እናቲቱ ምርጫው ተነቦላት የጠቀሰችው	1. ብዛት ያለው ደም ከማህፀን መፍሰስ 2. የእንሽርት ውሃ ከፈሰሰ በኋላ በ 6 ሰአት ውስጥ ምጥ አለመጀመር 3. የእንግዶ ልጅ ከወሊድ በኋላ በአንድ ሰአት ውስጥ አለመውጣት 4. የምጥ መርዘም (ከ12 ሰዓት በላይ) 5. የትኛውንም ምልክት አልጠቀሰችም		
405	ከዚህ በፊት ከወሊድ በኋላ ስለሚከሰቱ አደገኛ ምልክቶች ስምተሽ ታውቁያለሽ?	1. አዎ 2. የለም	መልሱ የለም ከሆነ ወደ ምእራፍ 5 ይለጩ	
406	እነዚህ አደገኛ ምልክቶች ምንምን ሳቸው?			በመጀመሪያ ምርጫው ሳይነበብላት የምታውቀውን ትመልስ ከዛ ቀጥሎ ደግሞ ምርጫው ተነቦላት የመረጠችው ይሞላል
	I. እናቲቱ በግል የጠቀሰችው	1. ብዛት ያለው ደም ከማህፀን መፍሰስ 2. ራስ ምታትና ብኸታ 3. መጥፎ ሽታ ያለው ከማህፀን የሚወጣ ፈሳሽ 4. ከፍተኛ የሆነ ትኩሳትና ከአልጋ ለመነሳት መቸገር 5. በመሸናት ጊዜ ህመም 6. የጡት ማቃጠል፤ ማበጥና ከፍተኛ ህመም		

		<p>7. ቶሎ ቶሎ መተንፈስ ወይም ለመተንፈስ መቸገር</p> <p>8. የትኛውንም ምልክት አልጠቀሰችም</p>		
	II. እናቲቱ ምርጫው ተነባላች የጠቀሰችው	<p>1. ብዛት ያለው ደም ከማህፀን መፍሰስ</p> <p>2. ራስ ምታትና ብክርታ</p> <p>3. መጥፎ ሽታ ያለው ከማህፀን የሚወጣ ፈሳሽ</p> <p>4. ከፍተኛ የሆነ ትኩሳትና ከአልጋ ለመነሳት መቸገር</p> <p>5. በመሽናት ጊዜ ህመም</p> <p>6. የጡት ማቃጠል፤ ማበጥና ከፍተኛ ህመም</p> <p>7. ቶሎ ቶሎ መተንፈስ ወይም ለመተንፈስ መቸገር</p> <p>8. የትኛውንም ምልክት አልጠቀሰችም</p>		
5. ቅድመ-ወሊድ እና የተወሳሰበ ችግር ዝግጅት				
501	በዚህ እርግዝና ወቅት ቀጥሎ በተዘረዘሩት ነገሮች ላይ ዝግጁ ነበርሽ?			
	1. የሚወልዱበትን ቦታ መምረጥ	<p>1. አዎ</p> <p>2. የለም</p>		
	2. ብቃት ያለው የሚያዋልድ ጤና ባለሙያ መምረጥ	<p>1. አዎ</p> <p>2. የለም</p>		
	3. ትራንስፖርት ማዘጋጀት	<p>1. አዎ</p> <p>2. የለም</p>		
	4. ብር ማጠራቀም	<p>1. አዎ</p> <p>2. የለም</p>		
	5. በምጥ ጊዜ አብሮ የሚሆን ሰው ማዘጋጀት	<p>1. አዎ</p> <p>2. የለም</p>		

	6. እናት ምጥ ሲይዛትና በምትወልድበት ጊዜ እቤቱንና ትናንሽ ልጆችን የሚንከባከብ ሰው ማዘጋጀት	1. አዎ 2. የለም		
<p>6. የጤና አገልግሎት ጥራት አመለካከትና በምጥና በመውለድ ጊዜ ያለን ልምድ በተመለከተ (በዚህ ወሊድ ወቅት) አሁን በዚህ ወሊድ ወቅት ባገኘሽው የወሊድ አገልግሎት ላይ ያለሽን አመለካከት ጠይቅሻለሁ። የሚሰማሽን በነጻነት መመለስ ትችያለሽ መልስሽ እዚህ በምታገኘው አገልግሎት ላይ የሚያመጣው ጥሩም ሆነ መጥፎ ተጽዕኖ የለም።</p>				
601	የጤና ተቋሙ አጠቃላይ ገፅታ በደንብ የተነገባ ነው ብለሽ ታስቢያለሽ(ማዋለጃ ክፍሉ)?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
602	ሽንት ቤቱ ንፁህ ነው?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
603	አልጋውና ማዋለጃው ንፁህ ነው?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
604	በወሊድ ጊዜ የተከታተሉሽ ወይም አጠቃላይ በዛ ክፍል የሚሰሩ ሰራተኞች ምቹትሽን ጠብቀው ነበር?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
605	የተከታተለሽ ወይም ያዋለደሽ ሰው በሚከተሉት ጉዳዮች ላይ በግል ያናግርሽ ነበር?			
	i. የምጥ ሁኔታ	1. በጣም እስማማለሁ 2. እስማማለሁ		

		3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
	ii. ስለሚሰራቸው ድርጊቶች/ህክምናዎች	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
	iii. ህመም ማስታገሻ	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
606	በአጠቃላይ የተሰጠሽ መረጃ በቂ ነው ብለሽ ታስቢያለሽ?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
607	ያዋለደሽ ጤና ባለሙያና በዛ ክፍል የሚሰሩ ሠራተኞች ጥያቄሽን ለመመለስ ፍቃደኛ ነበሩ?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
608	በወሊድ ጊዜ ባገኘሽው ብቻ የመሆን ነፃነት ደስተኛ ነበርሽ?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
609	በምጥ ወይም ወሊድ ወቅት አንቺን በሚያሰሳጭ ወይም በሚያንቋሽሽ መልኩ	1. በጣም እስማማለሁ 2. እስማማለሁ		

	ተናግሮሽ የሚያውቅ ጤና ባለሙያ አለ?	3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
610	የሚሰማሽን ሁሉ ከሚከታተልሽ ከጤና ባለሙያ ጋር ለማውራት ይቸግሮሽ ነበር?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
611	የተከታተለሽ ወይም ያዋለደሽ ጤና ባለሙያ ካንቺ ጋር በቂ ጊዜ አሳልፏል ብለሽ ታስቢያለሽ?	1. በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አይልም 4. አልስማማም 5. በፍጹም አልስማማም		
7. የጤና ተቋምን ተደራሽነትን በተመለከተ				
701	በዚህ እርግዝና ምጥ ሲጀምርሽ እዚህ ተቋም ለመምጣት የተጠቀምሽዉ ምንድን ነው?	1. በእግር 2. በመኪና(ክፍያ) 3. በመኪና(ነፃ)		
702	እዚህ ለመድረስ ምን ያህል ጊዜ ፈጅብሽ?	-----ደቂቃ		