WOLKITE UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCE DEPARTEMENT OF MIDWIFERY

ASSESSMENT OF PREVALENCE AND ASSCOTIATED FACTOR OF LATE INITIATION OF ANTENATAL CARE AMONG PREGNANT WOMENS WHO ATTEND ANTENATAL CARE IN BUTAGRA HOSPITAL, SNNP, ETHIOPIA JANUARY-JUNE 2019

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ARESEARCH PAPER SUBMITTED TO WOLKITE UNIVERSITY COLLEGE OF MEDICINE AND HEALTH SCIENCES, DEPARTMENT OF MIDWIFERY IN PARTIAL FULFILLEMENT OF THE REQUIREMENTS FOR THE DEGREE OF BACHELOR SCIENCE IN MIDWIFERY

January, 2019

Wolkite Ethiopia

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A RESEARCH PAPER SUBMITTED TO WOLKITE UNIVERSITY COLLEGE OF MEDICINE AND HEALTH SCIENCES, MIDWIFERY DEPARTMENT IN PARTIAL FULFILLEMENT OF THE REQUIREMENTS FOR THE DEGREE OF BACHELOR SCIENCE IN MIDWIFERY

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ABBREVATION/ACRONYMYS

ANC: Antenatal care

EDHS: Ethiopian demographic and Health Survey

HIV : Human Immune Deficiency Virus

MMR: Maternal Mortality Ratio

OR : Odd ratio

SPSS : Statistical Package Social Science

SNNP : South nation nationality and people

PMTCT: Prevention of mother to child transmission

WHO : World Health Organization

SSA: Sub- Sahara African

Abstract

Introduction: Antenatal care was more important in preventing pregnancy related complications when received early in the pregnancy and continued through delivery. The World Health Organization (WHO) recommends that a woman under normal circumstance should have at least four antenatal care visits, the first of which should take place during the first trimester. Proportion of reproductive age women in Ethiopia who received antenatal care (ANC) from skilled provider has increased from 32% in 2011 to 62% in 2016. But only 34% of them had at least four ANC

Visit during their last pregnancy. According to the survey (27) only 44% of women had their first ANC during the first trimester of pregnancy. For many of the essential interventions in ANC, it is crucial to have identification of underlying conditions earlier- for example prevention of congenital syphilis, prevention of maternal to child transmission of HIV from mother to child, to prevent maternal and neonatal tetanus, control of anemia, and prevention of malaria complications.

Objective: To assess the prevalence and associated factor of late antenatal care visit among pregnant women attending antenatal care in Butajira hospital, Ethiopia, 2019.

Methods: Institutional based cross-sectional study was conducted in 2019. Systematic sampling technique was used to select 369 study participants. Data was collected by trained data collectors by using pretested semi structured questioner from pregnant women who attend ANC in Butajira hospital. The collected data analysis was performed by SPSS statistical software version 20. Adjusted odds ratio with 95% Confidence interval. P-value less than 0.05 was considered as statistically significant association between covariates and dependent variable.

Result: Result show that women with age group 15-24) were (AOR 0.345, 95%CI 0.084, 0.586) (less likely to initiate ANC late compared to age group (25-34) .women with employed were (AOR 0.530, 95%CI 0.12, 0.93) less likely to initiate late compared to unemployed. Women with has not been schooled were 5 times (AOR 5.4, 95% CI 1.8, 16.7) more likely to initiate late compared to college/university educated.

Conclusion: Late antenatal care attendance low when you compare with EDH 2016 .despite this require focused work to minimize to zero level. Mother educational level, occupation, was significantly associated with late ANC attendance. Therefore, intervention efforts to improve ANC utilization targeting these impending factor. Moreover, strategies should be designed to intensify advocacy of female education, women empowerment activities need.

CHAPTER ONE

1. INTRODUCTION

1.1 BACK GROUND OF THE STUDY

Health care services during pregnancy and after delivery are important for the survival and well-being of both the mother and the baby. Skilled care during pregnancy, childbirth, and the postpartum time are crucial interventions in reduction of maternal and neonatal morbidity and mortality (1). Antenatal care was more important in preventing pregnancy related complications when received early in the pregnancy and continued through delivery. The World Health Organization (WHO) recommends that a woman under normal circumstance should have at least four antenatal care visits, the first of which should take place during the first trimester (2).

The new World Health Organization ANC model states that every pregnant woman was at risk of complications and recommends early an ANC visit, of which the first should be during the first trimester. The visit was used to classify pregnant women in to two groups based on previous history of pregnancy, current pregnancy state, and general medical conditions. Those eligible to receive routine ANC (basic component) and those who need special care on average account for 25% of all pregnant women initiating ANC [3]. Low ANC coverage, few visits, and late booking are common problems throughout Sub-Saharan Africa posing difficulty in accomplishing the WHO recommendation [4]

Worldwide, approximately 830 women died every single day due to complication during pregnancy or child birth in 2015 (5). Reducing maternal Mortality ratio from 216 per 100,000 live births in 2015 to less than 70 per 100,000 live births by 2030 will require a global annual rate of reduction of at least 7.5% -which is more than triple the annual rate of reduction that was achieved between 1990 and 2015 (6). Most maternal deaths are preventable as the necessary medical interventions are well known. Therefore, it is crucial to increase access of the women to quality care before, during and after child birth. Proportion of reproductive age women in Ethiopia who received antenatal care (ANC) from skilled provider has increased from 32% in 2011 to 62% in2016. But only 34% of them had at least four ANC visit during their last

pregnancy (1). According to the survey only 44% of women had their first ANC during the first trimester of pregnancy.

For many of the essential interventions in ANC, it is crucial to have identification of underlying conditions earlier- for example prevention of congenital syphilis, prevention of maternal to child transmission of HIV from mother to child, to prevent maternal and neonatal tetanus, control of anemia, and prevention of malaria complications. Hence the first ANC visit should be as early as possible in pregnancy, preferably in first trimester (7)

1.2 STATEMENT OF THE PROBLEM

Despite the global efforts initiated to improve maternal health, more than half a million women worldwide die each year as a result of complications arising from pregnancy and child birth (32). Almost all of these deaths occur in developing countries with sub-Saharan Africa accounting for almost 47% of the toll (25). The lifetime risk of maternal death in sub-Saharan Africa is 1 in 22 mothers compared to 1 in 210 in Northern Africa, 1 in 62 for Oceania, 1 in 120 for Asia, and 1 in 290 for Latin America and the Caribbean (30). In Zambia the maternal mortality ratio stands at 449 per 100 000 live births and neonatal mortality is estimated at 34 per 1000 live births (31).

Early initiation of ANC helps health care providers to diagnose pregnancy related complications and offers timely and appropriate intervention (7). Not attending the ANC service early has increase the risk of poor outcomes, maternal and neonatal death. Late initiation of ANC service affects the intended benefits of ANC service for pregnant mothers. Therefore, late initiation of ANC service imposes difficulty on effective implementation of the routine ANC strategies that facilitates maternal wellbeing and good perinatal outcome (8).

As reported by EDHS 2016 indicated that the percentage of ANC utilization had increased by 32% compared to the preceding EDHS survey and the national coverage was 31.8%.though good progress has been made in the total number of ANC initiation is still high in Ethiopia (27).

Pregnant women should be offered screening for HIV infection early in pregnancy since appropriate ANC interventions can reduce mother-to-child transmission of HIV infection. These enable the expectant mother to decide whether to share her HIV status with anyone and help to benefit from antiretroviral therapy where applicable and understand infant feeding options and choose that which is best in her circumstances. Moreover, the intervention help the woman learn

more about HIV infection and its implications for her health, access support groups and health services that promote positive living and make choices about sexual behavior and future fertility [10]

Even though the ANC coverage of Ethiopia was 62%, there was a problem in delayed start of ANC attendance (i.e. only 20% of women of age 15-49 years start their ANC in their first trimester of pregnancy) (1). Despite the fact that the ANC utilization was essential for further improvement of maternal and child health little was known about the factors affecting the use of this service timely in Ethiopia particularly in SNNP region. (4). Therefore, the aim of this study was to assess the prevalence and associated factor of late initiation of ANC visit in Butajira hospital previously no study was done .When I have observed the service provision late antenatal attendance make it difficult to implement effectively routine ANC strategies that enhance maternal wellbeing and good perinatal out comes.

1.3 Significance of the study

Literature has generally indicated the importance and the benefits of ANC, therefore research needs to be done to understand the reasons for late antenatal attendance. This study takes a unique approach to understanding factors affecting antenatal attendance as it looks not only at individualized factors. Hence, the study was focus on comprehending intrapersonal or individual factors, interpersonal factors, institutional or organizational factors, community factors affecting antenatal attendance. It was hoped that information obtained from this study was add to the existing body of knowledge in the area of maternal and child health. The results of this study may also be of use to health policy makers and other stakeholders for developing healthy public policies as regards reproductive health. Consequently, the findings might help to enhance family and social support system for pregnant women in communities.

CHAPTER TWO

2 LITERATURE REVIEW

2.1 Introduction

Despite the global efforts initiated to improve maternal health, more than half a million women worldwide die each year as a result of complications arising from pregnancy and child birth (32). Almost all of these deaths occur in developing countries with sub-Saharan Africa accounting for almost 47% of the toll (25). The lifetime risk of maternal death in sub-Saharan Africa is 1 in 22 mothers compared to 1 in 210 in Northern Africa, 1 in 62 for Oceania, 1 in 120 for Asia, and 1 in 290 for Latin America and the Caribbean (30).More than half of these deaths occurred in sub-Saharan Africa. In Ethiopia, maternal mortality and morbidity levels were among the highest in the world. The Maternal Mortality Ratio (MMR) in the year of 2011 was 676 per 100,000 live births [28].

FACTOR ASSOCITIATED WITH LATE INTIATION OF ANC

2.2 Socio-demographic characteristics

There were a number of studies done to establish factors relating to late antenatal attendance in the world. The related factors include place of residence, ethnicity, age, education, employment status, and parity, intention to get pregnant, use of contraceptive method, economic status, health insurance and travel time.

Younger women, especially teenagers, were more likely to have unplanned pregnancies and lack information and resources to access ANC services (14). As regards marital status, single women with unplanned pregnancies, like most pregnant teenagers, may have a negative attitude towards their pregnancy and, due to this, may be less aware of the signs of pregnancy and as a result seek care much later than would older women (15).

2.2.1Educational attainment

Compared to women of low literacy level, educated women bear fewer children and achieve better child survival, because they avoid early marriages, teenage pregnancy, and high parity because they attend antenatal and postnatal more frequently. A study done in Kwela district,

Kenya revealed that women with secondary education or above were more likely to attend for ANC (16). The same study also highlighted the relationship between ANC and good perinatal outcomes. Women should be educated on sex, pregnancy and contraceptive use early in life as this would help them make informed decision later on in life.

2.2.2Socio-economic conditions

Income at household level had a bearing on antenatal attendance. This was established in Studies from Jamaica that found that, an increased probability of early antenatal care attendance was associated with increased household expenditure (17).

2.2.3Intention to get pregnant

The use of antenatal care services can also be delayed by woman's attitude towards her pregnancy. Teenagers with unplanned pregnancies may have a negative attitude towards their pregnancy and, for this reason they may seek ANC much later than would older married women (15). Negative attitude of health providers In a study done by (22) some women stated that the reasons affecting their delay in or lack of antenatal clinic attendance were the long waiting hours, inconvenient 11 service hours and that they were not treated well by the service providers. The judgmental nature of some health workers towards pregnant adolescents may negatively influence pregnant teenagers' efforts to attend antenatal services (20).

2.3Knowledge

Inadequate knowledge about ANC and the benefits derived from it for the mothers and newborns has negatively influence utilization. Sometimes pregnant women especially adolescents, may not be aware of the problems that results from not attending ANC (21). Lack of knowledge about dangers of not seeking health care in pregnancy and delivery, including inability to make independent decisions were major barriers to seeking health care among pregnant women in Uganda (23).

2.4 Accessibility of antenatal care services

Physical accessibility of health services has been an important determinant of utilization of health services in developing countries. WHO reported that distance from MCH services, and the time and the cost involved in traveling to services were significantly associated not only with ANC use but also with the use of institutional delivery, postnatal and infant care services (25).

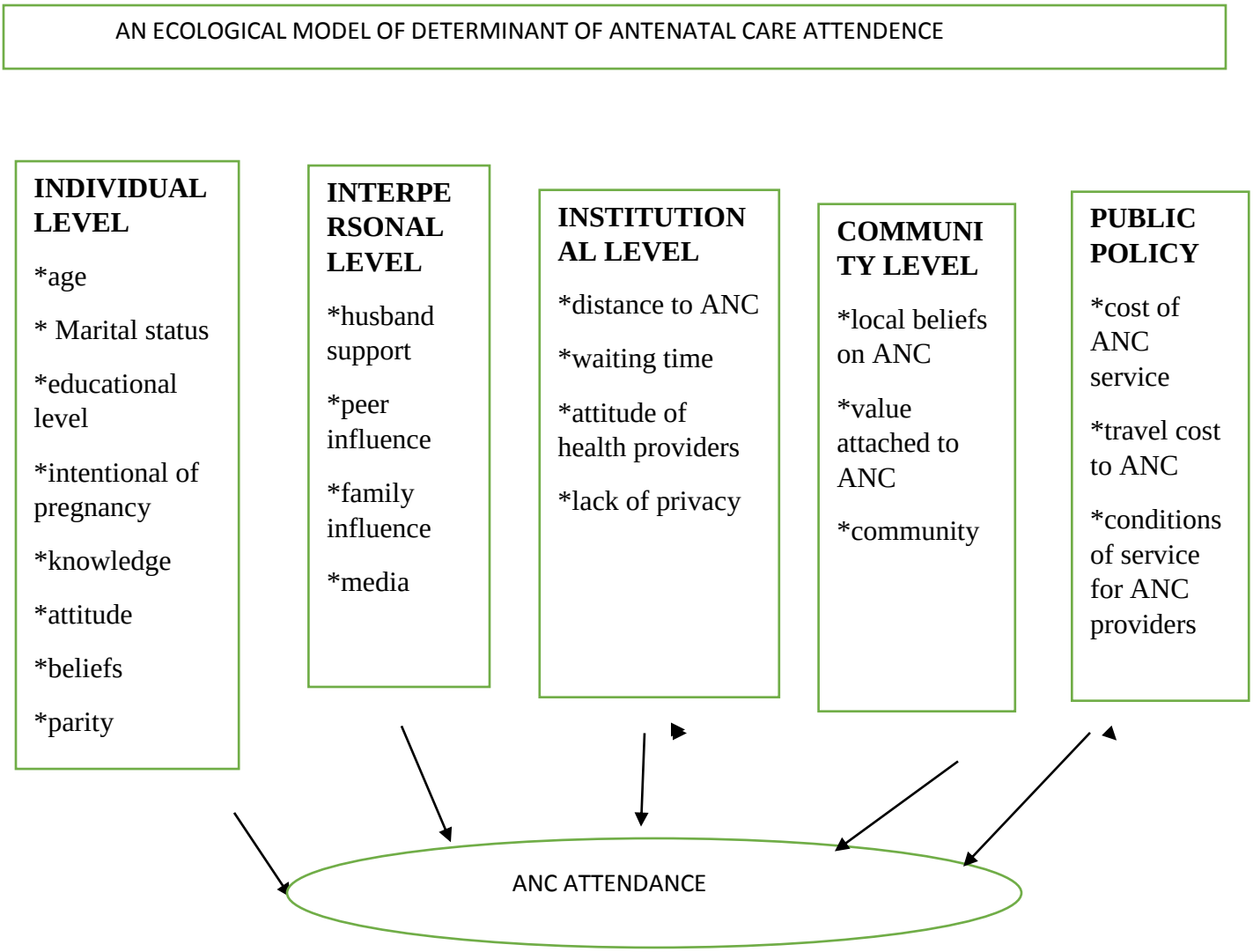
According to the WHO, a reasonable distance to the health facility should be about five to ten kilometers (21). Smart (1996) states that the environment

In which services were provided for young people should be appealing to them, probably by avoiding the ‘clinical’ atmosphere often associated with hospitals or hospital-based care.

Community based cross sectional study done in Kalabo district of Zambia on maternity services indicated that, distance was a significant factor affecting delay to decide to seek care from health facilities. It also influences the delay caused by the travel time from home to the clinic. The geographical features of Kalabo district, the uneven distribution of facilities and the absence of any roads or transport systems were also hindrance factors to maternity service utilization (24).

Younger women, especially teenagers, were more likely to have unplanned pregnancies and lack information and resources to access ANC services (14). As regards marital status, single women with unplanned pregnancies, like most pregnant teenagers, may have a negative attitude towards their pregnancy and, due to this, may be less aware of the signs of pregnancy and as a result seek care much later than would older women (15).

Figure 1: conceptual frame work



Conceptual framework. Adapted from theory at a Glance (26)

CHAPTER THREE

3. OBJECTIVES

3.1 General Objective

To assess the prevalence and associated factor of late antenatal care visit among pregnant women attending antenatal care in Butajira hospital Ethiopia, 2019.

3.2 Specific objective

To determine the prevalence of late antenatal care visit among pregnant women.

To assess associated factor of late antenatal care visit among pregnant women.

4 CHAPTER FOUR METHEDOLOGY

4.1 study area

The study was conducted in Gurage zone; SNNPR Ethiopia from in 2019.the zone has four public hospitals. Butajira General Hospital was one of the most popular public hospitals in Gurage zone; it was established in1973 EC. It is found in Gurage zone, Butajira city. Its distance was 135 km from Addis Ababa capital city of Ethiopia and 162 km from Hawassa which was capital city of the southern region. The hospital serves the entire Butajira city population, Gurage Zone and Silte Zone and it provides both in patient and out-patient services to the consumer.

4.2 study design and period

Institutional based cross sectional study from January to June 2019 GC

4.3 Population

4.31 source population

All pregnant mother who are ANC attendant at Butajira hospital.

4.32 study population

Selected pregnant mother who are living in the town and attending ANC clinic at Butajira hospital.

4.4 Criteria

4.41 Inclusive criteria

Pregnant women

Residents of the study area

Willing to participate in the study

4.42 Exclusive criteria

Pregnant women note able to speak

Women with mental disorder

Non pregnant women

Non residents

Not willing to participants

4.5 Sample size determination

Sample size was determined by using single population proportion formula based on the following assumption: 95% confidence level, 5% margin of error and prevalence of late initiation was 65% [from previous study conducted in Addis Ababa [4] Ni = (zα/2)2 p (1-p)/w2 Where n- Sample size

Zα/2- critical value =1.96 for 95% CI P- Prevalence of late initiation =65% from previous study w- Margin of error= 0.05 n= (1.96)2 0.65(1-0.65)/ (0.05)2 with the above inputs the total sample size required was 351. Ni=351 since the non-respondent of 5 % were added to calculate the sample size NF=351 *0.05 +351 so, NF=351+18=369

4.6 Sampling Technique

Systematic random sampling technique was used .about 351 women who attend ANC was selected randomly from the ANC attendant using sampling interval of every 2 attendant .by using sampling interval formula K=N/n, N the women attended ANC in past two month before data collection was 720

k=720/369=2

4.7 Study variable

4.7.1 DEPENDENT VARIABLE

* Late initiation of ANC

4.7.2 INDEPENDENT VARIABLE

* Distance to health facility

*waiting time

*attitude of health professional

*intention to get pregnant

*cost of service

*knowledge of ANC services

*parity

*local beliefs

*lack of privacy

4.8 operational Definition

Late initiation of ANC: The pregnant mother starts or receives ante natal care service after 20 weeks of gestational age.

Maternal mortality rate: The number of registered deaths among women, from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, for every 100 000 live births in a given year or period of time.

Neonatal mortality rate: The number of registered deaths in the neonatal period per 1000 live births in a given year or period of time

Prevention of mother to child transmission of HIV (PMTCT): This refers to the prevention of transmission of HIV from an HIV-positive woman during pregnancy, delivery or breastfeeding to her child. The term was used because the immediate source of the infection was the mother, and does not imply blame on the mother.

Attitude: "yes " if answered 1 or2 question from 2 attitude question and "no "if answered 0 from 2 attitude question.

Knowledgeable: knowing the recommended time ANC initiation

Not knowledgeable: not knowing the recommended time of ANC initiation

4.9 Data collection

4.9.1 Instrument

Data collection tools was adapted after review of relevant literatures .The questionnaire was prepared in English Language translated to Amharic.

4.9.2 Data quality and control

The questionnaire was prepared in English and translated to Amharic. Finally it was back translated to English by other person to ensure consistency. Pretest was done on 5% of the questionnaire found outside of the study area.

One day training was given for data collectors and supervisors on the questionnaire and data collection process. Close supervision was done by the principal investigators and supervisors throughout the data collection period. Collected data was checked for completeness and consistency.

4.10 Data processing and analysis

The collected data was analyzed using the SPSS statically software 20.0 after it was edited and checked for completeness and consistency. Descriptive analysis was used to describe the percentages and number distributions of both dependent and independent variables in the study. Bivariate binary logistic regression method was employed to compare which variable were relatively strong among the considered possible factor .variable with p-value < or = 0.25 in bivariate logistic regression were selected and included in the final logistic regression model to identify the predictor of the outcome variable at 5% level of significance. The result was presented using tables, graphs and figures as based on type of data.

4.11 Ethical consideration

Letter of authorization was obtained from Wolkite University to Butajira hospital Administration. Further, names of respondents will be excluded and confidentiality ensured for any information obtained from the patients. Oral consent was obtained from the respondents prior to the interview.

4.12 Dissemination of Results

The final report of the study was presented and submitted to Wolkite University, college of medicine and health science department of midwifery, in the form of written report and also the result was presented for the department members and also disseminated to student's library.

Chapter 5

5.0 Results

5.1 Sample Descriptions

Table 1 shows the socio-demographic characteristics of pregnant women who participated in the study. A total number of 369 women attending antenatal clinics were plan to include in the study, however 341 ANC attendant were participated which makes 92.4% response rate . The majority of the participants were in the age category of 18- 27 years, representing 68.3%. Most of the women who attending ANC were married 99.1 %. Unemployment level of participants was 61.3%. Most of the participant were Muslim 61.3%. Primary school was the highest level of education attained by participants in 31.1%.

5.2 Obstetric characteristics

Table 2 shows obstetric characteristics of women who participated in the study.

Majority of in had 1 or more children before 85.2%. The majority of women had 3 or more previous pregnancy 47.5%. Most of the respondents had their last child in the age category of 1-2 52.6%. Information on initiation of ANC revealed that 19.6% of the participants booked for ANC late.

Table 1: Socio-demographic characteristics of participant

Variable	Respondent rate	Frequency	Percentage (100%)
Age	18-27	233	68.3
	28-37	88	25.8
	>38	20	5.9
Marital status	Married	338	99.1

	Single	1	00.3
	Divorced	1	00.3
	Windowed	1	00.3
Occupation	Employed	132	38.7
	Unemployed	209	61.3
Religion	Christian	122	35.8
	Muslim	209	61.3
	Other	10	2.9
Level of education	Never been to school	102	29.9
	Primary	106	31.1
	Secondary	78	22.1
	College university	55	16.1

Table 2 obstetric character participant

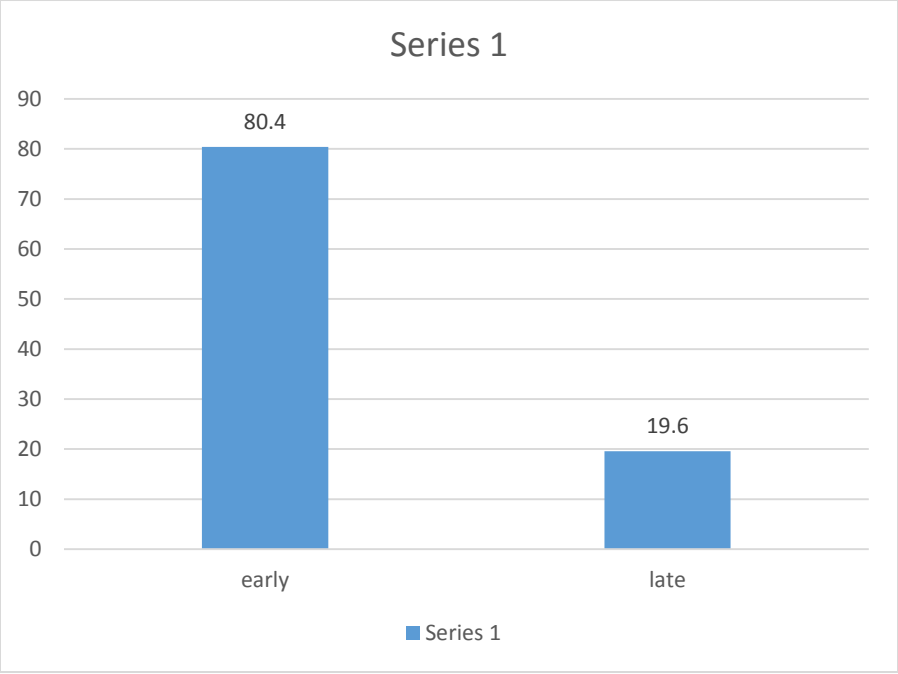
Variable	Frequency	Percentage (%)
Parity		
Nulliparous	54	15.8
1 or more	387	85.2
Gravidity		
1	41	12
2	104	30.5
3 or more	196	47.5
Age of last child		
<2	151	52.6
2-5	117	40.8
>5	19	6.6
ANC entry		

Early	274	80.4
Late	67	19.6

5.3 prevalence of late antenatal care in Butajira general hospital.

The prevalence of late ANC attendance, as table 2 indicate was 19.6% in Butajira general hospital.

Figure 2 show prevalence of late ANC



5.4 Factor associated with late ANC Initiation

Result show that women with age group 15-24) were (AOR 0.345, 95%CI 0.084, 0.586) (less likely to initiate ANC late compared to age group (25-34). women with employed were (AOR 0.530, 95%CI 0.12, 0.93) less likely to initiate late compared to unemployed. Women with has not been schooled were 5 times (AOR 5.4, 95% CI 1.8, 16.7) more likely to initiate late compared to college/university educated.

Table 7: predictor of late ANC attendance in logistic regression

Variable	AOR	P-value	Cl 95%
Age			
15-24	0.345	.002	(.084, .586)
25-34	0.328	.037	(.11, .936
>35	-	.617	
Occupation			
Employed	0.530	0.000	(.15, .576)
Unemployed		1	
Education			
Never been to school	3.842	0.003	(1.76, 16.7)
Primary	4.651	0.018	(1.272, 12.5)
Secondary	0.707	0.297	
College/university	1	1	

Chapter six

6.1 Discussion

The prevalence of late ANC attendance was 19.6% in this, but the proportion of pregnant mother who booked with in the recommended time was high in this study compared with the EDH 2016(34) .this observed difference due to Research was done on urban community and also the community have better health awareness comparing with other community.

Worldwide there was a big discrepancy in the prevalence of late ANC follow up among pregnant mother, ranging from 27.5 to 88% in developed and developing countries respectively (5) .low prenatal coverage, few visit, and delayed initiation of ante natal follow up are the predominate problem throughout SSA (Sub Sahara African) including Ethiopia resulting in failure of accomplishment of the who recommendation (39).

The minimum ANC visits recommended by WHO was possible only for less than about third of the pregnant women in some SSA Nigeria(15%),Ethiopia(19%),chad(23%),Burundi(33%),Mali and Rwanda(35%)(30).

Despite ANC is provided free of charge and there is increased accessibility; low utilization and late booking is still major problem(39) .according to Ethiopian demographic health survey 2014,only 17.5% mother started ANC early as per recommendation(9).

Prevalence of late booking vary from country to country to country, not only because of its real difference in occurrence but also due to difference in definition of late booking (40). According researcher maternal age, maternal education, women employment, parity are contributing factor (37).Although the national and regional data on ANC attendance illustrate varying trend across sub-Saharan African (35).

In general age, level of education, occupation, was significantly associated with late ante natal care entry in this study.

In this study, mother who are age 25 yrs. and above were less likely to started ANC with in the recommended period than those age was less than 25yrs .this finding is supported by studies done in Gondar and Addis Ababa (6, 33).this is possible that elder mother women feel more confident after previous experience and feel that starting ANC early is not necessary. The presence of high prevalence of late initiation of ANC among elder women in present studies supports this condition.

The study found that higher level of education of the mothers was positively associated with late ANC initiation .this is possible because education gives an opportunity for mother to develop greater confidence, to make better choice and to make decision regarding their own health as well as their children.it is also more likely that educated women demand higher quality service and pay more attention to their health in order to ensure better for themselves. This is in line with the finding of studies conducted in Gondar and Addis Ababa, ambo (6, 33).

The occupation of pregnant mother was another variable that was significantly associated with late initiation ANC. women with employment were more likely to be able to afford the cost related to the health service and tranportaion.this is consistent with the results of studies done in Kenya, Zambia (11, 24)

6.2 Conclusion

Late antenatal care attendance low when you compare with study done in Addis Ababa was 65%. Despite this require focused work to minimize to zero level. Mother educational level, occupation, was significantly associated with late ANC attendance. Therefore, intervention efforts to improve ANC utilization targeting these impending factor. Moreover, strategies should be designed to intensify advocacy of female education, women empowerment activities need

6.3 Limitations of the Study

One of the limitation is the study was facility based cross sectional study whose finding are not generalized to general population. Moreover, the pregnant women who attend ante natal care at private health facilities were not included in study. Also data collection was not quntative based.

6.4 Recommendations

*policy maker should make policy that provider increase accessibility of ANC services by proving scheduled outreach programs in remote areas

* Care provider should provide continuous health education on the importance of timely accessing of ANC services through the media and community sensitization meetings

*it is better Government to construct more health facilities to improve availability and accessibility especially in rural areas

*researcher should disseminate the result for responsible body

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Annex I: ENGLISH VERSION PARTICIPANT INFORMATION SHEET

Greeting: Good morning/afternoon!

My name is……I am working as a data collector for the study being conducted in this hospital by ----------we are studying for our BSc degree at Wolkite University, college of Medicine and Health science. Now you are randomly selected for this study and I kindly request you to lend me your attention to explain about the study and being selected as the study participants.

The Study Title: Assessment of prevalence and associated factors of late initiation of ANC among pregnant women who attend ANC in Butajira hospital

Name of Principal Investigator:

1 WEGAYEHU MARKOS

2 HIWOTZERASH ALEMAYEHU

3 MISIR KENO

Name of the organization: Wolkite University, College of Medicine and Health Sciences, Department of Midwifery.

Name of the Sponsor: Wolkite University.

Introduction: Information sheet and consent form is prepared for reproductive age group who will be volunteer to participate in research project, community based cross-sectional study will be conducted to assess cervical screening status at this community.

Purpose/aim of the study:

The finding of this study can be of a paramount importance for the Zonal Health Bureau and other concerned bodies to plan different programs for the purpose of decreasing maternal morbidity and mortality related to cervical cancer by knowing the gaps. Moreover, the aim of this study is to write a paper as a partial requirement for the fulfillment of a BSc in midwifery for the principal investigator.

Procedure and duration:

To assess women's cervical cancer screening status, you are invited to take part in this project. If you are willing to participate in this project, you need to understand and say "yes" on the agreement form. Then after, I will interview you and fill using structured questionnaires. There are 23 Questionnaires it will take about 20 minute to answer it, so I kindly request you to spare me this time for the interview.

Risk/ Discomfort: The risk of being participating in this study is very minimal, but you may feel some discomfort especially on spending time about 20 Minutes. We hope you will participate in the study for the sake of the Benefit of the research result. I am sure there is no risk in participating in this research project.

Benefits/incentives, payments: There will not be any direct payment for participating in this study. But the findings will help us to identify the gap and take the appropriate intervention by the authorized stakeholders. You will not be provided any incentive or payment to take part in this project.

Confidentiality: The information you will provide us will be confidential. There will be no information that will identify you in particular. The findings of the study will be general for the study population and will not reflect any thing particular of individual persons. The questionnaire will be coded to exclude showing names. No reference will be made in oral or written reports that could link participants to the research.

Right to refuse or withdraw: Participation for this study is fully voluntary. You have the right to declare participate or not to participate in this study. If you decide to participate, you have the right to withdraw from the study at any time and this will not label you for any loss of benefits

which you otherwise are entitled you do not have answer any questions that you do not want to answer.

Contact Address:

If there are any questions or enquiries any time about the study or the procedure, please contact:

Mobile Phone: +2519---------or **Email**; ----------

ANNEX II: ENGLISH VERSION PARTICIPANT CONSENT FORM

I have read/ was read to me the participant information sheet. I have clearly understood the propose of the research, the procedures, the risk and benefits, issues of confidentiality, the rights of participating and the contact address of any queries. I have been given the opportunity to ask questions for the things that may have been unclear. I was informed that I have the right to withdraw from the study at any time or not to answer any questions that I do not want. Therefore, I declare my voluntary consent to participate in this study.

If participant does not agree to be interviewed thanks her and go to the next participant.

If respondent say YES continue.

English Version Questionnaire

This is a data collection format to assess---------

Name of Data collector: ---------- Qualification: ----------

Time Interview Started: Hour: _____ Minute: _____ Ended: Hour: _____ Minute: _____

Questionnaire No_____

Date _____/_____/____ ____E.C. signature_____

Data Collector agreement

“I certify that I have filled the questionnaire in accordance with the training that is given to me and instructions stated in it. I have confirmed that the information in it is correct.”

Signature _____Date_____/_____/____ ____E.C

Checked by supervisor for completeness: Supervisor Name_____ signature____ Date___/___/__E.C.

ANNEX: III Questionnaire (English Version)

For each question, make a circle around the spelling that correspond to the answer; fill blanks with the answer or mark “X”.

Table3: Questionnaires to assess ----------from April1- 30, 2019

SOCIO-DEMOGRAPHICDATA

1. Age……

2 .marital status

1. Married ☐
2. Single ☐
3. Divorced ☐
4. Widowed ☐

3. Occupation

1. Employed ☐
2. Not employed ☐

4. What type of employment (specify)……..

5. Religion

1. Christian ☐
2. Muslim ☐
3. Hindu ☐
4. Others …….

6. Level of education

1. Never been to school ☐
2. Primary ☐
3. Secondary ☐
4. College/university ☐

SECTION B:

OBSTETRIC INFORMATION

7. Parity …… ☐

8. Gravidity ……..

9. Age of the last child ……..

10. How old was your pregnancy when you made

Your first ANC visit…….

(Age of pregnancy in weeks)

11. What family planning method did you use before you fell pregnant?

1. Pills
2. Injections
3. IUCD
4. Implants
5. Condoms
6. Breastfeeding
7. Nothing

12. What were the reasons for stopping using family planning methods……..

SECTION C

INDIVIDUAL LEVEL

13. List factors that influenced you to book for antenatal

……

……

……

…… .

14. What hindered you to book for ANC early? (Before 20th week of pregnancy)

1. Pregnancy was unintended
2. No knowledge about ANC
3. Not satisfied with service
4. No benefits of starting early
5. Others (specify…….)

15. Would being tested for HIV prevent you from attending ANC?

1. Yes
2. No

INTERPERSONAL LEVEL

16. Who motivated you to book for ANC?

1. Husband/spouse
2. Friend
3. Media
4. Health provider
5. TBA
6. Others (specify) ……..

17. What was/is your husband's attitude towards ANC?

1. Supportive

2. Not supportive

3. Don't know

If supportive, how were you supported?

……..

……

……

18. Do you think it would be a good idea for husbands to be accompanying pregnant women to ANC?

1. Yes

2. No

Give reasons for your answer to question 17 ……

……

Institutional level

19. Which of the following factors do you think could prevent you from attending ANC early?

1. Distance to ANC services
2. Long waiting time
3. Negative attitude of health providers
4. Lack of privacy

COMMUNITY LEVEL

20. What community influence could stop you attending ANC?

1. Misconceptions on ANC
2. Value attached to ANC (Community norm)
3. Cultural beliefs

Public policy

21. Could High cost of accessing ANC prevent you from booking early?

1. Yes
2. No

22. Could Traveling time hinder you from accessing ANC on time?

1. Yes

2. No

23. Could inadequate health facilities prevent you from accessing ANC on time?

1. Yes

2. No