Birth Preparedness and Associated Factors among Pregnant Women in Ana Lemmo District Hadiya Zone Southern Ethiopia. 2015.

By

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A Research Thesis Submitted to the Department of Health Education and Behavioral Sciences, College of Public Health and Medical Sciences, Jimma University; in Partial Fulfillment for the Requirements of Degree of Master of Public Health (MPH) in Health Education and Health Promotion

Jimma, Ethiopia

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Feb, 2015

Jimma, Ethiopia

Abstract

Background: Majority of maternal deaths occur during labour and delivery. Obstetric related complications cannot be reliably predicted. Hence, it is necessary to design strategies to overcome when such problem arise. To this end, one of the strategies is birth preparedness practice to get early services when problem may arise.

Objective: This study was conducted to assess birth preparedness practice and associated factors among pregnant women in Ana lemmo District, hadiya zone, Southern Ethiopia.

Methods: A community-based cross sectional study design was conducted in March 2015, on five hundred fifty two (552) pregnant women in Ana lemmo District. Simple random sampling method was used to select the required number of sample. Pretested structured questionnaire was used to collect data using a face-to-face interview. Data was entered into EpiData 3.1 and Analysis was done using SPSS version 20. Data Analysis statistical tools including descriptive statistics, bivariate and multiple logistic regression Analysis was done to identify factors significantly associated with birth preparedness practice.

Result: A total of 552 pregnant women involved in the study. Taking into account identifying place of delivery, means of transportation and saving money, about 32% of the respondents were prepared for birth. Preparation for birth was higher among literate mothers (AOR= 0.266, 95% CI (.113, .629)), married women (AOR= 0.148, 95% CI (.045, .494)), those who attended ANC sessions ((AOR= 3.081, 95% CI (1.13, 8.38)) and those who are pregnant for the first time.

Conclusion and recommendation

The study revealed low magnitude of birth preparedness practice in the study area. Strengthening ANC sessions and Community education about preparation for birth are important to improve birth preparedness practice.

Acknowledgements

I would like to acknowledge My Advisors Mr. Lakew Abebe and Mr. Abebe Mamo for their unreserved guidance, encouragement and sharing experience from the beginning of the proposal development to final research report.

I sincerely thank Jimma University, College of Public Health and Medical Sciences, Department of Health Education and Behavioral Sciences for providing me this educative opportunity

My special thanks also go to Ana Lemmo District health office for their cooperation and the input they made

Last but not least I would like to thank Peer students for their constructive comments and encouragements throughout the research process.

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Acronyms

ANC	Antenatal Care
BP	Birth Preparedness
EDHS	Ethiopian Demographic and Health Survey
HAD	Health Development Army
HEWs	Health Extension workers
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
NGO's	Non-Governmental Organizations
RHB	Regional Health Bureau
SNNPR	Southern Nations Nationalities Peoples' Region
SPSS	Statistical Package for Social Science
TBA's	Traditional Birth Attendants
TTBAs	Trained Traditional birth attendants
UNICEF	The United Nations Children's Fund
WHO	World Health Organization
ZHD	Zonal Health Department

CHAPTER ONE: - INTRODUCTION

1.1 Background

In human history, the birth of a baby has been remained a major celebration for thousands each day around the world [1]. Societies expect woman to bear children and honor her for her role as a mother [2]. On the contrary, pregnancy and childbirth remains a perilous journey [3]. Especially in developing countries where health service coverage and quality remain low pregnancy and delivery related mortality has been remaining rampant yet. For example, World Health Organization estimated that 289,000 women in 2013 alone died either during pregnancy or birth or following immediately after birth where 99% of all those mortality recorded in developing countries [1].

Improving maternal mortality has received recognition at the global level as evidenced by the inclusion of reducing maternal mortality in the Millennium Development Goals. Since it is not possible to predict which women will experience life -threatening obstetric complications that lead to maternal mortality, receiving care from a skilled provider (doctor, nurse or midwife) during childbirth has been identified as the single most important intervention in safe motherhood program. Since no action is taken prior to delivery, the family tries to take action when labor begins. Pregnancy related complications cannot be reliably predicted and it is necessary to design strategies to over- come those problems when they arise [4].

Birth preparedness is a strategy to promote the timely use of skilled maternal care, especially during childbirth, based on the theory that preparing for childbirth reduces delays in obtaining this care it motivates people to plan to have a skilled provider at every birth [4].Birth preparedness include the following elements: plan for where to give birth, plan for a skilled birth attendant, plan for transportation, plan for saving money and making other preparations for childbirth [3]. If women make the decision to seek care before the onset of labor, and properly follow through with this plan, the woman will reach care before developing any complications during childbirth [1]

Lack of advance planning for use of a skilled birth attendant for normal births, and particularly inadequate preparation for rapid action in the event of obstetric complications, are well documented factors contributing to delay in receiving skilled obstetric care[4]

1.2 Statement of the problem

Worldwide an estimated 289,000 maternal deaths occurred annually as a result of complications of pregnancy and childbirth [2]. Sub-Saharan Africa and Southern Asia were accounted for 85% of the global burden (245 650 maternal deaths) including Ethiopia. An estimated 40% of pregnant women (50 million per year) were experienced pregnancy- related health problems during or after pregnancy and childbirth with 15% suffering serious or long term complications. As a consequence, 300 million women suffer from pregnancy-related health problems and disabilities [1, 5-8].

The MMR in developing regions (230) is 16 times higher than in developed regions [1]. Sub-Saharan Africa had the highest MMR at 500 maternal deaths per 100, 000 live births. In addition, a woman's maternal mortality risk in sub-Saharan Africa is 1 in 30, compared to 1 in 5,600 in developed regions [9].

Globally, more than 70% of all maternal deaths are due to five major complications: hemorrhage, infection, unsafe abortion, hypertensive disorders of pregnancy and obstructed labor. In Ethiopia direct obstetric complication accounts for 85% of maternal deaths. [10].

Birth is profoundly affected by the environment in which it takes place. The home and birth center environments have distinctive features that support healthy women experiencing normal birth. The rural and urban women who could not afford to pay cash were attended by traditional birth attendants [11-17].

In many societies in the world, lacks of awareness inhibit preparation in advance for delivery. Since no action is taken prior to the delivery, the family tries to act only when complications occur, the unprepared family waste a great deal of time in recognizing the problem, getting organized, getting money, finding transport and reaching the appropriate facility [4].

Maternal and neonatal mortality and morbidity rates in Ethiopia are among the highest in the world [1].

In Millennium Development Goal five, countries have committed to reduce maternal mortality ratio by three quarters between 1990 and 2015. Following this commitment, Ethiopia is expected to reduce maternal mortality in 2015 to 267 maternal deaths per 100,000 live births. But according to 2011 Ethiopian Demographic and Health Survey report, the maternal mortality ratio is 676 maternal deaths per 100,000 for the seven year period preceding the survey [17].

In Ethiopia, only 15% of deliveries are attended by health professionals. This situation well explains the maternal mortality ratio of 676 per 100,000 live births, which is one of the highest in the world. Besides this, according to EDHS 2014 only 12 percent of births in SNNPR are delivered at health facilities, which is below the country's average [9].

Despite the fact that birth preparedness is essential for further improvement of maternal and child health little is known about the current magnitude and influencing factors in Ethiopia. This study therefore aims to fill this gap by assessing the current magnitude and factors associated with birth preparedness among pregnant women. It is hoped that the results of the study will provide valuable information for design of possible programs and interventions to improve maternal and neonatal health. And also may serve as baseline information for further study.

CHAPTER TWO: - LITERATURE REVIEW

2.1 Three Delays Model

Thaddeus and Maine (1994) have provided the safe motherhood community with an explanatory model of maternal mortality that identifies delays in seeking, reaching and obtaining care as the key factors leading to maternal death. This explanatory model, known as the Three Delays Model categorizes delays into three types: delays in seeking care, delays in reaching care, and delays in receiving adequate care once at the point of service [4].

Women and newborns need timely access to skilled care during pregnancy, childbirth, and the post-partum/newborn period. Too often, however, their access to care is impeded by delays — delays in deciding to seek care, delays in reaching care, and delays in receiving care. These delays have many causes, including logistic and financial concerns, as well as inadequate awareness and knowledge about maternal and newborn health issues.

Delays in deciding to seek care may be caused by failure to recognize signs of complications, failure to perceive the severity of illness, cost considerations, previous negative experiences with the health care system, and transportation difficulties.

Delays in reaching care may be created by the distance from a woman's home to a facility or provider, the condition of roads, and a lack of transportation.

Delays in receiving care may result from unprofessional attitudes of providers, shortages of supplies and basic equipment, a lack of health care personnel, and poor skills of health care providers. The causes of these delays are common and predictable. However, in order to address them, women and families must be prepared in advance. [13]

Birth Preparedness is the process of planning for normal birth and anticipating the actions needed in case of an emergency. Responsibility for birth preparedness must be shared among all families and women because a coordinated effort is needed to reduce the delays that contribute to maternal and new born deaths [4]

In a cross-sectional community-based study conducted in Adigrat Ethiopia on 534 mothers, taking into account place of delivery identification, means of transportation and saving money,

about 22% of the respondents were prepared for birth. preparation for birth is higher among literate mothers, married women, women with parity range of 2 to 4, women with history of still birth and those who were advised about birth preparedness during their antenatal care follow up and also practices of preparation for birth in the area is poor.[6]

In another Community-based cross-sectional study conducted in January, 2012. On a total of 575 women taking into account place of delivery identification, means of transportation, skilled attendant identification and saving money, about 16.5% of the respondents were prepared for birth. Preparation for birth was higher among educated mothers. Monthly income of >716 Ethiopian birr, Antenatal Care (ANC) visit, and those who had given birth at health facility before their last delivery were also significantly associated with birth preparedness [7].

In a community based cross sectional study conducted in 2007, in Wondo district in Sidama Zone, Southern Ethiopia on a sample 743 pregnant women only a quarter (20.5%) of pregnant women identified skilled provider. Only 8.1% identified health facility for delivery and/or for obstetric emergencies. Preparedness for transportation was found to be very low (7.7%). Considerable (34.5%) number of families saved money for incurred costs of delivery and emergency if needed. Only few (2.3%) identified potential blood donor in case of emergency. Majority (87.9%) of the respondents reported that they intended to deliver at home, and only 60(8%) planned to deliver at health facilities. Overall only 17% of pregnant women were well prepared. The significant predictors for being well-prepared were maternal availing of antenatal services and being pregnant for the first time [8].

In a cross sectional study conducted in Nigeria involving 800 women. Educational status was the best predictor of awareness of birth preparedness, Plan to identify a means of transport to the place of childbirth was related to greater awareness of birth preparedness. Parity was a highly significant predictor of planning to save money [11].

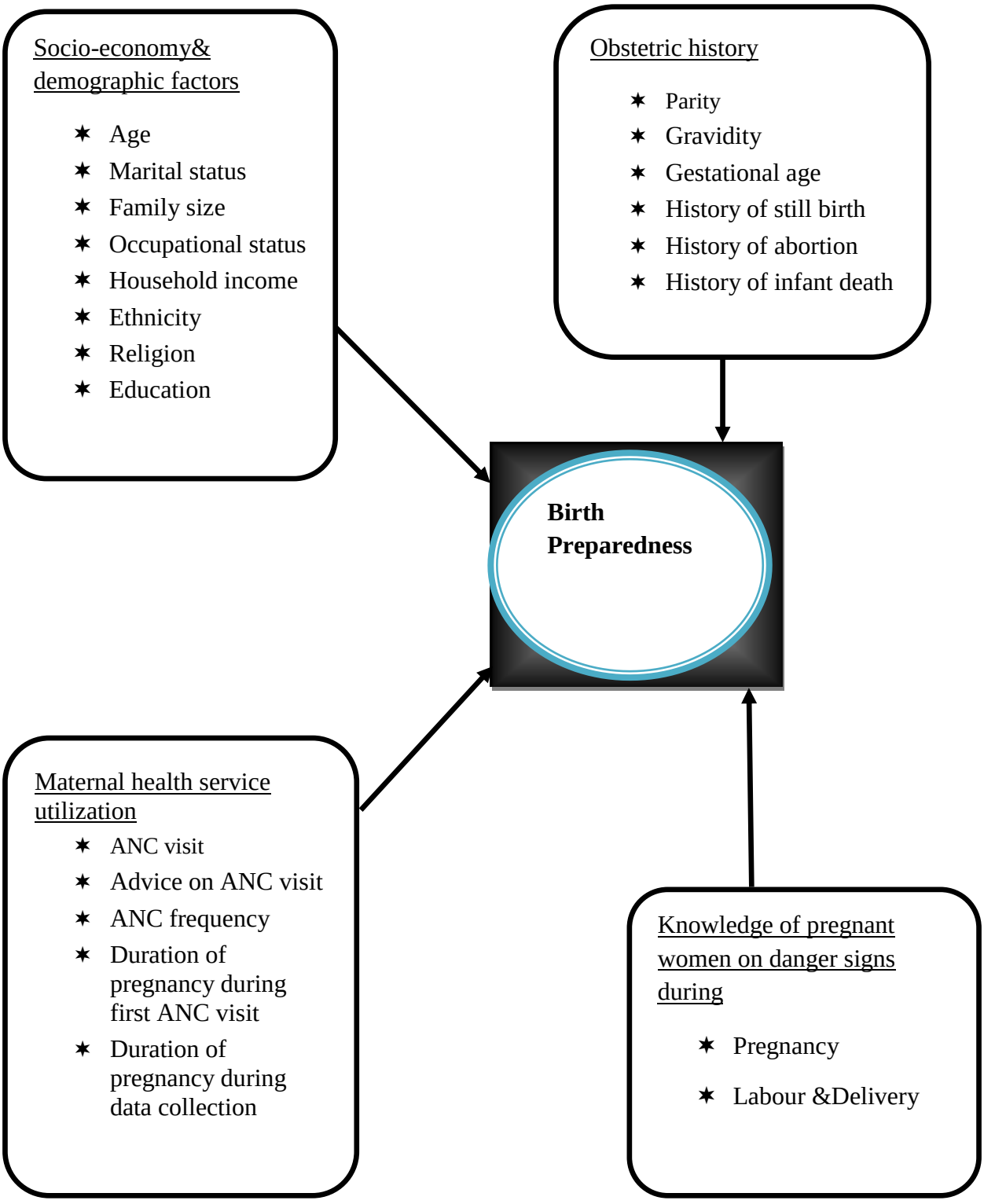
In a study conducted in India Factors associated with well-preparedness are maternal literacy and availing of antenatal services. Deliveries in the slum-home were high (56.4%). Among these, skilled attendance was low (7.4%); 77.3% of them were assisted by traditional birth attendants. Skilled attendance during delivery was three times higher in well-prepared mothers compared to less-prepared mothers [14].

2.2 Significance of the study

Since this study assesses birth preparedness status and associated factors among pregnant women in Ana Lemmo District, hadiya zone, Southern Ethiopia.

The findings of this study will serve as source of information for the District health office to develop action plan. In addition it will benefit different stakeholders like; NGO's working in the area of maternal and neonatal health in the District as well as in the country. Besides this, it will provide important information for public health practitioners and program planners to design possible programs and interventions to improve maternal and neonatal health. And also information generated from the study serves as baseline information for further study.

Figure 1: Conceptual frame work prepared after reviewing different literatures



CHAPTER THREE: - OBJECTIVE

3.1. General objective

- To assess birth preparedness practice and associated factors among pregnant women in Ana Lemmo District, hadiya zone, Southern Ethiopia.

3.2. Specific objectives

- To determine magnitude of birth preparedness practice among pregnant women.
- To identify factors associated with birth preparedness practice among pregnant women.

CHAPTER FOUR: - METHODS AND MATERIALS

4.1. Study area and period

The study was conduct from February 17-March 17/2015 in south Region Ana Lemmo, which is located 216 km south of Addis Ababa. Ana Lemmo is one of the Eleven Districts in Hadia Zone of South Nations, Nationalities and peoples Regional State. It has 27 Kebeles; according to the national census of 2007 the projected total population of the District is 86,380 with (42,457) male and (43,923) female. It shares border with Lemmo and shashogo District of hadiya zone and silte District of silte zone. According to the report from the District health office there are 5 government health centers and 27 Health posts. The people in the District are predominantly farmers. The proportion of pregnant women constitutes 3.46% of the total population that is 2989.

4.2 Study design

Community based Cross Sectional study was employed.

4.3 Population

4.3.1 Source population

All women living in Ana Lemmo District

4.3.2 Study population

Randomly selected mothers from family folder living in the District

4.4 Eligibility criteria

4.4.1 Inclusion criteria

- All selected pregnant mothers registered in the family folder and were able to comprehend and respond to the questions
- Whose pregnancies are three months and above

4.4.2 Exclusion Criteria

Respondents, who were critically sick and unable to communicate to answer questions

4.5 Sample size and Sampling technique /procedure

4.5.1 Sample size determination

Sample size was determined using single population proportion formula. By considering, 17% proportion of birth preparedness practice among pregnant women in wondo District, sidama zone, southern Ethiopia [8]

Assumption

- ✓ P = is the proportion of pregnant women who are prepared for birth/have birth plan 17%
- ✓ d = Acceptable margin of error (precision of measurement) = 3%
- ✓ Z-score (α = Critical value) at 95% confidence interval = 1.96
- ✓ Non-response rate=5%

The formula for calculating the sample size (n) is:

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

Then,

$$n = \frac{(1.96)^2 * 0.17\ (1-0.17)}{(0.03)^2} = 603$$

Since source population (N) is 2989 (<10000), using population correction formula

$$n_c = \frac{n}{1+(\frac{n}{N})} = 502$$

Considering a non-response rate of 5% the total sample size was =552

4.5.2 Sampling technique/ procedure

Nine kebeles randomly selected from the list of 27 kebeles. The sample was distributed to the selected kebeles by proportion to population size and then selected by simple random sampling using lists of pregnant women from family folder of the kebele health post as sampling frame.

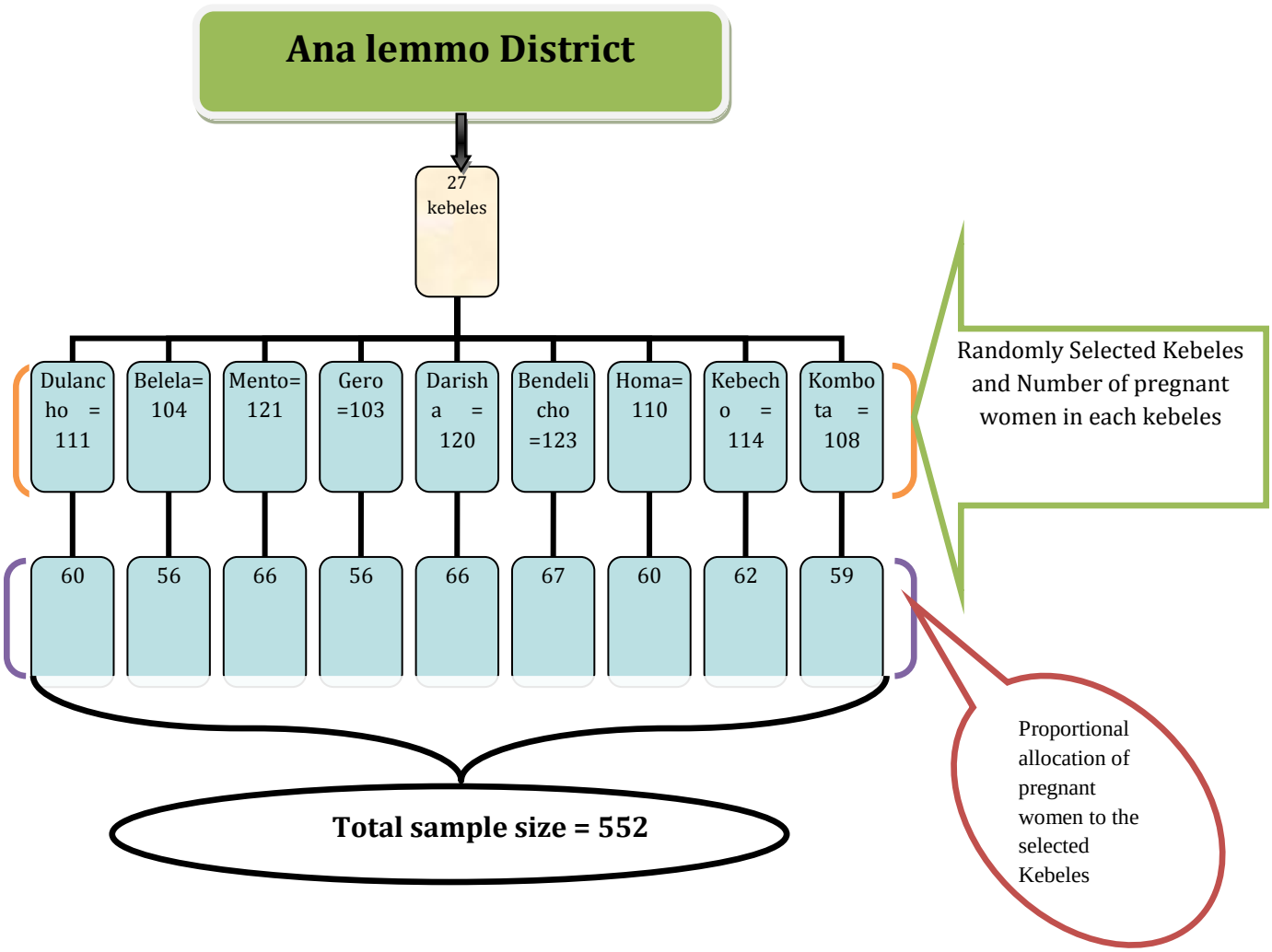


Figure 2: Schematic presentation of sampling procedure of pregnant women in Ana Lemmo District.

4.6 Variables

4.6.1 Dependent variable

- Birth preparedness practice

4.6.2 Independent variables

- Socio-economic and demographic characteristics
  - Age, Religion, Ethnicity, Marital Status, Educational Status, Occupation, Monthly Family income, Family Size,
- Obstetric characteristics
  - Gestational age, Parity, Gravidity, History of still birth, History of infant death, History of abortion
- Maternal health service utilization
  - ANC visit, Advice given on ANC visit, ANC frequency, Duration of pregnancy during first ANC visit.
- Knowledge on danger signs of pregnancy, labour and delivery

4.7 Data collection procedure and instrument

A structured questionnaire taken from the safe mother hood questionnaire developed by maternal and neonatal health program of JHPIEGO the affiliate of Johns Hopkins University and adopted from previous similar studies according to the context and objectives of the study. The questionnaire is prepared in English and was translated to Amharic language by an individual who have ability of both languages and retranslated to English by another person to check its consistency (conceptual equivalence) with the original English version. Sampling frame having list of all pregnant women in the selected kebeles was prepared from the family.

Experienced data collectors who completed diploma in Nursing and who know the culture and language of the community collected the data. Nine data collectors and three supervisors (B.Sc. Nurses) were trained on data collection tool and its procedures for one day by principal investigator. The data collectors interviewed eligible women at their house. The interview time

was whole day. In addition the interviewers were giving an appointment for those who could not be available at working days and interviewed them on weekend.

4.8 Data quality control

Data collectors was selected based on their ability to speak the hadiya language in addition to Amharic language and previous experience of data collection. Training was given to the selected data collectors and supervisors for one days on the objective and process of data collection. Unclear points and problems encountered was explained. Closer supervision undertaken during data collection. Every questionnaire was crosschecked daily by the supervisors and the principal investigator. Problems faced were discussed every night following data collection with data collectors and the supervisors.

4.9 Operational definitions

- **Birth preparedness practice:** The pregnant women was asked whether she followed the desired elements of birth preparedness practice. Which consists of 4 items, the responses was scored as "0" for no answer and "1" for yes answer. And the total score was obtained by computing all items, which range from 0 to 4 points. Respondents scores >=3 was considered as being well-prepared and the rest as not well prepared for birth.

- **A woman was considered knowledgeable on key danger signs of pregnancy**, if she can mention at least two of the three key danger signs during pregnancy (vaginal bleeding, swollen hands/face and blurred vision) spontaneously, she was considered as knowledgeable otherwise not knowledgeable.

- **A woman was considered knowledgeable on key danger signs of labour/childbirth**, if she can mention at least three of the key four danger signs during labour/childbirth (severe vaginal bleeding, prolonged labour (>12 hours), convulsion and retained placenta) spontaneously, she was considered as knowledgeable otherwise not knowledgeable.

4.10 Data processing and Analysis

Data was entered into EpiData Entry Version 3.1 and exported to SPSS version 20 for Analysis. Descriptive statistics like frequency, proportions, and descriptive summaries was used to describe the study variables. Bivariate Analysis was performed to see the existence of association between dependent and independent variables. Independent variables which show significant association with the dependent variable in binary logistic regression was enrolled in the multivariate Analysis. Using p- value less than 0.25 as cutoff point and odds ratios with 95% CI to see presence of statistical significance. Multiple logistic regression Analysis was performed to identify predictors of birth preparedness practice and variables having P value < 0.05 was considered as significant predicators. Finally, the results are compared with available findings from different literatures.

4.11 Data quality management

The quality of data was assured through pre-test on 5% of the total sample size, in nearest District in similar setting. It helped to ensure as the respondents were able to understand the questions. Also used to check wording and flow of the questionnaire. After pretest modifications were made accordingly.

4.12 Ethical consideration

The study does not have any experiment on human subjects. However, this study obtained ethical clearance from Research Ethics Committee of Jimma University. Permission was obtained from Ana Lemmo District Health office, the District administration. All interviews were made with strict privacy. After clear explanation about the purpose of the study, participant's verbal informed consent was taken from each respondents. The right of the respondents to refuse to answer for few or all of the questions was respected. Identification of study participants by name was avoided to assure confidentiality of the information obtained.

4.13 Dissemination plan

The result of this study will be presented to Jimma University, College of Public Health and Medical sciences. After having approval from the Department, it will be communicated to concerned bodies through reports. The findings will also be disseminated to different organizations like SNNPR Health Bureau, Hadiya zone health department, Ana Lemmo District

health office. And also for stakeholders or partners that have contribution improving maternal and neonatal health. The findings may be presented in different seminars, meetings and workshops and attempts will be made to publish in scientific journals.

CHAPTER FIVE: RESULTS

5.1 Socio demographic characteristics

In this study a total of 552 pregnant women in their third to ninth month of pregnancy were interviewed from nine kebeles of Ana lemmo District. All eligible pregnant women in the selected samples responded to the questionnaire.

Four hundred eight (73.9%) of the respondents were in the age group of 18-30 years, with a mean age of 26.9 (SD of 6.9) years with minimum 18 and maximum 49 years of age. Majority of the respondents 488 (88.4%) were married and 64(11.6%) were not in marital union. By ethnicity, majority of the respondents were Hadiya 473(85.7%), Silte 48 (8.7%), Amhara 11(2%) and others 20 (3.6%). A greater proportion of the respondents were Protestants 401(72.6%), followed by Muslim 99(17.9), Orthodox 29(5.3%) and Others 23(4.2%). 121(21.9%) of the respondents cannot read and write, 318(57.6%) were under secondary education and 113(20.5%) had secondary education and above. Almost two-third, 347(62.9%) of the pregnant women were housewives at the time of data collection. The mean family income was 1281 (SD of 1040) birr with its median of 1000 birr.

Table 1: Socio- economic and demographic characteristics among pregnant women in Ana lemmo District, March 2015.

Variables	Category	N (%)
Age	<=20	118(21.4)
	21–25	136(24.6)
	26–30	154(27.9)
	30-35	48(8.7)
	>35	96(17.4)
Religion	Protestant	401(72.6)
	Muslim	99(17.9)
	Orthodox	29(5.3)
	Others*	23(4.2)

Ethnicity	Hadiya	473(85.7)
	Silte	48(8.7)
	Amhara	11(2.0)
	Others**	20(3.6)
Marital status (currently)	In marital union	488(88.4)
	Not in marital union	64(11.6)
Women		
Education	Illiterate	121(21.9)
	Read and write	181(32.8)
	Primary education	137(24.8)
	Secondary education and above	113(20.5)
Women		
Occupation	Housewife	347(62.9)
	Farmer	77(13.9)
	Merchant	73(13.2)
	Others***	55(10.0)
Monthly family Income	< 650 Birr	208(37.7)
	651–1500 Birr	182(33.0)
	>1500 Birr	162(29.3)
Family size	0-2	420(76.1)
	3-4	90(16.3)
	>=5	42(7.6)

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* catholic, Jehovah, traditional beliefs.

** Gurage, Oromo and Halaba.

*** Daily laborer, civil servant, Private employee.

5.2 Antenatal care visits during current pregnancy

About 450(81.5%) Planned their pregnancy. 327(59.2%) attended ANC checkup, only 18(5.5%) attended Antenatal care four or more times during current pregnancy. 276 (84.4) got advice on preparation for birth during ANC visit.

Table 2: Antenatal care services and awareness on Obstetric danger signs among pregnant women in Ana lemmo District, March 2015.

Variables	Category	N (%)
Planned pregnancy	yes	450(81.5)
	No	102(18.5)
ANC checkup	yes	327(59.2)
	No	225(40.8)
Number of ANC	1	47(14.4)
visits (n=327)	2	147(45.0)
	3	115(35.2)
	>=4	18(5.5)
Timing of 1st ANC	3–6 months	319(97.6)
	7–9 months	8(2.4)
Personnel checked	Health professionals	314(96.0)
	Others*	13(4.0)
Advice given during ANC visit	yes	276(84.4)
	No	51(15.6)
Do you Know danger signs	yes	332(60.1)
	No	220(39.9)
Knowledge on danger		
Signs of pregnancy,	knowledgeable	206(62.0)

	Not knowledgeable	126(38.0)
Knowledge on danger Signs of labour and child birth	knowledgeable	256(77.2)
	Not knowledgeable	76(22.8)

others* TBA, HEW, HDA, Relatives

5.3 Obstetric characteristics of respondents related to previous pregnancy

Two hundred seventy one (49.1%) of the respondents are pregnant for the first time

Table 3: Obstetric characteristics related to previous pregnancy among pregnant women in Ana lemmo District, March 2015.

Variables	**category**	**N (%)**
Duration of pregnancy during data Collection	3–6 months	198(35.9)
	7–9 months	354(64.1)
First pregnancy	yes	271(49.1)
	No	281(50.1)
Gravida n=281 (total no. of pregnancy)	1-2	224(79.7)
	>=3	57(20.3)
Parity (total no. of birth)	0-1	19(6.8)
	2-4	223(79.4)
	>=5	39(13.9)
History of abortion	No	275(97.9)

	Yes	6(2.1)
History of stillbirth	No	228(81.1)
	Yes	53(18.9)
History of infant death	No	262(93.2)
	Yes	19(6.8)

5.4 Birth preparedness practices

Three hundred thirty five (60.7%) Respondents reported that they saved money, 179(32.4%) identified a mode of transportation, 371(67.2%) reported that they identified place of delivery and 173(31.3%) identified skilled birth attendant.

The birth preparedness practice score was computed considering key elements of birth preparedness practice saving money for delivery, arrangement for transportation, identifying skilled birth attendant and identifying a health facility for Delivery. Scoring three and above was considered as being well prepared. 176(32%) of the Respondents in this study was considered as being well prepared for birth.

Table 4: Practices of respondents on preparation for birth with current pregnancy among pregnant women in Ana lemmo District, March 2015.

Variables	**category**	**N (%)**
Saved money	yes	335(60.7)
	No	217(39.3)
Arranged transport	yes	179(32.4)
	No	373(67.60
Identified a skilled birth attendant	yes	173(31.3)
	No	379(68.7)
Identified facility for Delivery	yes	371(67.2)

	No	181(32.8)
Place of Delivery	Health institution	293(79.0)
	other place	78(21.0)
Final decision maker on birth place	both	261(47.3)
	Women	211(38.2)
	Husband	80(14.5)

Well prepared = 31.9 ~32

5.5 Factors associated with birth preparedness practices

In multiple logistic regression applying enter method, predictor variables for birth preparedness practices were identified. The independent variables which show association in binary logistic regression marital status, educational status, occupation status, planed pregnancy, Number of ANC visits, Advice given during ANC visit, Duration of pregnancy during data Collection, Know danger signs during labour and delivery and Have any plan on current delivery and its ceremony, first pregnancy were included in the final model to predict birth preparedness practice.

The specification of the model identified six significant predictors; marital status, educational status, occupational status, Number of ANC visits, first pregnancy and Duration of pregnancy during data Collection as significant predictors of birth preparedness practice, after adjusting others variables fitted in the model. Using p value as the significant level and variables having p value < 0.05 were considered as significant predictors, considering odds ratios and corresponding 95% confidence interval

Married women were 86% more likely to be prepared for birth than non-married (AOR= 0.148, 95% CI (.045, .494)). Pregnant women who attended primary education were 74% more likely to be prepared for birth than illiterate (AOR= 0.266, 95% CI (.113, .629)). Mothers who are farmers were 87% less likely to practice birth preparedness when compared to those of housewives (AOR= 0.137, 95% CI (.036, .530)).In this study those who attended ANC sessions for three or more times were three times more likely to be prepared for birth those who attended only once (AOR= 3.0, 95% CI (1.13, 8.38)). Pregnant women who are pregnant for the first time were 2.3

times more likely to practice birth preparedness when compared to their counter parts (AOR=2.3, 95% CI (1.0, 5.3)). Pregnant women who are in a range of 7-9 months are 5.3 times more likely to be prepared for birth than those who are 3-6 months during data collection (AOR=5.3, 95% CI (2.1, 13.3)).

Table 5: Factor associated with birth preparedness practices among pregnant women in Ana lemmo District, March 2015.

Variable	birth preparedness practice		AOR(95% CI)
	not well prepared	Well prepared	
	N (%)	N (%)	
Marriage			
Currently in marital union	342(70.1%)	146(29.9%)	1
Currently not in marital union	34(53.1%)	30(46.9%)	**0.148(.045,.494)**
Education			
Illiterate	220(72.8%)	82(27.2%)	1
Primary education	128(93.4%)	9(6.6%)	**0.266 (.113, .629)**
Secondary and above	28(24.8%)	85(75.2%)	**0.207 (.064, .675)**
Occupation			
House wife	213(61.4%)	134(38.6%)	1
Farmer	74(96.1%)	3(3.9%)	**0.137(.036, .530)**
Merchant	69(94.5%)	4(5.5%)	**0.037(.004, .323)**
others	20(36.4%)	35(63.6%)	**0.056 (.007, .448)**
Number of			

ANC visits			
1-2	95(49.0%)	99(51.0%)	1
3-4	100(75.2%)	33(24.8%)	**3.081(1.13, 8.38)**
First pregnancy			
Yes	187(69.0%)	84(31.0%)	1
No	189(67.3%)	92(32.7%)	**2.389(1.07,5.3)**
Duration of pregnancy during data Collection			
3–6 months	124(62.6%)	74(37.4%)	1
7–9 months	252(71.2%)	102(28.8%)	**5.3 (2.1, 13.3)**

CHAPTER SIX: DISCUSSION

This community based cross-sectional study assess the magnitude and factors associated with birth preparedness practice in Ana lemmo District. This study revealed that the proportion of birth preparedness practice is 32% implying that birth preparedness practice is less prevalent in the District. But the finding of this study showed that there is increment in magnitude of birth preparedness practice in comparison with other studies conducted in Ethiopia Wondo district in Sidama Zone(8), Adigrat Ethiopia(6) And lower than other African and Asian countries like, Nigeria(11) and India(14). This could be due to socio economic status and availability of health facility in nearby.

The study identified about arrangements made by pregnant women during pregnancy for birth and the result showed that one-third of respondents made arrangement in a comprehensive way for the current pregnancy by identifying a means of transportation, identifying skilled provider, saving money and identifying place of delivery.

About 67.2% of the respondents reported that they identified place of delivery for current pregnancy. Place of delivery identification is very important especially in this setting where the main means to get a skilled provider is to deliver at health institutions.

Transportation is a barrier to seek care and reaching medical facilities, money saved by pregnant woman or her family can be payed for health services and supplies, vital for transport, or other costs. In this study, 60.7% of the respondents saved money for childbirth which is lower compared to study in adigrat (68.9%) (8), and follow up study at which 81.4% of currently pregnant women said they had financial plans for delivery (20).

It could be difficult to secure transport at the last minute after a labour has occurred even when money is available. Arranging transport ahead of time reduces the delay in seeking and reaching services (3). In this study, 32.4% of the respondents have identified transportation ahead of childbirth which is higher compared to a study in adigrat 24.7% (8)

Married women were more likely to be prepared for birth than non-married. This could be because, married women may have wanted and planned pregnancies which enables them to demand better service and get prepared. On the other hand those who are not married may not want to be known as pregnant without being married.

Pregnant women who attended primary education were more likely to be prepared for birth than illiterate. This might be related to the fact that educated women have better power to make their own decision in matters related to their health and also it may be due to the nature of education that it develops individual minds to think critically and increase self-responsibility of their own health. Educated women can easily understand information from different media source and has the chance to practice them.

In this study those who attended ANC sessions for three or more times were more likely to be prepared for birth. This could be due to the fact that those who visit ANC session repeatedly may have the chance to get information on the importance of preparation for birth which could help them to make decision on their delivery plan.

Pregnant women who are pregnant for the first time are well prepared than their counter parts this may be, being pregnant for the first time may initiate them to take care of them themselves than others.

Pregnant women who are in a range of 7-9 months are more likely to be prepared for birth than those who are 3-6 months duration of pregnancy during data Collection maters birth preparedness practice

Limitation of the study

- Since the participants have not completed their pregnancies, they may have the opportunity or need to make arrangements related to birth preparedness practice.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

8.1 Conclusion

The conclusions drawn from this cross sectional study is that the magnitude of birth preparedness practice in the study area is 32%.

The factors that affect birth preparedness practice were women's marital status and educational status, occupational status, first pregnancy, duration of pregnancy and ANC visits.

8.2 Recommendation

For Regional HB/ Zonal HD or district Health office

Community-based education about preparation for birth and empowerment of women by expanding educational opportunities by all stakeholders working in maternal and neonatal health are important factors in enhancing birth preparedness practice.

More intensive counseling of mothers through peers, HDA, HEW and health care providers would be necessary.

For Researchers

To undertake analytical study to understand the effect of partner, community and health facility on birth preparedness practices for further understanding of the problem.

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Appendix

Annex 1: Verbal Consent form

JIMMA UNIVERSITY

COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES DEPARTMENT OF HEATH EDUCATION AND BEHAVIORAL SCIENCES

A QUESTIONNAIRE PREPARED TO ASSESS BIRTH PREPAREDNESS PRACTICE AND ASSOCIATED FACTORS AMONG PREGNANT WOMEN IN ANA LEMMO DISTRICT HADIYA ZONE SOUTHERN ETHIOPIA. A COMMUNITY BASED CROSS SECTIONAL STUDY 2015.

Consent form

You are among those who are selected to participate in this study. Here below I will mention you the important points that briefs you about the general nature of the study and your role in the study.

Purpose of the study

The purpose of the study is to assess Birth preparedness practice and Associated Factors among Pregnant Women in in your district

Your role

You will be asked some questions about your socio-demographic and socio-economic characteristics, maternal obstetric characteristics and health service utilization, knowledge on danger signs of pregnancy, labour and delivery and your opinion on the quality of maternal health service.

1. Benefit you will get

The result of this study is important to maternal and neonatal health, depending on the result of the study the government or other concerned body will act in a way to correct the maternal and neonatal service, if there is any and you will be one of those who will get the benefit.

2. Risk or discomfort of participating in the study

There is no risk or discomfort you should fear as a result of participating in this study.

3. Confidentiality

The information that you will give be available only for those who are engaged in this study and will be kept confidential. And also coding will be used in place of your name.

4. Time you may spend with us

Around 30 minutes is enough to complete the process

Participation

It is your wish to participate or not participate in this study. You will lose nothing for not participating in the study and you have full right to discontinue providing information any time of data collection and still you will not have any harm for discontinuing the process.

5. You can ask anything that is not clear to you

    1) Is all the information given above is clear to you? Yes___ No____

If No, re-explain the above information.

If yes, proceed to the next question.

    2) Are you willing to participate in the study? Yes_➔__ No____

Interviewer:

If yes, go to the questionnaire and start data collection. If no, skip to the next eligible.

For further information and concerns about the study, you can contact:

Principal investigator: Bereket Tsegaye

Mobile Phone: +251911929966

For question about one's rights as research participant

Secretary of Ethics advisory Board of Jimma University

Tel----fax +2511 471114484

Jimma University, college of Public Health and Medical Sciences

Dept. of Health Education and Behavioral sciences

Jimma, Ethiopia

Annex 2: English Questionnaires

Questionnaire No ----------

JIMMA UNIVERSITY

COLLAGE OF PUBLIC HEALTH AND MEDICAL SCIENCE,

DEPARTMENT OF HEALTH EDUCATION AND BEHAVIORAL SCIENCES

A QUESTIONNAIRE PREPARED TO ASSESS BIRTH PREPAREDNESS AND ASSOCIATED FACTORS AMONG PREGNANT WOMEN IN ANA LEMMO DISTRICT HADIYA ZONE SOUTHERN ETHIOPIA. A COMMUNITY BASED CROSS SECTIONAL STUDY 2015.

Code of household(ID) _____ Name of kebele _____

Data collector code No _____ Signature _____ Date ___/___/__

PART 1: SOCIO- ECONOMIC AND DEMOGRAPHIC QUESTIONS

Q. #	QUESTION	Responses	GO TO Q.
101	Age	……..in completed years	
102	Religion	Orthodox Muslim Protestant Catholic Others, specify……..	
103	Ethnicity	Hadiya Silte Gurage Oromo Amhara Other, specify…...	
104	Marital status	Single Married Divorced Widowed	
105	Educational status	In number……..	
106	Occupation	Farmer Merchant	

		House-wife Civil servant Others, specify……	
107	Monthly family income	In Birr……	
108	Family size	In number…….	

PART 2. ANTENATAL CARE SERVICE UTILIZATION AND PREFERENCE OF BIRTH ATTENDANT			
Q. #	QUESTION	Responses	GO TO Q.
201	Have you planned your current pregnancy?	Yes No	
202	Have you antenatal care checkup during the current pregnancy?	Yes No	If the answer is no go to part 3
203	How many times have you received antenatal care checkup during your current pregnancy?	Times..... Don't know..... 98	
204	How many months was your current pregnancy when you had your 1st ANC checkup?	Months.....	
205	Whom did you first see for a checkup on your current pregnancy?	Health professional Health extension worker TBA Relative/friend Other, specify…….	
206	During your current visit of ANC checkup during your current pregnancy, had a health worker advised you?	Yes No	No … part 3
207	If yes… what was/were the health worker advised	Danger signs..... 01..... 02.....98 Where to go.....01.....02.....98 Where deliver.....01…..02.....98 Transport..... 01.....02.....98 Money..... 01.....02..... 98 Health prof..... 01.... 02.....98	
208	Can unforeseen problems related to pregnancy occur during pregnancy or childbirth that could endanger the life of a woman?	Yes..... 01 No..... 02 Don't know..... 98	If the answer is (no/don't know) go to part 3

209	What are some serious health problems that can occur during pregnancy that could endanger the life of a pregnant woman?	Bleeding .....01 Severe headache .....02 Blurred vision .....03 Convulsions..... 04 Swollen hands/face.....05 High fever.....06 Loss of consciousness.....07 Difficulty breathing.....08 Severe abdominal pain .....09 Accelerated/ reduced Fetal movement.....10 Water breaks Without labor .....11 Other (specify)…….97	
210	What are some serious health problems that can occur during labor and childbirth that could endanger the life of a pregnant woman?	Severe bleeding.....01 Severe headache .....02 Convulsions.....03 High fever .....04 Loss of consciousness.....05 Labor lasting >12 hours.....06 Placenta not delivered 30 minutes after baby.....07 Other (specify)……..97	

PART 3. OBSTETRIC CHARACTERISTICS RELATED TO PREVIOUS PREGNANCY			
301	How many months pregnant are you?	Months _ _	
302	Is this your first pregnancy?	Yes No	If the answer is yes go to part. 4
303	How many pregnancies had you before this pregnancy?	……	
304	How many children do you have currently?	……	
305	Do you have any miscarriage/abortion?		
306	Have any of your pregnancies resulted in a baby that was born	Yes..... 1 No.....2	If the answer is no

	dead (a stillbirth)?		go to Q.308
307	How many of these pregnancies resulted in a baby that was born dead?	Babies born dead	
308	Have any of your pregnancies resulted in a baby that was born alive?	Yes No	If the answer is no go to part.4
309	How many of these pregnancies resulted in a baby that was born alive?	Babies born alive.....	

PART 4. PERSONAL EXPERIENCE WITH CURRENT PREGNANCY			
Q. #	QUESTION	Responses	GO TO Q.
401	Have you or your family made any arrangements for the birth of this child?	Yes No	No...Q. 411
402	If Yes, what kind	……	
403	Did you secure funds or plan to get funds?	Yes No	
404	If yes	Already deposited so far Plan to get from relative Plan to get loans I did not plan yet	
405	Did you speak with anyone outside of a health facility about arrangements for transportation?	Yes No	No….Q. 407
406	Whom did you speak with?	Husband Mother-in-law Other family member Friend/Neighbor Health extension worker	

407	Did you speak with anyone outside of a health facility about arrangements for a healthcare professional to deliver your child?	Yes No	
408	Whom did you speak with?	Skilled provider Husband Mother-in-law Other family member Friend/Neighbor Health extension worker	
409	Have you selected the place where to give birth?	Yes No	
410	If yes, where	At home assisted by TBAS At home assisted by TTBAs At home assisted by HEWs At home assisted by relatives At Health post At Health center At Hospital At TTBAs home	
411	Who made the final decision about where you will give birth?	No one Respondent Husband Both Sister/sister-in-law Other member of respondent's family Other member of husband's family Friend/Neighbor Health professional TBA Other, specify	

Thank you

Annex 3: የአማርኛ ትርጉም ቃለ-መጠይቅ

ጅማ ዩንቨርሲቲ

በህብረተሰብ ጤና እና ህክምና ሳይንስ ኮሌጅ፣ የጤና አጠባበቅ ትምህርትና ሥነ ባህሪይ ሳይንሶች ትምህርት ክፍል

በ2007 ዓ.ም በሀዲያ ዞን በአንሌሞ ወረዳ በሚገኙ ነፍሰ - ጡር ሴቶች ላይ የወሊድ ቅድመ ዝግጅትን በተመለከተ መረጃ ለመሰብሰብ የተዘጋጀ መጠይቅ

የቃል ስምምነት መግለጫ

ይህ የስምምነት መግለጫ መመሪያ የተዘጋጀው የጥናቱን አላማ ለነፍሰ ጡር ሴቶች ለማስረዳትና ነፍሰ ጡርሴቶችም በጥናቱ እንዲሳተፉ

ለመጋበዝ ነው፡፡

ጤና ይስጥልኝ፤ ሥሜ---------- እባላለሁ፡፡

በጅማ ዩንቨርሲቲ የድህረ ምረቃ ተማሪ አቶ በረከት ፀጋዬ በነፍሰጡር ሴቶች የወሊድ ቅድመ ዝግጅትን በተመለከተ በአንሌሞ ወረዳ በሚካሄደው ጥናት በመረጃ ሰብሳቢነት እሰራለሁ ፡፡

የዚህ ጥናት ዋና አላማ እርስዎ የወሊድ ቅድመ ዝግጅትን በተመለከተ በተዘጋጀው መጠይቅ መሰረት ከእረስዎ

መረጃዎችን በማሰባሰብ ነፍሰጡር ሴቶች የእናቶችና ህፃናት አገልግሎት ተጠቃሚነትን በመጨመር የተሻለ የአሠራር ሂደት

ለመፍጠር ነው፡፡ ስምዎን መናገር አይጠበቅብዎትም፡፡ መጠይቁ ከጥናቱ አዘጋጅ በቀር ለሌላ ሰው ስለማስይጥ

እና ለሌላ ሰራ ስለማይዉል ሚስጥራዊነቱ የተጠበቀ ነው፡፡በማንኛውም ጊዜ በጥናቱ ሂደት ውስጥ ማቋረጥ ወይም

የማይፈልጉትን ጥያቄ አለመመለስ ይችላሉ፡፡ ነገር ግን እርስዎ በጥናቱ ተሳትፈዉ የሚሰጡት መረጃ የጥናቱን ዓላማ ለማሳካትና የእናቶችና ህፃናት አገልግሎት ተጠቃሚነትን ለማሻሻል ከፍተኛ ጠቀሜታ አለዉ ።

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት? 1.አዎን 2.አይደለሁም

ለትብብርዎ በጣም እናመሰግናለን

የቀበሌ ስም————————————————የቀበሌ ኮድ ————————————————————

የቤት ቁጥር ————————————————————የተጠየቀበት ቀን ————————————————

የመረጃ ሰብሳቢው ስም ————————————————ፊርማ ————————————————

የሱፐርቫዘር ስም ————————————————————ፊርማ ————————————————

የአማርኛ ቃለ-መጠይቅ

ከተሰጡት አማራጮች ዉስጥ በመላሾች ምርጫ መሰረት አንዱን ያክብቡ።

ነ. አጠቃላይ ማህበራዊና ቤተሰባዊ መረጃን በተመለከተ የተዘጋጀ መጠይቅ፡ከዚህ በታች በተዘረዘሩት ጥያቄዎች

ክፍል 1: የተጠያቂው አጠቃላይ ማህበራዊና ኢኮኖሚያዊ መረጃን በተመለከተ የተዘጋጀ መጠይቅ			
ተ.ቁጥር	ጥያቄዎች	አማራጭ መልስ	እለፍ
101	እድሜዎ ስንት ይሆናል?	በተጠናቀቀ አመታት	
102	ሀይማኖትዎ ምንድ ነዉ?	1.አርቶዶክስ 2.እስልምና 3.ፕሮቴስታንት 4.ካቶሊክ ሌላ ካለ ቢገለጽ——	
103	ብሔረሰብ/ነሳ/	ነ.ሃዲያ 2.ስልጤ 3.ጉራጌ 4.አማራ 5.አሮሞ ሌላ ካለ ቢገለጽ——	
104	የጋብቻ ሁኔታ	1.ያገባች 2.ያላገባች 3.የፋታች 4.የተለያየች 5.ባል የሞተባት	
105	የሴትየዋ የትምህርት ደረጃ	1.ያልተማረች 2.መሠረተ ትምህርት 3.የአንደኛ ደረጃ ትምህርት 4.የሁለተኛ ደረጃ ትምህርት 5.የከፍተኛ ትምህርት(ቢገለጽ)	
106	የሴትየዋ የሥራ ሁኔታ	1.የቤት እመቤት 2.አርሶ አደር 3.ነጋዴ 4.የጉልበት ሠራተኛ 5.የመንግስት ሠራተኛ ሌላ ካለ ይገለጽ……	
107	የወር ገቢ በግምት ስንት ይሆናል	.....ብር (በኢትዮጵያ)	
108	የቤተሰብ ብዛት	በቁጥር….	

ክፍል 2. የነፍሰ ጡር እናቶች የጤና ምርመራ ክትትል ጥናት በተመለከተ የተዘጋጀ መጠይቅ			
ተራ ቁጥር	ጥያቄዎች	አማራጭ መልስ	እለፍ
201	ይህንን እርግዝና አቅደዉ ነበር?	1.አዎ 2.አይ	
202	ለአሁኑ እርግዝና የነፍሰ ጡር እናቶች የጤና ምርመራ ክትትል (ANC checkup) አድርገሻል?	1.አዎ 2.አይ →	ወደ ጥያቄ. 208
203	የነፍሰ ጡር እናቶች የጤና ምርመራ ክትትል (የሚያደርጉ ከሆነ) በአጠቃላይ ለስንት ጊዜ ሄደዉ ነበር?	ስንት ጊዜ..... አላወቅም..... 98	
204	ለነፍሰ ጡር እናቶች የጤና ምርመራ ክትትል ወደ ጤና ድርጅት የሄዱት በስንተኛዉ ወር ነበር?	በወር.....	
205	የነፍሰ ጡር እናቶች የጤና ምርመራ ያደረገልዎ ማን ነበር?	የጤና ባለሙያ የጤና ኤክስቴንሽን ባለሙያ የልምድ አዋላጅ ቤተ ዘመድ ሌላ ካለ ይገለጽ…	
206	የነፍሰ ጡር እናቶች የጤና ምርመራ ያደረገልዎ ባለሙያ የምክር አገልግሎት ሰጥተዎት ነበር?	1.አዎ 2.አይ →	ወደ ጥያቄ. 208
207	የነፍሰ ጡር እናቶች የጤና ምርመራ ያደረገልዎ ባለሙያ በምን ዙሪያ ነበር የመከረዎት?	አዎ አይ አላወቅም በእርግዝና ወቅት ስለሚከሰት አደገኛ ምልክቶች.....01..... 02.....98 ችግር ሲገጥም የት እንደሚሄዱ.....01.....02.....98 የት መዉለድ እንዳለብዎ.....01…..02.....98 ስለ ትራንስፖርት ዝግጅት.....01.....02.....98 ስለ ገንዘብ ማጠራቀም.....01.....02..... .98 ጤና ባለሙያ ስለ ማዘጋጀት.....01.... .02.....98	
208	ከወሊድ እና ከእርግዝና ጋር በተያያዘ በእናትየው ህይወት ላይ አደጋ ሊያመጡ የሚችሉ ችግሮችን ያውቃሉ?	አዎ.....01 አይ.....02 አላውቅም.....98 →	ወደ ክፍል 3
209	ከእርግዝና ጋር በተያያዘ በእናትየው ህይወት ላይ አደጋ ሊያመጡ የሚችሉ አደገኛ የጤና ችግሮች ይጥቀሱ?	የደም መፍሰስ .....01 ከፍተኛ የራስ ህመም .....02 አጥርቶ ማየት አለመቻል .....03 መንዘፍዘፍ.....04 የእጅና የፊት ማበጥ.....05 ከፍተኛ ትኩሳት.....06 አቅልን መሳት.....07	

		መተንፈስ አለመቻል.....08 ከፍተኛ የሆድ ህመም .....09 ያልተለመደ የጽንስ እንቅስቃሴ.....10 ምጥ ሳይኖር የሽርት ውሃ መፍሰስ.....11 ሌላ ካለ ይገለጽ……97	
210	ከምጥና ከወሊድ ጋር በተያያዘ በእናትየው ህይወት ላይ አደጋ ሊያመጡ የሚችሉ የጤና ችግሮችን ይጥቀሱ?	ከፍተኛ የደም መፍሰስ.....01 ከፍተኛ የራስ ህመም .....02 መንዘፍዘፍ.....03 ከፍተኛ ትኩሳት.....04 አቅልን መሳት.....05 ምጥ ከ12 ሰዓት በላይ መዘግየት.....06 የእንግዴ ልጅ ከ30 ደቂቃ በላይ መዘግየት.....07 ሌላ ካለ ይገለጽ……97	

ክፍል 3. የተጠያቂዋ ከዚህ እርግዝና በፊት በነበሩ እርግዝናዎች የነበሩ ገጠመኞችን በተመለከተ የተዘጋጀ መጠይቅ			
ተራ ቁጥር	ጥያቄዎች	አማራጭ መልስ	እለፍ
301	አሁን የስንት ወር እርጉዝ ኖት ?	በወር_ _	
302	ይህ እርግዝና የመጀመሪያዎ ነዉ?	አዎ ⟶ አይ	ወደ ክፍል 4
303	ከዚህ በፊት ስንት ጊዜ አርግዘዋል?	……	
304	አሁን ስንት ልጆት አልዎት?	……	
305	ዉርጃ (miscarriage/abortion) አጋጥሞት ያውቃሉ?	አዎ አይ	
306	ከዚህ በፊት በነበሩ እርግዝናዎች ሞተዉ የተወለዱ ህፃናት (stillbirth) ነበሩ?	አዎ.....1 አይ.....2 ⟶	ወደ ጥያቄ.308
307	ከዚህ በፊት በነበሩ እርግዝናዎች ሞተዉ የተወለዱ ህፃናት ቁጥር?	.....	
308	ከዚህ በፊት በነበሩ እርግዝናዎች በህይወት የተወለዱ ህፃናት (Babies born alive) ነበሩ?	አዎ.....1 አይ.....2 ⟶	ወደ ክፍል 4
309	ከዚህ በፊት በነበሩ እርግዝናዎች በህይወት የተወለዱ ህፃናት ቁጥር?	.....	

ክፍል 5. ተጠያቂዎች ከአሁኑ እርግዝና ጋር ተያይዞ ያላቸው ገጠመኞች እና የአዋላጅ ምርጫ በተመለከተ የተዘጋጀ መጠይቅ (በጤና ድርጅት ውስጥ በጤና ባለሙያ የተሰጣቸውን ምክር አያካትትም)			
ተራ ቁጥር	ጥያቄዎች	አማራጭ መልስ	እለፍ
401	በአሁኑ እርግዝና ለወሊድ ጊዜ የሚሆን ያቀዱት ቅድመ ወሊድ ዝግጅት አለ?	አዎ.....01 አይ.....02 →	ወደ ክፍል 6
402	መልስዎ አዎ ከሆነ, ምን ዓይነት?	……	
403	ለወሊድ ጊዜ የሚሆን ገንዘብ አዘጋጅተዋል?	አዎ.....01 አይ.....02 →	ወደ ጥያቄ.505
404	መልስዎ አዎ ከሆነ, እንዴት?	አጠራቅሜለሁ ከቤተዘመድ አገኛለሁ እበደራለሁ አላሰብኩበትም ሌላ ካለ ይገለጽ…	
405	በአሁኑ እርግዝና ለወሊድ ጊዜ የሚሆን ያዘጋጁት የትራንስፖርት አገልግሎት አለ?	አዎ.....01 አይ.....02 →	ወደ ጥያቄ.507
406	መልስዎ አዎ ከሆነ, ከማን ጋር ነው የተነጋገሩት?	ባል የባል እናት ሌላ የበቤተሰብ አባል ጎረቤት የጤና ኤክስቴንሽን ባለሙያ ቤተ ዘመድ ሌላ ካለ ይገለጽ…	
407	በአሁኑ እርግዝና እርስዎን እንዲያዋልድ ያዘጋጁት የጤና ባለሙያ አለ?	አዎ.....01 አይ.....02 →	ወደ ጥያቄ.509
408	መልስዎ አዎ ከሆነ, ከማን ጋር?	ልምድ ያለው ባለሙያ ባል የባል እናት ሌላ የበቤተሰብ አባል ጎረቤት የጤና ኤክስቴንሽን ባለሙያ የልምድ አዋላጅ ቤተ ዘመድ ሌላ ካለ ይገለጽ…	

409	ለአሁኑ እርግዝና የመውለጃ ቦታ መርጠዋል?	አዎ.....01 አይ.....02 →	ወደ ጥያቄ.511
410	መልስዎ አዎ ከሆነ, ዬት?	በቤት በልምድ አዋላጅ እገዛ በቤት በጤና ኤክስቴንሽን እገዛ በቤት በቤተዘመድ እገዛ በጤና ኬላ በጤና ጣቢያ በሆስፒታል ሌላ ካለ ይገለጽ…	
411	ስለ መውለጃ ቦተ የመጨረሻ ውሳኔ የሚወስነው ማነው?	ማንም ተጠያቂዋ ባል ሁለቱም ቤተ ዘመድ የጤና ባለሞያ የልምድ አዎላጅ ሌላ ካለ ይገለጽ	