

WOLKITE UNIVERSITY



COLLEGE OF MEDICINE AND HEALTH SCIENCE DEPARTMENT OF
PUBLIC HEALTH

ASSESSMENT OF MATERNAL AND CHILD HEALTH SERVICE
PROVISION IN WOLKITE UNIVERSITY SPECIALIZED HOSPITAL
GURAGE ZONE, SNNPR, ETHIOPIA 2014.

A RESEARCH PROPOSAL TO BE SUMMITTED TO WOLKITE UNIVERSITY
COLLEGE OF MEDICINE AND HEALTH SCIENCE DEPARTMENT OF
PUBLIC HEALTH IN PARTIAL FULFILLMENT FOR THE
REQUIREMENTS OF BACHLOUR DEGREE IN PUBLIC HEALT

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November, 2014
Wolkite Ethiopia

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ACKNOWLEDGMENTS

First of all we would like to thank GOD, but for his help no one is capable of doing nothing. Next we would like to thank Wolkite University College of medicine and health science, department of public health for giving us the chance to do this research. Then we would like to extend our deepest gratitude to our advisors Mr. Dereje and Mr Kifle for their constructive comments, suggestion and guidance throughout the development of the proposal, data collection and analysis. Last our gratitude goes to our respondent who provided us their voluble and priceless time.

Abbreviations and Acronyms

EPI- expanded program on immunization

MOH - Ministry Of Health

UTI-urinary tract infection

MTCT-mother to child transmission

ORS- oral rehydration solution

OCP - Oral Contraceptive

PRMR- pregnancy-related mortality ratio

HSTP- Health Sector Transformation Plan

RH - Reproductive Health

SPSS - Statistical Package for Social Science

SRH - Sexual and reproductive health

SRS - Simple Random Sampling

STI - Sexually Transmitted Infection

MOH- Ministry of Health

ANC- ante natal care

WHO- World Health Organization

MCH- maternal and child health

ITN: - insecticide treated net

WBC: - white blood cell

PPH: - post partum hemorrhage

CS: - cesarean section

ABSTRACT

Background: term health service referees wide array of service that affect health (physical ,mental, and social).so Maternal and Child Health service is service provided to women of reproductive age and children. Usually provide in health service center, but can be given in other institutions (school, religious place..). As revealed by maternal and child mortality and morbidity indicators the quality of maternal and child health service is still low. Ensuring quality of maternal and child health service significantly reduce 3.2 million stillborn babies, more than 4 million neonatal deaths, and more than half a million maternal deaths that occur globally per year .**Objective:** To assess maternal and child health service provision in wolkite university Specialized Hospital

Methodology: A descriptive cross-section study design was conducted on wolkite university Specialized Hospital from July 2013 to November 2014 EC. Stratified random sampling was employed for this study. Data collected by interviewer administered questioner was coded, entered analyzed by SPSS20.

Result: among 100 respondents of sick child questioner respondents 46% were told the diagnosis of illness the child has and 54.8% of lactating respondents were advised on their breast feeding habit. Among 100 respondents of ANC questioners 98%ofresponents have urine analysis, 44% of respondents have stool examination.51% of contraceptive users were advised to use condom,

Discussion and conclusions: most of respondents of family planning service are informed about possible side effect and helped by provider to make decision on their method of choice, so there is good counseling but, promoting use of long acting family planning is low. 40 % of ANC mother were neither advised to change their feeding habit nor to use ITN. So health promotion and prevention measure are poor at ANC level.

Budget: The total budget expended for the study is 920 birr.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Health is the state of complete physical , mental , and social wellbeing not merely absence of disease or infirmity (WHO) term health service referees wide array of service that affect health (physical ,mental, and social).so Maternal and Child Health service is service provided to women of reproductive age and children. It may provide in health center or other institutions. Quality: is the degree to which actual performance or achievement of the health service system corresponds to set standards. It is a reminder that quality is not identical to good outcomes. Poor outcomes occur despite the best possible health care because disease often defeats the best efforts of health care professionals. Conversely, patients may do well despite poor quality care because humans are resilient.

Establishing health care services that are more sustainable, cost effective and responsive to client needs is most important way to tackle highly prevalent maternal and child mortality and morbidity in developing countries like Ethiopia.

In recent years many countries are undertaking organizational restructuring of their health system. In addition many developing countries, influenced heavily by findings in developed countries, have become increasingly interested in assessing the quality of their healthcare (n, o). Previously, the health delivery system was highly centralized; delivered in a fragmented way and relied on vertical programs; and there was little collaboration between the public and private sectors. Consequently, the current Ethiopian government has initiated political, economic, and social changes resulting in the formation of the 1985 E.C. Health Policy and Strategy by giving special attentions to the family particularly women and children. (a. q). Improved quality of care is becoming an increasing concern and becoming an important goal of reproductive health interventions such as family planning programs, for a variety of reasons. Providing such quality Services such as family planning will lead to increased service utilization by more clients and resulting in higher contraceptive prevalence and lower fertility.

Since 1990, government health expenditure as proportion of total government expenditure has increased in Ethiopia Absolute government expenditure on health has risen dramatically in the last decade, from US\$ 5.6 per capita in 2000 to US\$ 20.77 per capita in 2010. Ethiopia was also the fourth largest recipient of official humanitarian aid in 2010, receiving US\$ 3.5 billion in total

aid which is US\$36 per capita. Per capita national health expenditure almost tripled from US\$ 7.14 per capita per annum in 2004/05 to US\$ 20.77 in 2010/11 but this is still far short of the US\$ 34 recommended by WHO in 2001 or the 2015 target of US\$ 60 per capita. Current spending is not adequate to buy good health for all Ethiopians. The 2007/08 National Health Accounts found that government spending on health was 4.5% of gross domestic product, nearly meeting the World Health Organization (WHO) recommendation that countries should spend 5% of gross domestic product on health.³² In the last two decades, the Ethiopian government introduced a wide-ranging health care financing reform initiative which

Provided for fee waivers for maternal and child health services and poor citizens. Operational and legal frameworks are being set up to introduce community-based and social health insurance schemes. The government also is pursuing a strong resource mobilization strategy that is enabling the country to secure an unprecedented amount of resources from donors. (g)

Much time, effort, and money allocated to enhancing health facilities and services that focus on improving maternal and child health. Despite this, the desired results are often not seen and explanations are sought as to why this is. Quaintly the explanations focus on a need for additional training of health staff and or the need of different interventions. There is little systematically collected information, however, on how well already existing activities and interventions are being provided. Identifying if the existing are, in fact being carried out as planned, and if not, which component of the system is weak, is necessary to develop the appropriate policy and program decisions for improving health outcomes

1.2 Statement of the Problem

Maternal and child health service is broad term that includes all service provided to women of reproductive age group and children. So it comprises family planning service, antenatal care service, service provided for laboring mother, new born care, immunization service and service to sick children. Having EPI recommendation we have taken immunization service as part of service provided for sick child. Service for labor, delivery and new born care will be discussed under ANC

ANC is defined as the complex of interventions that a pregnant woman and adolescent girl receives from skilled health care professionals in order to ensure the best health conditions for both mother and baby during pregnancy(m) The purpose of ANC is to prevent, identify and treat Conditions as well as help a woman approach pregnancy and birth as positive experiences.

The care should be appropriate, cost-effective and based on individual needs of the mother. Antenatal care is a key entry point for pregnant women to receive a broad range of health promotion and preventive health services

As highlighted in the 2015-16 Health Sector Transformation Plan (HSTP), maternal and New born health is priorities for the Government of Ethiopia (MOH, 2015). The HSTP key components are delivery at a health facility, with skilled medical attention and hygienic conditions; reduction in complications and infections during labor and , Risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion.(m)

In Ethiopia there is increment in the proportion of mother who seeks health service during pregnancy from 27%in 2000 to28% in 2005 to 34%in 2011 to 62%in 2016 these figures indicates that there is improvement health seeking behavior of population . Service provided to those mother is remains low even though some increment seen in last 2 decades. The no of women who have had measured their BP rises from 69% in 2000 to 75% in2016, no of mother who have blood sample rises from 25% in 2000 to 73%in2016, no of mother who have urine analysis rises from 21% in 2000 to 66% in 2016. Only 42 % of mother and 6% of mother receives Iron supplement and drug for intestinal parasite respectively (l)

Without adequate BP measurement blood and urine analysis how one can detect complications and screen mother for malaria, syphilis, HIV, hepatitis viruses, and UTI which adversely affects pregnancy outcome. Failure to provides these easily feasible and cost effective service

attributable to poor quality of health service which in turn result from either organizational or skill related problem. These poor quality ANC service will not adequately tackle spontaneous abortion, obstetric complication, stillbirth, preterm labor, MTCT, and neonatal death

The term contraception includes all measures temporary and permanent, designed to prevent pregnancy. The term family planning (fertility control) includes both fertility inhibition (contraception) and fertility stimulation.

Rapid population growth is a critical issue in most developing countries. Family planning methods save women's lives by preventing unintended pregnancies. Slower population growth conserves resources, improves health and living standard. Ideal contraceptive methods should be widely acceptable, inexpensive, simple to use, safe, highly effective and requiring minimal motivation, maintenance and supervision. So far there is no universally acceptable method.(m)

In Ethiopia there is steady increase in use of contraceptive methods from 6% in 2000 to 36% in 2016 EDHS even though regional variations are observed. Public sector contributes significant source of contraceptive but still failed to meet need of women (unmet need being 22%).only 46%of contraceptive user have informed decision these why 18% of user discontinued using method. Although there is improvement in contraceptive prevalence rate pregnancy outcome associated with unwanted pregnancy is still high like 48/1000 infant death in 2016 EDHS for which inter pregnancy interval less than 2 year nearly double risk of infantile death compared to inter pregnancy interval of 2 year and above 92/1000 Vs. 52/1000

Ethiopia achieved an under5 mortality rate (U5MR) of 88 per 1000 live births (LB) according to the Ethiopia Demographic and Health Survey (EDHS) in 2011, a 47% reduction since 2000, putting it on course to achieve its MDG 4 target of 68. United Nations (UN) interagency modeled data indicate that Ethiopia has already achieved this MDG 4 target. Under-5 mortality declined from 166 deaths per 1,000 live births in 2000 to 67 deaths per 1,000

Reductions in child mortality are associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality – in particular essential immunizations, malaria prevention and treatment, vitamin A supplementation, birth spacing, early and exclusive breast feeding and with improvements in socio-economic conditions. Ethiopia has made progress in expanding coverage of key interventions but there is room for improvement.

Despite of these much work is left, diarrhea in children remains leading Cause of mortality and morbidity (13%) which is mainly caused by poor hygiene and sanitation, among children who have diarrhea only 30% received ORS 19% advised to increase fluid intake, only 17% received both zinc and ORS. only 39% of children from 12-23 month received all basic vaccination (1)

1.3 Significance of the study

This study is aimed to asses quality of maternal and child health service. The result obtained from the research will be disseminated to study area. So the result will help the concerning body to plan and act accordingly.

Besides its important in study area it also significant for those who are interested in the study in similar area and population or other study population. As it contains numerical figure and change in time trend .of mortality and morbidity of mothers and children help as an input for researchers.

Here is also un important significant of the research that is improving the skill of research conductors as this research conducted by under graduate students it will develop our research doing skill which is what we expected to have to be graduated and which may also make us to be interested in the field.

CHAPTER TWO

LITERATURE REVIEW

The world population growth rate is very high compared with the socio-economic development, particularly so in developing countries where 80% of the world children die. This population is largely unhealthy. Each year 14 million under-five years old children die and 2000 children die every hour. Deaths in low-income countries comprise 98% of the world's, of which 60% are preventable.

Throughout the world, poor women and children are the most vulnerable and the least served groups. In the less developed areas of the world, disease and health take the highest toll among mothers and children who make up over two thirds of the population. Prenatal mortality is as much as ten times that of infants born in industrialized countries ;the infant mortality rate is six to twenty times greater than that the industrialized region of Europe and North America; the death rate among pre-school children is also up ten times high. Maternal mortality reaches as high as 1,000 per 100, 000 live birth in times high. Maternal mortality reaches as high as 1,000 per 100, 000 live birth in developing countries compared to 5 to 30 per 100,000 in industrialized countries (b)Every year, more than 200 million women become pregnant, and more than 15% are likely to develop complications that will require skilled obstetric care to prevent death or serious ill health. (a)

Family planning is a means of promoting the health of the women and families.

Ethiopia has a high incidence of unwanted pregnancies and incomplete and unsafe/septic abortions, particularly among adolescents. Several studies in the country have revealed that women who tend to undergo induced abortion are below the age of 30 years and are literate; many of whom being above the secondary educational level. (c). Consequences of unprotected sex, such as unintended pregnancy and unsafe abortion, can be prevented by access to contraceptive services or family planning (d). According to the report of Ethiopian demographic health survey (l) in Ethiopia only 36% of reproductive age women have access to contraceptives. In spite of the high rate of unwanted pregnancies, increased maternal and child mortality and morbidity population growth low income with a gross

Domestic product per capita of \$550 (nominal USD)(g) the uptake of contraceptive Ethiopia is low. This poses a range of major public health problems including an increased risk of

complications associated with illegal abortions in the country and may be associated with dropout and non-completion of education among students due to unintended pregnancies

All pregnant women, whether their pregnancies are complicated or not, need good quality maternal health services during pregnancy, delivery and in the postpartum period to prevent death and illness for both mothers and their infants.

In developing countries each year an estimated 585,000 women die from complication of pregnancy, childbirth, and unsafe abortion. On average, in developing countries a pregnancy is 18 times more likely to end in the women's death than in developed (b). Studies demonstrating the high levels of maternal mortality and morbidity in developing countries and researches identifying causes of maternal deaths have repeatedly emphasized the need for antenatal care and availability of trained personnel to attend women during labor and delivery (h, r, s)

ANC is key to promote the health of mother to diagnose and treat disease like syphilis, malaria, hepatitis, STI birth preparedness complication readiness .All this interventions are very important to promote health of both mother and child reduce mortality and morbidity. Despite this ANC coverage is still low.

The proportion of women age 15-49 in Ethiopia who received antenatal care (ANC) from a skilled provider has increased from 27% in 2000 to 34%in 2011, and 62% in 2016. Thirty-two percent of women had at least four ANC visits during their last pregnancy (l)

Ethiopia is one of the most populated countries in Africa with a total population of 71,066,000. The female population in the reproductive age group (15-49) is about 23.9% (16,984,774) and under-five years old children is about 16.8% (11,929,008). (i)In Ethiopia the levels of maternal and infant mortality and morbidity are among the highest in the world. The maternal mortality rate estimated to be between 700 and 1000 per 100,000 live births (k) with an infant mortality rate of 105 per 1000 and 172 per1000 for under- five children (h,k). The 1990 G.C. Family and Fertility Survey revealed that about 25% of mothers received at least one tetanus toxoid immunization and only 8% of the births were assisted by the health personnel at delivery (16).The majority of maternal deaths occur during or shortly after delivery, yet many women do not receive the health care they need during this time. Good quality health care during the critical period of labor and delivery is the single most important intervention for preventing maternal and newborn mortality and morbidity: for 1993(G.C), attendance of trained personnel during delivery was 98% in industrialized countries, 55% in developing countries and 27% in the least developed

countries pregnancy-related mortality ratio (PRMR) with confidence intervals for current and previous EDHS surveys. Estimates from EDHS surveys indicate a substantial decline in the pregnancy-related mortality ratio in Ethiopia since 2000, from 871 deaths per 100,000 live births in the 7 years before the 2000 EDHS survey to 673 deaths per 100,000 live births in the 7 years before the 2005 EDHS survey, 676 deaths per 100,000 live births in the 7 years

before the 2011 EDHS survey, and 412 deaths per 100,000 live births in the 7 years before the 2016 EDHS survey. The decline, both between 2000 and 2016 and between 2011 and 2016, is statistically significant. Information on child health and survival can help policymakers and programmer managers assess the efficacy of current strategies, formulate appropriate interventions to prevent deaths from child hood illnesses, and improve the health of children in the country. Because appropriate sanitary practices can help prevent and reduce the severity of diarrheal disease, providing information on disposal of children's fecal matter is mandatory.(1)

Main causes of children morbidity and mortality are ARIs, diarrheal diseases, malaria ,and neonatal problems like tetanus. Emerging health problems such as substance abuse, street children, and child labor make the situation worse.

In Ethiopian implied by EDHS 2016 Seven percent of children under age 5 had symptoms of ARI in the 2 weeks before the survey. Three out of 10 of these children sought treatment. Fourteen percent of children under age 5 were reported to have fever in the 2 weeks before the survey. Treatment from a health facility or provider was sought only for 35% of children with fever. Twelve percent of children under age 5 had diarrhea in 2 weeks before the survey. More than four out of 10 children under age 5 (44%) who had diarrhea sought treatment. Among children under age 5 with diarrhea, 46% received some form of ORT, while 39%received ORT or increased liquids. Close to two in every five children age 12- 23 months (39%) received all basic vaccinations at some time, and 22% were vaccinated by the appropriate age. The percentage of children age 12-23 months who are the prevalence of child hood mortality and mortality is still high as fully vaccinated increased by 15%, from 24% in 2011 to39% in 2016(1)

Nearly 14 million children under the age of five years die each year, 90% of them in 42 countries and 50% of them in six countries, including Ethiopia. Approximately six million of these deaths could be averted through efforts directed towards a handful of preventable and treatable disorders, including malnutrition, pneumonia, diarrhea malaria ,measles, neonatal asphyxia, and sepsis, and in certain countries AIDS (e).

In Sub-Saharan Africa region under-five mortality rate is 171 per 1000 live births. In Ethiopia each year an estimated of 472,000 under the age of five die. Placing Ethiopia sixth in the world in terms of absolute number of under-five deaths (p).

Basic health indicators show that in Ethiopia the infant mortality rate is 98.8 per 1000 live births. Low birth weight deliveries are 16%. Neonatal deaths, especially in the first one-week of life contribute a large fraction of infant deaths. Most of these deaths are easily preventable. But in Ethiopia still 49 out of 1000 live births die before the age of one-month. (f)

Close to half (46%) of children under age 5 with diarrhea in the 2 weeks before the survey received some form of ORT, either ORS packets (30%), recommended home fluids (19%), or increased fluids. One in three children (33%) under age 5 with diarrhea received zinc and 17% received a combination of ORS and zinc. Antibiotics were given to 9% of children with diarrhea. Close to two in five (38%) of children with diarrhea did not receive any treatment.

Over the past 30 years large amount of resources are allocated to increase access to basic health services in developing countries. Throughout the world the internationally

Institutional deliveries are Deliveries that occur in a health facility. Increasing institutional deliveries is important for reducing maternal and neonatal mortality. However, access to health facilities in rural areas is more difficult than in urban areas because of distance, inaccessibility, and the lack of appropriate facilities. Although institutional delivery has been promoted in Ethiopia, home delivery is still common, primarily in hard-to-reach areas. Twenty-six percent of live births in the 5 years before 2016 EDHS were delivered in a health facility.

Trends: Institutional deliveries have increased from 5% in 2000, 10% in 2011, and 26% in the 2016 EDHS. During the same period, a sharp decline in home deliveries was observed, from 95% in 2000 to 73% in 2016 (Figure 9.3). Institutional deliveries for women living in rural areas have substantially increased in the last 16 years, from 2% in 2000 to 20% in the 2016 EDHS. Facility delivery among urban women has also increased from 32% in 2000 to 79% in 2016.

Antenatal care increases the likelihood of an institutional delivery. Fifty-six percent of births to mothers who attended more than four ANC visits were delivered in a health facility compared to 8% of births to mothers with no ANC visits.

CHAPTER THREE: OBJECTIVE

3.1. General Objective

To assess maternal and child health service provision in wolkite university Specialized hospital from July 2013 to November 2014E.C

3.2. Specific Objectives

1. To assess family planning service and counseling
2. To assess ANC
3. To assess service given to sick child and vaccination.
4. To assess labor and delivery service

CHAPTER FOUR: METHODS AND MATERIALS

4.1 Study Area and Period

The study was conducted at Wolkite University Specialized Hospital which started service on 2012 E.C. The hospital is administered by Wolkite University which is built in 2004 and found in Gurage zone 168 K.M south of Addis Ababa. Besides providing health service for community it serves as teaching hospital for the university. The study was conducted from July 2013 to November 2014 E.C.

4.2 Study Design

Cross-sectional study was conducted to assess maternal and child health service provision in Wolkite University Specialized Hospital

4.3 Source and Study Population

All family planning clients, parent or care giver of sick under 5 years children, pregnant women and women in labor

Study population

Randomly selected clients who seek maternal and child health service at Wolkite University Specialized Hospital.

4.4 Sample size determination

Sample size is calculated by assuming, clients' satisfaction prevalence rate to the service they received. Research conducted in Tikur Anbessa hospital revealed clients satisfaction rate of 39.3 %. To determine the required data, representative sample is determined using formula for a single population proportion

$$N = \frac{z a_2^2 p q}{d^2}$$

While

N=sample size

P=Expected prevalence rate = 39.3%

D=Desire precision =5% (0.05)

Z=Significant level = 0.05

Q=1-p

So sample size will be calculated as

$$N = \frac{1.96^2(0.393)(0.607)}{0.05^2}$$

N=367

Non- respondents = 10%, 33

So total sample size is 400

4.5. Inclusion and exclusion criteria

Inclusion Criteria

Parent or care taker of sick child who brought child to hospital

Women who visits for family planning service and ANC. And women in labor

Respondents who are interested to be involved in study.

Exclusion Criteria

All clients those came second time for consultation during the data collection

Period /time will be eligible only once.

Critically ill respondent or care giver of critically ill child

Respondents who did not complete service(waiting for lab result, medication ...)

4.6. Study Variables

Dependent Variable

Maternal and child health Service Provision in WKUSH

Independent Variables

Skill of provider

Transport and communication service

Time at which care seeker visits the facility

Economic level of clients

Inaccessibility of service (electricity, water...)

Political issues

Age of respondent

Educational status

4.7 Operational definitions

Family planning:-is a means used by couple to limit and space the no of children they have.

Contraceptive:- is method used by fertile women to avoid pregnancy

Vaccination:- is the process of inducing immunity artificially.

ANC:- is wide range of cares provided to pregnant mother to make her and her baby healthy during pregnancy ,labor and after delivery

CS:- is delivery of fetus along with placenta and other product of conception through an incision made on abdominal wall and uterus

PPH: - Is vaginal bleeding of greater than 500ml or 1000ml following vaginal delivery and CS respectively or any amount of bleeding that cause sign and symptom of hypovolemia

4.8.1 Data collection instrument

Data was collated by using interview or researcher introduced questioners prepared in English after revising different literatures, after obtaining consent from each study participants.

4.8.2 Data quality management

After training data collectors on translation of each questions and sequential answering of question Pilot study was done for 5% of initial responders to check the appropriateness of questions so that accurate data was generated. After submission, completeness was checked instantly. Attempt, to make the data of high quality,

4.8.2. Data analysis and presentation

After collecting, data cleaning and checking for its appropriate level of quality, the data generated was transported to IBM SPSS Version 26 and analyzed. Descriptive analysis was presented in the form of frequencies and percentages.

4.9 Ethical Considerations.

Wolkite University specialized hospital .Verbal consent from respondents was obtained during the time of interview, including telling them the right to reject any of the questions during interview if discomfort occurred. Anonymity and confidentiality were ensured for information obtained from study subjects before the interview.

4.10 Dissemination of the result

The result of this study will be submitted to WKU department of public health in written document as part of partial fulfillment for graduation. Moreover, the result will be submitted to

WkUSH management. It is going to be essential asset for both hospitals and other policy makers in planning and decision making.

CHAPTER FIVE RESULTS

Results will be presented on the four priorities maternal and child health services, which are child health, family planning and maternal health that targeted on sick child health, family planning and antenatal care and labor and delivery services at OPD level. Using two different data collection instruments were used in this study. These are client exit interview and provider observation of personal information from records. The proposed no of respondent for the study was 400.as the study population was heterogeneous classified in to four strata and equal no of respondents were used in each group.

5.1 Result of family planning service

Table 1 family planning service

Variable	Response	Frequency	percent	Cumulative frequency
Age of respondents	15-19	2	2%	2%
	20-24	24	24%	26%
	25-29	36	36%	62%
	30-34	22	22%	84%
	35-39	16	16%	100%
	Total	100	100%	
Type of contraceptive women planned to use	Oral pill	30	30%	34%
	Inject able	44	44%	74%
	Implant	24	24%	98%
	IUCD	2	2.0%	100%
	TOTAL	100	100%	

Did you told the possible side effect it may have	Yes	80	80%	80%
	No	20	20%	100%
	Total	100	100%	
Result of current visit	Continue	88	88%	87.5%
	stop	12	12%	100%
	total	100	100%	
Did provider counsel you to use condom	Yes	51	51%	51%
	No	49	49%	100%
	Total	100	100%	
How do you see the service provided to you	Good	72	72%	72%
	Satisfactory	22	22%	94%
	Poor	6	6%	100%
	Total	100	100%	

Socio demographic characteristics of respondent, Among 100 respondents of family planning service 2% were in 15-19 year age group, 24% were in 20-24 age group, 36% were in 25-29 age group, 22% were in 30-34 age group ,and remaining 16% were 35-39 age group.

Among 100 respondents 30(30%) prefer to use oral pill 44 (44%) prefer to use inject able, 24 (24%) prefer to use implant and the remaining 2(2%) prefer to use IUCD. regarding the method used 78 %of respondents used the method they preferred to use the remaining 22% used other than their initial preference. 18.1% respondents used other method because their choice was not avail at time of visit. 36.4%of respondents used other method because they are ordered by provider to do so. the remaining 45.5% used other method after informed decision.

Among 100 respondents 80% told possible side effect it may have the remaining 20% not told. 87% of respondents know how to use it remaining 12% not told. 51% of respondents were advised to use condom and 49 % were not advised to use condom.

Among 100 respondents (88%) of respondents decided to continue or switch to other methods while the remaining (12%) decided to discontinue . regarding the reason for discontinuation 75% due to need to have children the remaining 25% are due to side effect and unavailability choice of respondent at time of visit 12.5% each.

72% of respondents said that the service they received is good, 22% as satisfactory while the remaining 6% see it as poor. If we see reason for visiting this hospital 24% of respondents said that it is nearest to me 42 % said that staff provides good service 30% said that there is better facility here remaining 4% were due other reason

5.2 Result of child health service

Table 2 child health service

Variables		Frequency	percent	Cumulative fr..
Did the child received ORS as treatment of diarrhea	Yes	36	94.7%	94.7%
	No	2	5.3%	100%
	Total	38	100%	
Did provider told you how to prevent diarrheal disease	Yes	28	73.7%	73.7%
	No	10	26.3%	100% ¹
	Total	38	100%	
Did weight of child measured	Yes	80	80%	80%
	No	20	20%	100%
	Total	100	100%	
Is child physically examined by provider	Yes	70	70%	70%
	No	30	30%	100%
	Total	100	100%	
Did he/she explain about examination	Yes	51	72.9%	72.9%
	No	19	27.1%	100%
	Total	70	100%	
Did you told that what illness did child had	Yes	46	46%	46%
	No	54	54%	100%
	Total	100	100%	
Did provider told you how to prevent the illness the child have	Yes	25	54.3%	54.3%
	No	21	45.7%	100%
	Total	46	100%	
Did the baby vaccinated today	Yes	12	12%	12%
	No	88	88%	100%
	Total	100	100%	

Did provider ask you frequency of breast feeding	Yes	44	53.7%	53.7%
	No	38	46.3%	100%
	Total	82	100%	

Socio demographic feature of children from whose parent data was collected

Age of all children was under 5 year (59 month) as single age category 12-23 month contributes (40%). Infants less than 6 month were 12% and 6-11 month were 14%.All children were sick child. Those brought to hospital due to other reason including vaccination were not involved.

Regarding service among 100 children of respondent 80% of respondent's children were measured their weight and 70% were physically examined .Among physically examined children 72.9 %of them were informed about the procedure to be done. From 38 respondents who have diarrhea almost all 94% were received ORS and 73.5% were told how to prevent diarrheal disease.92% of child received medication from which 97.4%were told how to prepare and give medications to their child.

Among 100 respondents 46% of them told diagnosis or type of illness child have from which 54.3% were told how to prevent the illness. From children of less than 2 year (breast feeding) 54% were asked how and how frequently feed their child .12% of children received vaccination during their visit

5.3Result of ANC

Table 3 ANC

Variables	Response	frequency	percent	Cumulative frequency
total no of pregnancy women ever had	Primi gravida	18	18%	18%
	Multi gravida	82	82%	100%
	Total	100	100%	
No of visit	One	40	40%	40%
	Two	28	28%	68%
	Three	24	24%	92%
	Four and above	8	8%	100%
	Total	100	100%	
did the provider ask you any chronic illness	Yes	72	72%	72%
	No	28	28%	100%

	Total	100	100%	
did he or she measure your weight	Yes	90	90%	90%
	No	10	10%	100%
	Total	100	100%	
during this pregnancy did a provider measure your height	Yes	66	66%	66%
	No	34	34%	100%
	Total	100	100%	
did stool examination done to you	Yes	44	44%	44%
	No	56	56%	100%
	Total	100	100%	
during this pregnancy did a provider tell you what to eat to ensure proper nutrition during your pregnancy	Yes	60	60%	60%
	No	40	40%	100%
	Total	100	100%	
did provider told/ asked you to use ITN	Yes	50	50%	50%
	No	50	50%	100%
	Total	100	100%	
did you screened for syphilis and other STI	Yes	90	90%	90%
	No	10	10%	100%
	Total	100	100%	

Socio demographic feature of respondents

The average duration of pregnancy of respondents was 5 month and two week the minimum being 2 month and the maximum being 9month. 82% of respondents were multi gravid remaining 18 % were primi gravida. About two-third of respondents have visited one or more time before this visit during current pregnancy for remaining (34%) it was the first time to visit hospital during current pregnancy.

74% of respondents were asked whether they have or no obstetric complication the remaining 26% were not asked about the condition.72%of respondents were asked whether or not have any of underlying medical conditions .nearly all (94%) respondents have checked for their blood pressure, 90% of respondents were measured their weight and 66% were measured their height.

urine analysis was done for 94% of respondents and 44 % of respondents revealed that stool examination was done to them.

Concerning health promotion and preventive measures advice on increasing frequency and Variety of food is given for 60% of respondents. About 50 % respondents were told by provider to use ITN. 80% of respondents were vaccinated with TT vaccine. 85% of respondents have given either supplementary or therapeutic Iron containing drugs. 90 % respondents were screened for syphilis and other STI.

Regarding reason for visiting and patients satisfaction 28% of respondents prefer to visit this facility because it is nearest to them, 40% of respondents think that facility provides good service and, the remaining respondents visit the facility because they think there is better facility there .regarding personal view of the service they received 95% of respondents said that the service they received is very well or well only 5% said it is poor.

5.4 Result of delivery service

Table 4 labor and delivery service

Variable	Response	frequency	Percent	Cumulative percent
age of laboring mother	20-24	24	24%	24%
	25-29	32	32%	56%
	30-34	18	18%	74%
	35-39	14	14%	88%
	40-44	12	12%	100%
	Total	100	100%	
Parity of women in labor	Primi para	10	10%	10%
	Multi para	90	90%	100%

	Total	100	100%	
does mother have history of CS	Yes	10	10%	10%
	No	90	90%	100%
	Total	100	100%	
what is RVI status of the mother	Pos	1	1%	1%
	Neg	94	94%	95%
	Unknwn	5	5%	100%
	Total	100	100%	
who is attending the labor	Midwife	56	56%	56%
	Nurse	6	6%	62%
	GP	38	38%	100%
	TOTAL	100	100%	

Age of mother ranges from 20-42 age group 25-29 contributes about 32% of respondents .99% of multi parous mother have no history of obstructed labor. Most of (90%) were respondents were multi parous.10% of respondents have history of caesarian section of which 50% were primary and remaining was repeated .Decision to do caesarian section was made for all mother with repeated CS. For all respondents maternal and fetal condition was being followed.

CBC was done to all respondents and % and % of respondents were anemic and raised WBC count antibiotics was given for all mother who have raised WBC and blood grouping and cross much was done to all mother . RVI states of almost all respondents were determined unless 5% of respondents left. 67.5% of respondents were in first stage of labor and remaining was on second stage .among 8 respondents who have CS 5 were midwife and 3 were being followed by

GP. nearly all respondents have cephalic presentation and adequate uterine contraction . among all respondents on which CS decide to be done informed consent was obtained .

CHAPTER SIX DISCUSSION AND CONCLUSION

6.1 Discussion

6.1.2 Family planning service

All respondents were reproductive age group (15-49) year. The age group 25-29 comprises largest (36%) of user; age group (15-19) contributes the least (2%) of user. Concerning type of contraceptive women prefer to use the proportion of respondents who want to use injectable takes largest part 44 % followed by oral contraceptive 30 % and implant 24 % while proportion of respondents who planned to use IUCD was very small (2%) so the study shows that injectable is most frequently used contraceptive method while IUCD is least frequently used.

Regarding the method used 78% of respondents used the method they prefer to use. This shows that most of respondents freely or independently decide on their choice. The remaining 22% used other than their preference. From which 18.1% were because of unavailability of preferred method or provider .although it is lower than unmet need for contraceptive (22%) of EDHS 2016 this is still high. Among those women who used other than their initial choice 36.4% were not clearly informed or they are influenced by providers to do so. And the remaining 45.5% of respondents used other method after the provider consult them .This indicates the number of respondent who used other than method they planned after discussing about their condition (health ,lactation status...) is significant.

Concerning side effect and STI prevention 80% of respondents were told side effect may it causes while the remaining 20% were not told (have no information about side effect) among the reason for discontinuation side effect accounts about 12.5%. Even though the method used by all respondents not provides protection against HIV and other STI only 51% of respondents are advised to use condom.

Regarding reason for preferring this facility 42% of respondents said that staff provides good service this means these respondents have visited before or have information about the service provide by staff. 30% of respondents prefer to visit this facility because of better facilities are there in this hospital .while 24% of respondents visit because of

nearest to them the remaining 4% was due to other reason. Regarding patients satisfaction 72% of respondents revealed that the service is very good and 22% as satisfactory while 4% as poor.

6.1.2 Child health

As seen in result most of children were under 2 year 62.5% of them this age group is the one highly susceptible to wide range of health problem due to their poor immunity and risk behavior. So adequate therapeutic and preventive measure is important. It is known that the diagnosis of health disorder in children is mainly depends on physical examination and investigation although history is important. The result shows that 80% were measured their weight, relative to higher burden of malnutrition in our country it is still low. Anthropometric measurements are very important screening and diagnostic tool for malnutrition .70% of respondents were physically examined and the remaining 30% treated with history alone or history with investigation. Due to low economic status to afford the cost of investigation and low reliability of history of parent to reach the diagnosis of disease in children missing 30% of child to examine physically is high, both in term of cost as well as public health importance.

Most children with diarrhea received ORS or some other medication. Which is important to reduce or prevent complications .But only 73.7 % were told how to prevent diarrheal disease. No measure is taken to prevent recurrent attack of diarrhea in 26.3% of children. This is preventable and common cause of morbidity and mortality in U5 children. Only 46% of respondents were told what illness the child has and from which 54.3% were told about the disease and how to prevent it. About two-third of respondents don't know what illness their child have or how to prevent that.

From children of less than 2 year (breast feeding) 54.8% were asked how and how frequently feed their child the remaining 45.2% were their breast feeding behavior .breast feeding besides its important in physical and mental development of the children it is important in health promotion only 12% of children were vaccinated during their visit. Concerning the reason for not vaccinated 80.6% were either fully vaccinated or recently vaccinated the remaining 19.4% were either due unavailability of vaccine (vaccine schedule) or poor link between vaccination and other health service.

6.1.3 ANC

On average the gestational age of respondent is 5 month and 2 week, the minimum is two month and the maximum is 9 month. Regarding number of visit for 40% of respondents it was the first visit. The remaining 60% visited at last once before current visit. regarding the no of pregnancy women ever had 82% of respondents have at least one pregnancy before so screening about previous obstetric complication was important. The result obtained revealed that 74% of respondents were screened (historically asked) if they had any of obstetric complications previously. Although obstetric complication can occur in any mother screening and giving special care for those at risk is important. one of important factor that affect pregnancy and pregnancy outcome is underlying medical illness only 72% respondents were screened if they have any of medical illness. Significant no of respondents were not screened. Inadequate screening and management of these conditions definitely affect pregnancy as well as its outcome. Almost all respondents have BP measure during their visit this is important for detection and treatment of hypertension which affect pregnancy adversely, 90% of respondents were measured their weight and only 66% of respondents were measured their height .the result shows that monitoring weight of respondents is good but the problem here is it is not known that the weight gain for 34% respondents is adequate or not. Because their BMI is not determined. result obtained shows that for 95% of respondents urine analysis was done either to confirm pregnancy or to screen for UTI. So early diagnosis and subsequent management of UTI (common medical condition during pregnancy) is possible. Although almost all respondents have urine analysis only 44% of respondents have stool examination. This low compared to high prevalence of anemia during pregnancy and intestinal parasites especially hook worm is cause of anemia. Regarding health promotion and preventive measures 60% respondents were advised on their habit nutrition. It is known that pregnancy is physiologic state at which nutritional demand of mother increase in frequency and variety. Too low or too much intake food affects pregnancy .so as revealed by result education on nutrition is low .one of the medical condition that affect pregnancy is malaria adequate treatment of mother and prevention is important one of important preventing method of malaria is use of ITN. Promoting use of ITN is important part of ANC. Despite it's important in prevention of malaria 50% of mothers are not advised to use ITN. Result shows most of respondents prefer to visit the facility because of nearest to them or they think there is better facility. It was only 39% of respondents prefer to visit since staff providers

good service. The respondent's satisfaction was high as most of them (96%) see the service they received as very good or good

6.1.4 Labor and delivery

As result shows most of respondents (90%) were multi para and have no history of obstructed labor. fetomaternal condition of all respondents was being followed this good which helps to detect complication early and act accordingly. 95% of respondents RVI states was determined this help in halting mother to child transmit ion as well as to provide special care to new born. For 98% of respondents either CBC result was obtained or waiting for result. Among respondents whose result obtained 12% has raised WBC and 7% had either anemia or thrombocytopenia. This indicates that there is poor ANC service on preventing and treating anemia. All respondents with raised WBC were on antibiotics .Also all respondents with anemia had cross much and blood grouping. Preparing blood group and cross much is important for women in labor especially for those who are anemic.98% of respondents had blood grouping. There were 13 respondents who have CS.10 respondents have primary type of CS while remaining three were repeated type, all respondents with repeated type CS was planned and informed consent was obtained for all. Among respondents with primary type of CS trial of labor was allowed vaginally

6.2 Conclusions

- ❖ Although contraceptive methods used by all respondents were not provides protection against HIV or STI much respondents were not advised to use condom. So promoting use of condom is low
- ❖ The proportion of mother who used long acting family planning mainly IUCD low.
- ❖ There is good counseling during family planning service as evidenced by most of respondents have informed about side effect associated with it and greater than one-third of respondents used other methods after they discuss with health workers.
- ❖ There is poor link between vaccination and other child health service at this hospital.
- ❖ Publically important interventions provided by health workers are low including advice on breast feeding and how to prevent diarrhea.

- ❖ There is limitation in health promotion and disease prevention as evidenced by much number of respondents were not advised on their nutrition and as providers are not promoting use of ITN as expected.
- ❖ Even though most of respondents were screened for UTI and STI lower number of respondents were screened for intestinal parasite.
- ❖ Health worker at this facility not routinely identify mothers as high risk or low risk even all mothers are at risk of obstetric complication those who have previous history have higher risk
- ❖ Since nearly all respondents of labor have CBC, blood grouping HIV test, and were being followed by charts the quality of labor and delivery service is good.

6.3 Recommendations

- All health service providers should promote use of condom to all women irrespective of the type of contraceptive women used. Since use of condom will reduce transmission of HIV and other STI
- Every children who visit this facility for other health service should receive vaccination unless fully vaccinated for his age or recently vaccinated .to achieve this there should be good link between those service and vaccination as recommended by EPI.
- Providers should promote health education on breastfeeding and on how to prevent communicable disease. This is important to decrease prevalence of malnutrition and communicable disease which are major health problem of children
- Health service providers should monitor weight gain of pregnant lades based on their BMI and advise them to change nutritional habit accordingly. Advise them to use ITN
- All pregnant women should be screened for intestinal parasite and treated accordingly
- So that women with any of chronic illness or previous obstetric complication receives special care all women should screened for these conditions.
- Vaginal deliver after one CS should always attended by professional who is capable of deciding or doing CS

CHAPTER EIGHT BUDGET

8.1 Budget justification of personnel

There was no cost for personnel during conducting this research

6.2. Budget breakdown for materials

Materials and supplies: Materials and supplies include paper, pens CDs face musk, sanitizer and other miscellaneous items necessary to conduct research. One of material used was personal computer but it has no cost. Materials were required to collect and code and analyses data. The source of money was the group members. All attempts to minimize cost without compromising quality of data collection were made.

Other than materials transport, communication, and internet service are also takes part of cost of research.

Table 5 budget breakdown

s.n	Material/other service	Cost in birr
1	Paper with print	240
2	Pen	45
3	Memory/flush	350
4	Communication	20
5	Transport	100
6	Internet	30
7	Face musk	90
8	Sanitizer	45
9	Total	920

Weakness of the study

Data was collected within short period of time that is In two week this may not represents usual performance of health worker or the whole institution better result might be obtained if data was collected for longer period of time that is half year or quarterly.

Works Cited

(CSA, C. S. (from January 18, 2016, to June 27, 2016). *Ethiopia Demographic and Health Survey (2016 EDHS) implemented by the Central Statistical Agency (CSA) from January 18, 2016, to June 27, 2016.*

- . FDRE, M. (2004). . *FDRE, MOH, Status of Maternal and Child Health and Millennium* .
- D, M. (1986). *Maine D. Maternal Mortality: helping women off the road to death in rural* . Bangladish.
- ESOG. (, Oct 2004). *ESOG (Ethiopian Society Of Obstetrics and Gynecologist) in collaboration with MOH & EC afrique, EC training Curriculum for mid level health workers in Ethiopia, Oct 2004.*
- Ethiopi, m. o. (2020). *Management protocol on selected obstetrics topics for hospitals ministry of health of Ethiopia 2020.*
- Ethiopi, T. F. (april 2001). *The Federal Democratic Republic of Ethiopia, Service Delivery Policy in the* .
- Ethiopia, M. o. *succesus factor for Women's And Children's Health Ministry of Health Ethiopia.*
- Ethiopia, T. G. (1993). *Transitional Government of Ethiopia, Health Policy, September 1993.*
- Fauveach V. Koeing M. Chakarabort I, e. a. (1976-1985). *Fauveach V. Koeing M. Chakarabort I, et al. Causes of maternal mortality in.*
- FDRE, M. (1990). FDRE, MOH; An Assessment of Reproductive Health Needs in Ethiopia,.
- Huckaby, F. (october 2002). *Frank Huckaby; Sandy Rice; Kathy Williams et al. Assessing Client.*
- J, F., S, S., & al, e. (1988). . Fortney J; Susanti S; et al. Maternal Mortality in Indonesia and Egypt. British.
- Jorge Mendoza Aldana, H. P.-S. (2001). *Jorge Mendoza Aldana, Helga Piechulek, Ahemed Al-Sabir, et al. Client.*
- MOH, .. (1996). . *MOH Guidelines for family Planning Services in Ethiopia. Addis Ababa.* Addis Ababa.
- Organization, W. H. (14 June 2011].). *World Health Organization. Selected Practice Recommendations for Contraceptive Use (2nd edn).2005.*http://www.who.int/reproductive-health/publications/spr_2/index.html [Accessed 14 June 2011].
- RE, B., & J., M. S. (2003). *Back RE; Morris SS and Bryce J. "Where and why are 10 million children.*
- The Federal Democratic Republic of Ethiopia, M. (2003/2004). *The Federal Democratic Republic of Ethiopia, MOH, Health Related.*
- Timothy Williams, J. S.-A. (june 2000). *Timothy Williams, Jessie Schutt-Ainé and Yvette Cuca, Measuring Family* .
- UNICE, W. a. (1996). *WHO and UNICEF, Revised 1990 estimates of maternal mortality. A new* . geneva.

ANNEXIS-1

Questioners for family planning service

. My name is _____. _____. I am from Wolkite University College of Medicine And Health science which this survey conducts for BCS thesis. We are going to conduct research on quality of maternal and child health service .This inquiry assists the quality increase of maternity health care services. The inquiry is confidential and the information provided by you will not identify with any third person. Can you spare me 20-25 minutes to answer our questions?

1. Age of respondent in year.....

2. How many children do you have.....

3. for how long do you want to use contraceptive 1.temporarily 2.permanently

4. Age of the last child if you have 1.less than or equal to 2 year 2 .> 2year

5. Which method did you plan to use when you came to here
1 oral pill 2.injectale 3 .implant 4.IUCD 5. Other

6. Which method did you use 1. What I want 2 . Other

7. If you used other than you planed why 1.not avail 2.provider asked to use other method
3. I have changed my plan after provider consults me

8. which questions did provider asked you 1. Menstral history 2.history of strock
3.hypertention 4. Lactational history 5.CVD

9. when was your last menses 1. Befor 1 week 2. Befor 2 week 3. befor three week
4. Befor 4 week

10did provider told you any possible side effect of method used 1. Yes 2.no

11. did provider told you how to use it 1. Yes 2. No
12. did you use contraceptive before this 1.yes 2 .no
13. result of current visit 1. Continue or switch to other method 2. Stop
- 14.if you decide to stop what is your reason 1. Want to have child 2. Side effect
- 3.ther was no my choice
15. did provider asked to use condom 1.yes 2 .no
16. How do you see service provided to you today 1.good 2 satisfactory 3. Poor
- 17 .Why do you prefer to come to here 1. Nearest to me 2. Staff provides good service
3. better facility 4. Other
- 18.do you know when to return 1.yes 2 no

ANNEXIS-2

Questionnaire for Exit interview for Caretaker of Sick Child

Hello, my name is _____. I am Wolkite University College of Medicine And Health science which this survey conducts for BCS thesis that helps to improve the quality of sick child health care services in the hospital. The inquiry is confidential and the information provided by you will not identified with any third person. Can you spare me 20-25minutes to answer our question? Can we begin?

1. Age of child in month.....
2. What is problem of child.... 1.cogh or shortness of breath 2.darrhea
3. Fever 4 ear problem
3. If child has diarrhea did he received ORS 1.yes 2. No
4. did provider told you how to prevent diarrheal disease 1.yes 2.no

5. If yes what methods did he /she told you 1.hygiene 2.sanitation 3.both 4. Other
6. did provider measure weight of the child 1.yes 2.no
7. did provider physically examine the child 1.yes 2.no
8. If yes to ab.question did he/she explain the procedure to you 1.yes 2. No
9. Has the child been to this hospital before for the same episode of illness 1yes 2.no
10. If yes to ab.question how long it was 1.befor 2 day 2. before 4 day
3.befor week
11. Did provider told you what illness the child has 1.yes 2.no
12. If yes what was that 1.pnumonia 2 .meningitis 3.malaria 4.other
13. Did he/she told you how to prevent it 1.yes 2.no
14. Did he/ she told you to bring back if not improving 1.yes 2.no
15. Is predication prescribed to the child 1.yes 2.no
16. If yes Did provider explain how to prepare and give it 1.yes 2.no
17. Did provider asked you frequency of breast feeding (for child less than 2 year)
1.yes 2.no
18. If no how often do you feed your baby 1.lessthan4 2. 4-8 3. 8and above
19. Did provider asked you when and how to start complementary(feeding for child less than 2 year) 1. Yes 2. no
20. Is the child vaccinated today 1. Yes 2. No
21. If not why 1. no schedule today 2. recently vaccinated 3.fullly vaccinated
22. How long have you stayed here 1.2 hrs 2. 3-5 hrs 3.>5hrs

23. Why you prefer to come here 1. Nearst to me 2. Staff provides good service
- 3.better facility 4. (feeding for child less than 2 year Other

ANNEXIS-3

Questioners for ANC service

Hello, my name is _____. I am Wolkite University College of Medicine And Health science which this survey conducts for BCS thesis that helps to improve the quality of ANC health care services in the hospital. The inquiry is confidential and the information provided by you will not identify with any third person. Can you spare me 20-25minutes to answer our question? Can we begin?

Sn	Question	Respondent
1	How many months are you pregnant?	Months ____ Don't know.....2
2	gravidity	Number of pregnancy
3	Including this visit, how many antenatal visits you made during your pregnancy?	Number of visits_____

4	Did the provider ask complication in previous pregnancies'	Yes.....1 No.....2
5	Did you have complication in previous pregnancies'	Yes.....1 No.....2
6	If yes to question above what was the complication	Headache and v. blurring.....1 Vaginal bleeding.....2 Gush of fluid.....3 ab. Pain and fever.....4
7	Do you have any chronic illnes	Yes.....1 No.....2
8	If yes to above question what is that	Hypertension.....1 DM.....2 renal disease.....3 Cardiac disease.....4
9	Did the provider ask you any chronic illness	Yes.....1 No.....2
10	Did he or she measures	Yes.....1

	your blood pressure	No.....2
11	Did he or she measure your weight	Yes.....1 No.....2
12	During this pregnancy, did a provider measure your height?	Yes.....1 No.....2
13	Did you have clinical exam during your visit today?	Yes.....1 No.....2
14	Did you have enough privacy during your exam?	Yes.....1 No.....2
15	Did the provider explain the examination before it was performed?	Yes.....1 No.....2
16	Did the provider explain the results	Yes.....1 No.....2

	of this examination?	
17	Did urine analysis and stool examination to you?	Yes.....1 No.....2
18	Did you vaccinated for tetanus?	Yes.....1 No.....2
19	did you screaned for syphilis other STI	Yes.....1 No.....2
20	Did you told the well being of your fetus	Yes.....1 No.....2
21	Did you told when to return ?	Yes.....1 No.....2
22	What were the complications that a provider told you	Yes No 1.Bleeding 1 2

	necessitate immediate medical attention? (CIRCLE ALL MENTIONED)	2.Acute/constant abdominal pain 1 2 3.Sever headache 1 2 4. Blurred vision 1 2 5. Swollen face or limbs 1 2 6. Fever 1 2 7. Accelerated or reduced fetal movements 1 2
23	During this pregnancy, did a provider give or prescribe any iron or folic acid pills?	Yes.....1 No.....2
24	During this pregnancy, did a provider tell you about the side effects of these pills?	Yes.....1 No.....2

25	were you told how often to take these pills?	Yes.....1 No.....2
26	How long were told to take these pills?	One week.....1 One month.....2 Three months.....3 During the whole pregnancy....4
27	During this pregnancy, did a provider tell you what to eat to ensure proper nutrition during Your pregnancy?	Yes.....1 No.....2 Don't know/remember.....3
28	Did provider told /advised you to use ITN?	Yes.....1 No.....2
29	During this visit at the hospital, how the provide treat you?	Very well.....1 Well.....2 Poorly.....3 Very poorly.....4
30	Did stool examination	Yes.....1

	done to you	No2
31	Where do you plan to deliver?	At this hospital.....1 At other facilities.....2 At home.....3 Others (specify).....4
32	Why not at this Hospital ?if so	Long distance.....1 High cost.....2 Poor service.....3 Other.....4
33	What is the major reason that you chose to come to this hospital?	
		YES NO
	1. Nearest to me	
	2. Staff provide good services	1 2
	3. Better facilities	1 2
	4.other	1 2

		1	2
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ANNEXIS-4

Questioners for laboring mother and delivery

Hello, my name is _____. I am from Wolkite University College of Medicine And Health science. We are conducting research on quality of maternal and child health service on wolkite university specialized hospital. We are collecting data as resource for the research . honestly speaking the information collected is only used for the research purpose only and The inquiry is confidential and the information provided by you will not identified with any third person. Can you spare me 20-25minutes to answer our question? Can we begin?

1. Age of laboring mother.....
2. Gravidity.....
3. Previous history of obstructed labor 1. Present 2. Absent
4. Did the mother have history of cs 1. Yes 2. No
5. If yes to above question what type 1.primary 2 repeated

6. What is RVI status of mother 1.pos 2. Neg 3 unknown
7. Result of CBC 1.normal 2.leukocytosis 3.anemia or thrombocytopenia 4. Sent to lab result not obtained 5. Not sent
8. If leukocytosis is present is antibiotics given 1.yes 2. No
9. If mother is anemic is blood obtained 1.yes 2. No
10. How long is after labor onset (in hrs) see in patients card.....
11. What is stage of labor see in chart 1.first 2primeryprimery, second 3. third
12. How long is after women enters stage described.....
13. Who is attending mother in labor 1.mid wife 2.nurse 3. GP
14. Intervention taken 1.NS 2 augmentation 3.instroment 4.no
15. Is uterine contraction adequate 1. Yes 2. No
16. What is the presentation of the fetus 1. Cephalic 2. Breach 3 shoulder
17. If women have malprsentation what is planned by attendant 1. Consulting seniors 2.dicsion to do CS 3.expectant 4.nothing
18. Is fetal condition being followed 1.yes 2.no
19. How much is fetal heart beat.....
20. What is the stage of meconium 1.G1 2. G2 3.G3
21. How is progress of labor process in partograph (for active first stage and above) 1. Good progress 2. Approaching action line 3 crosses action line
22. If crosses the action line what is planed 1. Consulting seniors 2.dicsion to do CS 3.expectant 4.nothing
23. If decision to do Cs is decided is mother informed 1.yes 2. No

