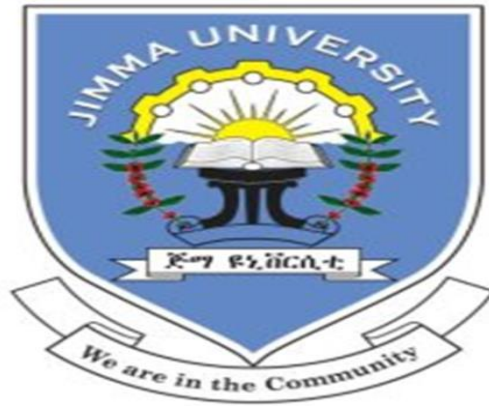


**DELAYS IN UTILIZATION OF INSTITUTIONAL DELIVERY SERVICE
AND ASSOCIATED FACTORS IN YEM SPECIAL WOREDA, SOUTH
WEST ETHIOPIA**



BY: SILESHI GEBREMICHAEL (Bsc)

**A RESEARCH PAPER SUBMITTED TO JIMMA UNIVERSITY COLLEGE
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JIMMA UNIVERSITY

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By: Sileshi Gebremichael

Advisor : Dr.Muluemebet Abera(MPH/RH, PhD)

Mr.Amanuel Tesfay(MPH/RH)

June, 2015

Jimma University

ABSTRACT

Background: Pregnancy and childbirth remain serious life threatening events for many women in low income countries. The death of a woman in child birth signifies far more than the tragic loss of a single life; it can threaten the survival of the whole family, especially the new born baby and other young children. Reducing maternal morbidity and mortality is a global priority which is particularly relevant to developing countries like Ethiopia. One of the key strategies for reducing maternal morbidity and mortality is increasing institutional delivery service utilization of mothers under the care of skilled birth attendants.

Objective: To assess delays in utilizing institutional delivery service and associated factors among women who gave birth at public health facilities in yem special woreda, south west Ethiopia.

Method: A facility based cross sectional study design supplemented with a qualitative method was used. The study was conducted at public health facilities which provide institutional delivery service in yem special woreda from February to April 2015. The sample size was 393 for quantitative study and 8 FGD for qualitative one. Data were coded, edited and entered to epi-data. After cleaning, analysis was done by using SPSS version 16.0. Both binary and multivariate logistic regressions were used to determine the association between dependent and independent variables. Odd ratio along with 95% CI was estimated to measure the strength of association and level of statistical significance was declared at p -value < 0.05 .

Result: A total of 389 women were included into the study. Of this 297 (76.3%) of mother faced delay in utilization of institutional delivery service from health facility. The prevalence of delays to utilize institutional delivery service was 76.3%. The mean (\pm SD) delay time was 5 (\pm 3.07) hours to utilize institutional delivery service. Delay in utilizing institutional delivery service was 2 times higher for those mother influenced by their husband for decision to utilize delivery service (AOR: 2.0(1.09, 3.95)) than those decide by their own for utilizing institutional delivery service, and 7 times higher among mothers who were not being prepared for institutional delivery service utilization (AOR: 7.18 (2.88, 17.85)) than mothers prepared. Women who have three or more children have 3 times more likely higher (AOR: 2.9(1.568, 5.444)) than mother who have two or less children in delay to utilize delivery service. Delay to utilize delivery service was 10 times higher among mother whose household monthly income less than 500 birr (AOR: 10.58(1.74, 64.11)) than whose monthly income greater than one thousand and 2 times higher among illiterate mother (AOR: 1.9 (1.07, 3.47)) than literate mother.

Conclusion:- There is delays in utilizing institutional delivery service in Yem special Woreda and associated with literacy status, occupation, parity, decision making power, birth preparedness, awareness on danger sign of pregnancy and benefit of utilizing institutional delivery service, decision making power, family monthly income and distance from health facility. Parity, not being prepared for birth, family monthly income, husband decision making and literacy status of mother were predictors of delay in utilizing institutional delivery service in the woreda. So it is important to reduce these delays by improving education status, decision making, improving birth preparedness and complication readiness practice of mother and increasing delivery service utilization and promoting early booking and regular visits to ANC service by women.

Key word: Delivery service utilization, Maternal delays, Yem Special woreda, Ethiopia.

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ACRONYMS

CSA- Central Statistical Agency

EDHS – Ethiopian demographic and health survey

EOC – Emergency Obstetric Care

FGD- Focus Group Discussion

FDRE- Federal Democratic Republic of Ethiopia

GSS- Ghana Statistical Service

HC – Health Center

HF – Health Facility

LMIC-Low and Middle Income Countries

MDG- Millennium Development Goal

MMR-Maternal Mortality Ratio

MWHs- Maternal Waiting Homes

PHCU- Primary Health Care Unit

SNNP- Southern Nations, Nationalities and Peoples

SPSS- Statistical Package for Social Sciences

UNFPA- United Nations Population Fund

UNICEF-United Nation International Children Emergency Fund

USAID- United States Agency for International Development

WHO - World Health Organization

CHAPTER-ONE INTRODUCTION

1.1 Background

Maternal mortality is a global problem. But the majority of maternal health complications and deaths occurred in low and middle income countries where three quarters of the deaths are due to direct obstetric complication(1). Institutional delivery service is one of the key and proven interventions to reduce maternal death. It ensures safe birth, reduce both actual and potential complications and maternal death and increase the survival of most mothers and newborns. But most deliveries in developing countries occur at home without skilled birth attendants. According to Ethiopian Demographic and Health Survey 2014 mini report 83.4% delivers take place at home and only 15.4% of delivers nationally and 12.2% in SNNP occur at health facility. Even this limited numbers of facility delivery itself not utilized timely. The reason for not utilizing timely were due to mothers fail on decision making, transportation problem, and not getting timely delivery care at health facility (2).

Many low and middle income countries tried their best to optimize key and effective maternal health interventions to improve maternal health and health facility deliveries. Like other low income countries there is some improvement in Ethiopia now a day in maternal health services including utilization of institutional delivery service. The country is working in expansion of health facility and training medical personnel. They have increased the number of health facility and trained midwives and implemented initiatives such as the health extension program me. The country also tried their best on the implementation of basic and compressive emergency obstetric care and strengthening the referral system. But still the proportion of facility delivery in Ethiopia particularly in SNNP is low and there are delays in utilizing institutional delivery service. Due to this the progress made in reducing maternal deaths was very low and far from the Millennium Development Goal targets.

1.2 Statement of the problem

The place of delivery and its determinants have been on the research agenda for a long time. Birth is an event of great importance in family life (57). Majority of the maternal deaths that occur are avoidable or preventable. An emerging consensus said that, these deaths can be prevented if deliveries are managed by skill attendants and utilized timely. However it has been estimated that only 50% of women in the world have access to such skilled care. Maternal deaths are strongly associated with delays to utilization of institutional delivery service and inadequate medical care at the time of delivery. Several factors have been identified as barriers to early access to skilled care by women especially in developing countries; these include perceived quality of care at health facility, inadequate number of skilled personnel, geographical inaccessibility and financial constraints, decision making power, awareness on danger sign of pregnancy and benefit of utilizing institutional delivery service (58).

A number of socio-demographic characteristics of the individual affect the underlying tendency to seek care in this regard, good examples is education status of mother, which have been examined as determinants of timely delivery care use .The greater confidence and experience of the older and higher parity women, together with greater responsibilities within the household to decision to use care, have been suggested as explanatory factors for their tendency to delay to utilize institutional delivery service. Maternal education (illiteracy) has also been shown to be positively associated with delay in utilization of institutional delivery services (59).

Most obstetric complications occur around the time of delivery and cannot be predicted. Therefore it is important that all pregnant women have access to a skilled attendant, i.e. someone with midwifery skills, who is able to manage a normal delivery and who can recognize and manage obstetric complications, or refer in time if needed.

Recent data show 15.4% of deliveries nationally and 12.2% in SNNP occur at health facility (EDHS MINI). Even this limited number of facility delivery itself not utilized timely. The reason for not utilizing timely were due to mothers fail on decision making, transportation problem, and not getting timely delivery care at health facility (2).

Labor and delivery are the shortest and most critical period during pregnancy and childbirth because most maternal deaths arise from complications during delivery. There is no way to know how quickly one will progress through labor, what complications that may arise, and what emotions one will go through during the process. Some of the complications that arise during child birth can be avoided simply by timely utilization of delivery care from health facility.

But in most cases mother not utilized the service timely due to different factors and this lead to maternal delay in utilization of the delivery service from health facility. Cross-sectional study done in public health facility in Bahir Dar on maternal delays to utilize delivery service shows 37.8% of study participants reported that they faced problem on making decision to seek emergency obstetric care from health facilities, 31.7% of mothers reported that they faced transportation problem to the health institutions for getting emergency obstetric services and 30.7% of mothers reported that they did not get timely the emergency obstetric care.

Even with the best possible antenatal care, it is established that delivery could be complicated and timely utilization of institutional delivery service is essential to safe delivery care. Due to numerous reasons however, many women delays to utilize delivery care, failure to recognize danger signs, poor decision making, transportation cost, the distance to the health facility, and the perceived quality of care thereby barrier to early utilization of the service (5). One of the key strategies for reducing maternal morbidity and mortality is increasing timely utilization of institutional delivery service of mothers under the care of skilled birth attendants. Therefore the aim of this study will be providing information on delay to utilization of institutional delivery services.

1.3 Significance of the study

Timing in utilizing institutional delivery during all births is critical in preventing maternal death and disability and also a key intervention for ensuring safe motherhood. Assessing determinants of delays helps to identify the points at which delays can occur in the management of obstetric complications. Understanding these delays can help the woreda health officials design programmes to address these delays. It is therefore essential to know which factors hinder on time to utilization of institutional delivery service in the woreda.

It is hoped that the provision of such vital information would inform better strategy in the bridging and/or elimination of the barriers that stand in the way of accessing institutional delivery. This would, in turn, contribute significantly to a reduction in pregnancy complications at birth, thereby reducing maternal deaths. Hence, this study was conducted to determine the status of delays and associated factors to utilize institutional delivery service in Yem special woreda, SNNP Regional State, Ethiopia.

CHAPTER –TWO LITERATURE REVIEW

2.1 Literature review

2.1.1 Maternal knowledge and attitudes on obstetric risks and care

The determinants of maternal health and mortality interact to produce a complex set of circumstances that involve clients, communities, the health system, and the government. These dynamics become urgent when a life-threatening obstetric emergency occurs. Recognizing danger signs and deciding to seek care are influenced by a woman's knowledge of pregnancy-related health risks (49). Several studies showed that women who knew risks of pregnancy, warning signs of pregnancy and labor, life threatening birth complications, existence of delivery service at health facilities, and who had positive attitudes towards health facility delivery care had higher probability of using modern health facilities for child birth (50).

A study in India indicated that many women, even if they received antenatal care services at a facility, they preferred to deliver at home in a familiar environment, often with the assistance of someone known to them and feeling that birth is a normal phenomenon that does not need an institutional setting (49). Progress in preventing and seeking care to reduce maternal deaths in rural Africa depends on women's and communities' knowledge and attitudes to maternal health. It has been shown that women individually have little knowledge of maternal health problems (51).

A study in Tanzania indicated women with knowledge of pregnancy risk factors are almost three times more likely to use skilled attendance at birth than those without the knowledge (OR 2.95 (95% CI 1.65-5.25) (31). A study in a semi-urban community of Nigeria found that women and their birth attendants did not seek help promptly because they lacked knowledge of warning signs, believed that supernatural forces caused 13 complications, faced transportation difficulties, and believed that hospitals provided poor care (52).

2.1.2. Delays to utilize institutional delivery service

Maternal delay in utilization of emergency obstetric care is one of the contributing factors for high maternal mortality in developing countries (10). Delay in receiving timely and appropriate care in the event of a pregnancy complication has been put forward as a major determinant in maternal mortality. According to Thaddeus and Maine, Maternal delays were described as having three levels: delay in making decision to seek care, delay in arrival at a health facility, and delay in receiving adequate treatment, which have been named first, second, and third delay maternal delays respectively (11).

The reasons for the first delay may be late recognition of the problem, fear of the hospital or the costs or lack of an available decision maker. ongoing cohort study in Hawassa University Hospital shows cultural barriers, religious influence, male dominance in household decision making, and bad experiences in available health facilities where shown a big delay in the health care seeking among Ethiopian pregnant women(12, 13). As a result of the big delay at home, pregnant women encountered the common life threatening obstetric complications: hemorrhagic, shock, severe anemia, sepsis, generalized peritonitis, obstructed labor, uterine rupture, eclampsia, aspiration pneumonia, coma, severe fetal asphyxia or fetal death.

Once a woman develops any of these clinical conditions, the chance of deteriorating to tertiary level complications (multiple organs failure and death) is very high partly because of the 2nd and 3rd delay. The second delay is usually caused by difficulty in transport and the third delay is often due to difficulty in getting

blood supplies, equipment and operation theatre. Low socio-economic status of women, illiteracy and residing in the rural areas may be the main factors responsible for delays in receiving care during delivery (16).

The first delay in utilization of delivery service stems from a failure to recognize danger signs. This is usually a result of the absence of skilled birth attendants. It may also stem from reluctance within the family or community to send (or allow) women to attend health facilities due to financial or cultural limitations. The second delay is caused by a lack of access to a health facility, a lack of available transport or a lack of knowledge of the existing services. The third delay relates to difficulties in the referral facility (including inadequate equipment or a lack of trained personnel, emergency medicines or blood).

All countries that have reduced maternal mortality have done it through a dramatic increase in hospital deliveries. Therefore, maternal mortality reduction programmers should give priority to the availability, accessibility and quality of obstetric facilities (14). It can be said that the delay due to failure of decision making was related to the procurement of services, whereas the second and the third are related to the offer of services. Strategies to improve maternal health care should contemplate both, offer and demand, due to the multiple origins of causes. However, distance and cost are major obstacles in reaching appropriate obstetric facilities. As a result, the governments of most developing countries are mainly trying to increase access and reduce the second delay.

Maternity waiting homes are one of the strategies most recommended as they are designed to reduce the gap between the community and the health system. MWHs try to reduce delays in treatment by moving women at risk into MWHs located near hospitals. MWHs therefore contribute especially to reducing the third delay in utilization of delivery service stated in the “three delays” model (15).

The three delays model aimed not only to classify in which of these steps maternal complications and deaths took place, but also to explore ways to prevent deaths by minimizing such delays. Evidence shows that almost 20 years later of development of the three delay model of maternal death, the same three delays are still contributing to maternal deaths in low-income countries (4).

According to study done by different researchers poor birth preparedness, distance, institutional delivery not thought as necessary, family influence on the decision making process, unmet needs for community-based care in obstetric emergencies and fear of hospital settings are common factors related to delay in utilization of institutional delivery service. Late and/or poor-quality referral, transport not available and inadequate decisions by husband/relatives have also been associated with the delay. Finally, lack of supplies and staff, poor quality of care and multiple delays due to second referrals have been reported in the literature as part of delay in utilization of institutional delivery service at health facility itself (16, 17). To promote institutional delivery and to prevent unnecessary suffering and deaths, it is important to recognize and understand the factors involved in these delays.

Cross-sectional study done in public health facility in Bahir Dar on maternal delays to utilize delivery service shows 37.8% of study participants reported that they faced problem on making decision to seek emergency obstetric care from health facilities. The mean delay time was 8 hours with a range of 1hour to 48 hours. 31.7% of mothers reported that they faced transportation problem to reach the health institutions for getting emergency obstetric services and they went a minimum three hours walking distance to reach the health care facilities. 30.7% of mothers reported that they did not get timely the emergency obstetric care at health facility.

The mean delay time was 4 hours. With regard to problems at health facility, 49 (12%) mothers reported as long time admission process, 44 (10.3%) lack of supplies and 32 (7.8%) staff work load were reasons for delays at health facility level (2).

A frequent problem cited for delays in reaching appropriate medical facilities in obstetric emergencies is distance. According to the 2011 Ethiopian Demographic and Health Survey study participants, the major barriers for pregnant women to access health services were lack of transport to a facility (71%), lack of money (68%) and distance to a health facility (66%). The most important reason why delay in getting access to health facilities had been a challenge in Ethiopia was because of the very limited number of health facilities and medical personnel availability in the rural areas; the few hospitals nationally available were constructed around the big towns while more than 85% of the population was living in the rural area, but there is some improvement now a days in expansion of health facility and training medical personnel. They have increased the number of trained midwives and implemented initiatives such as the health extension programme (7).

2.1.3. Access to health facility

The location of and long distance to health care facilities, particularly PHCU and district hospitals, and the lack of readily available and affordable means of transport constitute the major physical obstacles for pregnant women wishing to access health care, particularly in rural and mountain areas. It is estimated that 40-60% of people living in developing countries live at a distance of greater than 8 km from a health care facility (18).

Data from the Federal Ministry of Health revealed that coverage of basic health services and infrastructures in Ethiopia have been low and unevenly distributed. Health care coverage is measured by access, i.e. a health facility within a 10 kilometer radius. In 1997/8, it was estimated that only about 45% of the population had access to any type of health facility, with regional variations between 11% and 86%. By the end of 2005, the potential health service coverage had reached to about three-fourths of the population. According to FDRE Ministry of health 2011, Health and Health related indicators report primary health service coverage of Ethiopia was 92% (19). But this improvement does not address the issue of facilities being adequately equipped and staffed to handle emergency obstetric care.

2.1.3. Transport cost

Cost in obtaining transportation is a known deterrent to receiving appropriate care and may approach 25% of the total health care cost, and in some circumstances, far exceeds the direct costs (20).

A study in Nepal found that over half of the families of women who delivered in hospitals had to borrow money for transport (21). Asking for and collecting the money in itself contributes to the delay in definitive treatment. To reduce delay due to transport many low resource countries in which initiatives to provide low cost transportation have been successful in reducing maternal deaths (22). In Mali, the introduction of a maternal referral system which included transportation reduced maternal deaths with the greatest decrease in deaths due to haemorrhage (where time to care is the most critical).

In New Guinea, improving transfer management resulted in a decreased incidence of uterine rupture from 20% to 12%. In Sierra Leone, development of an ambulance service for obstetric emergencies increased the need for the service (23). The importance of transportation cannot be over-emphasized. According to World Bank Strategy, an estimated 75% of maternal deaths could be prevented through timely access to childbirth-related care, facilitated by transport (24).

2.1.4. Birth preparedness/complication readiness

Lack of advance planning for use of a skilled birth attendant for normal births, and particularly inadequate preparation for rapid action in the event of obstetric complications, are well documented factors contributing to delay in receiving skilled obstetric care. Birth Preparedness and Complication Readiness (BP/CR) is a strategy to promote utilization of skilled maternal and neonatal care timely, based on the theory that preparing for childbirth and being ready for complications reduces delays in obtaining this care (25).

In many societies in the world, cultural beliefs and lack of awareness inhibit preparation in advance for delivery and expected baby. Since no action is taken prior to the delivery, the family tries to act only when labor begins. The majority of pregnant women and their families do not know how to recognize the danger signs of complications. When complications occur, the unprepared family will waste a great deal of time in recognizing the problem, getting organized, getting money, finding transport and reaching the appropriate referral facility (26). For some of the complications like severe hemorrhage, a few minutes matter to save life, while for others hours. So Complication Readiness strategy in reducing the maternal and newborn deaths it is not well known in most developing countries including sub-Saharan Africa.

2.1.5. Health service factors and woman's decision making

Factors preventing women in developing countries from seeking life-saving healthcare services they need include: distance from health facilities, cost (fees associated with transportation), multiple demands on a woman's time and women's lack of decision-making power within the family (1) Studies in different developing countries showed that women who live closer to health facilities, who discuss with their partner the place of delivery, and able to pay user fee are more likely to use timely safe delivery service (31, 44). Moreover studies also indicated that lack of transport, poor road condition, poorly staffed or ill equipped institutions with poorly skilled or uncommitted personnel, and the need to secure husband approval were the most common factors that decreased maternal motivation to visit health facilities for care (44-48).

A study in India showed that women would consult family members, usually the head of the household and/or whoever controlled the cash/family finances before seeking care. Approximately half (51.2 percent) of women consulted their husbands, 44.5 percent consulted family members such as their mother-in-law or sister-in-law and 3 percent consulted neighbors and friends. It is not only the woman herself who decides whether to seek professional care or not. In countries like Ethiopia where conservative gender norms prevail, the husband is the one to have the most powerful say even to woman's health care use (7).

According to the qualitative study by Warren (2010), also the decision about the location for the birth is usually made by the husband (or partner). In addition, other extended family members like mother-in-law and sister-in-law might get involved in the decision-making. A few studies were done in our country related to delays and associated factors in utilizing institutional delivery service. Therefore this study provides information on delays to utilize institutional delivery service.

Conceptual framework

The independent variable classified to socio- economic/demographic, accessibility and perceived quality of care while the dependent variable was delays to utilize institutional. The socio-economic variable includes failure to recognize danger sign, decision making power, and poor birth preparedness. Socio-demographic factor include age, parity, occupation and education of mother. Accessibility of facility should be considered

distance, cost of transportation and lack of transportation. Perceived quality of care includes staff availability, supplies and equipment and waiting time to utilize delivery care.

Conceptual framework on factors associated with delay in utilization of institutional Delivery service

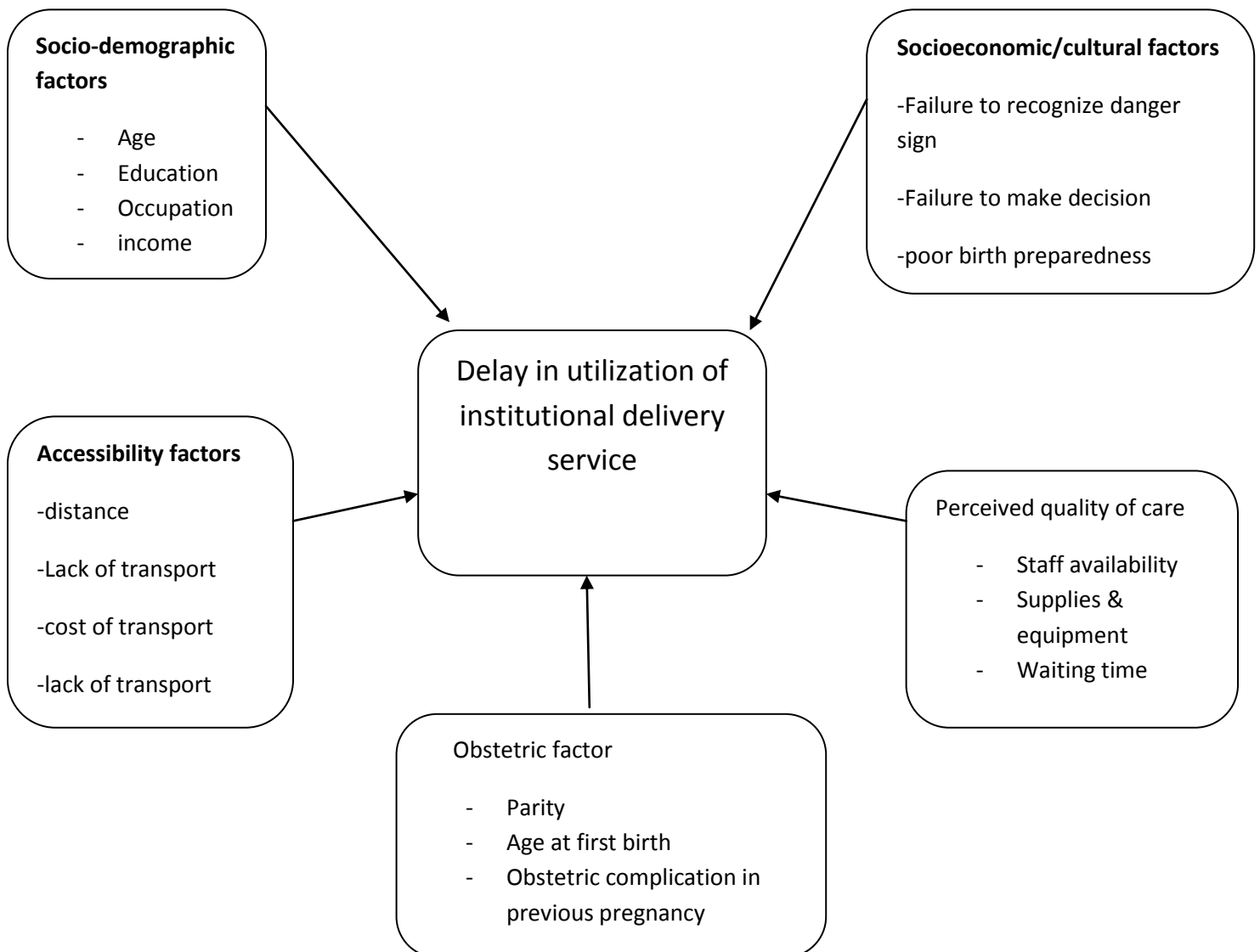


Figure 1 Conceptual framework for delays in utilizing institutional delivery service.

CHAPTER- THREE OBJECTIVES

3.1 General Objective

To assess prevalence of delays in utilizing institutional delivery service and the associated factors among women who gave birth at public health facilities in Yem special woreda, south west Ethiopia, 2015.

3.2 Specific Objectives

1. To determine the prevalence of delays to utilize institutional delivery service.
2. To identify factors associated with delays to utilize institutional delivery service.

CHAPTER-FOUR METHODS AND MATERIALS

4.1 Study area and period

The study was conducted in six health centers which provide institutional delivery service in yem special woreda from February to April 2015. Yem Special Woreda is located 297 kilometres from Addis Ababa in Southwest Ethiopia. According to CSA's population census of 2007, the projected population of the woreda in 2014 is estimated to be 99,714. From these 50,854 is male and 48,860 female (CSA, 2007). The Woreda has 3 towns and 34 kebeles(3 urban and 31 rural). There are six-Health Centres, 27 Health Posts, 2 Preparatory schools, 3 High schools and 14 elementary schools in the Woreda. All of the health centers have telephone services, but only 13kebeles access to mobile network services. There is 27kms all weather and 15kms dry weather road in the woreda. But majority of areas in the woreda are mountainous and having difficult topography.

4.2 Study design

A facility based cross - sectional study design complemented with qualitative inquiry was used.

4.3 Population

For Quantitative Study

4.3.1 Source population

All randomly selected women who came to the six public health center to utilize delivery services.

4.3.2 Study population

Women who utilized delivery service at the six public health centers within the data collection period.

For Qualitative Study

Study population

All purposely selected delivery care service providers such as nurses and health officers who were working at the public health centers and mother who came for utilizing MCH service during the time of data collection.

4.4 Inclusion and Exclusion criteria

Inclusion:

✓ All women getting delivery service in the six public health centers were included.

Exclusion:

✓ All women who were severely sick and unable to respond during data collection period were excluded.

✓ Women who utilized maternal waiting home were excluded.

4.5 Sample size determination and sampling technique

4.5.1 Sample size

For Quantitative Study: The required sample size for the study was determined using a single population proportion formula with the following assumption:

- Degree of error 5%
- Significance level 95%
- Prevalence of First delays in utilizing institutional delivery service 37%(P=0.37) (2)

Sample size determination formula

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

$$n = \frac{(1.96)^2 (0.37) (0.63)}{(0.05)^2} = 358$$

With 10% contingency for non-response the total sample size was 393.

For qualitative study:

A total of 8 FGD were conducted (6 FGD for MCH service users one FGD in each health center and 2 FGD for service providers conducted by selecting two health center from the six by lottery method).

4.5.2 Sampling technique

For Quantitative study/client exit interview: The total sample size was allocated to each facility based on their previous three months delivery service utilization load.

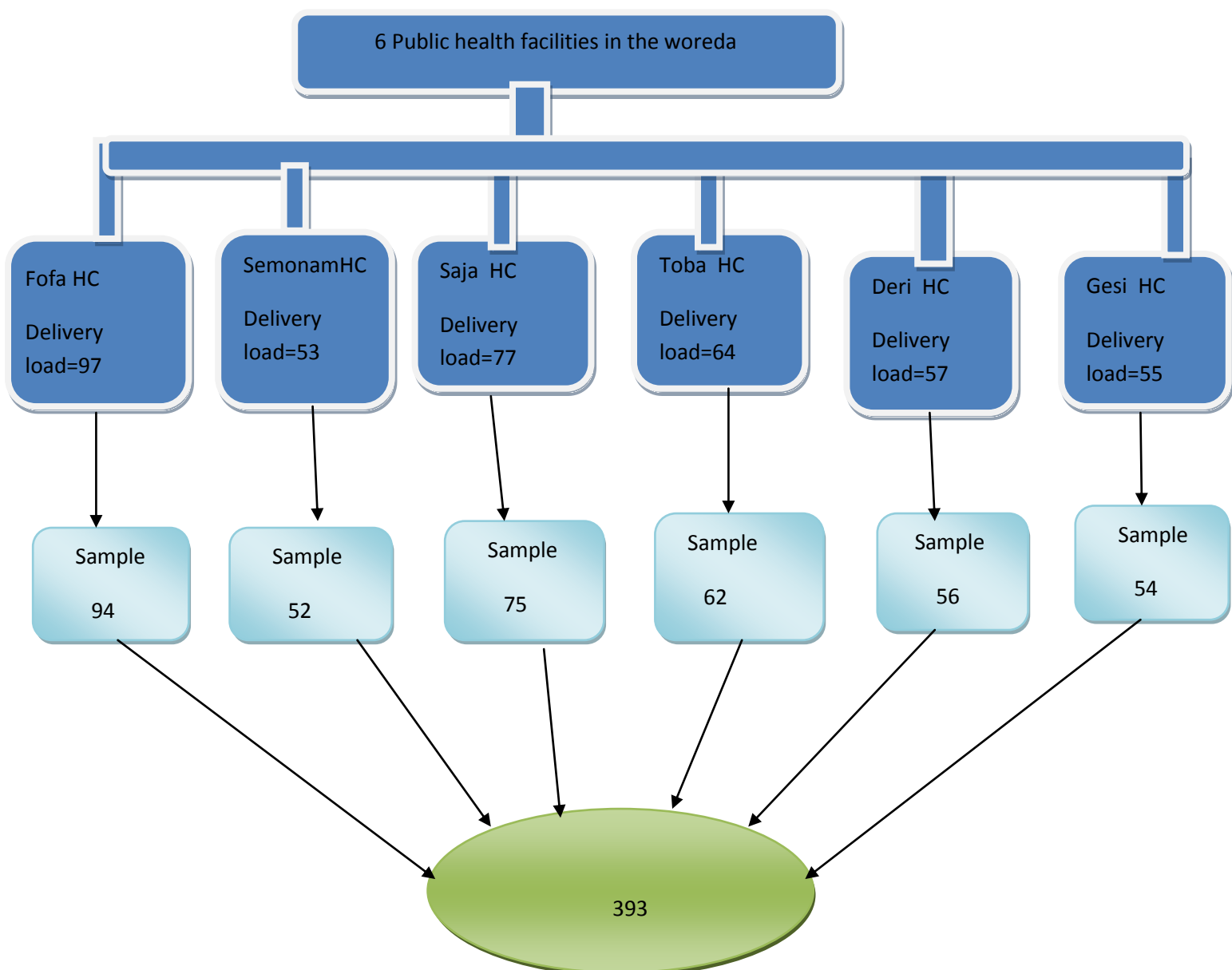


Figure 2 Schematic presentation of sampling procedure for the selection of study unit Yem special woreda, south west Ethiopia, 2015

Due to minimum number of mothers who utilizing institutional delivery service in the area, all pregnant women who utilize institutional delivery service in each health center during data collection period were included consecutively until it reach to their required proportional sample size.

For qualitative study:

For service Providers and clients: Delivery - care providers such as nurses and health officers who were working at the public health centers and mothers who came for MCH(antenatal and post natal care, immunization service and family planning service) during the data collection period were purposively included in FGD. Participants interviewed in the quantitative survey were excluded from the FGD.

4.6. MEASUREMENTS

4.6.1 Study Variables

Independent variables

- Socio-demographic variables (Age, marital status, educational level, religion, occupation and residence).
- Awareness on danger sign of pregnancy
- Decision making power
- Distance
- Transportation cost
- Availability of transportation facility
- Perceived Quality of care (staff availability, supplies and equipment)

Dependant variables

Delay to utilization of institutional delivery service

4.6.2 Data collection *instrument* and pre-testing

For Quantitative study

The data for the quantitative study were collected using pre-tested structured questionnaire which will have socio-demographic and delivery service utilization related variables.

The questionnaire was prepared in English and was translated to Amharic and it was checked for its consistency by back translation to English by different individual. The instrument was adopted from JHPIEGO tools and indicators for maternal and neonatal health (25).

For Qualitative study

Semi-structured FGD topic guide was used to facilitate the discussion. Eight Focused Group Discussions (FGDs) were held (6 FGD for mothers and 2 FGD for providers) in the woreda. Each FGD had 6-12 participants and a total of 72 participants (59 service users and 13 service providers) were participated. The participants were within the age range between 19–37 years and each FGD's took 45 – 60 minutes. The FGDs were facilitated by principal investigator assisted by the one research assistant. Written notes were taken; in addition all the discussions were tape recorded.

FGD guidelines included information on users' and providers' perspectives on barriers to accessing timely delivery services, transport issues, cultural issues in utilizing delivery service, perceived quality of care (e.g. availability, capacity, human resources, health infrastructure). Some probing questions explored the quality of care and perceived strategies to overcome the barriers.

Pre- test

Before starting the actual data collection, the quantitative questionnaire was pre-tested on 5% of the total samples that is on 14 women utilizing institutional delivery service at Sokoru health center which is 12km away from yem special woreda one week before data collection period. Based on information obtained from pre-test necessary modification in the questionnaire was made like category formation and sequencing of questions.

4.6.3 Data collector

Six diploma Nurse Graduates from medical college who are working in the health facility were recruited. Two Health officers were recruited to supervise the day to day data collection activity together with the principal investigator. Two days training was given for data collectors and supervisor on the objectives of the study and how to interview, how to fill the questionnaire and handle questions asked by clients during interviewing by the principal investigator.

4.6.4 Data collection process

For Quantitative study: One trained data collector to each health facility was assigned to collect the data. The client was interviewed after utilizing delivery service and just before the client left the delivery room of the respective health institution.

For Qualitative study: The FGDs were facilitated by principal investigator assisted by the one research assistant. Written notes were taken; in addition all the discussions were tape recorded. Data were transcribed into English text by the principal investigator by replaying the recorded interview. Different ideas in the text were merged in their thematic areas and a thematic framework analysis was employed manually. Then, result was presented in narration by triangulating the quantitative findings.

4.7 Operational Definition

Delays in utilization of institutional delivery service:-refers to time taken more than one hour to make decision to seek care or more than one hour to reach health facility after making decision or waiting for more than one hour in health facility to receive delivery care.

Delay in making decision to seek care: refers to the time interval between first onset of labor or recognition of the complication and start for the facility to seek care. Time taken ≥ 1 hour to make decision to seek care was considered as delay and less than an hour considered no delay (25, 27).

Delay in arrival at the health facility including time needed for transport: refers the time interval from starting to reach. Time taken ≥ 1 hour to reach facility considered as delay (25, 27).

Delay in receiving treatment was the time interval between reaching the facility and the treatment received. Time taken ≥ 1 hour to receive treatment considered as delay (27, 25).

Access to health facility: refers to health facility with one hour or 5km travel by local means of transportation (foot, animal ride) (25).

Institutional delivery utilization: when a mother gave birth at health institution and delivery was assisted by skilled birth attendance. Institutional delivery is interchangeably used by facility based delivery and skilled birth attendance.

Skilled Birth Attendant: An accredited health professional (such as a midwife, doctor, or nurse) who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. (World Health Organization, 2004)

Public health facilities: Government health facilities which provide delivery service such as health center.

4.8 Data processing and Analysis

For quantitative study

The collected data was cleaned, edited and entered into a computer using Epi-Data and Exported into SPSS version-16 statistical software. The data was summarized and Descriptive statistics were computed for all variables according to type. Frequency, mean and standard deviation were obtained for continuous variables while the categorical variables were assessed by computing frequencies. Unadjusted odds ratio (OR) and 95% confidence interval (CI) for each variable of interest were calculated. *P-values* < 0.05 were considered significant for all the independent variables in the model. Bivariate analyses with 95% confidence interval were used to infer associations and predictions. In the first step bivariate analysis was employed to see the association between exposures versus outcome variables. Then, to control the effect of confounding factors, each variables was entered in to logistic regression model as the independent variable with delays to utilize institutional delivery being a dependent variable (i.e. unadjusted odds and adjusted odds ratio were calculated for each exposure variables). Finally, variables that are found statistically significant under bivariate analysis with *P-values* < 0.25 was entered into multiple logistic regression models in order to identify independent predictors of delays to utilize institutional delivery service.

For qualitative study

First, we compiled notes from all 8 FGDs and labelled them according to participant type. After reviewing individual FGD transcriptions, we organized the data. Second, thoroughly reviewed the language (Yemenga) transcriptions, translated them into Amharic then English language, and reviewed each translation to understand the meaning of its content. Third, all data organized according to theme and summarized manually. The result was presented in narratives triangulated with the quantitative results

Table 1 Themes and categories of data of FGD participants, in Yem special woreda, 2015.

No	Themes	Categories
1	Delay in seeking care (awareness, cultural and birth preparedness issues)	Awareness on delays and danger sign, birth preparedness issues and role of the mother in decision making
2	Delay in reaching health facility: (accessibility issues related to distance, road, transport availability, and cost of transport)	Distance, poor road condition, lack of public transport , cost of transport, topography of the woreda (mountains)
3	Delay in receiving care (human resources and logistic supply)	Human resource availability, and lack of equipments and supplies

4.9 Data quality control

To keep the quality of the quantitative data the English version questionnaire was translated in to Amharic and then back to English to maintain its consistence for actual data collection purpose with great emphasis given to local vocabularies. The questionnaire was also being pre-tested on pilot area, necessary modification in the questionnaire was made like category formation and sequencing of questions to ensure their accuracy and consistency prior to actual collection of data. Detail two days training for data collectors and supervisors were given by the principal investigator on the study instrument, the general objective of the study, how to keep

confidentiality and privacy, consent form and others. Also one day training was given for the note taker & recorder of FGD and a guiding document was given to them.

For the qualitative part, the FGDs was facilitated by the principal investigator and supervisor and adequate field notes was taken by experienced note taker, the discussion was tape recorded and transcribed word by word on daily bases. Furthermore, the principal investigator and supervisor were give feedback and correction on daily basis for the data collectors before they deployed to the field and completeness, accuracy, and clarity of the collected data was checked carefully. Any error, ambiguity, incompleteness encountered was addressed on the following day before starting next day activities.

4.10 Ethical consideration

Letter of ethical clearance was obtained from Research Ethics Committee of Jimma University. Letter of permission was obtained from the Yem special woreda health office and respective health facilities. All the study participants were informed about the purpose of the study, their oral consent were obtained, and privacy& confidentiality was also kept.

4.11 Dissemination plan of the study findings

The result of the study was presented to JU community as part of MPH thesis and it is disseminated to JU College of public health and medical science, department of population & family health, Yem special woreda health offices and to the targeted health facilities. Further attempt was made to publish it on national and international scientific journals.

CHAPTER-FIVE: Results

5.1 Socio-Demographic characteristics of the study participants

From a total of 393 who utilized institutional delivery service, 389 of them gave their oral consents and interviewed, yielding a response rate 98.9%.

Out of 389 mothers who were interviewed 315(81%) were in the age range of 20 and 34 and the mean (\pm SD) age of the mothers were 26(\pm 5). 204(52.4%) were orthodox Christian and 306(78.7%) of mother were married. Majority of respondents, 292(75.1%) were Yem in ethnicity. 291(74.8%) were house wife, 27(6.9%) were Government employees by occupation. The mean (\pm SD) family income was calculated to be 683(\pm 499) Ethiopian Birr per month. Two hundred sixteen (56.3%) of them cannot read and write (Table 1)

Table 2. Distribution of socio-demographic characteristics of respondents, in Yem special woreda, April 2015.

Variables	Frequency	Percent	
Age of mother	15-19	39	10
	20-34	315	81
	\geq 35	35	9
Marital status	Married	306	78.7
	Single	31	8
	Divorced	33	8.5
	Widowed	19	4.8
Monthly income of households	\leq 500	306	78.7
	501-999	75	19.2
	\geq 1000	8	2.1
Educational status of mother	Illiterate	219	56.3
	Write and read	82	21.1
	1-4	44	11.3
	5-8	23	5.9
	9-12	19	4.9
Religion	Orthodox	204	52.4
	Muslim	88	22.7
	Protestant	97	24.9
	Total	389	100
Occupation	House wife	291	74.8
	Student	30	7.7
	Merchant	37	9
	Government employee	27	6.9
	Other	4	1
Ethnicity	Yem	292	75.1
	Oromo	83	21.3
	Amhara	6	1.5
	Other	8	2.1

5.2 Obstetric characteristics of mother

Out of the ever married 358 women 130(36.3%) were married before the age of 20 years. From 389 mothers who were interviewed, 275(70.7%) mothers had ANC follow up. Of these 176(64%) had four and more visits. 169(43.4%) and 142(36.5%) of mothers faced maternal complication at previous and current pregnancy respectively. 324(83.3%) of mother know the danger sign of pregnancy. 151(38.8%) of mother decide themselves, 151(38.8%) decided by their husband and 87(22.4%) decided by their family member to utilize delivery service. 143(36.8%) of mother not prepared to utilize delivery service (Table 2).

Table 3. Obstetric characteristics of respondents, in yem special woreda, April 2015

Variables	Frequency	Percent
Age at first marriage N=358*		
Less than 20 years	130	36.3
20-24 years	188	52.5
25-29 years	36	10.1
>= 30 years	4	1.1
Age at first pregnancy N=389		
Less than 20 years	114	29.30
20-29 years	274	70.40
>= 30 years	1	0.30
Number of children N=389		
1-2	179	46
3-4	136	35
5 and more	74	19
Respondent who attend ANC service N=389		
Yes	275	70.7
No	114	29.3
Number of ANC visit N=275		
once	16	5.8
twice	41	14.9
three times	42	15.3
four and above	176	64

* Not ever married are excluded

With regard to current preference of utilization of institutional delivery service, 297(76.7%) mother prefers health facility delivery and the rest 92(23.7%) do not. The reasons for those who do not prefer facility delivery were 11(12.1%) due to fear, 16(17.6%) lack of money, 40(44.0%) far from my house and 24(26.4%) poor treatment from professionals. Reason for the mother why they utilized institutional delivery service were, 9(2.3%) because the facility near to our house, 132(33.9%) for getting good care, 12(3.1%) we get good care previously, 102(26.2%) we told to deliver in health center, 95(24.4%) due to labor problem and the rest 39(10%) we faced difficulty in delivery previously.

5.4 Delays in utilizing institutional delivery service and associated factor

Of the total study participants, 172 (44.2%) of them reported that they faced problem on making decision to utilize delivery service from health facilities. The mean (\pm SD) of delay time was 2(\pm 1.5) hours. 168(43.2%) mothers reported that they faced transportation problem to the health institutions for getting delivery services and majority 271(70%) of the mother not access to or live in a walking distance of more than one hour from health facility which provide delivery service. In average they were walking a distance of two hours to reach health center for utilizing institutional delivery service.

The prevalence of delay to utilization of institutional delivery service in the study area were 76.3% and the mean (\pm SD) of delay time to utilization of delivery service was 5(\pm 3.08) hours.

As to the means of transportations, 198(50.9%) mothers were travelled on foot, 101(26%) of mothers were carried by wooden stretcher and the remaining 90(23.1%) mothers were travelled by car (figure 5.1).

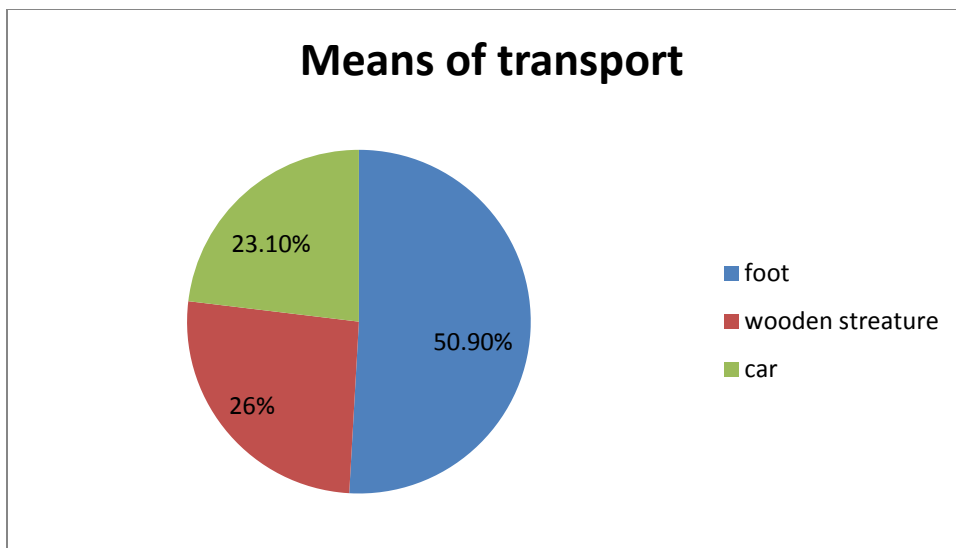


Figure 3 Means of transportation of respondents in Yem special woreda , April 2015.

There was transportation problem in timely utilizing institutional delivery service. The reason for transportation problem was, 103(39.9%) lack of public transport (car problem), 106(41.1%) due to absence of road, and the rest 49(19%) was cost of transport.

A qualitative result showed that, distance and poor road conditions made it virtually impossible for many pregnant women to reach the health facility. In some instances, inadequate or inappropriate transport made it difficult for women to reach the health facility. In the rural areas, the common means of transport is foot; in hills and mountain districts, people carried pregnant women to the health facility on stretchers. Pregnant women faced difficulties in reaching the health facility, especially at night or during the rainy season.

A 30 years old mother from “Toba kebele” commented: “It is particularly difficult if the labor begins at night. There is no transport facility and the way is dark. In such a situation, how can we go to the health facility to utilize delivery service?”

Lack of transport, distance and absence of delivery care centres appear to be significant contributory factors for delay to seek delivery service. Women who travelled the shortest distance had a high chance of attending and coming early to utilize delivery car from health centres, where as women who were travelling long distances had little chance to seek treatment as early as possible. Additionally, cost of the transport and drivers who were not willing to take women to facility delivery made it difficult for women to access care. Generally, the chance of not to delay was inversely related with the length of time taken to reach the health institution.

After mother arrivals’ at health facilities, 135 (34.7%) mothers reported that they waited for more than one hour to get delivery care. The mean (\pm SD) waiting time to utilize delivery care was 1.5 (\pm 1.23) hours. Regarding on the feeling of mother on the service provided by the facility, 276 (71%) of the mothers reported that they were happy with the service provided and the rest 113(29%) unhappy. Lack of drug 5(4.4%) and poor treatment from professional 108(95.6%) were making them unhappy to the service provided by the health facility.

The qualitative result showed that both there are shortage of midwives and presence of staffs work load in the health facilities. Due to these the women waited for long time to utilize delivery service after they reach to the health facility.

A 27 years old Nurse, service provider, from ‘Gesi health center’ commented: “Only one Midwife is available in most of the health facilities in the woreda, thus when she is on leave, in training or transferred to another

health facility, women cannot get timely delivery service from the health facility. And also when the number of deliveries exceeded ability to provide services and staff members became overburdened.”

A 34 years old, Health officer, from same health center said that “The absence of a clear division of roles among staff members who shared responsibility for providing maternal health services further aggravated this situation and affected worker motivation and performance. This condition leads to delays in utilizing delivery service.”

The bivariate analysis showed that there was a statistically significant association between not having information about benefit of utilizing institutional delivery service, lack of awareness on health risk, occupation, education, husband decision making, monthly family income, parity, lack of awareness on danger sign of pregnancy, not being prepared for birth, distance from health facility and preference of delivery in health facility with delay in utilizing institutional delivery service at p-values ≤ 0.05 . Adjustment of variables using logistic regression was carried out to predict delay in utilizing institutional delivery service with associated variables during the crude analysis.

Parity or having three or more children, not being prepared for birth, education status of mother, monthly family income and decision made by husband were independent predictors of delay in utilization of institutional delivery service.

Delay to utilize institutional delivery service was 2 times higher for those mother whose decision made by their husband (AOR: 2.08(1.0, 3.9)) than those decide by their own for utilizing institutional delivery service (Table 5.3).

Qualitative result showed that, many women preferred home delivery because they were feeling shame to deliver at the health facility, even when it was near their residence. Further, the cultural practice of isolating women during delivery and a few days after childbirth prevented some women from visiting the health facility and using the service timely. Some families did not allow women to deliver at the health facility because they feared an evil spirit might haunt the mother and the baby.

Women’s lack of autonomy in decision making also affected timely delivery service utilization because their husband or head of household decided whether they should access health care. Indeed, some families prevented women from going to the health facility.

A 30 years old mother from Gesi kebele said: “Many husbands do not allow their wives to visit the health facility for seeking delivery services because of traditional beliefs. They lack money and cannot manage transportation. Women cannot ignore their husband’s decision and cannot express their opinion in the family”.

Delay in utilizing delivery service was 7 times higher among mothers who were not being prepared for birth from institutional delivery service utilization (AOR: 7.1 (2.8, 17.8)) than mothers prepared

The qualitative result also showed this; many women in the study area were unaware of the importance of utilizing institutional delivery service timely and not prepared for birth. Indeed, participants did not think it was necessary to go to a health facility for normal delivery until and unless they experienced a serious problem.

A 29 year old mother from Fofa said: 'If the labor pain is very serious then we mostly visit the health facility for delivery or we call a Health extension worker to come to our home'. Additionally, women and their families could not prepare for an institutional delivery because they were unable to accurately predict the expected date of delivery'.

Women who have three or more children have 3 times more likely higher (AOR: 2.9(1.568, 5.444)) than mother who have two or less children in delay to utilize delivery service.

The qualitative result showed that lack of money also prevented some women from going to a health facility for delivery. Transport cost some times very high and women paid 300 to 400 birr for transport. They were waited longer time to their home until their husband negotiated to reach agreement on the transport cost with the transport service providers. If there were no money at hand and families cannot cover these costs themselves, women delay for longer time or deliver their babies at home.

A 21 year women from Deri kebele commented that ".....there no mony at hand when labor start my husband search money from someone who have money in the village due to this I waited at home for longer time."

Delay to utilize delivery service was 10 times higher among mother whose household monthly income less than 500 birr (AOR: 10.58(1.74, 64.11)) than whose monthly income greater than one thousand. And 2 times higher among illiterate mother (AOR: 1.9 (1.07, 3.47)) than literate mother.

Table 4 Delay in utilization of institutional delivery service and associated factor of respondents in Yem special woreda, April 2015.

Variables	Categories	Delay to utilize facility delivery		COR(95%CI)	AOR(95%CI)
		No delay	Delay		
Occupation	Employed	13	14	1	1
	Unemployed	79	283	3.326(1.502,7.366)	2.214(0.848,5.781)
Education	Literate	50	120	1	1
	Illiterate	42	177	1.756(1.096,2.813)	1.936(1.078,3.475)*
Do you have information about benefit of health facility delivery?	Yes	87	244	1	1
	No	5	53	3.780(1.463,9.763)	1.472(0.458,4.725)
Number of children(parity)	1-2	60	119	1	1
	>=3-4	32	178	2.805(1.722,4.568)	2.922(1.568,5.444)*
Are you prepared (planned) in advance to deliver in health institution?	Yes	82	164	1	1
	No	10	133	6.650(3.318,13.327)	7.180(2.888,17.850)*
Do you know any danger signs of labour?	Yes	83	241	1	1
	No	9	56	2.143(1.016,4.522)	0.431(0.098, 1.903)
Do you prefer health facility delivery?	Yes	80	217	1	1
	No	12	80	2.458(1.272,4.749)	0.387(0.144, 1.045)
Distance	Yes	36	83	1	1
	No	56	214	1.657(1.016,2.704)	1.354(0.758,2.387)

Health risks a woman might experience during pregnancy	Yes	79	217	1	1
	No	13	80	2.240(1.181,4.250)	2.732(0.821,9.092)
Decision maker for delivery service utilization	Women	47	104	1	1
	Husband	32	119	1.681(0.999, 2.828)	2.080(1.094,3.955)*
	Family member	13	74	2.572(1.300,5.091)	1.518(0.628, 3.669)
Family monthly income	> = 1000	6	2	1	1
	501-999	16	59	11.062(2.035,60.132)	23.275(3.485,155.448)*
	< = 500	70	236	10.114(1.997,51.230)	10.584(1.747, 3.475)

* P-value < 0.05

CHAPTER SIX: DISCUSSION

This facility based cross-sectional study tried to assess factors affecting delays in utilization of delivery services from public health facilities of Yem special woreda of south nations and nationalities' Region was conducted. In addition, the study tried to investigate prevalence of delays in utilization of institutional delivery service.

In this study finding prevalence of delays in utilization of institutional delivery service was 76.3% and the mean (\pm SD) of delay time to utilize the service was 5(\pm 3.08) hours. This study finding was higher than a cross-sectional study done in rural Bangladesh in which 69.3% of mothers delay in utilization of delivery service (27).

The finding of this study show that 172(44.2%) of the mothers were facing problem in making decision in utilization of institutional delivery service, this figure lower than study done in Nigeria in which 57% of mother faced problem in decision to seek care and higher than the study done at public health facility in Bahir Dar city in which 37.8% of the mother faced problem in deciding to seek care (43). The mean delay time to decide for utilization of institutional delivery service in this study was 2 hours. This is lower than the findings of the previous studies in Bangladesh and India documenting that women took 6 hours and 8 hours in making decision to seeking care (44).

The possible explanation for this finding could be our study participants live in rural area and the difference in finding from the urban (Bahir Dar) was due to the presence of higher proportion of educated mothers live in urban area as compared to rural area. In addition to this, mothers in urban area could be autonomous in making decision, have good knowledge of pregnancy and delivery complications, and better access to information than rural mothers. Studies have shown that the presence of positive association between utilization of maternal health care and residence; those living in urban and closest to health facilities tend to utilize skilled delivery services more than rural dwellers (46).

With regard to delay due to transportation, 168(43.2%) mothers faced transportation problem for utilizing institutional delivery service. This study finding higher than the study done in Bahir Dar city which is 31.7% mothers reported that they faced transportation problem to reach the health institutions for utilizing delivery service (31).

The reason for transportation problem in this study was, 103(39.9%) lack of public transport, 106(41.1%) due to absence of road, and the rest 49(19%) was cost of transport. This study finding result lower than from 2011 EDHS reports, in that report the major barrier for pregnant women to utilize the health services timely was lack of public transport (71%) and lack of money (68%). And also the result of this finding lower than study done in Nepal in which over half of women who delivered in health institution had to borrow money for transport and asking for and collecting the money in itself contributes to the delay (37).

Regarding physical access to health facility, majority of mother 270(69.4%) not access to health facility (health center) or live in a walking distance of greater than one hour and the mean walking distance from their homes was two hours. This study finding was slightly higher than study done in selected developing countries by Babinard in 2006. In that study 40-60% of people living in developing countries live at a walking distance of more than one hour from a health care facility (18). And also slightly inconsistency to EDHS 2011 result in

which 66% of mothers not access to or live in a walking distance of more than one hour from institutional delivery service in Ethiopia(7).

Lack of transport, distance and absence of delivery care appear to be significant contributory factors for delay to seek delivery service. Women who travelled the shortest distance had a high chance of attending and coming early to utilize delivery car from health centres, where as women who were travelling long distances had little chance to seek treatment as early as possible. Additionally, cost of the transport and drivers who were not willing to take women to facility delivery made it difficult for women to access care. Generally, the chance of not to delay was inversely related with the length of time taken to reach the health institution (56).

After mother arrives to health facility they faced problem in timely utilizing institutional delivery service. In this study 135(34.7%) of the mother waited for more than one hour to utilize institutional delivery service after they arrive the health facility. The mean delay time was one and half hour. This study finding higher than the study done in Bahir Dar city which is 30.7% of respondents waited for more than one hour to utilize delivery service and the mean delay hour in health facility was 4 hours.

The qualitative study finding result from both service providers and service users shows that long time admission process, staffs work load and lack of supplies were the main reason for third delay to utilize institutional delivery service at health facility.

Both service providers and users mentioned that there is shortage of midwives and presence of staffs work load in most of the health facilities. Due to these the women waited for long time to utilize delivery service after they reach to the health facility.

A 27 year old ,Nurse who was working in 'Gesi health center' commented: "Only one Midwife is available in most of the health facilities in the woreda, thus when she is on leave, in training or transferred to another health facility, women cannot get timely delivery service from the health facility. And also when the number of deliveries exceeded ability to provide services and staff members became overburdened."

A 32 years old Health officer from 'Gesi health center' said that "The absence of a clear division of roles among staff members who shared responsibility for providing maternal health services further aggravated this situation and affected worker motivation and performance. This condition leads to delays in utilizing delivery service."

In this study literacy status of mother, family monthly income less than 500 birr, higher parity, husband decision making for delivery service utilization and not being prepared in advance for utilizing delivery service from health institution were independent predictors of delays in utilizing institutional delivery service.

Husband's decision making power is a critical factor for delay to utilization of institutional delivery service, due to cultural or other reason women's delivery service utilization decided by their husband. In this study finding decision made by husband was predictor to delay to utilize delivery service.

Delay to utilize institutional delivery service was 2 times higher for those mother whose decision made by their husband (AOR: 2.08(1.0, 3.9)) than those decide by their own for utilizing institutional delivery service.

This study finding consistent with cross-sectional study done in rural Bangladesh and public health facility in Bahir Dar, in which decision made by husband was predictor delay in utilizing delivery service. And also the study done in Hawassa University Hospital shows male dominance in household decision making was shown a big delay in the health care seeking among Ethiopian pregnant women (2, 31).

Again, this study finding was consistent with findings from another study conducted in India, which shows that lack of decision-making power by women could result into lesser timely health seeking behavior and the same study finds out that utilization of institutional delivery services was higher for women who have full health care autonomy, the autonomy of deciding to utilize the services (49).

The qualitative result supports the above idea. Most FGD participants stated that male dominance for decision and not being prepared for delivery was the main reason for delays to utilize delivery service. Majority of women requests permission from their husbands and relatives to go to the health facilities. In any case the husband seems to be the most key person in the decision-making process. The participant also stated that unless labour is complicated their husband would not allow her to go health facilities.

A 34 year old mother from 'Gesi' kebele said that "labor comes suddenly, we are not prepared for birth and there is no money at hand due to this we waited at home for longer time until our husband collected money and decided to utilization of the health facility"

The possible explanation for this finding could be certain cultures maintain that women must wait for approval from male relatives before seeking delivery service (45).

In this study finding not being prepared for birth was a factor for delay to utilization of institutional delivery service. Delay in utilizing delivery service was 7 times higher among mothers who were not being prepared for birth from institutional delivery service utilization (AOR: 7.1 (2.8, 17.8)) than mothers prepared

This finding consistent to with cross-sectional study done in Adigrat town lack of advance planning for use of a skilled birth attendant for normal births, and particularly inadequate preparation for rapid action in the event of obstetric complications, are well documented factors contributing to delay in receiving skilled obstetric care. Study done in Kenya also showed that not being prepared for birth associated with first delay in utilizing institutional delivery service (26, 47).

The qualitative result also showed this; many women in the study area were unaware of the importance of utilizing institutional delivery service timely and not being prepared for birth. Indeed, participants did not think it was necessary to go to a health facility for normal delivery until and unless they experienced a serious problem.

A 29 year old mother from Fofa said: 'If the labor pain is very serious then we mostly visit the health facility for delivery or we call a Health extension worker to come to our home'. Additionally, women and their families could not prepare for an institutional delivery because they were unable to accurately predict the expected date of delivery'.

Women who have three or more children have 3 times higher in delay to utilization of delivery service (AOR: 2.9(1.568, 5.444)) than mother who have two or less children. According to cross-sectional study done in rural Bangladesh, parity was associated with delay to utilize skilled delivery service (48).

A study in Nigeria showed that parity has a significant influence on delay in utilization of institutional delivery service (60).

The possible explanation for this is that women who have higher parity develop experience and confidence regarding child birth due to this they may be delay to utilize delivery service.

Educational status of the women was found as one of significant predictors for delay in utilization of delivery service. In this study finding delay in utilization of institutional delivery service was 2 times higher among illiterate mother (AOR: 1.9 (1.07, 3.47)) than literate mother.

This study finding consistent with various studies such as studies done in Bangladesh, Pakistan, Nepal, and Nigeria it showed that education was independent predictor of delay to utilization of institutional delivery service (59, 60, 61, 62, 63).

Women who were illiterate were more likely to delay to utilization of delivery service from health facility as compared to women who were literate. Study conducted in Syrian women indicated that the demographic variables like woman's education were statistically related to delay to utilize delivery service. Literate women utilize timely hospital delivery service compared with illiterate women. Cross-sectional study conducted in Tigray was also consistent with this study (53).

The possible explanation for this is that educated women are expected to have knowledge and awareness about the advantages of institutional deliveries. They are more likely to seek modern health care than those who are not. Education is likely to improve the general status of women and help them to build up confidence to make decisions about their own health. Educated women could have better access to information through reading and following media about maternal health care and they could have better knowledge about the advantages of maternal health care and pregnancy related complications.

Delay to utilize delivery service was 10 times higher among mother whose household monthly income less than 500 birr (AOR: 10.58(1.74, 64.11)) than whose monthly income greater than one thousand.

A study carried out in Sudan also revealed one of the root causes for delay in seeking delivery care was poverty. Poverty plays a major role particularly as it reduces the chance of getting medical help such as delivery care when there is a need (54). The findings of this study have similarities with other studies carried out in African countries in which the income of the family is strongly associated with delay in seeking delivery care. Poverty is a significant covariate affecting women's health service seeking practice for their health problems (55).

Strength and Limitation of the study

Strengths of the study

The study used both qualitative and quantitative method of data collection to triangulate the findings. In order to avoid information bias pre-test was conducted in population with similar socio-economic status of the study population.

Limitation of the study

As this was a cross-sectional study some limitations were unavoidable. Time calculations for three delays were collected through recall of the women. As a result, a recall bias could not be avoided. The questionnaire were administered by health workers, there may be some chances of reporting wrong data to please the researcher. The magnitude of these chances of biases could not be directly and easily established.

Chapter seven: Conclusion and Recommendation

7.1 conclusion

Despite the progress that has been made to improve maternal and child health outcome in recent year's maternal mortality remain higher in Ethiopia. Many factors contribute to maternal morbidity and mortality and affect the health outcome of mothers.

The present study tried to identify delays in utilizing institutional services and associated factors with the aim of improving the information that is available to decision makers responsible for planning and administering maternal health care. A number of factors were identified that have important influence on delays in utilization of institutional delivery service in Yem Special Woreda. These factors include occupation, parity, husband decision making power, birth preparedness, family monthly income, awareness on danger sign of pregnancy and literacy status of mother. Parity, decision made by husband, literacy status, family monthly income and not being prepared for birth were independent predictors of delays in utilization of institutional delivery service.

7.2 Recommendations

Based on the results of this study, the following recommendations are made:

Yem special woreda health office

- ✓ Need to avail the necessary supplies and equipments to all health centers in the woreda and also remove the shortage of midwives in most of the health centers.
- ✓ Promotes utilization of maternal waiting homes (MWHs) for pregnant mothers.
- ✓ Strengthen the effort to improve accessibility of health facilities in the rural areas by increasing the number of health facilities as well as transport.
- ✓ All six health centers, the health center staff and the health Extension Workers in the Woreda need to promote utilization of antenatal care services at community level as those attending antenatal clinic acquire enough information about safe delivery and majority of those attending antenatal care ending up to deliver timely in health facility.

Yem special Woreda Female, Child and Youth office

- ✓ Need to promote empowerment of women through integrated activities including girls education will be helpful to enable them decide by themselves about their delivery practices.

For researchers

- ✓ This research is institution based in which it could not include most of the mothers who utilized institutional delivery services before data collection period so that community based research that assesses causes of delays to utilize delivery service may be recommended.

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SECTION 2: ACCESSIBILITY INFORMATION TO HEALTH SERVICES

No	Question	Responses	Skip
201	How far is the nearest health post from your home?	1. Kilometres..... 2. Hours	
202	How far is the nearest health center from your home?	1. Kilometres..... 2. Hours	
203	What means of transport do you use to reach the health post facility?	1. motorized transport 2. on peoples Back 3. Animal 4.Walking 5.others(specify)	
204	What means of transport do you use to reach the health center?	1. motorized transport 2. on peoples Back 3. Animal 4.Walking 5.others(specify).....	
205	Did you have money for transport when labour started?	1. Yes 2. No	If no skip to Q.207
206	How many hours did it take for you to reach to public transport facility from your home?	..... hours	
207	Is there a transportation problem on the way to Health facilities?	1. Yes 2. No	If no skip to Q.301
208	If the response to Q. 207 is yes What is you reason?	1.Inaccessible to car 2.Only dry weather road 3. Expensive. 4. Others (specify).	

SECTION 3 WOMEN'S PAST OBSTETRICAL HISTORY

No	Question	Response	Skip
301	Age at first marriage?	.....year	
302	Age at first pregnancy?	.....year	
303	Gravidity/total number of pregnancy	.....
304	Parity/total number of births	.....
305	Do you have any information about the benefit of delivery in health institution?	1.Yes 2. No	If no skip to Q.307
306	If Q.305 is yes what is the primary source of information?	1.Health workers 2.Frinds, neighbors who get similar service 3.Media	
307	Have you come across any obstetric difficulties in previous delivery? (prolonged labour, haemorrhage)	1. Yes 2. No	If no skip to Q.401
308	If Q.307 is Yes What specific measures were taken?	1. Nothing 2.Visit health institution 3. Other specify	

SECTION 4: ANTENATAL AND DELIVERY INFORMATION

No	Question	Responses	Skip
401	Did you attend antenatal clinic during current pregnancy?	1. Yes 2. No	If no skip to Q.403
402	If the response to Q 401 is yes How many times did you visit the clinic?	1. Once 2. Twice 3. Thrice 4. Four times 5. Over 4 times	
403	Do you face Maternal complication in previous pregnancy?	1. Yes 2. No	If no skip to Q.405
404	If the response to Q 403 is yes mention maternal complication you faced?	-----	
405	Do you face Maternal complication during current pregnancy?	1. Yes 2. No	If no skip to Q.407
406	If the response to Q.405 is yes mention maternal complication you faced?	-----	
407	At what time the signs and symptoms of labour or the complaint began?	Date _____ Time _____ am/pm	
408	When was the decision to seek care made?	Date _____ Time _____ am/pm	
409	What is the reason to make decision at that time?	.....
410	When did you get first evaluated at this Health center?	Date _____ Time _____ am/pm	
411	Are you a referral case from elsewhere?	1.yes 2.No -----	
412	Time of referral	Date _____ Time _____ am/pm	
413	Duration of stay at referring health institution?	_____ hrs	
414	What is the Type of referring unit?	1 H/post 2.private clinic 3.health center 4.other	
415	What is the Reason for referral?	1. lack of trained staff 2 lack of medicine/equipment 3. absent staff. 4.obstetric complications 5. others.	
416	Do you prefer health facility delivery?	1. Yes 2. No	If yes skip to Q.418
417	If the answer to Q.417 is no What is you reason?	1. Fear of discrimination 2.Distance 3. Financial problem. 4. Physical abuse by the care Providers. 5.others	

418	Why did you prefer to deliver at Health facility?	1.Health facility was near to me 2. Need Better service 3. Previous better out come with delivering at Health facility 4. I was told to deliver at health facilities 5. Difficult labour 6. Bad outcome with previous Delivery 7. Other, specify-----	
419	How did you receive current delivery service?	1.Free of charge 2. On payment basis	
420	If you received on payment, how much did you pay during your most recent Health facility delivery service?	-----ETB	
421	What was your opinion on the payment?	1. Unaffordable 2. Fair 3. Cheap 4. I do not have suggestions	
422	Are you prepared (planned) in advance to deliver in health institution?	1.yes 2.no	
423	Who decides your health service utilization?	1. Self 2. Husband 3. Relatives 4. Religious leader 5.Other, specify	
424	Are you aware of any health risks a woman might experience during pregnancy?	1. Yes 2. No	If no skip to Q.426
425	If response to Q 425 is yes what are the risks?	1. Pregnancy related disease 2. Maternal death 3. Fatal death 5. Other, specify	
426	Do you know any danger signs of labour?	1. Yes 2. No	If no skip to Q.428
427	If response to Q 427 is yes, what are the danger signs do you know? Multiple responses are possible.	1. Prolonged labour 2. Early rupture of membrane 3. vaginal bleeding 4. Placenta retention 5. Mal-presentation 6. Increased Blood Pressure 7. Convulsion 8. Cessation of labour pain 9. Severe continuous abdominal pain 10.Other, specify	
428	Do you think delays to seek care to be a factor in pregnancy outcome	1. Yes 2. No 3. Do not know	
439	Are you happy with the services provided at the health facility?	1. Yes 2. No	If yes skip to Q.431

430	If the response to Q 430 is no, what things make you unhappy with the services provided at the facility?	1. No drugs and supplies 2. Bad behaviour of health workers 3. Lack of privacy 4. Other specify	
431	Health professionals at Health facility are skilled enough to detect and treat or refer delivery complications.	1. Agree 2. Disagree 3. In different	
432	Health facilities in nearby are adequately equipped to provide delivery service.	1. Agree 2. Disagree 3. In different	
433	Health facilities in nearby are staffed with skilled professionals to provide delivery service.	1. Agree 2. Disagree 3. In different	
434	Is there any traditional issue that cause women to delay to utilize delivery service at Community?	1. Yes 2. No	

435. List those traditional/cultural factors that cause women to delay to utilize institutional delivery service in your community?

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.....

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Annex 2 FGD GUIDE

Service users

My name is _____ and this is my partner _____. We came from Jimma University and doing a research on causes of delays to utilize institutional delivery service. Here you invited to discuss freely issues what we are going to pose. The points are simple and understandable. Whatever you feel and believe on the raised idea is allowed since there is no right or wrong answer. We are going to audiotape your discussion but know that it is confidential and used only for research purpose. Any personal identification will not pass to anybody. We are going to stay about 40 minutes discussing in ordered manner. Thank you for giving your time!

Questions

- What do you know about pregnancy complication? List pregnancy complication?
- What you should do when pregnancy complication occur? How?
- What do you know about delays to utilize institutional delivery service? What are they?
- What is the reason for delays to utilize institutional delivery service in your area? Why?
- How do you see the decision making power of pregnant women during labour and delivery in your area? How? Way?
- Who should decide for utilization of institutional delivery service in your community? Way?
- Is there any transportation problem in your community in a way to utilizing institutional delivery service? What are they? If there is no any public transport service in your area what means of transport you should use?
- Are you access to institutional delivery service? How? How far from your community?
- Are you happy with service provided at this health facility? How many professionals the health facilities have? How? (no of midwives, nurses, health officers.....), is it enough?
- Is the health professional at this health facility skilled enough to treat, detect or refer delivery complications?
- Is health facilities in nearby are adequately equipped to provide delivery service? How?
- Is health facilities in nearby are staffed with skilled professionals to provide delivery service? How
- Is there any traditional issue that causes women to delay to utilize delivery service at community? What are they? Way?
- Are you prepared (planned) in advance about any payment regarding utilization of institutional delivery service? (Transport, drug, health care cost)

Service providers

My name is_____ and this is my partner_____. We came from Jimma University and doing a research on causes of delays to utilize institutional delivery service. Here you invited to discuss freely issues what we are going to pose. The points are simple and understandable. Whatever you feel and believe on the raised idea is allowed since there is no right or wrong answer. We are going to audiotape your discussion but know that it is confidential and used only for research purpose. Any personal identification will not pass to anybody. We are going to stay about 40 minutes discussing in ordered manner. Thank you for giving your time!

Questions

1. Do you know about delays to utilizing institutional delivery service?
2. What are the factors which associated with delays to utilizing institutional delivery service? Way?
3. Are health service providers having any part in delays to utilizing institutional delivery service? How?
4. What is your role to minimize delays to utilizing institutional delivery service?
5. Is your facility equipped enough to minimize institutional delivery service? How?
6. Long waiting time to utilizing institutional delivery service observed is this health facility? Why? What is the reason?

ጅማ ዩኒቨርሲቲ

የህብረተሰብና ህክምና ሳይንስ ኮሌጅ የድህረ ምረቃ ት/ቤት የስነ- ህዝብና የቤተሰብ ጤና ት/ቅሬታ

ስማ _____ ባላለፈ::

የጅማ ዩኒቨርሲቲ የድህረ ምረቃ ት/ቤት በሚያካደው ጥናታዊ ምርምር አባል ነኝ። የዚህ ጥናት ዋና አላማ እናቶች ከጤና ድርጅት የወልድ አገልግሎት ለመጠቀም የሚዘገዩበትን ምክንያቶች ምን ምን እንደሆኑ ለማወቅ ሲሆን። ጥናቱ የሚያካትተው በጤና ድርጅት የወልድ አገልግሎት ያቸኑ እናቶችን ስለሆነ እርስዎም በዚህ ጥናት ተካፋይ ይሆኑ ዘንድ ተመርጠዋል ስለዚህ ፍቃደኛ በመሆን አስፈላጊውን መረጃ እንዲሰጡን በማክበር እንጠይቃለን።

ስለ እርስዎ ማንነትና የወልድ አገልግሎት ከጤና ድርጅት መጠቀም ጋር ተያያዥ የሆኑ ጥያቄዎችን እንጠይቃለን። ጊዜዎን መሰዋት አደገው ስጥያቄዎችን መልስ ለመስጠት አቃቅኛ ከሆኑልን ምስጋናችን ከፍ ያለ ነው። ስመዎና የካርድ መለያ ቁጥረዎ ከዚህ መጠይቅ ላይ አይሞላም። የሚሰጧቸው መረጃዎች ሙሉ-በሙሉ ሚስጥራቸው በከፍተኛ ደረጃ የተጠበቀ መሆኑን ልናረጋግጥሎት እንወዳለን። የጥናቱ ተሳታፊ ከሆኑ የሚሰጡት ትክክለኛና እውነተኛ መረጃ ወልድንና ከወልድ ጋር ተያያዥ የሆኑ አገልግሎቶችን ለማሻሻልና ጥራት እንዲኖራቸው ለማድረግ ከፍተኛ አስተዋፅኦ ያደርጋል።

በዚህ ጥናት ተሳታፊ ለመሆን ፍቃደኛ ነዎት? አዎ, ቀጥሎ አልፈልግም, አመለካከት!

የመረጃ ሰብሳቢው ስም _____ ፊርማ _____ ቀን _____

ክፍል1: የተጠያቂዎ አጠቃላይ የማህበራዊና ኢኮኖሚያዊ መረጃን የተመለከተ መጠይቅ

የጤና ድርጅት ስም _____

ት/ቅሬታ ኮድ _____

ቀበሌ _____

ተ.ቁ	<input type="checkbox"/> ት/ቅሬታ	አማራጭ መለያ ኮድ	<input type="checkbox"/> ስል
101	<input type="checkbox"/> እትሚሽ ስንት ነው?	በአመት _____	
102	አሁን ያሰበት የጋብቻ ሁኔታ? <input type="checkbox"/>	1. በጋብቻ ሳይ ያለች 2. ያሳገባች 3. ከባላ <input type="checkbox"/> ትኛታች 4. ባላ የሞተባት	
103	የትምህርት ደረጃሽ ምን ያህል ነው?	1. ማንበብና መጻፍ የማይችሉ 2. ማንበብና መጻፍ ብቻ 3. መጠና ትምህርት----- <input type="checkbox"/> አል	
104	ሐይማኖትሽ ምንድነው?	1. እርቶዶክስ ክርስቲያን 2. ሙሴሲም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ (<input type="checkbox"/> ትሰጥ)_____	
105	ብሔረሰብሽ ምንድነው?	1. <input type="checkbox"/> ም 3. እርሞ 2. አማራ 4. ሌላ (<input type="checkbox"/> ትሰጥ)_____	
106	ሥራሽ ምንድነው?	1. የቤት እመቤት 2. ተማሪ 2. የቀን ሰራተኛ 4. ነጋዴ 5. የመንግስት ሰራተኛ 6. የግል መስሪያ ቤት ሰራተኛ 7. ሌላ	
107	<input type="checkbox"/> ቤተሰብ <input type="checkbox"/> ጠር ቸቢ በብር	_____ በብር	

ቅጽ 2: መሰረተ ልማት ነገ ጥያቄዎች

ተ.ቁ	□□ቁ	መልስ	□□ስል
201	የእርሶ ቤት ከዚህ ጤና ድርጅት ያለው ርቀት ምን ያህል ነው?	1. በኪ.ሜ..... 2. በሰዓት.....	
202	የእርሶ ቤት ከዚህ ጤና ጣቢያ ያለው ርቀት ምን ያህል ነው?	1. በኪ.ሜ..... 2. በሰዓት.....	
203	ወደዚህ ጤና ድርጅት በምን መጡ?	1. በመኪና 2. በቃረዛ 3. በፈረስ 4. በእግራ 5. በሌላ ምክንያት	
204	ወደዚህ ጤና ጣቢያ በምን መጡ?	1. በመኪና 2. በቃረዛ 3. በፈረስ 4. በእግራ 5. በሌላ ምክንያት	
205	ምጥ ሲጀምሩት የትራንስፖርት ገንዘብ በእጅ ነበረ ወይ?	1. አዎ 2. አልነበረም	
206	የእርሶ ቤት ከመኪና መንገድ ጋር ያለው ርቀት ምን ያህል ነው?	1. በኪ.ሜ..... 2. በሰዓት.....	
207	ከእርሶ ቤት ወደ ወደዚህ ጤና ድርጅት ሲመጡ የትራንስፖርት ችግር ገጥሞት ነበር ወይ?	1. አዎ 2. አልገጠመኝም	አልገጠመኝም ካሉ ወደ ጥያቄ ቁ 301 ይዘለሉ
208	የጥያቄ ቁ. 207 መልስ አዎ ከሆነ ምክንያቱ ምንድን ነው?	1. የመኪና ችግር 2. የመንገድ ችግር 3. የትራንስት ወድ መሆን 4. በሌላ ችግር.	

ቅጽ 3: ከወለድ ጋር የጠያያብ ጥያቄዎች

ተ.ቁ	□□ቁ	መልስ	□□ስል
301	ለመጀመሪያ ጊዜ ትዳር ሲመሰርቱ ዕድሜዎ ስንት ነበር?	-----	
302	ለመጀመሪያ ጊዜ ሲያረግዙ ዕድሜዎ ስንት ነበር?	-----	
303	ያሁኑን ጨምሮ እስካሁን ምን ያህል ጊዜ አርግዘዋል?	.....
304	ያሁኑን ጨምሮ እስካሁን ምን ያህል ጊዜ ወልደዋል?	.....
305	በጤና ድርጅት መወለድ ጥቅም እንዳለው ያውቃሉ ወይ?	1. አዎ 2. የለውም	አላጠቀም ካሉ ወደ ጥያቄ ቁ 307 ይዘለሉ
306	የጥያቄ ቁ. 305 መልስ አዎ ከሆነ ስለጥቅሙ መረጃ ከማን አገኘሽ?	1. ከጤና ባለሙያ 2. ከጋደኞቹ 3. ከጎረቤት 4. ከመገናኛ ብዙሃን	
307	ከዚህ በፊት በፊት በነበረስ እርግዝና ከእርግዝና ጋር ተያይዞ የገጠመሽ ችግር ነበር ወይ? (የምጥ መዘግደት, የደም መፍሰስ)	1. አዎ 2. የለኝም	የለኝም ካሉ ወደ ጥያቄ ቁ 301 ይዘለሉ

308	የጥያቄ ቁ. 307 መልስ አዎ ከሆነ ምን እርምጃ ወሰድሽ?	1. ምንም አላደረሁም 2. ወደ ጤና ድርጅት ሄጃለዉ 3. ሆደን ታሽቻለዉ/የአበሻ መድሀንት ተጠቅማለዉ 4. ሌላ ምክንያት.....	
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ክፍል 4: የቅድመ መሰደድና ወሰድ ነክ ጥያቄዎች

ተ.ቁ	□□ቁ	መልስ	□□ስል
401	በዚህ እርግዝና የቅድሚያ ወልድ ምርመራ አድርገሻል ወይ?	1. አድርጋለዉ 2. አላደረሁም	አላደረሁም ካሉ ወደ ጥያቄ ቁ 403 ይዝለሉ
402	የጥያቄ ቁ. 401 መልስ አድርጋለዉ ከሆነ ስንት ጊዜ አድርጌሻል?	1. 1 ጊዜ 2. 2 ጊዜ 3. 3 ጊዜ 4. 4 ጊዜ 5. ከ 4 ጊዜ በላይ	
403	ከዚህ በፊት በነበረ እርግዝና ምጥ ከመጀመሩ በፊት ወይም በምጥ ወቅት ከእርግዝና ጋር የተያያዙ ችግር ገጥሞት ነበር?	1. አዎ 2. አልገጠመኝም	አልገጠመኝም ካሉ ወደ ጥያቄ ቁ 405 ይዝለሉ
404	የጥያቄ ቁ. 403 መልስ አዎ ከሆነ ምን ምን ገጠሞት? ይግለጹ?	-----	
405	በዚህ እርግዝና ምጥ ከመጀመሩ በፊት ወይም በምጥ ወቅት ከእርግዝና ጋር የተያያዙ ችግር ገጥሞት? ነበር?	1. አዎ 2. አልገጠመኝም	አልገጠመኝም ካሉ ወደ ጥያቄ ቁ 407 ይዝለሉ
406	የጥያቄ ቁ. 405 መልስ አዎ ከሆነ ምን ምን ገጠሞት ይግለጹ?	-----	
407	በዚህ ወልድ ምጥ መቼ ጀመርኩት?	ቀን _____ ሰዓት _____	
408	ምጥ ሲጀምሩት ወደ እዚህ ጤና ጣቢያ ለመምጣት መቼ ወሰኑ?	ቀን _____ ሰዓት _____	
409	በዚህ ጊዜ ለመወሰን ምክንያቶች ምንድን ነዉ?	.....
410	ወሳኔዉን ማን ወሰነዉ?	1. እኔ ራሴ 2. ባለቤቴ 3. ዘመዶች 4. ሌሎች ሰዎች ይግለጹ.....	
411	እዚህ ጤና ጣቢያ መቼ/ስንት ሰዓት ደረሱ?	ቀን _____ ሰዓት _____	
412	የመጀመሪያ ምርመራ መቼ/ስንት ሰዓት ጀመሩ?	ቀን _____ ሰዓት _____	
413	ለምንድን ነዉ በዚህ ሰዓት ምርመራ የጀመሩት?	.....
414	ከሌላ ጤና ድርጅት በሪፌራል ነዉ የመጡት?	1. አዎ 2. አይደለም	አይደለም ካሉ ወደ ጥያቄ ቁ 416 ይሂዱ
415	የጥያቄ ቁ. 414 መልስ አዎ ከሆነ መቼ ነዉ? ሪፌራል የተደረገት?	ቀን _____ ሰዓት _____	
416	ሪፌራል ያደረገዉ ጤና ደርጅት ምን ያህል ጊዜ ቆዩ?	_____ ሰዓት	
417	ሪፌራል አድራጊዉ ጤና ደርጅት ምን ዓይነት ጤና ድርጅት ነዉ?	1. ጤና ኬላ 2. የግል ክሊኒክ 3. ጤና ጣቢያ 4. ሌላ.....	

418	ሪፌር የተደረገበት ምክንያት ምንድን ነው?	<ol style="list-style-type: none"> 1. የሰለጠነ ባለሙያ እጥረት 2. የመድሀኒት/መሳሪያ እጥረት 3. የባለሙያ ያለመኖር 4. ችግሩ ከጤና ደርጅት አቅም በላይ መሆን 5. ሌላ ምክንያት 	
419	በጤና ድርጅት መውለድ ምርጫዎ ነበር ወይ?	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 	አይደለም ካሉ ወደ ጥያቄ ቁ 421 ይሂዱ
420	የጥያቄ ቁ. 419 መልስ አይደለም ከሆነ ምክንያቱ ምንድን ነው?	<ol style="list-style-type: none"> 1. ፍርሃት 2. ርቀት 3. የገንዘብ እጥረት 4. የጤና ባለሙያዎች በአግባቡ አያስተናግዱንም 5. በሌላ..... 	
421	በጤና ጣቢያ ለመውለድ ለምን ፈለጉ?	<ol style="list-style-type: none"> 1.ጤ/ጣቢያው ቅርብ ስለሆነ 2.ጥሩ አገልግሎት ለማግኘት 3.ከዚህ በፊት በጥሩ ሁኔታ እዚህ ስለወለድኩኝ 4.ጤ/ጣቢያ ወለጂ ስለተባልኩኝ 5. ምጥ ስላስቸገረኝ 6.ከዚህ በፊት በወሊድ ምክንያት መጥፎ ነገር ስለገጠመኝ 7.በሌላ ምክንያት..... 	
422	የወሊድ አገልግሎት እንዴት አገኘሽ?	<ol style="list-style-type: none"> 1.በነጻ 2. በክፍያ 	
423	አገልግሎቱን በክፍያ ካገኘሽ ምን ያህል ብር ከፈልገሽ?	-----ብር	
424	በክፍያው ላይ ያለሽ አስተያየት ምንድን ነው?	<ol style="list-style-type: none"> 1. አቅም ያላገናዘበ/ወደ 2. አቅም ያገናዘበ 3. ሪካሽ 4. አስተያየት መስጠት አልፈልግም 	
425	ለወልድና ከወለድ ጋር ተያይዞ ሊፈጠሩ ለሚችሉ ህመሞችን የህክምና አገልግሎት በወቅቱ ከጤና ድርጅት ለማግኘት በገንዘብ ተዘጋጅተሻል ወይ?	<ol style="list-style-type: none"> 1.አዎ 2.አልተዘጋጀውም 	
426	የአንቺን ከጤና ድርጅት አገልግሎት የማግኘት ሂደት የሚወስንልሽ ማን ነው?	<ol style="list-style-type: none"> 1. እራሴ 2. ባለቤቴ 3.ዘመዶቻችን 4.የኃይማኖት አባቶች 5.ሌሎች..... 	
427	ከወልድ ጋር ተያይዞ አንድ እናት ሊገጥማት ስለሚችል አደገኛ ሁኔታዎችን ታወቃለሽ ወይ?	<ol style="list-style-type: none"> 1.አዎ 2.አልወቅም 	አሳዘቅም ካሉ ወደ ጥያቄ ቁ 429 ይሂዱ
428	የጥያቄ ቁ. 427 መልስ አዎ ከሆነ እነዚህ አደገኛ ሁኔታዎች ምን ምን ናቸው?	<ol style="list-style-type: none"> 1. ከእርግዘና ጋር የተያያዙ ህመሞች 2. የእናቶች ሞት 3. የህጻን ሞት 4. ሌሎች..... 	
429	ከወልድ ጋር ተያይዞ አንድ እናት ሊገጥማት ስለሚችሉ አደገኛ የህመም ስሜቶች ያወቃሉ ወይ?	<ol style="list-style-type: none"> 1. አዎ 2.አሳዘቅም 	አሳዘቅም ካሉ ወደ ጥያቄ ቁ 431 ይሂዱ
430	የጥያቄ ቁ. 427 መልስ አዎ ከሆነ እነዚህ ከወልድ ጋር ተያይዞ የሚመጡ አደገኛ ምልክቶች ምን ምን ናቸው?	<ol style="list-style-type: none"> 1. ከማሕፀን ደም መፍሰስ 2. ራስ ምታት 3. ራስ ማዞር 4. ከፍተኛ የሆድ ህመም 5. ሌሎች ካሉ ይጥቀሱ.... 	

431	ዘግይቶ ለወልድ ወደ ጤና ተቋም መሄድ ለጤና አደገኛ ነው ብለው ያስባሉ?	1. አዎ 2. አልወቅም	
432	እዚህ ጤና ተቋም ስለሚሰጥ አገልግሎት ደስተኛ ናት?	1. አዎ 2. አይደለም	ክፍል ካሉ ወደ ጥያቄ ቁ 434 ይሂዱ
433	የጥያቄ ቁ. 432 መልስ አይደለም ከሆነ ደስተኛ ያልሆኑበት ምክንያት ምንድን ነው?	1. መድሀኒትና መሳሪያዎች ዕጥረት አለ 2. የጤና ባለሙያዎች በአግባቡ አያስተናግዱም 3. የአገልግሎት ዋጋ ወድ ነው 4. ሌላ ምክንያት ካለ ይጥቀሱ	
434	እዚህ ጤና ተቋም ያሉ ባለሙያዎች ብቃት ያላቸው በአግባቡ የሚያስተናግዱ ናቸው	1. አዎ እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
435	ይህ ጤና ተቋም በመድሀኒትና ህክምና መሳሪያ በአገልግሎት አሰጣጥ የተሟላ ነው	1. አዎ እስማማለሁ 2. አልስማማም 3. ምንም አስተያየት የለኝም	
436	በአካባቢያችሁ ለነፍሰጡር እናቶች ወደ ጤና ጣቢያ ዘግይቶ ለወልድ አገልግሎት መምጣት ምክንያት የሆኑ ባህላዊና አስተሳሰባዊ ምክንያቶች አሉ?	1. አዎ 2. የሉም	

437. በአካባቢያችሁ ለነፍሰጡር እናቶች ወደ ጤና ጣቢያ ዘግይቶ ለወልድ አገልግሎት መምጣት ምክንያት የሆኑ ባህላዊና አስተሳሰባዊ ምክንያቶችን ዘርዝሩ?

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የሚመለከታቸው አካላት ወይይት መመሪያ/FGD GUIDE/

ስሜ.....ይባላል። የንደኛዬ ስም.....ነው። የመጣነው ከጅም ዩንቨርሲቲ ሲሆን በእናቶች በወልድ ጊዜ የጤና ተቋም ለመጠቀም መዘግዬት ዙሪያ ጥናት ለማድረግ ነው። ስለዚህ በዚህ ዙሪያ ግልፅ ወይይት ለማድረግ እዚህ ስለተገኛችሁ በጣም አመሰግናለሁ። የወይይታችን አርዕስት ቀላልና ግልፅ ነው። በተነሳው ሀሳብ ዙሪያ የሚታስቡትንና የሚታምኑትን ሁሉ በነጻነት መናገር ትችላላችሁ። የሚታደርጉት ወይይት በቴፕ ይቀዳል። ነገር ግን የዚህ ወይይት ሀሳብ የሚያገለግለው ለጥናት ዓላማ ብቻ ነው። የግል ጉዳዮችሁ ለማንም ተላልፎ አይሰጥም። እዚህ የሚንቆየሁ ለ 40 ደቂቃ ያህል ነው። ሰዓታችሁን ስለሰጣችሁን እናመሰግናለን።

የወይይት ጥያቄዎች

- ከወልድ ጋር ተያይዞ ስለሚከሰቱ ህመሞች ምን ምን ያወቃሉ?
- ህመሞቹ ሲከሰቱ ምን ያደርጋሉ?
- ዘግይቶ የወልድ አገልግሎት መጠቀም ጋር ተያይዞ ስላሉ ጉዳዮች ምን ያወቃሉ?
- ዘግይቶ የወልድ አገልግሎት መጠቀም ምክንያቶች ምን ምን ናቸው?
- በአካባቢያችሁ የነፍሰጡር እናቶች ከጤና ተቋም የወልድ አገልግሎት ተጠቃሚ የመሆን ጉዳይ የሚወሰነው በማን ነው?
- ማን ነው የሚወስንላት? ለምን?
- የወልድ አገልግሎት ከጤና ተቋም ተጠቃሚ ለመሆን በአካባቢያችሁ የትራንስፖርት ችግር አለ ወይ? ችግሮቹ ምን ምን ናቸው? ወደ ጤና ተቋም ለወልድ ለመምጣት ስንት ሰዓት ይፈጅባችዋል?
- በሰለጠነ ባለሙያ የወልድ አገልግሎት ተጠቃሚ ነዎት? እንዴት?
- እዚህ ጤና ተቋም ስለሚሰጥ አገልግሎት ደስተኛ ናት? አገልግሎቱ በቂ ነው ብለው ያምናሉ?
- እዚህ ጤና ተቋም ያሉ ባለሙያዎች ብቃት ያላቸው በአግባቡ የሚያስተናግዱ ናቸው?
- ይህ ጤና ተቋም በመድሀኒትና ህክምና መሳሪያ በአገልግሎት አሰጣጥ የተሟላ ነው? እንዴት?
- በአካባቢያችሁ ለነፍሰጡር እናቶች ወደ ጤና ጣቢያ ዘግይቶ ለወልድ አገልግሎት መምጣት ምክንያት የሆኑ ባህላዊና አስተሳሰባዊ ምክንያቶች አሉ? ምን ምን ናቸው?
- ነፍሰጡር እያሉ በጤና ጣቢያ የወልድ አገልግሎት ተጠቃሚ ለመሆን በገንዘብ እራሶን ዝግጁ አድርገው ነበር ነው? እንዴት?

Declaration

Assurance of Principal Investigator:

I, the undersigned, agree to accept responsibility for the scientific Ethical and technical conduct the research project and for provision of required progress reports as per terms and conditions the public health and medical sciences in effect at the time of grant are forwarded the result of this application.

Name of the student _____

Date _____ signature _____

Approval of the Advisors:

This thesis has been submitted with my approval as University advisor.

Name of first advisor _____

Date _____ signature _____

Name of second advisor _____

Date _____ signature _____