

A RESEARCH PAPER SUBMITTED TO WOLKITE UNIVERSITY COLLEGE OF MEDICINE AND HEALTH SCIENCES, DEPARTMENT OF PUBLIC HEALTH IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR BACHELOR DEGREE IN PUBLIC HEALTH

TITLE: ASSESSMENT OF KNOWLEDGE AND PRACTICE ON BIRTH PREPAREDNESS AND COMPLICATION READINESS AMONG ANTENATAL CARE CLIENTS (ANC) IN WOLKITE UNIVERSITY TEACHING AND SPECIALIZED HOSPITAL GURAGE ZONE, SNNPR, ETHIOPIA, 2021 GC

BY: EPHREM DIRIBA
HABTAMU BERGA
MEKISUD ZEYINU

ADVISORS: - Mr. Samuel D (B.Sc., MSC)
Mr. Ebrahim Muktar (MPH, Ass't prof)

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ABSTRACT

BACKGROUND :Birth Preparedness and Complication Readiness was the process of planning for normal birth and anticipating the actions needed in case of an emergency. Responsibility for Birth preparedness and complication readiness must shared among all safe motherhood stakeholders policy makers, facility managers, providers, communities, families, and women because a coordinated effort was needed to reduce the delays that contribute to maternal and new born deaths. Each stakeholder has an important role to play from creating appropriate policies to strengthening facilities and providers to implementing effective community systems to adopting informed practices at home.

OBJECTIVE:-General objective of the study was to assess knowledge and practices with respect to birth preparedness and complication readiness among antenatal clients in Wolkite University Specialized and Teaching hospital, wolkite town.

METHOD:-This study were conducted at Wolkite University specialized and Teaching Hospital ANC follow up women. the source of population for the study subject were all client attended ANC mother in wolkite university teaching and specialized hospital.pregnant Women were randomly selected by using simple random sampling technique from the whole pregnant women were be Sample size was 354 , decided based on sample size formula cross sectional study design after correction & adding 10% non-response rate.

RESULT: From total respondents, 279 (78.8 %), 153(43.2%), and 146(41.2%) of pregnant women had knowledge about obstetric danger sing during pregnancy. labor and postpartum period. There source of information is mainly from health professional which accounts (68.6%), (24%), (51.5%) (55.5) was from school. Media, and others like one to five network and from their neighbor's the study also revealed that 156 (44%) of mothers had good practice on BPCR plans, whereas the rest, 2198 had no good practice.

Conclusion and recommendation: Although majority of the respondents had good knowledge about obstetric danger sing during pregnancy. Labor and postpartum period. Most of them had gap on practice on BPCR plans. Based on the findings, the appropriate recommendations were forwarded to concerned body. Therefore, the policy makers, health sectors and other stakeholders better to work on practice of BPCR plans.

LIST OF ABBREVIATIONS AND ACRONYMS

ANC Antenatal care

BP Birth preparedness

CR Complication readiness

CBE Community Based Education

EDHS Ethiopia Demographic and Health Survey

EMDHS Ethiopia Mini Demographic and Health Survey

ESOG Ethiopian society of Obstetrics and gynecology

GM Group Member

HIV/AIDS Human immune deficiency virus/acquired immune deficiency Syndrome

HSDP Health sector development plan

IEC Information, education& communication

MNH Maternal and neonatal health

MDG Millennium development goal

UN United nation

UNICEF United Nations international children's fund

WHO World health organization

WUTSH Wolkite University Teaching and Specialized Hospital.

1. Introduction

1.1 Background

Birth Preparedness and Complication Readiness (BP/CR) was the process of planning for normal birth and anticipating the actions needed in case of an emergency. Responsibility for BP/CR must be shared among all safe motherhood stakeholders' policy makers, facility managers, providers, communities, families, and women because a coordinated effort was needed to reduce the delays that contribute to maternal and new born deaths. Each stakeholder have an important role to play from creating appropriate policies to strengthening facilities and providers to implementing effective community systems to adopting informed practices at home.(1)

It was widely accepted that pregnancy and childbirth are normal physiological events and that medical intervention without evidence was inappropriate and potentially harmful for women and infants. But any woman can develop serious, even life-threatening complications that require medical intervention. Because there is no reliable way to predict which women were develop these complications, it was essential that all pregnant women have access to high quality obstetric monitoring throughout their pregnancies, but especially during and immediately after childbirth, when most emergency complications may arise. The single most critical condition for safe motherhood was to ensure that a health worker with midwifery skills was present at every birth, and that proper transportation to a health facility was available in case of an emergency. Therefore, sufficient numbers of health care workers must have been trained and these need to have essential supplies and equipment at their disposal, especially when working in poor and rural communities (2)

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 was impeded by 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, unsupportive policies, and gaps in services, as well as inadequate community and family awareness and knowledge about maternal and newborn health issues. For example: 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 emergency 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 and the communities, providers, and facilities that surround them must been prepared in advance and ready for rapid emergency action. (1)

In order to prevent obstetric complications on pregnant women there must been aware of the danger signs. It was not enough that the pregnant women are aware but the people around them including immediate family members and other also have to get relevant knowledge on how to respond when these emergencies are occurred. Danger signs are not the actual obstetric complications, but symptoms that are easily identified by non-clinical personnel. Standard danger sign of pregnancy, labor and delivery are indicted below, the key danger signs during pregnancy include: Severe vaginal bleeding, swollen hands/face, blurred vision. The key danger signs during labor and childbirth include: Severe vaginal bleeding, prolonged labor (> 12 hours), convulsions, retained placenta. The key danger signs during the postpartum period include: Severe vaginal bleeding, foul smelling vaginal discharge, high fever. The key danger signs in the newborn include: Convulsions/spasms/rigidity, difficult/fast breathing, very small baby, and lethargy/unconsciousness. (3-4)

Decision to seek care once the emergency was realized, the family who was unprepared wastes more valuable time deciding what to do or who to call for help, where to go, who should accompany the woman, as well as organizing transport and funds The principle and practice of birth preparedness and complication readiness (BP/CR) in a third world setting where there was prevailing illiteracy, inefficient infrastructure, poor transport system, and unpredictable access to skilled care provider have the potential of reducing the existing high maternal and neonatal morbidity and mortality rates. BP/CR promotes skilled care for all births and encourages decision making before the onset of labor. (3-4)

1.2 Statement of the problem

Globally 40% or more of pregnant women may experience acute obstetric problems. The WHO estimates that 300 million women in the developing world suffer from short-term or long-term illness brought about by pregnancy and childbirth. Most of maternal deaths occur in the developing world. For example from 342,900 maternal deaths in 2008, 52% occurred in sub Saharan Africa. This was because of several reasons one of which was inadequacy or lack of birth and emergency preparedness, which was a key component of globally accepted safe motherhood programs. According 2016 EDHS the estimate of the maternal mortality ratio for the 7-year period preceding was 412 deaths per 100,000 live births; that was, for every 1,000 births in Ethiopia, there are about 4 maternal deaths. The 95% confidence +interval for the 2011 maternal mortality ratio ranges from 541 to 810 deaths per 100,000 live births.(2) According to the Ethiopian Federal Ministry of Health, only18.4% of the deliveries are attended by health professionals. In one nation where the maternal mortality ratio was 673 per 100,000 live and IMR 77/1000 and NMR 39/1000 live births which are the highest in the world. (4)

Though birth preparedness and complication readiness has got much attention in the global and local area the progress was not formidable. Shortage of skilled midwives, weak referral system at health center levels, lack of inadequate availability of BEmONC and CEmONC equipment, and under financing of the service were identified as major supply side constraints that hindered progress. On the demand side, cultural norms and societal emotional support bestowed to mothers, distance to functioning health institution and financial barrier were found to be the major causes. (5)

The problem was raised from unjoin work of this university and governmental health institution so in the grass root of the community to reduce /minimize the problem that cause in adequate for magnitude and complications Despite the fact that birth preparedness and complication readiness was essential for further improvement of maternal and child health little was known about the current magnitude and influencing factors in Gurage zone. This study therefore aims to fill this gap by assessing the awareness of local community from the very beginning about birth preparedness and complication readiness among pregnant

women who have follow up and those who comes incidentally in WUST hospital, Ethiopia, through institutional based cross sectional study. (5-6) it was hoped that the results of the study were provide valuable information for design of possible programs and interventions to improve maternal and neonatal health. And also serve as baseline information for further study. (6) So far very few studies are conducted focusing this issue in Ethiopia, therefore current trends are difficult to show. This study aims on assessing the current trend and factors related with birth preparedness and complication readiness among pregnant women in Wolkite University specialized and teaching hospital Gurage Ethiopia, through a community based cross sectional study.(6)

1.3 Significance of the Study

Limited study was found in Ethiopia on bp/cr specially in health center attendants, Therefore, this research was designed to evaluate birth preparedness and complication readiness and factors associated with their practices among antenatal care clients, in WUST hospital in which the clients are manly from Wolkite town and surrounding areas, There was no such an organized research made in the area which based the clients of ANC of the Hospital. The study were provide basic data on the issue that may help health workers and policy makers to implement and scale up safe mother hood program in an attempt to reduce the highest maternal mortality rate and neonatal mortality rate around Wolkite area and Ethiopia. The study was come up with relevant information that was help in the improvement of the service. Beneficiary bodies from this research are; first to aware community about birth preparedness and complication readiness during pregnancy. Secondly, Health centers or Hospital for planning and achievement about birth preparedness and complication during pregnancy. Lastly, other researchers who was work on mother use as are reference.

CHAPTER TWO

2. Literature Review

Birth preparedness and complication readiness strategy encourage women's to be informed of danger signs of obstetric complications and emergencies, choose a preferred birth place and attendant at birth, make advance arrangement with the attendant at birth, arrange for transport to skilled care site in case of emergence, saving or arranging alternative funds for costs of skilled and emergency care, finding a companion to be with the woman at birth or to accompany her to emergency care source. (1)

Other measures include identifying a compatible blood donor in case of hemorrhage, obtaining permission from the head of household to seek skilled care in the event that a birth emergency occurs in his absence and arrange a source of household support to provide temporary family care during her absence (2).

According to study made for assessing birth preparedness and complication readiness intervention in Rewa District of Madhya Pradesh, India. BP/CR Index in the study population was found to be 47.5%. This index was significantly high in above poverty line in higher educational level and in service and business group. BP/CR was significantly higher in primi-para as compared to multipara, BP/CR was significantly lower in population experiencing morbidity and mortality BP Indicators: from this study undergone those did not about BP/CR is (18.6%). This trend was indicate that BP/CR not fully addressed and early intervention should important in saving of maternal and child life (4)

According to research done on birth preparedness and complication readiness among pregnant women MP WAPWA district, Tanzania's total of 600 women were enrolled into the study. Among them 587 (97.8%) attended antenatal clinic at least once during their last pregnancy. Two thirds of those who attended antenatal care made four or more visits. Five hundred and three (95.9%) of the women had antenatal cards at their homes used during the last pregnancy at the time of interview. The median gestation age at booking for antenatal care was 16 weeks (Range: 8-32), however 434 women booked after 16 weeks of gestation. Out of 600 women 89 knew three or more obstetric danger signs.

A cross-sectional descriptive study was conducted in Nigeria to assess the awareness of birth preparedness and complication readiness in multi-center among 800 women. Awareness of the concept of birth preparedness was is high (70.6%), knowledge of specific key danger signs was poor. Plan to use maternity services during pregnancy and access skilled attendance in child birth was positive (69.5%-83.5%). Educational status was the best predictor of awareness of birth preparedness and help to Plan greater awareness of birth preparedness (7&13)

According to cross-sectional community-based study Adigrat town by Mihret Hiluf and Mesganaw Fantahun: 40.4 % of them are aware about danger signs of the pregnancy, 86.9% identified their place of delivery, 92.7 postpartum were aware of the postpartum period, 33.1% arranged emergency funds, 40.4% Identified skilled provider, 40.8% mentioned identifying a mode of transportation as elements of birth preparedness, One hundred eighteen (22.1%) of the respondents reported that they identified place of delivery. The study identified poor comprehensive knowledge and practices of birth preparedness in general and very poor knowledge on danger signs in selected health particular. (8)

According to a study made by Luchia Araya in five selected health centers in Addis Ababa, 2011 less than half of the respondents were knowledgeable about danger sign during pregnancy, delivery, and postpartum period respectively. Regarding to knowledge to birth preparedness almost half of the respondents were knowledgeable and more than half of them stated that they were prepared for birth and its complication. In this study educational status of mothers and their knowledge about danger sign during pregnancy was associated. Mothers who are Illiterate were less knowledgeable about danger sign during pregnancy as compared to those who were secondary and above. Likewise, mothers with the income of 500-1000 Birr per month were also more likely to have knowledge about danger signs during pregnancy as compared to those who were with no income but the significant association between educational status, income and danger sign during pregnancy was not retained in the multivariate analysis. (9&14)

According to research done on birth preparedness and complication readiness among pregnant women in southern Ethiopia, Sidama zone Among 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. 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 adjusted multivariate model showed that significant predictors for being well-prepared were maternal availing of antenatal services (OR = 1.91 95% CI; 1.21–3.01) and being pregnant for the first time (OR = 6.82, 95% CI; 1.27–36.55). (10-11).

According to cross-sectional community-based study among Slum Women in Indore City, India Three hundred twelve mothers of infants aged 2-4 months in 11 slums of Indore, India, were interviewed to assess birth preparedness and complication readiness (BPACR) among them. The mothers were asked whether they followed the desired four steps while pregnant: identified a trained birth attendant, identified a health facility, arranged for transport, and saved money for emergency. Taking at least three steps was considered being well-prepared. Taking two or less steps was considered being less-prepared. One hundred forty-nine mothers (47.8%) were well-prepared. Factors associated with well-preparedness were assessed using adjusted multivariate models. Factors associated with well-preparedness were maternal literacy 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 mother's Antenatal outreach sessions can be used for promoting BPACR. It were be important to increase the competency of slum-based traditional birth attendants, along with promoting institutional deliveries. (4)

CHAPTER THREE

3. OBJECTIVES

3.1 General objective

- ☑ To assess Knowledge and Practice with respect to birth preparedness and complication readiness among antenatal clients in Wolkite University specialized and teaching hospital, in Gubrye sub city, wolkite town Gurage zone SNNPRS from July 10 to October 25 Ethiopia 2021 G.C

3.2. Specific objectives;

- To assess knowledge of birth preparedness and complication readiness among antenatal clients in Wolkite University specialized and teaching hospital, in Gubrye sub city, wolkite town Gurage zone SNNPRS from July 10 to October 25 Ethiopia 2021 G.C
- To identify practices related to birth preparedness and complication readiness among antenatal client in Wolkite University specialized and teaching hospital, in Gubrye sub city, wolkite town Gurage zone SNNPRS from July 10 to October 25 Ethiopia 2021 G.C

CHAPTER FOUR

4. METHODOLOGY

4.1 Study area

The study were conducted in Wolkite University specialized and teaching Hospital, among pregnant women in Gurage zone whose comes for ANC follow up. Gurage is one of the zone of SNNP of Ethiopia wolkite is the center of Gurage and Wolkite university specialized and teaching Hospital, was founded in 2011 E.C, it is located in sub urban setting of wolkite town, the regional state of SNNPR (the administrative center of Gurage zone) which about 158 km south west of Addis Ababa. The Hospital is located in Gubrye, a small town 10 km to the south of Wolkite. Health coverage of the Gurage zone is about 99% having 6 hospitals 24 health centers and 8 private health institution. from the above wolkite university specialized and teaching hospital is one of them it was built in 2011 E.C and it is a teaching hospital wolkite university students in under the , Collage of medicine and other Health Science .The Hospital has 376 beds distributed in different departments like obstetrics and gynecology ,surgery, internal medicine , that having annual bed accompany rate of 80%.it has also outpatient services like MCH and ART clinic with collaboration of 307 staffs from this 79 are administrative staff. The composition of professional staffs is 18 specialist and 42 general practitioners 12 health officers,106 nurse,16 laboratory technicians, 22 pharmacist, 5 Anesthesia Nurse and 9 Radiologist.

4.2. Study period

The study were conducted from October 5 to October 15, 2021 G.C.

4.3 Study design

Institutional based descriptive cross sectional survey were conduct to assess the knowledge attitude and practice toward breast self-examination at Wolkite University among regular female students

4.4 Population

4.4.1 Source Population: all pregnant women were have ANC follow up in Wolkite University specialized and teaching Hospital, in Wolkite Town

4.4.2 Study Population selected pregnant women who were and those already start for ANC follow up in Wolkite University specialized and teaching Hospital.

4.5. Eligibility criteria

4.5.1 Inclusion criteria

-pregnant lady who had ANC follow up at Wolkite university specialized and teaching Hospital, in Wolkite Town on her 2nd and 3rd TM

4.5.2 Exclusion criteria

-pregnant lady who had ANC follow up at Wolkite university specialized and teaching hospital

4.6Sample size and sampling techniques

4.6.1 Sample size

Sample size was determined by using single population proportion based on the following Assumptions: 95% confidence level, and a 5% margin of Error.

$$n_o = \frac{\left(Z\alpha/2\right)^2 * P(1-P)}{d^2}$$

Where: - n= sample size

Z^2 = critical value = 1.96 for 95% CI

q Is complementing of proportion (1-p)

p = prevalence of BP/CR= 37.2% proportion of women who practice BPCR in reference to a previous study in rural women of reproductive age in Abeshige district, Guraghe zone, SNNPR, Ethiopia

d = precision (marginal error) = 0.05

Ni= (1.96)0.778(1-0.778) (.05)2= calculated sample size was be 358

10% of 358 and the final sample size is =393

4.6.2 Sampling technique

Pregnant women was be randomly selected by simple random sampling who was on their 2nd and 3rd TM, who had appointed every month and the sample size was attendants for 1 month at the Hospital.

4.7 Variables

4.7.1 Dependent variables

Knowledge practice about birth preparedness and complication readiness

4.7.2 Independent Variables

Age	Religion
Education	Ethnicity
Income	Family size
Occupation	Husbands' age
Marital status	Parity
Still birth	Complication experience

4.8 Data Collection Technique and procedures

4.8.1 Data collection Tool

Valid and reliable modified standard questionnaires were used to collect data from respondents. The questionnaire was adopted from program of JHPIEGO the affiliate of Johns Hopkins University (1)

4.8.2 Data collectors

The data were collected by our self or members of group's students of Wolkite university department of Public Health 4th year BSc public health student. It's prefer for more interaction between the respondents for great accuracy of information, Great care were taken to avoid differences in interpreting the interview schedule.

4.8.3 Data collection method

The Data collection method of this study were conducted by face to face interviewing with administered questioners for women who were attend ANC at MCH in Wolkite University specialized and teaching Hospital.

4.8.4. Data collection period

The data were collected from October 17-27 (2021).

4.9 Methods of data analysis

The collected data were check for completeness; exploratory data analysis were carried out to check the levels of missing values. The data were coded and entered in to a computer and it was analyzed by using the software SPSS version 20 and then finally summarized and presented in frequencies, percent, texts, tables, and graphs.

4.10.Quality control methods

Pre-test was done in a health institution different from the study area to check the feasibility of the study and quality of questionnaires. After the data collection, the questionnaires were checked for completeness and correctness each day by group leader and the questionnaire was translate from English to Amharic.

4.11 Operational definition

Birth preparedness; - A woman was considered as birth prepared if she identified (already decided) more than five component of birth preparedness.

Complication readiness; any symptoms of obstetric complication reported by woman which may occur during pregnancy ANC follow up

Practice: A woman's activities or behavioral experience in relation to normal and complications of pregnancy, labor/childbirth and postpartum period

Antenatal clients: Pregnant women attending the antenatal clinic in Wolkite University specialized and teaching Hospital.

Saved money: Any money put aside by the woman or her family for childbirth reported

Identified place of deliver: A place for delivery planned ahead of childbirth reported by the woman.

Identified mode of transport: Any kind of transport which was identified ahead by the women or her family for the purpose of transportation to place of childbirth.

Skilled provider; persons with midwifes skills (physicians, health officers, nurses/midwives) who can manage normal deliveries and diagnose, manage or refer obstetric complications.

Knowledge on key danger sighs of pregnancy; A woman was considered knowledgeable if she can mention at least three key danger signs for pregnancy.

Knowledgeable on key danger signs of labor/childbirth: A woman was considered knowledgeable if she can mention at least three key danger signs for Labor/childbirth.

Knowledgeable on key danger signs of post-partum: A woman was considered Knowledgeable if she can mention at least the three key danger signs for post-partum

4.12 . Ethical Considerations

Official letters was written from Wolkite University College of medicine and health science department of public health to Wolkite University specialized and teaching Hospital. Indicating the purpose and objective of the research and requesting their necessary cooperation. After the objective & purpose of the research and the data collection process was explained to each respondent, their verbal consent were obtained by participating on voluntary basis, they have skipped and another respondent to taken alternatively. Data were collected anonymously and privacy of individuals kept secure throughout the study process.

4.15. Dissemination plan:

The findings of this study was submitted and presented to Wolkite University College of medicine and health science, department of public health. The copy of the results was disseminated to the Wolkite University Specialized and teaching Hospital**,** Gurage zone health office, Wolkite town administrative body and other concerned bodies.

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CHAPTER FIVE

5-RESULTS

In this study a total of 393 Pregnant women will be randomly select all pregnant woman who was on their 2nd and 3rd TM, who had appointed every month and the sample size was attendants for 1 month at the Hospital Out of these 354 were interviewed making a response rate of 90%. The rest were not found in ten times of visit.

5.1: Socio-demographic characteristics

Out of 393 mothers identified for the study, 354 (90%) responded to the interview. From those Respondents 287(81.1%) were found between age 25-49, 67(18.9%) were between age 15 and 24. 164(46.3%) of the participants were Muslim, 142(40.1%) were Orthodox in religion and 18(5.1%), 26(7.3%) were catholic and protestant. Majority 335 (94%) of respodents were married and 135(38.1%) of mothers had educated up to secondary school in their educational status. Most of the respondent were 168 (47.5%) with monthly income of >160, 183(51.7%) of the respondents were House wife and 229(64.7%) of respondents had household family size of 1-3 and in regard to their husbands, 183(51.6%) of husbands had secondary and above educational level %), were housewives and governmental employee was the leading occupation of their partners.

Table 1: Socio-demographic characteristics of study population at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Variables		Number	Percentage
Age	15-24	67	18.9
	25-45	287	81.1
	>45	0	0
Religion	Muslim	164	46.3
	Orthodox	142	40.1
	Protestant	26	7.3
	Catholic	18	5.1
Marital Status	Single	7	1.98
	Married	335	94
	Widowed	10	2.8
	Divorced	3	2.27
Occupation	Housewife	183	51.7
	Government employee	108	30.5
	Private employee	25	7.1
	merchant	19	5.4
	other	19	5.4
Educational status	Cannot read & write	43	12.1
	Primary school completed	105	29.6
	Secondary school completed	135	38.1
	Collage & above	71	20.1

Maternal Income	<400	83	23.4
	401-800	45	12.7
	801-1200	34	9.6
	1201-1600	24	6.8
	>1600	168	47.5
	<400	132	100
Husband's occupation	Gov't employee	111	31.4
	Private employee	31	8.8
	merchant	72	20.3
	Other	140	39.5
Husbands educational status	Uneducated	43	12.1
	Primary school completed	14	4.0
	Secondary school completed	114	32.2
	Collage & above	183	51.6
Family size	1-3 children	229	64.7
	4-6 children	120	33.9
	More than 6	5	1.4

5.2: Past obstetric history

From the respondent number of pregnancies ever had, ranged from 2 to 3 were 146 (41.2%), those who was pregnant for the first time were 129(36.4%), 147(41.5%) of respondent total number of gave birth were range from 1-2 Similarly, number of live births ever had 156(44.1%), give birth one time and 104(29.4%) were not give birth still. Among those who ever had two or more pregnancies, 94 (26.6%) and 32(9%) had life time history of abortion and stillbirth, respectively.

Table 2: Obstetric characteristics of the respondents at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Variables		Number	Percentage
No of Gravid	1	129	36.4
	2-3	146	41.2
	≥4	79	22.3
No of Para	0	128	36.2
	1-2	147	41.5
	>3	79	22.3
No of still birth	0	322	91
	1	32	8.33
	≥2	0	0

5.3 **Knowledge of key danger signs during pregnancy**

About 279(79.8%) reported spontaneously that they heard about serious problems/danger signs during pregnancy, the three key danger signs during pregnancy: severe vaginal bleeding, swollen hands/face and severe headache were spontaneously mentioned by 277(78.2%), 238 (67.2%) and 211 (59.6%), respectively. However, only 68.4% were able to spontaneously mention all the three key danger signs. Besides this, 118 (22.3%) of the respondents spontaneously mentioned at least two danger signs of pregnancy complications (Table 3)...

5.3.1: Knowledge of key danger signs during labor and delivery

The majority of the respondents 153(43.2%) reported to be informed about danger signs during labor and delivery. Among those who had information, 123(34.7%), 89 (25.1%), 86 (24.3%), and 72(20.3%) of the respondents spontaneously mentioned vaginal bleeding, loss of consciousness, prolonged labor, and retained placenta, respectively, as danger signs associated with labor/delivery (Table 2). On the other hand, 153(43.2%) of the respondents spontaneously mentioned at least one of the key danger signs associated with labor/delivery (Table 3)...

5.3.2: Knowledge of key danger signs during post-partum period

One hundred forty six (41.2%) of the research participants reported that they were informed about danger signs during postpartum. One hundred and forty four (40.6%), 67 (18.9%), and 59 (16.7%) of the respondents spontaneously mentioned severe vaginal bleeding, foul smelling vaginal discharge, high fever, and respectively, as danger signs associated with the postpartum period. In addition, 211 (59%) respondents spontaneously mentioned at least two of the danger signs of postpartum mentioned earlier (Table 3)…

Table 3: Respondents knowledge about danger sign during pregnancy labor and post-partum at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Danger sign during pregnancy	Sever Vaginal bleeding	277	78.2
	Saver headache	211	59.6
	Blurred vision	189	53.4
	Severe abdominal pain	235	66.4
	Swollen hand (face)	238	67.2
	High fever	153	43.2
	Reduced fetal movement	207	58.5
Danger sign during labor	Sever Vaginal bleeding	123	34.7
	Saver headache	89	25.1
	Convulsion	17	4.8
	High fever	72	20.3
	Labor lasting >12 hr.	86	24.3
	Placenta not delivered after 30'of delivery	63	17.8
	Blurred vision	27	7.6
Knowledge of danger sign during post-partum period	Sever Vaginal bleeding	144	40.7
	High fever	59	16.7
	Malodorous Vaginal bleeding	67	18.9

	Convulsion	26	7.3
	Saver weakness	65	18.4
	Blurred vision	47	13.3

5.4Respondents considered knowledgeable during pregnancy labor and post-partum

Out of the total respondents who respond yes for knowing danger sign during pregnancy ,labor and post-partum period 279(78.8%)are considered knowledgeable on danger sign during pregnancy,153(43.2%)were considered knowledgeable on danger sign during delivery, 146(41.2%) considered knowledgeable on identifying danger sign during post-partum period. See table 8 below.

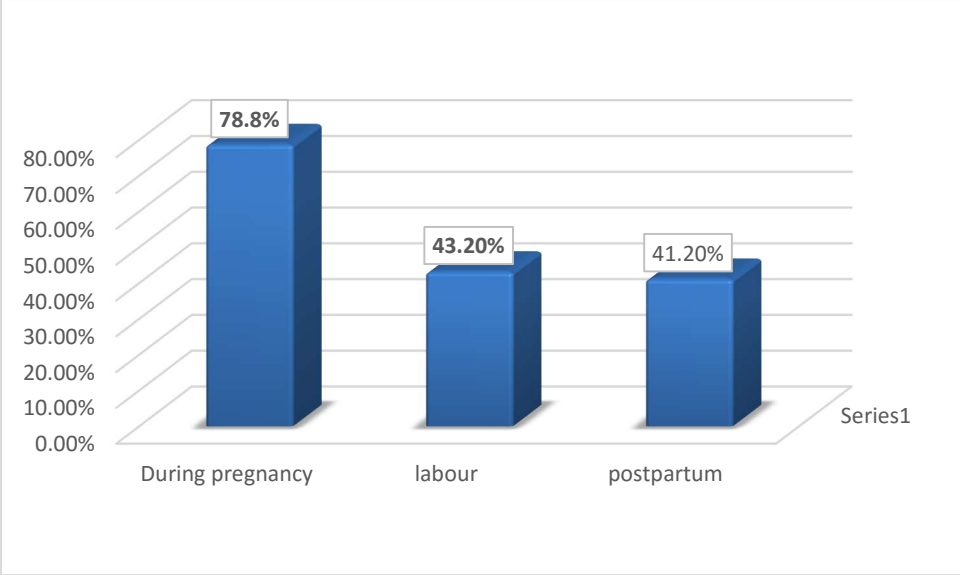


Figure 1. Knowledge of the study participant about danger sign at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Table 4 Respondents considered knowledgeable during pregnancy labor and post-partum at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

VARIABLS	Category	Frequency	percentage
Knowledgeable about danger sign during pregnancy	Yes	279	78.8
	No	75	21.2
knowledgeable about danger sign during labor	Yes	153	43.2
	No	201	56.7
knowledgeable about sign during postpartum period	Yes	146	41.2
	No	208	58.7

5.5: Source of Information about birth preparedness

Vast majority of respondents (96.6%) reported to have been informed about BPCR. Regarding the recommended elements which have to be done as birth preparedness, Multiple responses revealed that Source of information about BPCR were (243 68.6%), health workers at the health facility level, 181(51.1%), were information shared through media (radio/Television), 195 (55.1%), one-to-five women networks at the village level and from neighbor, it were also major sources of information about BPCR.

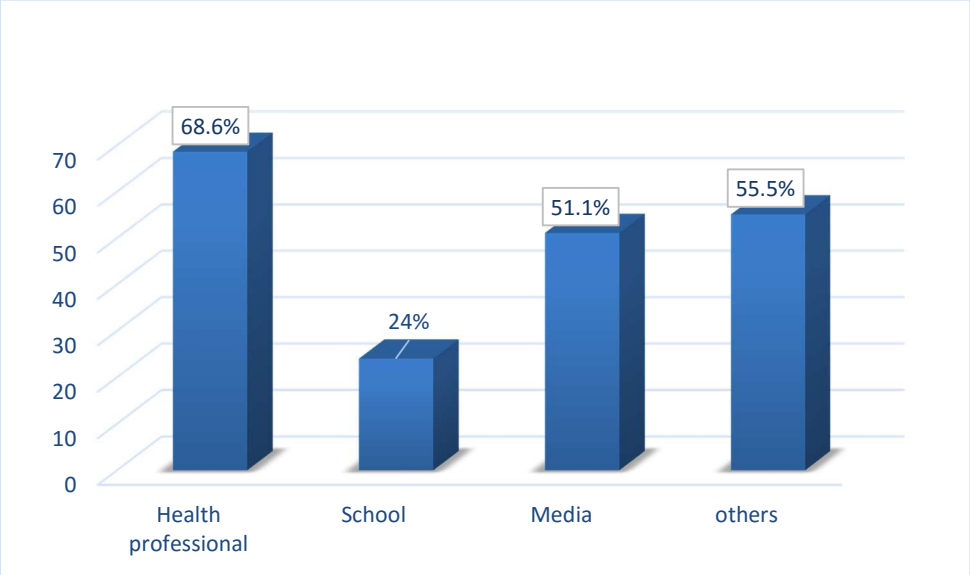


Figure 2. Source of Information about birth preparedness at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Two hundred seventy two (76.8%), 260(73.4), 143(40.4%), 29(8%), 171(48.8), 179(50.6) and 275(77.7%) were spontaneously identify and mentioned place of birth, saving money, prepare essential items for labor and delivery, Identify skill provider, arranging a way to communicate with a source of help, identifying the nearest institution that has 24 hours functioning EmOC services.

5.6: Practice of the respondent regarding preparation for birth and complication

Majority (60%) of the respondent reported that they made some arrangement for the birth of their baby. Of those 301(85%) reported spontaneously that they identified place of delivery 216(61%) saved money, 127(35.9%) prepare essential items for their delivery, 85(24%) identified skilled provider and 190(53.7%) identified mode of transport See table 5 below.



Figure 3. Practice of the study participant regarding preparation of birth and its complication at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Table 5. Practice of respondents on preparation for birth at Wolkite University Specialized and teaching Hospital, Guraghe zone, SNNPR, Ethiopia, 2021

Variables	Prepared for birth			
	yes	No	Yes (%)	No (%)
identify place of delivery	272	82	76.8	23.2
identified skilled health provider	29	325	8.2	91.8
saving money	216	138	61	39
Prepare essential items	143	211	40.4	59.6
Identify nearest institution that has24 hours functioning EmOC services	275	79	77.7	22.3
Arranging emergency funds	72	281	20.6	79.4
Identify a mode of transportation	179	175	50.6	49.4
Arranging blood donors	15	339	4.23	95.8

CHAPTER SIX

6-DISCUSSION

The main objective of this study is to assess knowledge and practices with respect to birth preparedness and complication readiness among antenatal clients in Wolkite University specialized and teaching Hospital, ANC client .the important Aspect of assessing birth preparedness and complication readiness is measuring spontaneous knowledge of essential danger sign of obstetric and newborn complication knowledge of the danger sign of obstetric complication is the first step in the appropriate and timely referral for essential obstetric care (3).

In this study (79.8%), are informed about danger sign during pregnancy which is higher than from study done in Addis Ababa 2011 which accounts (70.3%). The reason behind is that the trend of information in Addis Ababa at the time relatively lower compare to our study.(15) But our study was relatively lower when compared to study in Abeshige district in Gurage zone which account 90% of the participants reported that they were informed about danger signs related to during pregnancy. The possible reason for this may be mothers in Abeshige was educated about the effect of danger sign during pregnancy this indicate that the concerned bodies in Abeshige district in Gurage zone may play their role to increase knowledge danger sign during pregnancy and (43.2%) and (41.2%) are informed about danger sign during labor and post-partum period respectively which are relatively lower than from study done Abeshige district in Gurage zone in 2016 G.C which is (91.5%), (88.8%) in labor and post-partum period respectively. The reason behind is the same as above (16).

In this study (79.8%) are informed about danger sign during pregnancy. Among this majority of them (78.2%), sever vaginal bleeding as danger sign during pregnancy, our study is comparable to the study done Abeshige district in Gurage zone (73.1%), vaginal bleeding, as danger signs during pregnancy. Among those who had information danger signs associated with labor/delivery and postpartum period. (34.7%),(40.6%), majority of the respondents mentioned vaginal bleeding, compare to the study done Abeshige district accounts (74.2%), (71.3%), our study was lower the reason behind this was that concerned body in Abeshige district in Gurage zone may be focus on providing information play increase knowledge of danger sign during pregnancy, labor/delivery and postpartum period.(16)

Three hundred thirty two (96.6%) of the respondents reported that they heard the term birth preparedness. Lack of money and transportations is a barrier to seeking care as well as identifying and reaching medical facilities .the money saved by women or her family can pay for health service, vital for transport or other costs such as loss of work. Likewise if a women can afford to pay for this costs she is more likely to seek care (16). In this study (20.6%) of mothers saved money in case of emergency during labor.

This finding was lower when compared with the finding from Addis Ababa, 2011 in which 106(36.6%) of mothers saved money for emergency and also, the possible reason for this is since the proportion of educated people is higher in Addis Ababa (96.4%) compare to the people live in Abeshige district area (38.1%) so they know reason wise of saving money. Place of delivery identification is very important especially in this setting where the main means to get skilled provider is to deliver at health institution. In this study (76.8%), of the respondents spontaneously mentioned identifying place of delivery. This finding is higher when compared with study done in in Adigrat 2008 which is (26.6%). (15&17).

Findings on the practice of BPCR show that 22% of women participants from Tigray, 16.5% from Robe, 23.3% from Jimma, 17% from SNNPR, 37.2% from Abeshige district in Gurage zone 68.6% from Addis Ababa, 30% from Goba18 were found to have made BPCR plans. Our findings on BPCR, however, showed that 44% of the women who participated in the study made BPCR plans. This finding is far higher as compared with the studies from rural settings, although the findings from the study in Addis Ababa17 are understandably much higher. The difference with findings from rural settings may have to do with the difference in the study time and advantages of improved service delivery. The qualitative findings in the current study revealed that, generally, people are aware of the danger signs and what actions to take. It is also important to recognize the extensive community mobilization through health education in many ways, particularly focusing on encouraging women to deliver in health facilities. This may explain the relatively higher practice of BPCR compared with the previous reports, although this is not satisfactory in view of expectations. The current study has documented that 76.8% of research participants identified place of delivery, which is important to obtain services of a skilled provider at a health facility-level institution. Among those who identified place of delivery, (77.7%) planned to deliver at the nearest health facility, implying that the overwhelming majority prefer to deliver in health

facilities. This finding is quite high as compared to other studies. this could be explained by the fact that in recent years, since health coverage of Gurage zone is 99% there has been an extensive campaign to ensure maternal health service utilization, and women's live near to wolkite university specialized and teaching hospital have benefited from this. Yet, it should also be noted that as the study is cross-sectional in design, the findings may not provide strong evidence of underlying contexts beyond the study time. It is difficult to ascertain if those who planned to deliver at a facility would indeed do so. To reach the place of delivery, plans were made to set aside money for necessary expenses, and on how to organize transport. Although saving money appears to be common in preparation for birth as revealed from studies from Tanzania (89%) and Uganda (91%), findings from this study (26.6%) and from Adigrat (68.9%) revealed that saving money as part of BPCR is relatively limited, which may have to do with socioeconomic differences and the fact that, women's live near to wolkite university specialized and teaching hospital in particular, people live from hand to mouth and they may not have money to set aside in preparation for delivery. Arranging transport ahead of time reduces the delay in seeking and reaching services.(16,18,19)A study report from Uganda showed that 61% of pregnant women organized transportation well ahead of their due date.(18) In this study, almost half (50.6%) of the respondents organized transportation mechanisms ahead of scheduled due date, which is higher compared to studies done by Adigrat (24.7%), Robe (28.5%), and Jimma (3.2%).(17,19,20) This may have to do with the fact that there are different transportation options and relatively better road networks in the community. As was demonstrated in the qualitative findings, the community has an established practice of using the local ambulance and others can use other means of transport, to carry laboring woman to the main road where transport can be caught. Of all components of BPCR, identification of a blood donor was found to be relatively neglected (4.2% of the respondents reported to have identified blood donor in case of emergency, while the wider majority did not). This finding is consistent with the previous study from Ethiopia and another study from Tanzania. (19)

CHAPTER SEVEN

7. CONCLUSION AND RECOMMENDATION

7.1: CONCLUSION

The overall most of the respondent were knowledgeable regarding danger signs during pregnancy, labor and postpartum period.

- Most of the respondents reported that they heard the term birth preparedness. But, lack of money and transportation is a barrier to seeking care as well as identifying and reaching medical facilities.
- most of them got information about birth preparedness and complication readiness from health professionals
- Place of delivery is identification is very important especially in this setting were the main means to get skilled provider is to deliver at health institution. In this study most of the respondents spontaneously mentioned identifying place of delivery.
- As part of BPCR, plans to deliver in a health facility in our study area is found to be high. However, overall BPCR practice was found to be low in the Wolkite University specialized and teaching hospital. Comprehensive community mobilization through Health education and the one-to-five networks is believed to have played important role. Nonetheless, this has not been translated into improved uptake of BPCR and resultant outcomes.

7.2: RECOMMENDATION

- From the result of the study We recommend that to Health planner, ministry of health, administrative body, responsible health professional's governmental and nongovernmental health organizations to designed best strategies to increase the knowledge and practice of pregnant mothers about birth preparedness and complication readiness.
- Thus, policy makers has to collaborate to enhance promotion of birth preparedness and complication readiness at different levels in the health sector by improving socio-economic and food security status of women. Community-based education on complete attendance of ANC should be strengthened on sustainable basis and antenatal care clinics should

strengthen their advices on the components of BP/CR and obstetric danger signs with particular emphasis on multiparous pregnant women. The ministry of health in collaboration with regional health bureau, zonal health desks and other non-governmental partners has to strengthen its work on the provision of women friendly service in health institutions.

- Further studies assessing birth preparedness and complication readiness beyond individuals (pregnant or postnatal women) level at family, health facility and community level were recommended to bring further evidence in the efforts to end preventable maternal death.
- Finally we also recommend Wolkite University specialized and teaching Hospital**,** to advice and counsel on danger sign during pregnancy, labor and post-partum period. This should be significantly increase the knowledge of birth preparedness and complication readiness.

8. SRTENGTH AND LIMITATIONS OF THE STUDY

Strength of the study

- The study included all the illegible respondents in the hospital.
- The questioner was pre-tested on similar settings and modified based on the findings to minimize difficulty during data collection.
- Recall bias was minimized since the questionnaire emphasizes only on mothers.
- Could be a base line data for other researcher since there is scarcity of similar articles done in our country.

Limitation of the study

- The cross-sectional nature of this study may not explain temporal relationship between the outcome variable and certain explanatory variables.
- The state and months of pregnancy was self-reported by the woman or it was not confirmed by any diagnostic test. Pregnant women who were not registered in the family folders of the HEWs could underestimate the actual number of pregnant women living in the woreda. Thus, the findings of this study should be interpreted with consideration of these limitations

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ANNEX

Questionnaire

WOLKITE UNIVERSITY

COLLAGE OF PUBLIC HEALTH AND MEDICAL SCIENCE

DEPARTMENT OF PUBLIC HEALTH

QUESTIONER DESIGNED TO ASSESS KNOWLEDGE AND PRACTICE,WITH RESPECT TO BIRTH PREPAREDNESS AND COMPLICATIN REDINESS AMONG ANTENATAL CLIENT IN WOLKITE UNIVERSITY SPECIALIZED AND TEACHING HOSPITAL IN 2013 EC.

We are Regular Public health department graduating class students in Wolkite University, are conducting a research for the partial fulfillment of our bachelor degree. Our research is on Knowledge and Practice of birth preparedness and Complication readiness. We assure you that the confidentiality of any of your information is kept throughout this research and your name is not needed at all, the information you give will be coded only in letters and numbers. You can skip questions that you are not comfortable to answer and you can also refuse to participate any time. We also want to inform you that there is no payment given in return for filling this questionnaire.

If you agree to participate please sign on the format below to proceed with the research. I read the above information and I understand all about it, I am volunteer to participate in this research, so I put my sign below.

Sign _____

Please circle the alternatives that consists an opinion you agree with.

Section 1: Socio-demographic Information

1. Age in completed years in year: ----------
2. Marital status: - 01. Single 02. Married 03. Widowed 04. Divorced
3. Religion: 01. Orthodox 02. Catholic 03. Protestant 04. Muslim
   05. Other (Specify) _____
4. Occupation: 01. Housewife 02. Govt. employee 03. Private employee 04. Business
   Other (Specify) _____

5. Educational status 01. Illiterate 02. Primary completed 03. Secondary completed 04. College and above
6. Monthly income in Eth. Birr: 01. < 400 02. 400 – 800 03. 801 – 1200 04. 1201-1600 05. ›1600
7. Husband's occupation: - 01. Govt. employee 02. Private employee 03. Business. 04. Other (Specify)_____
8. Husband's educational status 01. Illiterate 02. Read & write 03. Primary 04. Secondary and above,
9. Family size: 01. 1 – 3 02. 4 – 6 03. More than 6

Section 2: Gravidity and parity

1. . How many times in total you became pregnant? 01. 1 02. 2 – 3 03. 4 and above
2. How many times in total you gave birth? 01. 0 02. 1 – 2 03. > 3
3. How many of your pregnancies resulted in a baby that was born Alive?
   01. 0 02. 1 03. 2 and above
4. How many of your pregnancies resulted in a baby that was born Dead?
   01. 0 02. 1 03. 2 +

Section 3: Knowledge on birth preparedness and complication readiness

1-yes 2-no

1. Which one of the following signs/symptoms do you know that it happens during pregnancy? merge 1 & 2
2. . Can you mention them?
   1. Vaginal bleeding yes no
   2. Severe headache yes no
   3. Blurred vision yes no
   4. Convulsions yes no
   5. Swollen hands/face *yes no*
   6. High fever yes no
   7. Loss of consciousness yes no
   8. Difficulty breathing yes no

9. Severe weakness yes no
10. Severe abdominal pain yes no
11. Accelerated/reduced fetal movement yes no
12. Water breaks without labor yes no
13. Other (Specify)---------- yes no

3. Do you know any/some serious health problem/s that can occur during labor and Child birth? That could endanger the life of a pregnant woman? (Merge 3 & 4th)

01 Yes 02 No

4. Can you mention them?
   1. Severe vaginal bleeding
   2. Severe headache
   3. Convulsions
   4. High fever
   5. Loss of consciousness
   6. Labor lasting>12hours
   7. Placenta not delivered 30 minutes after delivery
   8. Other (Specify)_____

5. Do you know any/some serious health problem/s that can occur during the first 42 Days after birth that could endanger the life of the women? (Merge 5&6)

01 Yes 02 No

6. Can you mention them?
   1. Severe vaginal bleeding
   2. Severe headache
   3. Blurred vision.
   4. Convulsions
   5. Swollen hands/face
   6. High fever
   7. Loss of consciousness.
   8. Difficulty breathing.

9. Severe weakness
10. Malodorous vaginal discharge
11. Others (specify)_____

7. Have you ever heard the term “birth preparedness?

01 Yes 02. No

From whom did you get the information?

01. Health professional

02. School or through education

O3. Media

04. Other (specify) _____

02 In your opinion, what are some things a woman can do to prepare for birth?

1. Identify place of delivery
2. Save money
3. Prepare essential items for clean delivery & postpartum period
4. Identify skilled provider
5. Being aware of the signs of an emergency & the need to act immediately
6. Designating decision maker on her
7. Arranging a way to communicate with a source of help
8. Arranging emergency funds
9. Identify a mode of transportation
10. Arranging blood donors
11. Identifying the nearest institution that has24 hours functioning EmOC services
12. Other. (specify) ----------

Section 4 Practices of respondents on preparation for birth..

1. Do you Identify place of delivery *01. Yes* ___ *02. No* ___
2. Are you saving money? 01. *Yes* ___ *02. No* ___
3. Are you preparing essential items for clean delivery &post-partum?
   01. Yes ___ *02. No* ___
4. Have you identified skilled provider *01. Yes* ___ *02. No* ___

5. Can you detect early signs of an Emergence? *01. Yes* ___ *02. No* ___
6. Have you Designated decision maker *01. Yes* ___ *02. No* ___
7. Have you arranged for emergency funds *01. Yes* ___ *02. No* ___
8. Have you Identified mode of Transportation *01. Yes* ___ *02. No* ___
9. Have you arranged blood donor *01. Yes* ___ *02. No* ____
10. Have you Identified institution with 24 hr. EmOC services *01. Yes* ___ *02. No* ___

This is the end of the interview.

THANK YOU!

Date of data collection _____