

**UTILIZATION OF SKILLED BIRTH ATTENDANT IN BONGA
TOWN, KAFA ZONE, SOUTH WEST ETHIOPIA**



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**Utilization of skilled birth attendant in Bonga town, Kafa zone,
Southwest Ethiopia**

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Abstract

Background

Ethiopia with maternal mortality ratio of 676 per 100,000 live births, the majority of births are delivered at home and the proportion of deliveries assisted by skilled attendant is very low, among the total urban births 51% are used skilled delivery, in EDHS 2011. Implementing and assuring utilization of skilled delivery services is potentially one of the most effective maternal health interventions for preventing maternal morbidity and mortality.

Objective

To assess utilization of skilled birth attendant among mothers who gave birth the last one year prior to the data collection period in Bonga town.

Methodology

Community based cross-sectional study employing quantitative methods was conducted from June 1 to July 25, 2013. Stratified random sampling technique was employed to select a sample of 296 participants, by using list of mothers who gave birth in the last one year in each kebele of the Bonga town as strata. Kebele health extension workers registration book was used as a sampling frame. The total sample size was allocated according to the proportion of total mothers who gave birth in each kebeles. Data were collected by using structured questionnaire. And then the collected data was cleaned, and analyzed using stastical package for social sciences version 16.0 soft ware. Odds ratio and 95% Confidence interval were calculated. $P < 0.05$ was considered statistically significant. The aim of this study filling the gaps, by attempting to explore the extent of the problem and factors attributed to poor skilled delivery service utilization and can help for program planners, policy makers and health care providers to focus on the factors and the disadvantaged women in Bonga town, Kafa zone, Southwest Ethiopia.

Result:

A total of 296 women were included in the study yielding a response rate of 100%. From the total deliveries 78.6% of the women utilize skilled birth attendant during delivery. If women have secondary education and more they are more likely to utilize skilled delivery attendant, $OR=8.06$ with 95%CI of (1.75, 37.12) and $OR=4.82$ with 95%CI of (1.03, 22.52) respectively. Women who had ANC visits were more likely to utilize skilled delivery attendant when compared to those who did not have antenatal visit, $OR=9.87$ 95%CI of (1.79, 54.40). Women who know about pregnancy and delivery complication are about twelve times, $OR = 12.45$ and 95%CI of (3.15, 49.26) more likely to utilize skilled delivery attendant when compared to those who had no information about pregnancy and delivery complication. Women who decided to deliver at health facility by themselves were twice more likely to utilize skilled delivery attendant than others.

Conclusion

Women's educational status, their number of pregnancy, ANC visit, knowledge about risk factors related to pregnancy and women's power to make the decision in terms of getting skilled delivery are important predictors for their utilization of skilled birth attendant. Interventional IEC activities focusing on pregnancy complications and benefits of ANC for reproductive age women will be helpful in utilizing skilled delivery attendant so that their influences can be directed in the line of encouraging women to utilize skilled delivery services.

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Acronyms

ANC	Antenatal Care
BEmOC	Basic emergency obstetric Care
CI	Confidence Interval
CSO	Central Statistics Office
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
FMOH	Federal ministry of health
HD	Home Delivery
HF	Health Facility
ICPD	International Conference on Population and Development
ID	Institutional Delivery
MCH	Maternal & Child Health
MDG	Millennium development goal
MMR	Maternal Mortality Rate
OR	Odds Ratio
SDA	Skilled Delivery Attendant
SSA	Sub-Saharan Africa
SNNPR	South Nation Nationality People Region
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

1.1 Background

Health services accessibility has been a challenge globally especially in developing countries. Utilization of maternal health services in developing countries is bedeviled with not only infrastructural and quality issues but also in access. The effect of low utilization of quality maternal care services is known to be a contributory factor to the high incidence of avoidable deaths of pregnant women in mostly developing nations including Ethiopia. The use of skilled delivery is desirable as it is recognized to yield positive delivery outcomes by reducing maternal and infant morbidity and mortality. Sub-Saharan Africa (SSA) contributes to 57% of the 358, 000 global maternal deaths despite the fact that it has 17% of the global births (1). This shows that maternal mortality is a major public health problem in SSA countries. The life time risk of dying during pregnancy, childbirth or in the early post natal period is very high in this area; 1 in 31 compared to 1 in 4300 in developed regions (2). Similarly, more than a third of the approximately 2.65 million stillbirths and 3.3 million neonatal deaths globally occur in SSA (2, 3).

Access to Skilled Birth Attendance during childbirth and in the immediate post natal period, and access to Emergency obstetric care in case of obstetric complications are considered to be effective interventions to reduce the number of global maternal and newborn deaths (4)

As shown in assessment of trends in maternal mortality for 181 countries from 1980 to 2008, it was estimated to be 342,900 maternal deaths world- wide in 2008 decreasing from 526,300 in 1980. More than 50% of all maternal deaths were only from six countries in 2008 (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of Congo) [5].

It is known about 80% of maternal deaths are due to causes directly related to pregnancy and childbirth [6]. Worldwide, the major causes of maternal mortality are haemorrhage (24%), infection (15%), unsafe abortion (13%), prolonged labour (12%) and eclampsia (12%) whereas primary causes of maternal mortality in Africa are haemorrhage (34%), other direct causes (17%), infection (10%), hypertensive disorders (9%) and obstructed labour (4%), abortion (4%) and anemia (4%) [6].

Many countries are encouraging women to deliver at health facilities implying that the facilities are well equipped and have skilled health personnel. The Government of Ethiopia is committed to improve maternal health with a target of reducing the maternal mortality ratio

(MMR) by three-quarters over the period 1990 to 2015. In accordance with this, the Federal Ministry of Health (FMOH) has applied multi-pronged approaches to reduce maternal and newborn morbidity and mortality. It is striving to assure improved access to emergency obstetric services and to create home delivery free kebeles in each woreda. Avail where hospitals with trained professional staff exist. Improving access to and strengthening facility-based maternal and newborn services is one such approach, and is also a Health Sector Development Plan (HSDP) strategic objective, and yet maternal mortality remains unacceptably high. According to the 2011 Ethiopian Demographic and Health Survey (EDHS) report, MMR was 676 deaths per 100,000 live births. Maternal deaths represent 30% of all deaths to women age 15–49, compared with 21% in the 2005 EDHS and 25% in the 2000 EDHS (7).

1.2 Statement of the problem

In 2008, from the estimated 358 000 maternal deaths worldwide, developing countries accounted for 99% (355 000). Nearly three fifths of the maternal deaths (204 000) occurred in the SSA region alone followed by South Asia (109 000). Together the two regions accounted for 87% of such deaths globally. Southern Asia has made steady progress, with a 53% decline in maternal mortality between 1990 and 2008. In contrast, the ratio has fallen by only 26% in Sub-Saharan Africa, though evidence suggests that progress has picked up speed since 2000. More than 50% of all maternal deaths were in only six countries in 2008 (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo) (5). According to the 2011

Ethiopian Demographic and Health Survey (EDHS) report, MMR was 676 deaths per 100,000 live births. Maternal deaths represent 30% of all deaths to women age 15–49, compared with 21% in the 2005 EDHS and 25% in the 2000 EDHS (7). The proportions of births attended by skilled personnel are very much lower than SSA. Even for women who have access to the services, the proportion of births occurring in health facilities is very low. Only 6% of births were delivered in health facilities and there is no significant difference in proportions of delivery service utilization between EDHS 2000 and 2005 however this figure moderately increased to 10%, among the total urban delivery 51% are utilized skilled delivery, in EDHS 2011. Surprisingly, twenty eight percent of mothers delivered by traditional birth attendants; while the majority of births were attended by a relative or some

other person (61%) and 5% of all births were delivered without any type of assistance at all (8).

In Ethiopia first births are much more likely than births orders six or higher to be delivered in a health facility (21 percent versus 4 percent). Delivery in a health facility is more common among births to mothers age 20-34, births to mothers who had at least four ANC visits, and births to highly educated mothers and mothers in the highest wealth quintiles. The coverage of skilled delivery is different from region to region. The percentage of births delivered in health facility ranges from less than 10 percent in SNNP, Affar, Oromiya, Somalia, and Benishangul-Gumuz regions to 82 percent in Addis Ababa. The proportion of births assisted by a skilled provider ranged from 6 percent in the SNNP region to 84 percent in Addis Ababa. This indicates regional differences in skilled delivery utilization are large (7).

Since there was a limited study in the urban area of the countries related to this topic, particularly in the study area.

Therefore, this study has tried to find the extent of the problem which is, basic information on the proportion of deliveries conducted by skilled delivery attendant, and identify the possible factors that affect the utilization of skilled birth attendant among mothers who gave birth in Bonga Town, Kafa Zone, South west Ethiopia.

2. Literature review

2.1 Definition

According to a joint statement by WHO, the International Confederation of Midwives (ICM), and the International Federation of Obstetricians and Gynaecologists (FIGO), a ‘Skilled Birth Attendant’ (SBA) is defined as “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 identification, management and referral of complications in women and newborns” (9).

One of the major challenges in measuring and interpreting the skilled attendant indicator is determining who is counted as a skilled attendant. Many attendants who are described as “skilled” may not meet the internationally accepted criteria. Therefore, doctors, midwives, nurses, health assistants and auxiliary midwives are considered as skilled attendant, who have been regularly admitted to an educational programme, recognized in the country, have successfully completed the prescribed course of studies in midwifery and acquired the qualifications to be registered and legally licensed to practice midwifery. This definition of skilled attendant clearly distinguishes between providers who are simply trained. “Trained” implies but does not guarantee the acquisition of knowledge and competence with regard to midwifery skill. Therefore, trained or not adequately skilled community health worker TBA, TTBA do not fall under the WHO accepted definition of skilled attendant (10).

2.2 Maternal health

Skilled delivery utilization has been adopted as a leading indicator of maternal health for numerous international agreements and agencies.

The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. This definition allows identification of maternal deaths, based on their causes, as either direct or indirect. Direct maternal deaths are those resulting from obstetric complications of the pregnant state (pregnancy, delivery and postpartum), interventions, omissions, incorrect treatment, or a chain of events resulting from any of the above. Deaths due to, for example, obstetric haemorrhage or hypertensive disorders in pregnancy, or those due to complications of anaesthesia or caesarean section are classified as direct maternal deaths. Indirect maternal

deaths are those resulting from previously existing diseases, or from diseases that developed during pregnancy and that were not due to direct obstetric causes but aggravated by physiological effects of pregnancy. For example, deaths due to aggravation of an existing cardiac or renal disease are considered indirect maternal deaths (11).

The mortality of a woman of reproductive age also brings significant economic losses and setbacks to community development. Hence, most recently, at the millennium summit in 2000, the UN member states issued the MDG that call for a three-fourth reduction in maternal mortality rate by the year 2015 (10).

Globally, the main causes of maternal death are haemorrhage (24%), infection (15%), unsafe abortion (13%), prolonged labour (12%) and eclampsia (12%) whereas primary causes of maternal mortality in Africa are haemorrhage (34%), other direct causes (17%), infection (10%), hypertensive disorders (9%) and obstructed labour (4%), abortion (4%) and anemia (4%) [5].

Worldwide, an estimated 287 000 maternal deaths occurred in 2010, a decline of 47% from levels in 1990. Sub-Saharan Africa (56%) and Southern Asia (29%) accounted for 85% of the global burden (245 000 maternal deaths) in 2010. At the country level, two countries account for a third of global maternal deaths: India at 19% (56 000) and Nigeria at 14% (40 000). The global MMR in 2010 was 210 maternal deaths per 100 000 live births, down from 400 maternal deaths per 100 000 live births in 1990. The MMR in developing regions (240) was 15 times higher than in developed regions (12). Sub-Saharan Africa had the highest MMR at 500 maternal deaths per 100 000 live births, while Eastern Asia had the lowest among MDG developing regions, at 37 maternal deaths per 100 000 live births. The MMRs of the remaining MDG developing regions, in descending order of maternal deaths per 100 000 live births are Southern Asia (220), Oceania (200), South-eastern Asia (150), Latin America and the Caribbean (80), Northern Africa (78), Western Asia (71) and the Caucasus and Central Asia (46). A total of 40 countries had high MMR (defined as $MMR \geq 300$ maternal deaths per 100 000 live births) in 2010. Of these countries, Chad and Somalia had extremely high MMRs (≥ 1000 maternal deaths per 100 000 live births) at 1100 and 1000, respectively. The other eight highest MMR countries were: Sierra Leone (890), the Central African Republic (890), Burundi (800), Guinea-Bissau (790), Liberia (770), the Sudan (730), Cameroon (690) and Nigeria (630) (11).

Ethiopia is one of the countries in sub-Saharan Africa with markedly high maternal mortality ratio. The maternal mortality ratio (MMR) in the country has stagnated at 676 per 100,000 live births after declining from 871 per 100,000 live births in 2000 to 673 in 2005. Efforts to reduce maternal mortality should focus on reducing the likelihood that a woman will have a high risk pregnancy; reducing the likelihood that a pregnant woman will experience a serious complication of pregnancy or childbirth and improving the outcomes for women with complications (13).

2.3 .Factors influencing utilization of skilled attendant at birth

2.3.1 Socio-demographic factors

Study in EDHS 2011 report highly educated mothers were most likely to have their births assisted by a skilled provider (74 percent)(7) so women's literacy is an important predictor for the use of maternal health care services. It is well recognized that a woman's educational level has a positive impact on health care utilization. Increased education influences service use by increasing female decision-making power, increasing awareness of health services, changing marriage patterns, and creating shifts in household dynamics(11) .Women's education may also act as a proxy variable of a number of background variables representing women's higher socioeconomic status, thus enabling them to seek proper medical care whenever they perceive it as necessary. In Afghanistan, study report that low female literacy is associated with lower skilled birth attendant use in a country in which, nationwide, only 6% of women can read (14).

A number of socio demographic and economic factors were found to have a significant influence on use of skilled care at delivery. They include women's age, education level, marital status and income. Study in Tanzania revealed that young women are just starting child bearing and are told to be in high risk group, they tend to fear home deliveries. It is also possible that the new generation with the higher proportion of women who have formal education have different perspectives in delivery care when comparing to older generation (15).

Other study done in Ethiopia showed that the use of delivery care services is significantly shaped by place of residence, women's education, number of children under five, and year of birth. Accordingly, women from Addis Ababa are about five times more likely to receive

delivery care from a health professional than women from other urban areas. Women's education also found to be an independent predictor of utilization of delivery care services in urban Ethiopia, women with at least secondary education, seven times higher than women with primary education, also women with primary education two times higher compared with women with no education (16).

Perhaps the clearest and best documented example of link between women status and maternal health is the impact of women's education and use of contraceptive, ANC, delivery care and post natal care, as a result education affects maternal health by improving women's access to information and their ability to make choices about their bodies; education can also develop the skills and confidence they need to demand better maternal health (17).

Other study in Southern Tanzania reported that years spent in schools also showed a significant association with seeking of skilled care during delivery with women who have more schooling years having a higher proportion of delivered (50.4%) attended by skilled personnel compared to those with fewer schooling years or those who did not go to formal schooling (15). Study in North Gondor zone showed mothers whose educational status was secondary school and above, eleven times more likely to give birth at health institutions than women with other level of education (18).

Study in Adigrat town revealed that literate mothers were about two times more likely to prepare for birth and complication than their illiterate counterparts (19). Regarding income and place of residence EDHS 2005 showed those having highest quintile of wealth were used professionally assisted delivery, nearly twenty six times higher than lowest quintile; also 45 percent of birth in urban area were assisted by trained health professional compared with only 3 percent of births in rural area (20).

2.3.2 Obstetric factors

During pregnancy, skilled attendants monitor the progress of the pregnancy, detect complications, provide preventive measures, develop birth and emergency plans with the woman and her family and advise women on health, lifestyle and nutrition in pregnancy. Studies carried out in different parts of the world concerning maternal health care utilization had identified many factors related to pregnancy and child birth.

Strong and positive correlations between the number of antenatal visits and the use of skilled birth attendants and postpartum care use were found. Women who receive antenatal care were more likely to receive skilled birth attendants for delivery as well as postpartum care (13).

Women in Undra Pradesh, India are more likely to get care for their first delivery than others that follow. This is associated with factors like fear of the unknown or excitement that is probably associated with the first child birth (21).

According to the 2011 EDHS data, the proportion of women that delivered in health institution increased from a low of 3.3% among those who did not have any ANC, to 8.8%, 8.9%, 20.1% and 35.2%, respectively, among those who had one, two, three and four or more ANC visits(7)

Study conducted in Mekele town reveals that women with first pregnancy were four times more likely to utilize skilled delivery attendant than women who have ≥ 5 pregnancies. Women who had ANC visits were three times more likely to utilize skilled delivery attendant when compared to those who did not have ANC visit. The presence of pregnancy and delivery complications is another significant variable that is women who know about presence of pregnancy and delivery complication are three times more likely to utilize skilled delivery attendant. .Women who obtained MCH information was two times more likely to utilize skilled delivery attendant (22).

The study done in Oromia Region, Southeast Ethiopia showed that mothers who had ANC visits during the last pregnancy were about four times more likely to deliver at health facilities compared to those who did not have any visits (23).

2.3.3 Women's decision making power

Decision making power in the household, and access to education and economic opportunities, they are better able to get and use services before, during, and after pregnancy and childbirth. Women's involvement in household decision making is also positively associated with use of maternal health services, one study in Nepal, women with significant decision-making power were more than twice more likely to deliver at health facility than women with more limited decision-making power (24).

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. Women who earned money through self-employment or credit used the small amount of money they earned to pay for health care, but most women would only seek care on their own accord if services were free (25). Study in North Gonder showed that 44.8 percent of women it was the husbands who decide where and when to seek help during labour (18).

2.3.4 Health service factor

Accessing quality care in health facility includes availability of skilled birth attendant with competed skills, availability of supplies, adequate equipment, drugs and actual quality of care provided, means of referral, appropriate treatment, guide line/protocol, availability of BEmOC and CEmOC.

The availability of health facilities is important in determining the utilization of skilled attendants. Access to such facilities should be such that roads to and from it are easily accessible, in times, cost and means.

A study in Mozambique had revealed that the health care accessibility is significant and important factor in women's choice of delivery location, 75 % of mothers with a distance less than half an hour had utilized the service, while 42% of mothers greater than three hours had utilized the service (15). The proportion of women with skilled care at delivery had decreased with increasing distance to the health facility. Women living within one hour walking distance were 50% more likely to utilize the service (26).

Payment for health care especially for the poor is one of the hindering factors that prevent women from seeking medical attention from skilled personnel. Even where exemptions exist, there are a lot of informal payments in form of cash or in kind to health workers. These payments are sought by health workers who earn meager salaries and intend to survive on these payments (27).

In Ethiopia women's get access to maternal health services are very few. According to Ethiopian DHS 2011 report women who did not deliver at a health facility were asked the reasons they did not deliver in a health facility, more than six women in ten (61 percent) stated that a health facility delivery was not necessary, and three in every ten (30 percent) stated that it was not customary. Fourteen percent of women said that the health facility was either too far or that they did not have transportation. Rural women were more likely than urban women to report that health facility deliveries are not customary, at 31 percent versus 17 percent, or that health facilities were too far or they had no transportation, at 15 percent versus 8 percent(7).

2.3.5. Women's Knowledge and attitude on obstetric risk

Lack of knowledge and attitude makes incorrect perception of maternal health practices which deals with the mothers to move towards the unskilled delivery, but these can be prevented if the mother had a teaching on antenatal care during her pregnancy. According to EDHS 2011 report among women who were informed of signs of pregnancy complications at an ANC visit for their last live birth, almost half (48 percent) were informed of abdominal pain as a sign of pregnancy complications. More than one-third (36 percent) were informed of severe headache, one-fourth (25 percent) were informed of vaginal bleeding, and about one-fifth (22 percent) were informed of vaginal gush or fluid as signs of pregnancy complications. Fourteen percent of women were informed of fever, and 7 percent were informed of blurred vision as possible signs of pregnancy complications (7).

Study in Mekelle town shows among the respondents only 43.0% were knowledgeable about the advantage of prenatal care service. When the women who were knowledgeable about the advantage of prenatal care service compared with those who used the service they were below half of them. Regarding attitude of mothers who delivered at health facility towards institutional delivery 97.5% were having good attitude while 2.2% had bad attitude (22).

Other study in North Shoa Zone, considering the maternal knowledge about obstetric risks during pregnancy, mothers who did not know danger sign during pregnancy were less likely to give birth at HF than those mother who knew at least one danger sign of pregnancy (OR 0.47, 95%CI=0.31-0.72). On other hand mothers who have knowledge about the risk of giving birth at home or benefits of giving birth at health facility were significantly associated with the use safe place of delivery (OR 10.08, 95%CI=5.63-18.30) and ($\chi^2=52.37$, $P=0.000$)

respectively. Experiencing a danger sign during pregnancy was associated with the place of delivery. Mothers who did not encounter a problem during pregnancy were 43% less likely to utilize health facility delivery service (OR 0.57, 95% CI= 0.35-0.92)(26).

The Government of Ethiopia is committed to improve maternal health with a target of reducing the maternal mortality ratio (MMR) by three-quarters over the period 1990 to 2015. In accordance with this, the Federal Ministry of Health (FMOH) has applied multi-pronged approaches to reduce maternal and newborn morbidity and mortality. It is striving to assure improved access to emergency obstetric services and to create home delivery free kebeles in each woreda. Avail where health centers and hospitals with trained professional staff exist. Improving access to and strengthening facility-based maternal and newborn services is one such approach, and is also a Health Sector Development Plan (HSDP) strategic objective, and yet maternal mortality remains unacceptably high(7,13).

Therefore, this study was done to measure the proportion of utilization of skilled attendant at birth and identify factors influencing utilization of skilled birth attendant among mothers who gave birth for the past one year in Bonga town.

3. Significant of the study

Every year around eight million mothers suffer from pregnancy-related complications and over half a million die. In developing countries, one woman in 16 may die of pregnancy-related complications compared to one in 2800 in developed countries (17).

In Ethiopia, the level of maternal morbidity and mortality are among the highest in the world. According to the EDHS 2011 report, the maternal mortality ratio was 676 per 100,000 live births (7). One possible explanation for poor health outcomes among women is non-availability and non-use of modern health services by a sizable proportion of women. Several studies have clearly demonstrated that utilization of existing maternal health services especially skilled delivery service is very low in the country. Only a quarter of Ethiopian women received ANC and less than 10 percent of mothers received professionally assisted delivery (20). A number of studies confirmed that the use of skilled birth attendant at every delivery is found to be the best process indicator that correlates with maternal mortality and poor delivery outcome (9).

This study, therefore, aimed at filling the gaps, by attempting to explore the extent of the problem and factors attributed to poor skilled delivery service utilization and can help for program planners, policy makers and health care providers to focus on the factors and the disadvantaged women in Bonga town, Kafa zone, Southwest Ethiopia.

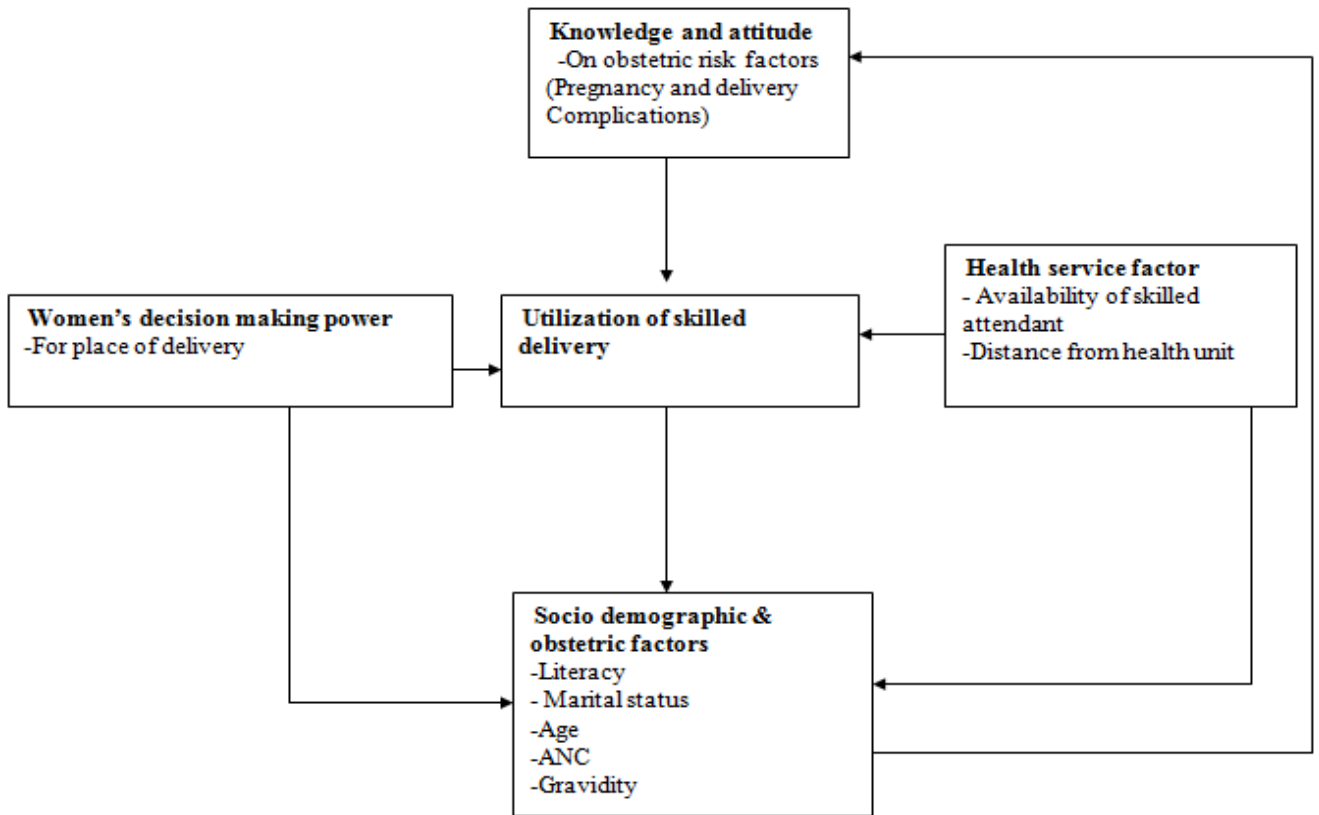


Figure 1: Conceptual frame work developed from literature reviews, August 2013

4. Objective

General Objective

To assess utilization of skilled birth attendant among mothers who gave birth during the last one year in Bonga town.

Specific Objectives

- To measure the proportion of deliveries assisted by skilled birth attendant, among mothers who gave birth during the last one year.
- To assess the factors affecting of utilization of skilled birth attendant by using crude odds ratio and adjusted odds ratio among mothers who gave birth during the last one year.

5. Method and materials

5.1 study area and period

Data was collected from June 1 to 30, 2013 in Bonga town, Kafa zone in Southwest Ethiopia. Bonga, administrative town of Kafa zone is located at 105 kilometers from Jimma town and 465 kilometers southwest from the capital city, Addis Ababa. The total population of the town is estimated to be 27634 of which 13624 (49.3%) are males and 14010 (50.7%) are females (33). The town has total of 3 administrative kebeles, one General Hospital, and one type “A” health center.

5.2 The Study design

The design was community based cross-sectional study

5.3 Population

5.3.1 Source population

All women of childbearing age, (15-49yrs) residents in Bonga town.

5.3.2 Study population

All women’s who gave birth in the last one year prior to the time of the interviews and are permanent residents of the Bonga town.

5.3.3 Study Unit

Selected women who gave birth in the last one year and permanently residing in the Bonga town were included in the study.

5.4.1. Sample Size

Sample size is determined using single proportion population formula:

$$\frac{(Z_{\alpha/2})^2 \times P(1 - P)}{(d)^2}$$
$$\frac{(1.96)^2 \times 0.51(1 - 0.51)}{(0.05)^2} = 384$$

Where,

d = Degree of precision or margin of error (0.05)

α = Risk of rejecting the null hypothesis (0.05)

P = population proportion of skilled birth attended in urban 51% EDHS 2011

Z= Standard score corresponding to 95% confidence interval

Since the source population <10, 000, the population correction formula is employed.

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

N = 901 delivered mothers

Final no. mothers in the study was $n_f = 269$

Considering 10 % non-response rate, the total sample was settled at **296**.

5.4.2. Sampling procedure

Stratified random sampling technique employed by using list of mothers from registration book of kebeles health extension workers. The total respondents were allocated according to the proportion of total mothers who gave birth in each kebeles by using lottery method. From K1= 121, K2= 70, K3= 105 **totally 296** mothers will be selected.

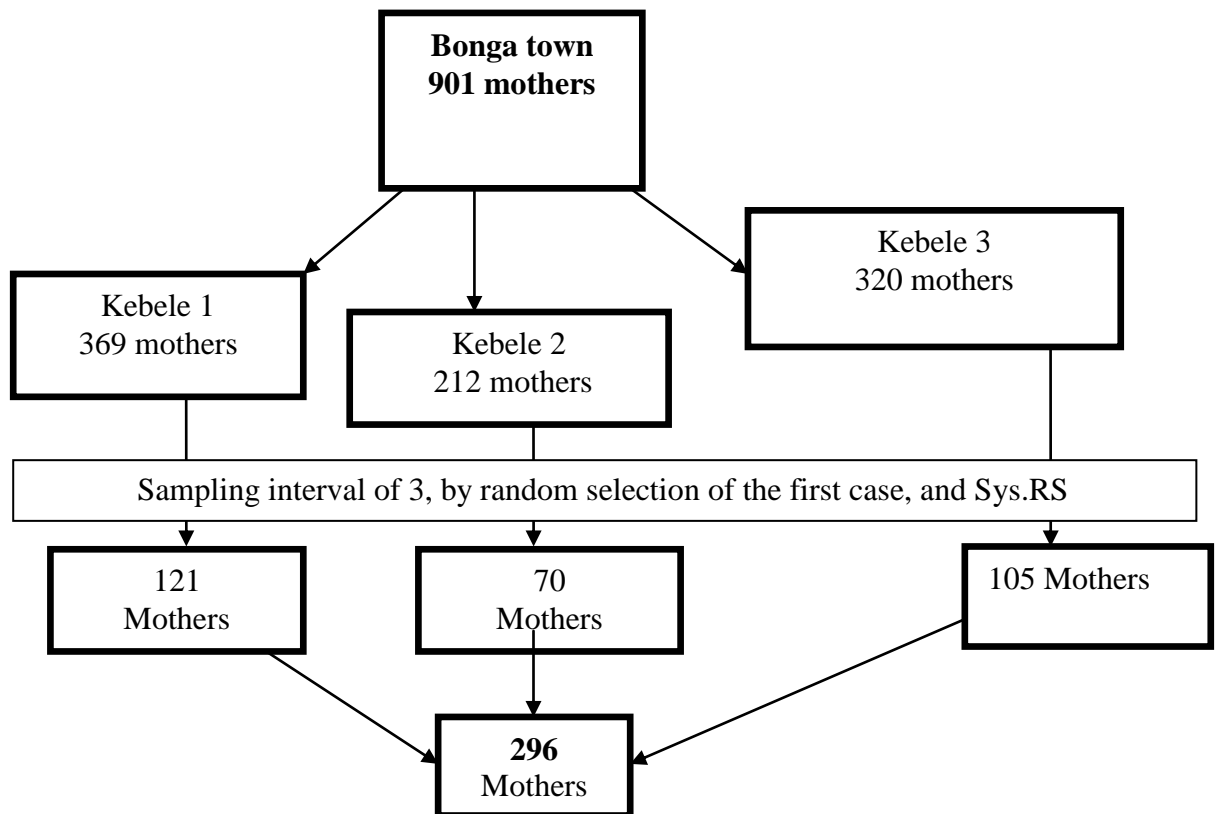


Figure 2: Schematic presentation of sampling procedure of selecting study participants August 2013

5.4.3. Inclusion

- Women who gave birth in the last one year and who have been residing in the study area for at least six months prior to the last birth.

5.5 Data collection.

5.5.1 Data collection tools

Structured questionnaire was adapted from previous related study and different literature for face to face interview(7); the major change in this study questionnaire is data about economic status is measured by wealth index because income is not a valid to measure the economic status of the family for the developing country like Ethiopian. The main themes of the questionnaire were demographic data; Utilization of Skilled Birth, Knowledge and attitude, Pregnancy and labour danger sign.

5.5.2 Pre-testing

The interviewer administered structured questionnaire will be translated in “Kaffinoo” and Pre test was conducted on 5% of the study population at Gimbo town. The logical sequence of the questionnaire and the appropriateness of questions, the wording and clarity of language will be checked after pretest. And data collection tools were modified according to the pretest findings.

5.5.3 Data collection procedure

Data collection was conducted by six graduate TTC students and two supervisors (HO's) were participated in the data collection process. Data collectors were trained about the data collection tools and procedures for two days.

5.5.4 Data quality control

The questionnaires was prepared in English & translated to Amharic and “Kaffinoo” then again translated back to English to ensure its consistency and validity. Training was given for data collectors and supervisors for two days. The collected questionnaires was submitted and edited on daily bases; immediate feedback was given for the problems.

5.5.5 Study variables

Dependent Variable:

- Utilization of skilled birth attendant.

Independent Variable:

- Socio demographic factor: age, marital status, occupation, wealth index, education, place of residence
- Obstetric factor: parity, ANC
- Knowledge and attitude factor: Pregnancy and labour danger sign, knowledge about pregnancy risk, attitude on health facility.
- Health service factor- Accessibility of institutional skilled delivery services
- Women's decision making for place of delivery.

5.6 Data processing and analysis

Quantitative data was entered, cleaned and analyzed using SPSS version 16.0 statistical software. Errors related to inconsistency of data was checked and corrected during data cleaning. The univariate analysis such as proportions, percentages, ratios, frequency distributions and appropriate graphic presentations besides measures of central tendency and measures of dispersion were used for describing data. Bivariate analysis of socio-demographic, obstetrics factors, Health service factors, Women's decision making power and Women's Knowledge and attitude on obstetric risk were included. Then multivariate logistic regression model was used to control confounding variables. Variables which were included in the multivariate logistic regression model were those significantly associated to the outcome in the bivariate level.

5.7 Ethical Consideration

Ethical approval of the research proposal was received from Ethical approval committee at Jimma University college of public Health and medical science and letter of permission was taken from department of Health Services Management and Bonga town administration health unit. Individuals' verbal informed consent was taken and confidentiality with privacy was ensured for all participants.

Everyone was given right to voluntarily participate or decline to participate in the interview at any step. The data collector would respect the client's ability to choose, make decision, and change in the light of his/her own beliefs, values and

circumstances. The individual could refuse or interrupt at any step of the participation. Whether or not responded no harm to the individuals with regard to the service they intend to get

5.8 Operational definition

- **Skilled attendant:** are Doctors, Health officers, Midwives, Nurses and urban health extension workers who undergo formal education in educational programme, and successfully completed the qualification to be registered and legally licensed to practice midwifery and who is identified and stated by mothers.
- **Predisposing factors:** Any characteristics of the mother which facilitates or hinders utilization of skilled birth attendant, like knowledge and attitude on obstetric risk factors, Socio demographic & obstetric factor
- **Permanent residence-** women who have been residing in the study area, at least six month prior to the data collection which is stated by the mothers.
- **Wealth index-** The wealth index was developed on the basis of household owning durable goods such as a television, radio and certain housing characteristics such as access to electricity, source of drinking water, type of toilet facilities, type of flooring material, types of roofing materials and type of cooking fuel. All the yes/no variables should be recoded in to binary variables and create the wealth index by using the Principal Component Analysis (PCA). The output show us which are the original variables that contributed to explain/create the first factor. We used first component as wealth index. The households were then classified into five wealth quintiles: Poorest, Poorer, middle, Richer and Richest quintile.
- **Knowledge: -** Women who know at least two danger signs of pregnancy and labor.

5.9 Dissemination plan

The primary objective of this paper is a partial fulfillment of the degree of masters in health care and hospital administration . So it was submitted to Jimma University College of public health and medical science, department of health services management. The findings were also disseminated to the concerned bodies of governmental and nongovernmental organization in the area of study.

6 RESULT

6.1. Socio-Demographic Characteristics of study population

A total of 296 women who were included in the study, yielding a response rate of 100%. The majority, 246(83.1%) were between the age of 20 and 34 with mean age of 25.8 ± 5.13 . Concerning marital status, 268(90.5%) of the women were currently married followed by 12(3.5%) single and the rest 17(5.8%) were divorced, widowed, married but living in separate. With regard to religion 208(70.3%) were Orthodox Christian while 15.9% were Muslims and 10.5% were protestant. The majority, 240(81.1%), belong to the Kafa ethnic group. Among the interviewed mothers 125(42.2%) have primary education, 66(22.3 %) were with secondary education and 47(15.9%) were with 12 plus education and the rest 58(19.6%) were with no education. With husband's education of the respondents' 98(33.1%) were having primary education, 76(25.7%) secondary education and 86(29.1%) were with 12 plus education and the rest 36(12.1%) has no education (Table.1).

Table 1: Selected Socio-demographic characteristics of respondents, Bonga Town, June 2013, (n=296)

Variable	Frequency	Percent
Age of respondent		
<20	24	8.1
20-34	246	83.1
>=35	26	8.8
Marital status		
Married	291	98.3
Single	12	0.7
Divorced	2	0.7
Separate	1	0.3
Widowed	1	0.3
Religion		
Orthodox	208	70.3
Muslim	47	15.9
Protestant	31	10.5
Catholic	10	3.4

Ethnicity

Kafa	240	81.1
Amhara	20	6.8
Guraghe	8	2.7
Oromo	20	6.8
Others	8	2.7

Women's education

Illiterate	39	13.2
Read and write	19	6.4
Primary	125	42.2
Secondary	66	22.3
12 plus	47	15.9

Women's Work status

Household wife	228	77
Gov. employer	37	12.5
Daily laborer	4	1.4
Merchant	18	6.1
House worker	7	2.3
Student	2	0.7

Wealth index

Poorest	58	19.6
Poorer	61	20.6
Middle	58	19.6
Richer	59	19.9
Richest	59	19.9

Husband's education

Illiterate	22	9.1
Read and write	9	3
Primary	98	33.1
Secondary	76	25.7
12 plus	86	29.1

6.2 Obstetric factors

For 131 (44.3%) mothers the last pregnancy was their first and 24 (8.1%) of them had more than 5 pregnancies. Among the respondents 137 (46.3%) had one child, 143 (48.4%) have 2-4 children, 16 (5.4%) have >5 children with mean parity of 2.01 ± 1.25 . Regarding the prenatal service utilization of respondents 280 (94.6%) had attended at least once for the last pregnancy and 269 (90.9%) have received information on pregnancy and delivery complications during their visit. Only 277 (93.6%) were informed to deliver in health facility and 278 (93.9%) of them were recommended to use health professional during their delivery. The median age at first pregnancy was 21 years. 110 (37.3%) women become pregnant at the age of <20 years, 183 (61.8%) between the age of 21- 29 years and the rest 3 (1%) at the age of > 30 years.

Table 2: Obstetric History and Reasons for visiting Health Facility, Bonga Town, June 2013, (n=296)

Variable	Frequency	Percent
Gravidity (Total No. of Pregnancy)		
1	131	44.3
2-4	141	47.7
>=5	24	8.1
Parity (total No. of Children)		
1	137	46.3
2-4	143	48.4
>=5	16	5.4
ANC visits during the last pregnancy		
Yes	280	94.6
No	16	5.4
Age at first pregnancy		
<20	110	37.2
21-29	183	61.8
>=30	3	1
Any visit to health facility during last pregnancy		
Yes	280	94.6
No	16	5.4

6.3. Delivery Practice of respondents during the last delivery prior to the study

Utilization of skilled delivery attendant among total number of live births surveyed among the age group 15-49 years with a birth in the one year prior to the study was 232(78.3%). Among the 296 interviewed mothers, 227(76.7%) were having institutional delivery while 69 (23.3%) home delivery. Among the total home deliveries only 5(7.2%) were attended by skilled attendants. From the total births 291(98.3%) were live birth and 5(1.7%) were still births. From the total ANC service attendants 276 (92.6%) have used health professional during their actual delivery. Delivery in health facility is more common among younger mothers (age 20-35 yrs), 192 (79.7%).Among home deliveries 12(17.4%) encountered problem at the time of delivery. Reasons given for home delivery includes, feeling more comfortable giving birth at home 22 (31.9%), usual practice 24 (34.8%), close attention from relatives and family members 18(26%), do not like the service in the health facility 5 (7.2%) (Figure 3).

Reasons given for health institution delivery are, better service in health facility 20 (8.8%), Health institution is nearby to the residence 12 (5.3%), better outcome from institutional delivery 173(76.2%) informed to deliver in HF 5 (2.2%), poor out comes from home delivery 25 (11%) (Figure 4).

Figure 3: Reason for home delivery of respondents Bonga town, June 2013 (n=69)

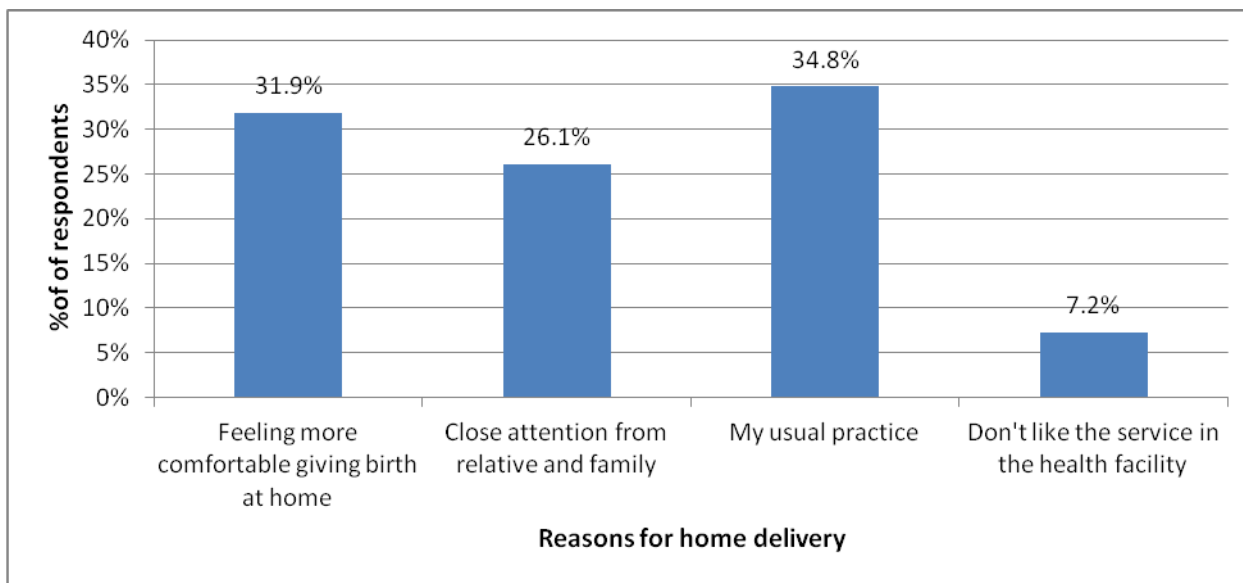
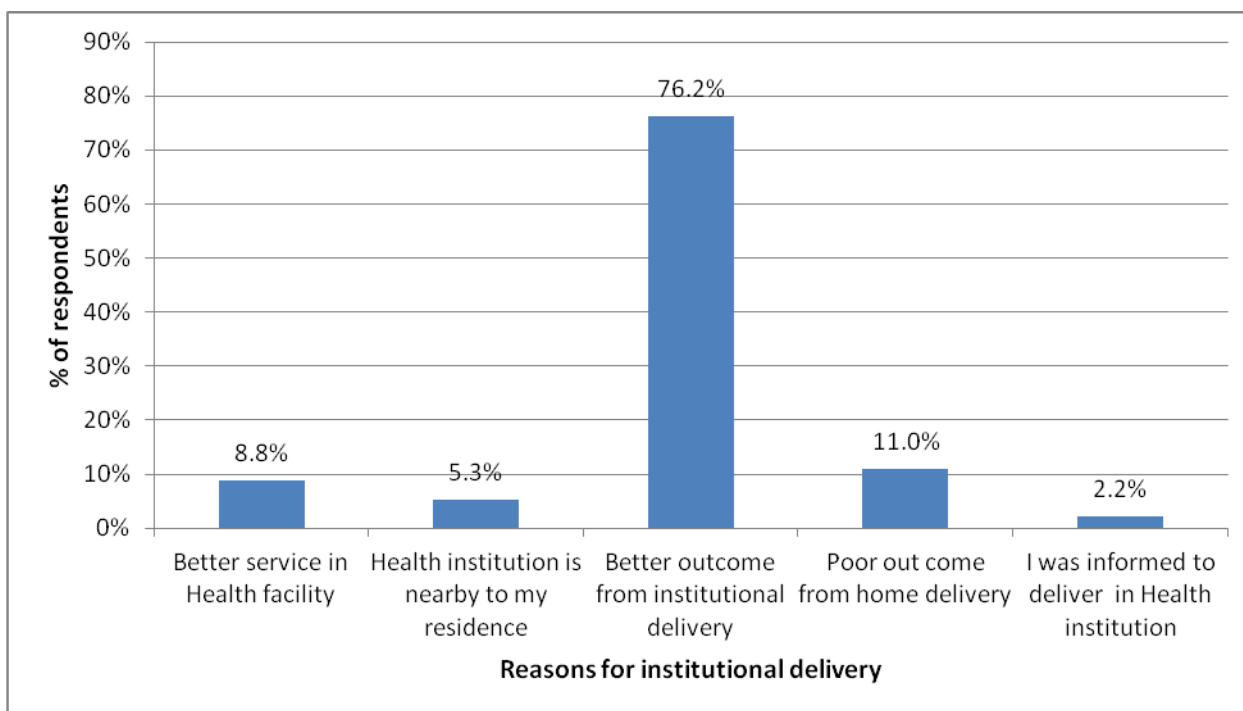


Figure 4: Reason for Institutional delivery of respondents Bonga town, June 2013 (n=227)



6.4. Knowledge and attitude of respondents and their preference and also other's preference during the last delivery

Among the respondents only 268 (90.5%) women who knew at least two danger signs of pregnancy and labor. Regarding attitude of mothers who delivered at health facility towards institutional delivery, 278 (93.9%) had positive attitude while 18 (6.1%) had negative attitude. For 221 (74.7%) of the respondents their reason for positive attitude to the institutional delivery service is because of better outcome of institutional delivery, 26(8.8%) because of better quality of service and 21(7.1%) were good approach of health workers.

Table 3: health service factors in utilizing SDA at the last delivery, Bonga town, June 2013. (n=296)

Variable	Frequency	Percent
Payment for skilled delivery attendant		
Yes	232	78.4
No	15	5.1
I don't know	49	16.6
Information about referral to Higher Health Facility		
Yes	260	87.8
No	12	4.1
I don't know	25	8.4
Time taking up to nearby Health Facility		
<30 minutes	193	65.2
30min__1 hour	93	31.4
>1 hour	10	3.3
Information about MCH during ANC service		
Yes	277	93.6
No	19	6.4

6.5: Factors influencing utilization of skilled delivery attendant

6.5.1: Socio-demographic influencing factors on Utilization of skilled Delivery attendant

By Applying multiple logistic regression on socio demographic variables age of respondents, religion, women's education, women's work status, wealth index and husbands education, only their educational status and their husband's educational status were significantly associated with utilization of skilled delivery attendant (p-values<0.05), though women's work status were significant using the crude odds ratio. If women have secondary education and more, they are eight and four times more likely to utilize SDA, OR=8.06 with 95%CI of (1.75, 37.12) and OR=4.82 with 95%CI of (1.03, 22.52) respectively. Likewise, if husbands can read and write, have primary education, secondary education and above they are more likely to utilize skilled delivery attendant, OR=38.01 and 95%CI of (3.43, 421.89), OR=9.23 and 95%CI of (2.64, 32.26) and OR=36.64, 95%CI of (8.22, 163.23) and OR = 14.31 with 95%CI of (3.30, 62.10) respectively (Table 4).

Table 4: Socio- demographic factors influencing Utilization of skilled birth attendant adjusted for Socio- demographic variables, in Bonga Town, June 2013

Variables	Utilization of skilled delivery attendant		Crude ORs (95% CL)	Adjusted Ors (95% CL)
	Yes (%)	No(%)		
Age group				
<20	16 (7)	8(11.6)	1.00	1.00
20-34	192(84.6)	54(78.3)	1.78 (0.72,4.38)	1.02(0.35,3.00)
35-49	19 (8.4)	7(10.1)	1.36 (0.40,4.56)	0.95(0.18,5.11)
Religion				
Orthodox	160(70.5)	48(69.6)	1.00	1.00
Muslim	39(17.2)	8 (11.6)	1.46 (0.64,3.34)	1.78(0.65,4.88)
Protestant	22(9.7)	9 (13)	0.73 (0.32,1.70)	1.60(0.56,4.55)
Catholic	6 (2.6)	4 (5.8)	0.45 (0.12,1.66)	0.21(0.05,1.01)
Women's education				
Illiterate	20 (8.8)	19 (27.5)	1.00	1.00
Read and write	15 (6.6)	4 (5.8)	3.56 (1.01,12.67)*	1.47(0.31,7.08)
Primary	87 (38.3)	38 (55.1)	2.17 (1.04,4.53)*	1.14(0.43,3.04)
Secondary	62 (27.3)	4 (5.8)	14.72 (4.48,48.41)*	8.06(1.75,37.12)**

12 plus	43 (19.0)	4 (5.8)	10.21 (3.07,33.96)*	4.82(1.03,22.52)**
Women's occupation				
Household wife	173(76.2)	55(79.7)	1.00	1.00
Gov. employer	35 (15.4)	2 (2.9)	5.56 (1.29,23.88)*	3.17(0.50,20.07)
Daily laborer	1 (0.4)	3(4.3)	0.11 (0.01,1.04)	0.56(0.03,10.39)
Merchant	15 (6.6)	3 (4.3)	1.59 (0.44,5.59)	0.97(0.23,4.10)
House worker	2 (0.9)	5 (7.2)	0.16 (0.03,0.89)*	0.16(0.01,2.03)
Student	1 (0.4)	1 (1.4)	0.32 (0.02,5.17)	0.47(0.03,8.30)
Wealth index				
Poorest	42 (18.5)	16 (23.2)	1.00	1.00
Poorer	51 (24.2)	10 (14.5)	1.94(0.80,4.72)	1.37(0.47,3.97)
Middle	40 (17.6)	18 (26.1)	0.84(0.38,1.88)	1.26(0.46,3.41)
Richer	46 (20.3)	13 (18.8)	1.34(0.58,3.13)	0.77(0.25,2.00)
Richest	47 (20.7)	12 (17.4)	1.49(0.63,3.51)	0.66(0.20,2.08)
Husband's education				
Illiterate	4 (1.8)	18 (26.1)	1.00	1.00
Read and write	8 (3.5)	1 (1.4)	36.00(3.45,375.30)*	38.01(3.43,421.89)**
Primary	70 (30.8)	28 (40.6)	11.25(3.50,36.20)*	9.23(2.64,32.26)**
Secondary	70 (30.8)	6 (8.7)	52.50(13.38,206.00)*	36.64(8.22,163.23)***
12 plus	74 (32.6)	12 (17.4)	27.75(8.00,96.21)*	14.31(3.30,62.10)**

* Statistically significant at P<0.05 in the crude analysis

** Statistically significant at P<0.05 after adjusting

*** Statistically significant at P<0.001 after adjusting

6.5.2 Obstetric factors on utilization of Skilled Delivery Attendant

When the obstetric factors, parity, ANC visit and age at first pregnancy were adjusted, all were significantly associated with utilization of skilled delivery attendant (P-values<0.05) Women with first pregnancy were about three times, OR= 2.70 and 95%CI of (1.02, 7.15) more likely to utilize skilled delivery attendant than women who have > 5 pregnancies. Women who had ANC visits were about ten times more likely to utilize skilled delivery attendant when compared to those who did not have ANC visit, OR=9.87 95%CI of (1.79, 54.40). (Table 5)

Table 5: Association of skilled delivery attendant utilization with women's selected obstetric factors, Bonga Town, June 2013

Variables	Utilization of skilled <u>delivery attendant</u>		Crude ORs (95% CL)	Adjusted ORs (95% CL)
	Yes (%)	No (%)		
Gravidity (No. of pregnancy)				
1	108(47.6)	23 (33.3)	2.82(1.10,7.22)*	2.70(1.02,7.15)**
2-4	104(45.5)	37 (53.6)	1.68(0.68,4.18)	1.86(0.70,4.91)
>=5	15 (6.6)	9 (13.0)	1.00	1.00
ANC Visit during last pregnancy				
No	2 (0.9)	16 (23.2)	1.00	1.00
Yes	225(99.1)	53 (76.8)	29.17(6.44,132.17)*	9.87(1.79,54.40)**

* Statistically significant at P<0.05 in the crude analysis

** Statistically significant at P<0.05 after adjusting

6.5.3 Information and knowledge about obstetric risks and Women decision making power

When Information about pregnancy & delivery complication, Information about MCH and Knowledge about risk factors related to pregnancy were adjusted and all except Information about MCH, were significantly associated with utilization of skilled delivery attendant (P-values<0.05). Women who informed about pregnancy and delivery complication are about twelve times, OR = 12.45 and 95%CI of (3.15, 49.26) were more likely to utilize skilled delivery attendant when compared to those who had no information about pregnancy and delivery complication. Women who had Knowledge about pregnancy and delivery complication, OR = 4.6 95%CI of (1.31, 16.16) were five times more likely to utilize skilled delivery attendant when compared to those who had no Knowledge about pregnancy and

delivery complication. Women who decided to deliver at health facility by themselves were twice more likely to utilize skilled delivery attendant than others. (Table 6)

Table 6: Association of availability of service and awareness of women with their actual utilization of skilled delivery attendant, Bonga Town, June 2013

Variables	<u>Utilization of SDA</u>		Crude ORs (95% CL)	Adjusted Ors (95% CL)
	Yes	No		
Information about pregnancy and delivery complication				
No	9 (4.0)	17 (24.6)	1.00	1.00
Yes	218(96.0)	51 (75.4)	8.55 (3.63,20.13)*	12.45(3.15,49.26)**
Information about MCH during ANC service				
No	7 (3.1)	13 (18.8)	1.00	1.00
Yes	220(96.9)	56 (81.2)	3.93(2.93,5.26)*	1.15(0.24, 5.54)
Knows at least two danger signs about pregnancy and delivery complication				
No	7 (3.1)	21 (30.4)	1.00	1.00
Yes	220(96.9)	48 (69.6)	13.75 (5.53,34.18)*	4.60(1.31,16.16)**
Decision by women for place of delivery				
No	61 (26.9)	69 (100)	1.00	1.00
Yes	166(73.1)	0 (0)	1.58(1.35,1.87)*	2.1(1.81,2.41)**

* Statistically significant at $P < 0.05$ in the crude analysis

** Statistically significant at $P < 0.05$ after adjusting

7 Discussion

This community –based study has attempted to identify the extent and factors associated with utilization of skilled attendant at delivery in Bonga town. Utilization of skilled delivery attendant is relatively higher (78.6%) than studies done in urban areas of Ethiopia, which revealed 51% of deliveries, were assisted by health professionals (7). Bonga town has relatively higher level of skilled delivery utilization may be due to the charge free of delivery service in Bonga hospital, and urban health extension program (HEP) is providing equitable access to promotive, preventive and select curative health interventions through health extension workers (HEWs). Among the services based on health packages, maternal health is part of the family health package. Other justification is the newly introduced free ambulance services could have also positive impact on utilization of skilled professionals.

However, it is less than Addis Ababa (83.9%) and more than Gambela (27.4%) (7). This could be probably due to the level of awareness and women's decision to ward place of delivery.

As this study revealed utilization of skilled birth attendant is small difference with institutional delivery, only about two percent from the total deliveries were assisted by home skilled delivery. The study finding revealed that proportion of institutional delivery was 76.7% and skilled delivery attendance was 78.6%. So utilization of skilled delivery attendant is more likely to be similar or slightly increase from institutional delivery because births delivered at a health facility are more likely to be delivered by a trained health professional and births delivered at home are usually more likely to be delivered without assistance of health professionals (7, 20).

Some of the reasons given by the respondents for utilization of health facility for delivery are, better service in health facility 8.8%, better outcomes from Institutional delivery 76.2%, information received from health professionals to deliver in health institution 2.2%, closeness of HF to where they live 5.3%, and poor outcomes from home delivery (11.0%). An earlier study conducted at Gulelle district in Addis Ababa also shows that the reasons given for preferring to deliver in health institution is high quality of service 50.1%, following by nearness of health institution 36.8%, and the approach of good health workers 9.0 %. (28).

The study has identified several variables that have important influence on utilization of skilled delivery attendant. It revealed women's education, husband's education, gravidity (total number of pregnancy), ANC visit, those who knows about risk factors related to

pregnancy and delivery, and women decision making power for place of delivery. Most of these findings are consistent with previous studies (7, 11, and 16).

In this study women's literacy was found to be an important predictor for the use of maternal health care Services. Women with secondary educational level are eight times more likely to use skilled delivery attendant as compared to illiterates and women with twelve and above educational level are five times more likely to utilize skilled birth attendant than illiterate women. This finding is similar with findings of Bangladesh studies, women with twelve and above educational level are almost seven times more likely to utilize skilled birth attendant than illiterate (30, 32). This is due to the fact which was acknowledged by Shieh C and Halstead JA., 2009 which revealed as women education increased, health literacy and utilization to use higher quality services increased (32). If the husband can read and write and has more education, women are more likely to utilize SDA. The finding is consistent with the findings in North Gonder and Adigrat Town and from elsewhere in the world (18, 19). Women with elementary, secondary and above schooling were 3 and 13 times more likely to use institutional delivery than illiterate mothers. The possible explanation for why education is a key determinant could be that as a woman go up through the ladder of education, the more knowledgeable she will be about the use of health facility also education is likely to enhance female autonomy so that women develop greater confidence and capability to make decision about their own health. Husband education is also a factor for utilization of facility based delivery service. Consistent with different studies (23), mothers whose husbands had completed at least read and write were more likely to seek skilled delivery service compared to their counter parts.

Gravidity (total number of pregnancy) is another obstetric variable found to be significantly affecting the utilization of skilled delivery attendant. Women with first pregnancy were three times more likely to utilize skilled delivery attendant as compared to those who were pregnant for greater than five. Similarly study in India revealed that women are almost five more likely to get care for their first delivering than others that follow (21). This is due to the fact that fear of a complication or lack of confidence in the face of problems may motivate women to use skilled delivery attendant (28).

Prenatal services can provide opportunities for health workers to promote a specific place of delivery or give women information on the status of their pregnancy which in turn alerts them to decide where to deliver. In the present study, about 94.6% had received prenatal care during the last pregnancy. This coverage could be due to ANC service is strongly given at the newly expanded growing health centers by way of strong linkage with health extension workers, strong community mobilization is being done to avert complication during pregnancy and child birth. This study revealed that those who have ANC visits were almost ten times more likely to utilize skilled delivery attendant than those who did not have ANC visit. This may be due to the fact that during ANC women are provided with health education and information about the benefits of having a skilled birth attendant for childbirth. From the total ANC service attendants 71.6% have used skilled attendants during their delivery.

Those who were informed about the presence of pregnancy and delivery complication were twelve times more likely to use skilled delivery attendant during their delivery, the finding that women informed about pregnancy complications during ANC visits were more likely to deliver in health facilities suggests that the quality of ANC may influence delivery patterns. In Rwanda, women informed about danger signs during antenatal care were more likely to deliver at a health facility. Other studies from India and Iraq also showed that lack of recognition of perceived seriousness of health problems are significant reason for not using available health care that accounts for half of maternal deaths. An earlier community- based study in Addis Ababa on maternity mortality also found that one of the reason for not having ANC was low level awareness of problems of child bearing (18,22,28 and 29).

Women's who had decision making power was found as significant factor of utilization for skilled birth attendant. Mothers who decide to use modern health service and place of delivery by themselves were more likely to give birth at health facilities (OR 2.1, 95%CI= 1.81-2.41) than mothers who could not decide by themselves. A consistent study in Bangladesh had also showed that the decision on who and where to deliver the baby is taken before labour pain starts. In the same study, only 20% of the cases do women themselves take the decision about who will deliver their baby. Other consistent study in Bangladesh, women with significant decision-making power were more than twice more likely to deliver at health facility than women with more limited decision-making power (24, 30).

Limitations of the study

- Selected variables that affect utilization of skilled delivery attendant have been investigated, and their importance was determined by comparing users and non users at a specific point in time. So difficult to know whether the determinant or the outcome occurred first. For example, some factors (parity, age at first pregnancy etc.) were present before ANC attendance or preferences of delivery place and delivery attendant where as if we take knowledge on maternal health care like the knowledge on pregnancy and delivery problems could either follow or precede the outcomes of interest (no cause and effect relationship).
- Recall bias- because respondents were asked for past activities
- The respondents might not know the qualifications of their birth attendants which might increase the rate of skilled birth attendant

8. Conclusion

- Even though this study demonstrated that utilization of skilled delivery services during the period of the survey were relatively higher than previous studies but inadequate in general. Because it is below the plan that the federal government strive to create home delivery free kebeles in each town (woreda).
- Number of pregnancy , women educational status (twelve and above educational level), husband's educational status, ANC visit, mothers knows at least two danger signs about pregnancy and delivery complication, and women's power to make the decision in terms of getting skilled delivery were found to be factors associated with the utilization of skilled birth attendant.

9. Recommendation

Health facility level

1. Interventional IEC activities focusing on women and husbands will be helpful in utilizing these people, so that their influences can be directed in the line of encouraging women to utilize skilled delivery services.
2. Community education about pregnancy, child birth and postpartum, particularly the danger sign of pregnancy, labour and delivery and the actions ensuing complication need to get particular attention.

Stakeholders

1. Stakeholders like educational department and women's affairs should be involved to promote empowerment of disadvantaged women through integrated activities including girls education will be helpful to enable them decide by themselves about their delivery practices.
2. Further studies should be conducted on quality of delivery service utilization and from provider perspective of the service.

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Annex II. Questionnaires (Tools)

Jimma University College of public health and medical science, department of Health service management structured questionnaire on Assessment of utilization of skilled birth attendant at delivery in Bonga town, Kafa zone, Southwestern Ethiopia (English)

Consent form:-

My name is _____ I am a part of research work team of Jimma University. This research will assess the utilization of skilled birth attendant in Bonga town. It does not cause any harm other than expensing you a few minute for interview. I would also like to assure you about the confidentiality of information. The information will only be used for this research. You have full right to reject, to participate or to interrupt the interview at any time. The information that you will give us is very important to meet the objective of study to bring changes on utilization of skilled birth attendant at delivery, program implementation and policy formulation for utilization of skilled birth attendant.

Are you willing now to participate in the study? Tick one. Agree_____ do not agree_____ thank you.

If they are not willing, do not force people to participate in the study but as much as possible convince by clarifying the aim of study.

Date of data filled _____

Participant's ID No_____

Questionnaires (Tools)

Part I. Respondent's Socio demographic factors

No	Questions	Alternative /choice of response	Skip
101	Age in Years at interview time		
102	Marital Status	<ol style="list-style-type: none">1. Married2. single3. Divorced4. Widowed5. Separated	
103	Religion	<ol style="list-style-type: none">1. Orthodox2. Catholic3. Protestant4. Moslem5. Other, Specify	
104	Ethnicity	<ol style="list-style-type: none">1. Keffa2. Amhara3. Gurage4. Oromo5. Others	
105	Occupation	<ol style="list-style-type: none">1. Housewife2. Private employee3. Gov. Employee4. Private business5. Others, Specify	
106	Educational Status	<ol style="list-style-type: none">1. Illiterate2. Only read and write3. primary Education (1- 8)4. Secondary education (9-12)5. 12th plus (above 12)	
107	Do you have monthly income	<ol style="list-style-type: none">1. Yes2. No	

		3. I don't want to tell	
108	Monthly Income in Birr		
109	Family Size (in No.)		
110	Husband's Education Status	1. Illiterate 2. Read and write 3. primary Education (1- 8) 4. Secondary education & above (9-12+) 5. 12 th plus	

Part II Wealth index

No	Questions	Alternative /choice of response	Skip
201	Drinking water source	Rain water	
		Pond/ lake/ dam	
		River	
		Open spring	
		Open well	
		Covered spring	
		Covered well	
		Piped outside compound	
		Piped into compound	
		Piped into dwelling	
202	Type of toilet facility	No facility/ bush/ field	
		Traditional pit latrine	
		Improved ventilated pit latrine	
		Flush toilet	
203	Electricity	Yes	
		No	
204	Radio possession	Yes	
		No	
205	Television possession	Yes	
		No	
206	Main floor material	Earth/ sand	
		Dung	
		Wood planks	
		Reed/ Bamboo	
		Parquet	
		Vinyl sheets/ tiles	
		Cement	
		Cement tiles/ brick	
		Carpet	
207	Roof material	Wood/ mud	
		Thatch	
		Reed/ Bamboo	

		Plastic sheet	
		Mobile roof	
		Iron sheet	
		Cement	
208	Cooking fuel	Dung	
		Firewood	
		Charcoal	
		Coal	
		Kerosene	
		Biogas	
		Natural gas	
		Electricity	

Part III. Obstetric Factors

No	Questions	Alternative /choice of response		Skip
301	Age at first marriage			
302	Age at first Pregnancy			
303	Gravidity(Total No. of pregnancy)			
304	Parity(Total No. of births)			
305	Any visit to health facility during your last pregnancy?	1.Yes 2.No		
306	What was your reason for visiting Health Facility?		Yes(1) No (2)	If ANC response is 2 skip to Qu. 307
		For ANC		
		Delivery		
		PNC		
		Problem not related to pregnancy		
		Other , Specify 88		
307	If your visit was for ANC, how many times do you visit?	1. 1-3 visits 2. 4 visit 3. 4+visits		
308	During ANC follow up did you get any information	1. Yes 2. No		

	regarding pregnancy and delivery complications?	3. I do not know	
309	Were you informed about where to deliver?	1. Yes 2. No	
310	If yes where did they recommend you to deliver?	1. Health facility 2. Home	
311	Were you informed as to who should attend you during delivery?	1. Yes 2. No	

Part IV. Practice of women's

No.	Questions	Alternative /choice of response			Skip
401	Did the birth in the last 12 months resulted in a baby that was born alive or dead?		Yes(1)	No(2)	
		Live birth			
		Still birth			
402	Where did you deliver (this specific birth?)		Yes(1)	No(2)	
		Home			
		Health Facility			
		Other, Specify			
403	If your answer to question No.402 is Home, why did you choose to deliver at home?		Yes	No	
		I feel more comfortable just being at home	1	2	
		Close attention from relatives & family members	1	2	
		It is my usual practice	1	2	
		I don't like the service in the health facility	1	2	
		Previous bad experience from institutional delivery	1	2	
		Unwelcoming approach of Health workers	1	2	
Other,					
404	If you deliver at Home Who assisted you during delivery		Yes(1)	No(2)	
		No attendant			
		Health professional			
	Trained TBA				

		Untrained traditional birth attendant			
		Family Members & Relatives			
		Others, Specify_____88			
405	Have you had any problem while you give birth at home?	1. Yes 2. No			
406	If your answer to question No.402 is Health Facility, why do you choose to deliver in health Facility?		Yes	No	
		Better service in health facility -----	1	2	
		Close to where I live -----	1	2	
		Better outcomes from Institutional delivery---	1	2	
		Poor out comes from home delivery-----	1	2	
		I was informed to deliver in health institution-	1	2	
		Other, specify_____88			
407	Which Health Facility did you use to deliver?		Yes	No	
		Hospital-----	1	2	
		Health station/clinic-----	1	2	
		Health center-----	1	2	
		Other, Specify-----88			
408	Who assisted you during delivery?		Yes	No	
		No attendant-----	1	2	
		Doctor-----	1	2	
		Health Officer -----	1	2	
		Midwife & Nurses-----	1	2	

Part V Women's decision making for place of delivery

No	Questions	Alternative /choice of response	Skip
501	If you give birth in Health Facilities, who make the final decision to deliver in Health Facility	Yes No Just me 1 2 My husband/ partner- 1 2 My family & relatives-- 1 2 .Health Professionals--- 1 2 Health extension workers 1 2	

		Other people, Specify_____88																						
502	If you give birth at Home Who make the final decision to seek help when you have problem?	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Just me</td> <td>1</td> <td>2</td> </tr> <tr> <td>My husband/ partner-</td> <td>1</td> <td>2</td> </tr> <tr> <td>My family & relatives--</td> <td>1</td> <td>2</td> </tr> <tr> <td>.Health Professionals---</td> <td>1</td> <td>2</td> </tr> <tr> <td>Health extension workers</td> <td>1</td> <td>2</td> </tr> <tr> <td>Other people, Specify_____</td> <td>88</td> <td></td> </tr> </table>		Yes	No	Just me	1	2	My husband/ partner-	1	2	My family & relatives--	1	2	.Health Professionals---	1	2	Health extension workers	1	2	Other people, Specify_____	88		
	Yes	No																						
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My husband/ partner-	1	2																						
My family & relatives--	1	2																						
.Health Professionals---	1	2																						
Health extension workers	1	2																						
Other people, Specify_____	88																							

Part VI Health service factors

No	Questions	Alternative /choice of response	Skip
601	Is there a Health facility with skilled Delivery attendant in your nearby?	1.Yes 2.No 87.Do not know	
602	Can you afford to pay for services from Skilled delivery attendant?	1.Yes 2.No	
603	Have you heard that Health Centers refer mothers to higher Health Facility?	1.Yes 2.No	
604	How long does it take to travel from your home to the nearest health facility which gives delivery service?	1.≤30minutes 2. One hour 3. >one hour	
605	Do you have access to Maternal and Child Health information?	1.Yes 2.No	
606	If yes to Q.No.505,What is the source of the information	1.Radio 2.TV 3.Newspaper 4.Health workers 87. Others	

Part VII Women Knowledge and Attitudes on Obstetrics risk

No	Questions	Alternative /choice of response	Skip																																	
701	Are there some health problems that can occur during pregnancy that could endanger the life of a pregnant woman?	1.Yes 2.No 87.Don't know	If no skip to 704																																	
702	Can you mention obstetric problems that can occur during pregnancy? (Probe: ask for the problems which are not mentioned spontaneously)	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Vaginal bleeding-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Severe headache -----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Blurred vision-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Convulsion-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>High fever-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Marked and fast weight gain----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Loss of consciousness-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Severe abdominal pain-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Others, specific</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>88</td> </tr> </tbody> </table>		Yes	No	Vaginal bleeding-----	1	2	Severe headache -----	1	2	Blurred vision-----	1	2	Convulsion-----	1	2	High fever-----	1	2	Marked and fast weight gain----	1	2	Loss of consciousness-----	1	2	Severe abdominal pain-----	1	2	Others, specific					88	
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703	Are there some obstetric problems that can occur during labor and child birth that could endanger the life of a pregnant woman? (Probe: ask for the problems which are not mentioned spontaneously)	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Sever vaginal bleeding-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Severe headache-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Convulsion-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>High fever -----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Loss of consciousness-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Labor lasting >12 hours -----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Placenta not delivered after 30 minutes baby is delivered-----</td> <td>1</td> <td>2</td> </tr> <tr> <td>Others specify_____</td> <td></td> <td>88</td> </tr> </tbody> </table>		Yes	No	Sever vaginal bleeding-----	1	2	Severe headache-----	1	2	Convulsion-----	1	2	High fever -----	1	2	Loss of consciousness-----	1	2	Labor lasting >12 hours -----	1	2	Placenta not delivered after 30 minutes baby is delivered-----	1	2	Others specify_____		88							
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704	What do you think the advantages of pregnancy and delivery related services?	<p style="text-align: right;">Yes</p> <p>No</p> <p>For anticipating problems-----1 2</p> <p>For early detection of health Problems-----1 2</p> <p>For appropriate management of health problems--1 2</p> <p>For better health care to the women-----1 2</p> <p>For better care to the newborn -----1 2</p> <p>Others Specify----- 88</p>	
705	If you deliver at health facility what is your attitude towards delivery services?	<p>1. Positive (Good)</p> <p>2. Negative (Bad)</p>	If bad,70 7
706	Why good attitude to the institutional delivery service?	<p style="text-align: right;">Yes No</p> <p>Better quality of service ----- 1 2</p> <p>Good approach of health workers-----1 2</p> <p>Fair price of services-----1 2</p> <p>Better outcome of institutional delivery -1 2</p> <p>Other specify_____88</p>	
707	Why bad attitude to the institutional delivery service?	<p style="text-align: right;">Yes No.</p> <p>Poor quality of services -----1 2</p> <p>Unable to perform cultural ceremonies-----1 2</p> <p>Unpleasant approach of health worker -----1 2</p> <p>Unfair & expensive price -----1 2</p> <p>Poor outcome of services-----1 2</p> <p>others, specify_____88</p>	

708	If you deliver at home what is your attitude to home delivery?	1.Excellent 2.Good 3.Indifferent 4.Fair 5.Bad	If bad, 710																											
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Assurance of principal investigator

The undersigned agrees to accept responsibility for the scientific ethical and technical conduct of the research project and for provision of required progress reports as per terms and conditions of the Faculty of Public Health in effect at the time of grant is forwarded as the result of this application.

Name of the student: _____

Date. _____ Signature _____

APPROVAL OF THE ADVISORS

Name of the first advisor: _____

Date. _____ Signature _____

Name of the second advisor: _____

Date. _____ Signature _____

በጅማ ዩኒቨርሲቲ የሕብረተሰብ ጤናና የሕክምና ትምህርት ኮለጅ የጤና አገልግሎት አስተዳደር ትምህርት ክፍል፤ በሰለጠነ ባለሙያ የወለዱ እናቶች ላይ ለማጥናት የተተዘጋጀ የግለሰቦች ፍቃደኝነት መጠየቅያ ቅፅ (Amaharic) ::

እንደምን አደሩ/ዋሉ? ስሜ _____ይባላል። በጅማ ዩኒቨርሲቲ የሕብረተሰብ ጤናና የሕክምና ትምህርት ኮለጅ ጤናአገልግሎት አስተዳደር ትምህርት ክፍል የጥናት ቡድን አባል ነኝ። የገዘህ ጥናት ዋና አላማ በሰለጠነ ባለሙያ የወለዱ እናቶች እና እንዳይጠቀሙ የምያደራጉ ተዛማች ሁኔታዎችን ለማጥናት ነው። እርሶዎ በጥናቱ እንድትተቱ የተደረጉት በዕጣ ነው። የእረሶን የወሊድ ሁኔታ እና ተዛማች ሁኔታዎችን በምመለከት እጠይቅዎታለሁ። ቃለምልልሱ በግምት ከ15-20 ደቂቃዎች ይፈጃል። እርሶዎ የምስጢኝ መረጃ ምስጢራዊነቱ ሙሉ በሙሉ የተጠበቀ ነው። የእርሶዎ ስምም ሆነ መለያ መረጃዎች አይመዘገቡም። እርሶዎ በጥናቱ የመሳተፍም ሆነ ያለመሳተፍ፤ ያለመመለስ ወይም የማገረጥም መብትዎ የተጠበቀ ነው። ነገርግን እርሶ የምስጢር መረጃ በማዕከላቱ የምስጢርን አገልግሎት ለማሻሻል እና ፖሊሲዎችን ለማወጣት ጠቃም ነው።

እባክዎት ጥናቱን በተመለከተ የምጠይቁኝ ነገር አለዎት?

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት?

- 1.አዎ
- 2.አይደለሁም

አወ ካሉ፤ አመሰግናለሁ ቃለመጠይቁን ይቀጥሉ
አይደለሁም ካሉ ፤አመሰግናለሁ ደንበኛዎን አሰናብተዋል ወደ ሌላ ተጠያቂ ይለፉ
ፍካደኛ ስለመሆናቸው የጤያቅወ ፍርማ _____
ቀን: _____
ኮድ ቁጥር: _____

1. ለጠቃላይ የቤተሰብ መረጃ

001. የመጠይቁ መለያ ቁጥር-----

002. ወረዳ/የከተማው -----

003. ቀበሌ-----

004. የቤት ቁጥር -----

ክፍል አንድ፤ የተጠያቂው አጠቃላይ የማህበራዊና ኢኮኖሚያዊ መረጃ የተመለከተ መጠይቅ

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ	
101	ይህ ቃለ መጠይቅ ሲደረግልዎ እድሜዎ ስንት ነዉ(በዓመት)			
102	የጋብቻ ሁኔታ	1. ያገባች አብረዉ የሚኖሩ 2. ያላገባች 3. አግብታ የፈታች 4. አግብታ ተለያይተዉ የሚኖሩ 5. ባልዋ የሞተባት 88. ሌላ (ይጠቀስ)		
103	ሐይማኖት	1. ኦርቶዶክስ 2. እስላም 3. ፕሮቴስታንት 4. ካቶሊክ 88.ሌላ (ይጠቀስ)		
104	ብሔር	1. ካፋ 2. አማራ 3. ጉራጌ 4. ኦሮሞ 88. ሌላ		
105	የትምህርት ደረጃዎ	1. ምንም አላዉቅም 2. ማንበብና መጻፍ ብቻ 3. ከ1-8ኛ ክፍል 4. ከ9-12ኛ ክፍል 5. ከ12ኛ ክፍል በላይ		
106	የስራ ድርሻዎ	1. የቤት እመቤት 2. ግብርና 3. የመንግስት ሰራተኛ 4. የቀን ሰራተኛ 5. ነጋዴ 6. የሰው ቤት ሰራተኛ 7. ተማሪ 8. ጠላና አረቁ ነጋዴ		

		88. ሌላ (ይጠቀስ) -----		
107	የወር ገቢ አልዎት?	1. አዎ 2. የለኝም 3. ለመናገር ፍቃድኛ አይደለሁም		
108	የወር ገቢ በወር ሲሰላ?			
109	የቤተሰብ ብዛት (በቁጥር)			
110	የቤተሰቡ ሃላፊ ትምህርት ደረጃ(አእርስዎ ሌላ ከሆነ)	1. ያልተማረ 2. ማንበብና መጻፍ የሚችል 3. ከ1- 8ኛ ክፍል 4. ከ9 - 12ኛ ክፍል 5. ከአስራ ሁለተኛ ክፍል በላይ		

ክፍል 2- የሀብት ልኬት

ቁጥር	ጥያቄዎች	አማራጭ መልሶች		
201	የሚጠጣ ውሃ ከየት ይጠቀማሉ	1. የዝናብ ውሃ		
		2. ኩራ/ ሐይቅ/ ግድብ		
		3. ወንዝ		
		4. ክፍት የምንጭ ውሃ		
		5. ክፍት የጉድጓድ ውሃ		
		6. የተከደነ የምንጭ ውሃ		
		7. የተከደነ የጉድጓድ ውሃ		
		8. የቧንቧ ውሃ ከጊቢ ውጭ		
		9. የቧንቧ ውሃ ከጊቢ ውስጥ		
		10. የቧንቧ ውሃ በመኖርያ ቤት ውስጥ		
202	የሚገለገሉበት ሽንት ቤት አይነት	1. ሽንት ቤት የላቸውም/ በሜዳ/ በጫካ		
		2. በአከባቢ ቁሳቁስ የተሰራ		
		3. ሽታ ማስወጫ ቱቦ ያለው		
		4. በውሃ የሚሰራ ሽንት ቤት		
203	የኤሌክትሪክ አገልግሎት	1. አለ		
		2. የለም		
204	ፊደዮ	1. አለ		
		2. የለም		
205	ቴሌቪዥን	1. አለ		
		2. የለም		
206	የቤቱ ወለል ከምን ተሰራ	1. አፈር/ መሬት		
		2. እቦት		

		3. ከተጠረበ እንጨት	
		4. ከቀርከሃ	
		5. የወለል ጣውላ	
		6. የሽክላ ምንጣፍ	
		7. የሲሚንቶ ወለል	
		8. የሴራሚክ ወለል	
		9. ስጋጃ ወለል (በሲሚንቶ ወለል)	
207	የቤቱ ጣርያ	1. ከእንጨት/ ከጭቃ	
		2. የሳር ኪዳን	
		3. ከቀርከሃ	
		4. የላስቲክ ኪዳን	
		5. ተንቀሳቃሽ ጣርያ	
		6. ቆርቆሮ	
		7. ሲሚንቶ	
208	የሚጠቀሙበት ማገዶ	1. እበት	
		2. እንጨት	
		3. ከሰል	
		4. ቡታጋዝ	
		5. ባዮጋዝ	
		6. ኤሌክትሪክ	

ክፍል ሦስት: የእርግዝናና የወሊድ ሁኔታን በተመለከተ መጠይቅ

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ		
301	ሲያገቡ እድሜዎ ስንት ነበር ?				
302	በመጀመሪያ እርግዝናዎ እድሜዎ ስንት ነበር?				
303	በአጠቃላይ በእድሜዎ ለምን ያህል ጊዜ ነፍሰጡር ሆነው ያወቃሉ?				
304	በአጠቃላይ ስንት ልጅ ያልደገዩ?				
305	በመጨረሻ እርግዝናዎ ወቅት ወደ ጤና ተቋም ሄደው ያወቃሉ?	1. አዎ 2. አላወቅም			
306	ወደ ጤና ተቋም የሄዱበት ምክንያት?	አዎ(1) አይደለም(2) ለቅድመ ወሊድ ለወሊድ ለድህረ ወሊድ ከእርግዝና ውጭ በሆነ ምክንያት ሌላ ምክንያት ካለ ይግለፁ 88			

307	የሄዱት ለቅድመ ወሊድ ምርመራ ከሆነ ለምን ያህል ጊዜ ሄዱ?	1. 1-3 ጊዜ 2. 4 ጊዜ 3. ከ 4 ጊዜ በላይ		
308	በቅድመ ወሊድ ክትትል ወቅት ስለ እርግዝናና በወሊድ ምክንያት ስለሚከሰቱ ችግሮች ተነግሮዎታል?	1. አዎ 2. አልተነገረኝም 3. አላስታውስም		
309	የት መውለድ እንዳለበዎ መረጃ አግኝተዋል?	1. አዎ 2. አላገኘሁም		
310	አዎ ከሆነ የት እንዲወልዱ አሳስቦት?	1. በጤና ተቋም 2. በመኖርያ ቤት		
311	ማን ማዋለድ እንዳለበዎ መረጃ አግኝተዋል?	1. አዎ 2. አላገኘሁም		
312	አዎ ከሆነ ማን እንዲያዋልደት አሳስቦት?	1. የጤና ባለሙያ 2. የልምድ አዋላጅ 3. ቤተሰብ 88. ሌላ ካለ ይግለጹ		

ክፍል አራት - የመጨረሻውን ወሊድን በተመለከተ

401	ከ12 ወር በፊት ሲወልዱ የህፃኑ ሁኔታ እንዴት ነበር ?	1. በህይወት ነዉ የተወለደዉ 2. ሞቶ ነዉ የተወለደዉ		
404	የት ነበር የወለዱትዱት?	1. በቤት ውስጥ 2. በጤና ተቋም 88. ሌላ ካለ ይጠቀስ		
405	ምርጫዎ ቤት ከሆነ ቤት ውስጥ መውለድ የመረጡበት ምክንያት ምንድነው?	1. ቤት ውስጥ መሆኔ ራሱ የበለጠ ይመቸኛል 2. ከቤተሰቦቼና ዘመዶቼ አንክብካቤ ስለማገኝ 3. ከዚህ በፊት የምወልደው ቤት ስለሆነ 4. ጤና ተቋም ውስጥ ያለው አገልግሎት ስለማልወደው 5. ከዚህ በፊት ጤና ተቋም ውስጥ ወልጄ መጥፎ ነገር ስለገጠመኝ 6. የጤና ባለሙያዎቼ አቀራረብ መጥፎ በመሆኑ 88. ሌላ ምክንያት ካለ ይጠቀስ		
404	በቤት ውስጥ ወሊድ ወቅት ከሚከተሉት ሠዎች የትኞቹ አዋለደት?	1. ያለምንም ረዳት 2. የሠለጠነ የጤና ባለሙያ 3. የሰለጠነ የልምድ አዋላጅ 4. ያልሠለጠነ የልምድ አዋላጅ 5. ዘመድ ወይም ሌላ የቤተሠብ አባል 88. ሌሎች ምርጫ ካለዎት ይጥቀሱ.....		
405	ቤት ቢሚወልዱ ወቅት ችግር ገጥመዎታል?	1. አዎን 2. አልገጠመኝም		

406	በጤና ማእከል ውስጥ ለመውለድ የወሰነ-በት ዋና ምክንያት ምንድነው?	<ol style="list-style-type: none"> 1. ጤና ተቋም ውስጥ ያለው አገልግሎት ጥሩ ስለሆነ 2. ጤና ተቋሙ ለመኖርያዬ ቅርብ ስለሆነ 3. ጤና ተቋም ውስጥ መውለድ ውጤቱ ጥሩ በመሆኑ 4. .በቤት ውስጥ መውለድ ውጤቱ አስከፊ ስለሆነ 5. ጤና ተቋም ውስጥ እንደወልድ መረጃ ስለተሰጠኝ <p>88. ሌላ ምክንያት ካለ ይጠቀስ</p>	
407	የትኛው ጤና ተቋም ወለዱ?	<ol style="list-style-type: none"> 1. ሆስፒታል 2. ጤና ጣቢያ <p>88. ሌላ ምርጫ ካለዎት ይጥቀሱ.....</p>	
408	በጤና ተቋም ውስጥ ሲወለዱ ማን ረዳዎት?	<ol style="list-style-type: none"> 1. ሀኪም 2. ጤና መኮንን 3. አዋላጅ ነርስ / ነርስ 4. ያለ ረዳት 	

ክፍል 5: የሴቶች በወሊድ ቦታ ላይ ወሳኔ ሰጪነትን በተመለከተ

ተ.ቁ.	ጥያቄዎች	አማራጭ መልሶች	
501	በጤና ተቋም የወለድሽ ከሆን ማን ነው በጤና ድርጅት እንደትወልጁ የመጨረሻ ወሳኔ የሰጠው	<ol style="list-style-type: none"> 1. እኔ እራሴ ነኝ 2. ባለበቴ ነው 3. በተሰባቸው እና ዘመዶቹ ናቸው 4. ጤና ባለሙያ 5. የጤና ኤክስፐርትን ሠራተኞች 6. ሌሎች----- 	
502	በመኖርያ ቤት የወለድሽ ከሆን ችግር ካጋጠመሽ እርዳታ መፈለግ እንዳለብሽ የመጨረሻ ወሳኔ የሰጠው ማን ነው	<ol style="list-style-type: none"> 1. እኔ እራሴ ነኝ 2. ባለበቴ ነው 3. በተሰባቸው እና ዘመዶቹ ናቸው 4. ጤና ባለሙያ 5. የጤና ኤክስፐርትን ሠራተኞች 6. ሌሎች----- 	

ክፍል 6: ከጤና አገልግሎት ጋር የተገናኙ ሁኔታዎች

ተ.ቁ.	ጥያቄዎች	አማራጭ መልሶች	
601	በአቅራቢያሽ አዋላጅ ባለሙያ ያለ ጤና ድርጅት አለ ወይ?	<ol style="list-style-type: none"> 1. አለ 2. የለም 3. አላውቅም 	
602	ለማዋለጃ አገልግሎት ክፍያ እንድትከፍሉ ትጠየቃላችሁ?	<ol style="list-style-type: none"> 1. አዎ 2. አንጠየቅም 3. አላውቅም 	
603	ጤና ጣቢያዎ እናቶችን ወደ ክፍተኛ	<ol style="list-style-type: none"> 1. አዎ 2. አልሰማሁም 	

	ጤና ድርጅት ይልካል ስባል ሰምተሻል?	4.	አላውቅም	
604	የማዋለጃ አገልግሎት የምሰጥ ጤና ድርጅት ከመኖሪያ ቤትሽ ምን ያህል ይርቃል?	1. 2. 3.	ከ 30 ደቂቃ በታች አንድ ሰዓት ከአንድ ሰዓት በላይ	
605	ስለ እናቶች እና ህፃናት ጤንነት መረጃዎችን የማገኘት ዕድል አለሽ ዎይ?	1. 2.	አዎ የለም	
606	ለጥያቄ ተ.ቁ. 505 መልሱ አዎ ከሆነ፤ የመረጃ ምንጮች ምን ምን ናቸው?	1. 2. 3. 4.	ሬድዮ ተለ-ቭሻርን ጋዜጣ ጤና ባለሙያ	

ክፍል 7 -የእናቶች የግንዛቤና አመለካከትን በተመለከተ

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	
701	ከእርግዝና ጋር በተያያዘ የነፍሰጡር እናቶች ላይ አደጋ ሊያመጣ የሚችል የጤና ችግሮች ያውቃሉ?	1. 2.	አዎ አላውቅም
702	ለጥያቄ ተ.ቁ. 601 መልሱ አዎ ከሆነ፤ ችግሮችን ይጥቀሱ	1. 2. 3. 4. 5. 6. 7. 8. 9.	ከማህፀን ደም መፍሰስ ከፍተኛ ራስ ምታት የአይን ብሻርታ ማንቀጥቀጥ ከፍተኛ ትኩሳት ከመጠን በላይ ክብደት መጨመር ራስ መሳት ከፍተኛ የሆድ ህመም(ቁርጠት) ሌላ ካለ ይጠቀስ
703	ከእርግዝና ጋር በተያያዘ በወሊድ ወቅት እናቶች ላይ አደጋ ሊያመጣ የሚችል የጤና ችግሮች ያውቃሉ?	1. 2. 3. 4. 5. 6. 7. 8.	ከማህፀን ደም መፍሰስ ከፍተኛ ራስ ምታት ማንቀጥቀጥ ከፍተኛ ትኩሳት ራስ መሳት ከ 12 ሰዓት በላይ የቆየ ምጥ እንግዶ ልጅ ልጁ ከተወለደ 30 ደቂቃ በኋላ ካልተወለደ ሌላ ካለ ይጠቀስ
704	የእርግዝናና የወሊድ አገልግሎት ጥቅሙ ምንድነው ብለው ያስባሉ?	1. 2. 3. 4. 5.	ችግሮችን ቅድሚያ ለመለየት ችግሮችን ቅድሚያ ለመለየት ለጤና ችግሮች ተገቢውን ህክምና ለመስጠት ለእናቶች የተሻለ የጤና እንክብካቤ ስለሚሰጥ ለህፃናት የተሻለ የጤና እንክብካቤ ስለሚሰጥ

		6. ሌላ ካለ ይጠቀስ	
705	በጤና ተቋም ለመውለድ ይለዎት አመለካከት ምንድን ነው?	<ol style="list-style-type: none"> 1. ጥሩ 2. መጥፎ ነው 	
706	በጤና ተቋም መውለድ ለምን ጥሩ አመለካከት ኖሮት?	<ol style="list-style-type: none"> 1. ጥራት ያለው አገልግሎት ስላለ 2. ጤና ባለሙያዎች አቀባበላቸው ጥሩ ስለሆነ 3. ተመጣጣኝ የአገልግሎት ክፍያ ስላለ 4. በጤና ተቋም መውለድ ውጤቱ ደህና ስለሆነ 5. ሌላ ካለ ይጠቀስ 	
707	በጤና ተቋም መውለድ ለምን መጥፎ አመለካከት ኖሮት?	<ol style="list-style-type: none"> 1. ጥራት የሌለው አገልግሎት ስላለ 2. ባህላዊ ስርአት መፈጸም ስለማልችል 3. ጤና ባለሙያዎች አቀራረባቸው ጥሩ ስላልሆነ 4. ተመጣጣኝ ያልሆነ ውድ የአገልግሎት ክፍያ ስላለ 5. በጤና ተቋም መውለድ ውጤቱ መጥፎ ስለሆነ 6. ሌላ ምክንያት ካለ ይጠቀስ 	
708	ቤት ውስጥ መውለድ ይለዎት አመለካከት ምንድን ነው?	<ol style="list-style-type: none"> 1. እጅግ በጣም ጥሩ 2. ጥሩ 3. አሁን መግለፅ አልችልም 4. ምንም አስተያየት የለኝም 5. መጥፎ ነው 	
709	በቤት ውስጥ መውለድ ለምን ጥሩ አመለካከት ኖሮት?	<ol style="list-style-type: none"> 1. ቤት ውስጥ መሆኔ ራሱ በጣም ይመቸኛል 2. ክቤተሰቦቼና ዘመዶቼ እንክብካቤ ስለማገኝ 3. ባህላዊ ስርአት መፈጸም ስለማልችል 4. ከዚህ በፊት የምወልደው ቤት ስለሆነ 5. ጤና ተቋም ውስጥ ያለው አገልግሎት ስለማልወደው 6. ከዚህ በፊት ጤናተቋም ወልጄ ውጤቱ መጥፎ ነገር ስለገጠመኝ 7. ጤና ባለሙያዎች አቀራረባቸው ጥሩ ስላልሆነ 	
710	በቤት ውስጥ መውለድ ለምን መጥፎ አመለካከት ኖሮት?	<ol style="list-style-type: none"> 1. ጥራት ያለው አገልግሎት ስላለ 2. በጤና ተቋም መውለድ ውጤቱ ደህና ስለሆነ 3. ጤና ባለሙያዎች አቀባበላቸው ጥሩ ስለሆነ 4. በጤና ተቋም መውለድ ውጤቱ መጥፎ ስለሆነ 5. ሌላ ምክንያት ካለ ይጠቀስ 	

Jimmi Univerisiti Maccee Iiwoonaa Dawee sayinnise Doyee Kollejje Inddeena'och Iiwee Qopoonaa Guttinee Diggiri (Mastireete) Doyee kuxo qoppechino'na ichebeeti shimi gaacoon daamiti inddeenaon ariyoona gaacee imooch beeti eriteenaon xiishooch yesheti nabeena'on Phirooch qanniti qelli qelli echo (Kaffi Noono).

Diggoona qeyitotee/heeemitotee? Ta shigo _____geteehe. Jimmi Univerisiti Maccee Iiwoonaa Dawee sayinnise Doyee Kollejje Iiwee managementee Qopoonaa Guttinee Diggiri (Mastireete) Doyee kuxe phire guupho taane. Hini Phireechi inde naboo qoppechino'na ichebeeti shimi gaacoon daamiti inddeenaon ariyoona gaacee imooch beeti eriteenaon xiishooch yesheti gaachoonaa yesheti nabeena'on Phiroone. Itto hini echa wochoochi qaaweto ixoonane. Itoch wokiishim attoon baccii gaache shuriyoona yesheti nabeena'onon ciinnimi eho echeemotaane. Echa wochoo gimitoona 10-15 daqiqoye beshanoone. Ito imibeeti qiho hini phiroochi gaachoye maachi bare ashich koochona beshiita echiyaachemone. Etti shigo hini phire qihoochi qaawiyaaache. Itto hini phire echoochi Gimono, giyaachegetono, echooni woachaachegetono tuneba kuxxi neechon hakiyote. Tunebaani itto emiibeeti qiho itoshichi echeebeti gaaconi gaawuchoochi tuneba gaace yaabon qanayooch gaaciye.

Hini phirooni ciinnimi echo itto echeemo beete?

Echa-wochoochi itti giyeemoch daagiyeehote? 1. Gaawa daagiyo 2. Ta qaawachi Bo mashaamiga gallettoye geti echooni dabiibi.

Ta qaawache bogetigaata gallettehooye geti deenichi bareewan besheb.

Echiyeechino mashaamoch echechinoch dukko _____

Deco _____

Id no:_____

Uba kechi ashe dachoo**001 Echiye yaree hadoo 02****002 dubiyoo/kattamoo****003 xugo 03****004 kechi haddoo****1. Echiyecho uubba mabberawe ikkonomi marajjye Echoo**

Y.H	Echo	Wochena'o	Kooddoo	
101	Ebi echawocho gimmona eno ambichole			
102	Shakiyye ayineto	1. Shakiyaa ikkoch 2. Shagene 3. Shakiya bichetti 4. Shakiya baraabeetti 5. Keno gittitoo 88. Barro (gettot		
103	Gibbenno	1. Kittino 2. Isillamo 3. Gigotestanto 4. Kattoliko 88. Batto (getto)		
104	Yarroo	1. Kaffecho 2. Amarro 3. Gurago 4. Oromo 88. Barrolgettot		
105	Doyee darajjoo	1. Amona ariyachi 2. Shemana koroona bachi 3. 1-8 neekimoo 4. 8-12neekimoo 5. 5-12nee kimooyedamba		
106	Shunne dirishoo	1. Kechiigenne 2. Gibirino 3. Menigiste shunecho 4. Heyishunecho 5. Gixxecho 6. Ashikechi serategne 7. Doyeechi 8. Docoona arekona gitech 9. .8 barrolgettot		
107	Agene gebbi bette	1. Eee 2. Ale 3. Gettoch kawaach		
108	Aggene gebbi akiche mena			

109	Kechiasha ha'ddo			
110	Kechiashe halafinete doyoo (ittichoye barrone)	<ol style="list-style-type: none"> 1. Doyaano 2. Shemona korennon hakibato 3. .1-8 snee kimo 4. 9-12neekimo 5. 12 isimooye dambaa 		

2. ganneetino

Y.H	Echo	Wochena'o	Kooddoo
201	Uchemi aco abichedamiyotte	<ol style="list-style-type: none"> 1. Amiye accoo 2. Kure/hayiq/gidiyoo 3. Wonizoch 4. Kifite miniche acoo 5. Oggeacoo 6. Kereti minicee acoo 7. Kereti ogge acoo 8. Buambe aco gibeyemach 9. Buambaci gibemaci 10. Bumbeaco kechimaci 	
202	Bono shechi kechi shaho	<ol style="list-style-type: none"> 1. Shechi kexo alolkubooch 2. Akababe kusakusena shunetoo 3. Cinne kichiye tubo bette 4. Acooche shunebetisheehi kexo 	
203	Yeselectirich ageligiloto	<ol style="list-style-type: none"> 1. Betee 2. Alee 	
204	Redio	<ol style="list-style-type: none"> 1. Betee 2. Alee 	
205	Televiuno	<ol style="list-style-type: none"> 1. Betee 2. Alee 	
206	Kechiwolelo amecheniye bishuneto	<ol style="list-style-type: none"> 1. Shewoche 2. Ibochee 3. Xaretti mitoche 4. Karikaroche 5. Wolele tawulo 6. Shakille minitafo 7. Sinimite wolaloo 	
207	Kechitariyoo	<ol style="list-style-type: none"> 1. Mitooche/denigochee 2. Moccoche 3. Karikahoche 4. Lasitike keroo 5. Shuraree tariyoo 6. Korikoro 7. Sinimitoo 	
208	Bonoshi axibeeti mixoo	<ol style="list-style-type: none"> 1. Ibee 2. Mitoo 	

		3. Kasalo 4. Butega 20 5. Bayoga 20 6. electiriko	
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3. xiffoona shimii huneto katataliye echo

Y.H	Echo	Wochena'o	Kooddoo
301	Shakiye gara enoambichone		
302	Majamaha tiffoche eno ambichoone		
203	Bulaa itti enon ambiche kallotifetote		
304	Bula ambiche bushoo shitote		
305	Ciree tifona iwee beroch hamitote	1. Eee 2. Ariyachii	
306	Iwee berochitihamiti mikininato	E'ee Toonene 1. Xife mirmaarooch 2. shimooch 3. Dhire welidi 4. Tifeeye bare oirto 5. Baree irto	
307	Kidime wolide mirimarech ambiche kalohamitote	1. 1-3 kaalo 2. 4 kaalo 3. 4kaaloye dambaa	
308	Kidime wolde kittitile tiffonna shimi irtoch bidannon wahettoti	1.geteete 2.getiyaach 3.shaligichaach	
309	Aabich iti shimo qawiton mahaso danetotee	1. Danetee 2. daniyantaane	
310	Eeegata aabich iti shiyemoo gaata aritoote	1.iiwe kexxoch 2. beemi xexxoch	
311	Koni shijjeemon gaata marajjyo shagitte	1.daneetotaane 2. daniyaach	
312	E'ee gata kooni shijjemmen ariitootee	1. iiwee qopechinaao 2. mgafooch shijibete"lemde shijechnawo' 3. kechi asho 4. baroo beegata	

4 .cirre shimmon shahiyoona

Y.H	Echo	Wochena'o	Kooddoo
401	Agenoye affi shijjemona busho amomona busho amomone	1. Kashonane bi shijjeto 2. Kittine bi shijjeto	
402	Abichiye bishijjeto	1. Kechimaci 2. Tena tabiyoch 3. Baroo begaa	
403	Kechimaci itiyetigatait irton amone	1. Kechimaci tuno kawiyoo 2. Tatibe beshe gacoodanoo 3. Abiyeafe tashiyabeti kodooch 4. Tena tabiyoch beti gacoon kawach beken	

		5. Tena tabiye akerarebo gento tuneii 6. Tanidamemo mucaa	
404	Keehimaci shimigizoch konishijjyee	1. Amona iridato aloo 2. Gawee tenne balemuyoona 3. Gawe limide awalajoona 4. Gonde limide awalajoona 5. Xiboo woyee barre beteseboo 88. barro begata	
405	Kexochi iti shimona irtodannete	1. E'ee 2. Dniyachee	
406	Tena tabiyoochi itshiyemon qawit inde irta amonaa	1. Xena tabiyoch beti gacoo gaweto tunnetoch 2. Xena tabiyo takexochi katino tuneetoch 3. Xena tabiyoch shimo gawetoo funeetoch 4. Kechimaci shimo goonido tunnetoch 5. Xena tabiyo tashiyemomo geteti kodooch 88. baroo begate	
407	Abitena teku wamoch shihote	1. Husigitaloch 2. Xena tabiyoch 3. Baroo begata	
408	Xena tabiyoch shimoona Amo gachoote	1. Hakimoo 2. Xena mokonino 3. Shijjiyee nerso 4. Redate aloo	

5. maachena' o shimi xaa' on maacee imoon ciinyee

H.H	Echeena' o	Wocheena' o	
501	Iiwexooch iti shimooch maacoo immito konee?	1. Taane 2. Ta mageechoone 3. Ta xibeena' o 4. Iwee qopechinaa' o 5. Iwee extentione' nao 6. Bareena' o	
502	Kexooch ne shiyeto gaata ne iwee iretooch gaach ne qawemoona konee maaco imetoo?	1. Taane 2. Ta mageechoone 3. Ta xibeena' o 4. Iwee qopechinaa' o 5. Iwee extentione' nao 6. Bareena' o	

6: iwee gaacoona ciinimi mooyinaao

H.H	Echeena' o	Wocheena' o	
601	Katinooch shimi gaacoo imibeeti iwee kexo beete?	1.beete 2.aloone 3.ariyaach	
602	shimi gaacooche gijjoo qochbeete?	1.qochbeete 2.echiyaachoon 3. ariyaach	

603	Iiwe aado indeenaoon ooge gaaco imibeeti iiwe kexoch bi dachimoon ariyaabeetinee?	1. areeho 2. waayataanee 3. ariyaach	
604	shimi gaacoo imibeeti iiwe kexo ne kexoch bi wohoo ambiichoone?	1.30 daqqiqo 2.1 saato 3.1 saatooyee daambaa	
605	Indeenaona naleefe iiwe areyooch xaa'o beete	1.beete 2.aala	
606	Echee 605 "beete" ne getigaata ,aabich ne daneetoo?	1.radyoochee 2.televisinoochee 3.gazetooche 4.iiwee qopechoochee	

7.Indeenaoochi aryoona gaaboon ciinemoona

H.H	Echeena'o	Wocheena'o	
701	Xifeechinaa'on shagibeeti iiwe ireteenaoo'on areyaabeetinee?	1. areeho 2. ariyaach	
702	Echee 701 "areehoa' negetigaata ami amee ireetoo ariyaabetiine?	1. damee ufoo 2. magee qeeli cadoo 3. aafee shaawoo 4. qeewiimoo 5. beshiti ache gaamoo 6. ache nafoo 7. qelee tuushoo 8. maacee biiyo 9. baroo beegaata getiite	
703	Shimoona shagibeeti iiwe ireteenaoo'on areyaabeetinee?	1. damee ufoo 2. magee qeeli cadoo 3. aafee shaawoo 4. qeewiimoo 5. beshiti ache gaamoo 6. maaxxo 12 saatooye bi beshegaata 7. shuyoo 30 daqqiqoyee bi beshegaata 8. baroo beegaata getiite	
704	Xifeechinaaona shiimi gaacoon daamoo bi imibeete gaacoo ariyaabeetite?	1. iriiteenaoon shiichi barooch 2. iiwee iriiteenaooch gaaco iimooch 3. indeenaooch gaawe gaaco imooch 4. nalfeenaooch gaawe gaaco imooch 5. baroo beegaata getiite	
705	Iiwe kexoch shimooch iti gaboo amoone?	1. gaawetoone 2. gondoone	
706	Iiwe kexoch shimooch iti gabeto amoochyee?	1. gaawe gaaco beetoch 2. qopeechina'o digyoona no one bo katinitooch 3. qochbeeti gijoo giishech tunetooch 4. Iiwe kexoch shimo gaweto tunetooch 5. baroo beegaata getiite	

707	Iiwe kexxoch shimo gondoone iti ito amoochye?	<ol style="list-style-type: none"> 1. gaawe gaaco aalo tunetooch 2. no qocoon shuunooch bachetooch 3. qopeechina'o noon shiimiyachete 4. qochbeeti gijoo wodoo tunetooch 5. Iiwe kexxoch shimo gondo tunetooch 6. baroo beegaata getiite 	
708	kexxoch shimooch iti gaboo amoone?	<ol style="list-style-type: none"> 1. bulii mooyo gaawetoone 2. gaawetoone 3. andi geto haakach 4. amoonna ta geteemo aala 5. gondoone 	
709	kexxoch shimooch iti gabeto amoochye?	<ol style="list-style-type: none"> 1. kexxoch shimoo teach bi gaawetoochiye 2.ta xibeen'o booneshi degibeetoch 3. no qocoon shuunooch gaawetooch 4. aafi shimoon kexxooch ta sheyetooch 5. Iiwe kexxoch shimo ta shixetooch 6.aaf. Iiwe kexxoch shiya'a iritooch ta giyetooch 7. qopeechina'o noon shiimiyachete 	
710	kexxoch shimo gondoone iti ito amoochye?	<ol style="list-style-type: none"> 1.iiwe kexoch gaawe gaaco beetoch 2. Iiwe kexxoch shimo gaweto tunetooch 3. qopeechina'o shiimebeti qoodoc 4. . Iiwe kexxoch shimo gondo tunetooch 5. baroo beegaata getiite 	