MALE INVOLVEMENT IN MATERNAL HEALTH CARE SERVICE AND ASSOCIATED FACTORS IN SHASHEMENE TOWN,OROMIA REGION,SOUTHERN ETHIOPIA

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Abstracts

Background: Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labor and after delivery. Men, as partners and decision makers, need to be involved in maternal health care services, Low male involvement in maternal health care services results in low utilization of Antenatal care, health facility delivery and postnatal care leading to high maternal morbidity and mortality.

Objective: To asses male partner involvement in maternal health care service and associated factors in shashemene town oromia region, Ethiopia,2014.

Method and material: community based cross sectional study was conducted from April 1-30/2014 , in Shashemene town, with 362 sample size of male partner who have infant and multistage sampling method was used. Quantitative Data was collected by using structured questionnaire through face to face interview. Data was entered by using epi-data version3.1 and analyzed by using SPSS version 16.0 .Bivariate analysis was employed and those variables had p-value $\leq$ 0.25 was candidate for multivariable analysis. The degree of association between independent and dependent variables was assessed using logistic regression and variables which had p-value < 0.05 were selected as predictors. Factor analysis was done for likert scale questions of Attitude.

Result: From the total of 362 households, 355 gave complete response to the interview yielding a response rate of 98%. About 59.7% of the men in Shashemene town involved in maternal health care service,59.8% of them were involved in delivery care service,39.6% in Antenatal care and 20.2% in PNC service. Factors that predicted male involvement in maternal health care services were include:- educational level of wife (AOR 6.5, 95% CI:3.5-11.9), spouse communication (AOR 3.2,95%CI:1.8-5.8),Type of marriage(AOR 3.195%CI:1.1-9.6), knowledge about maternal health care (AOR 2.7,95%CI:1.4-5.2) and Health facility factors like, opening time(AOR 2.4 95%CI:1.2-4.6), health provider approach(AOR 4.7,95%CI:2.3-9.6) .

Conclusion and Recommendation: The proportions of males who involve on maternal health care service were low. Strategies for improvement of male involvement in maternal health care services should include, encouraging couple communication on matters concerning maternal health care services, encourage education for both male and female, strengthening health education by health provider on male involvement on maternal health care service and on services.

Key words: Male involvement in Antenatal care service, Male involvement in delivery care service and male involvement in postnatal care service.

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ACRONYMS

- ANC ----------Ante natal Care
- AOR----------Adjusted Odds Ratio
- BSC----------Bachelor of Science
- COR----------Crude Odds Ratio
- EC----------Ethiopia Calendar
- EDHS----------Ethiopia Demographic Health and survey
- FP----------Family Planning
- HIV----------Human Immune Deficiency Virus
- HH----------House Hold
- MDG----------Millennium development Goal
- MMR----------Maternal Mortality Ratio
- PMTCT----------Prevention Mother to Child Transmission
- PNC----------Post Natal Care
- SPSS----------Statistical Package for Social Science
- UNAIDS----------United Nation on HIV
- UNFPA----------United Nations population Fund
- UNICEF----------United Nations Children's Fund
- WHO----------World Health Organization

Chapter One: INTRODUCTION

The safe motherhood initiative, launched in 1987 by WHO, UNICEF, UNFPA, the World Bank and other organizations placed maternal health at the forefront of international public health[1] .

Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labor and after delivery. Maternal health services include the following, preconception care, antenatal care (ANC), Prevention of Mother to Child Transmission of HIV (PMTCT), safe delivery (intra-partum care); post natal care (PNC) and emergency obstetric care/management of obstetric complications. [2]

Until the late nineties', reproductive health program focused entirely on women, viewing men as non actors whose role was regarded as irrelevant , an observation further alluded to by , who point out that maternal health issues have traditionally been treated as a feminine matter that men were less concerned about. This has led to poor male participation in maternal health care services. In addition, men have for a long time been ignored or believed to be the stumbling blocks when it comes to the health of their partners [3].

This prevents women from accessing critical health information and services and can lead to poor reproductive and maternal outcomes, including unwanted infections and unwanted pregnancies. The UNFPA explains male involvement as an umbrella term which comprises of the several aspects of men and reproduction: reproductive health problems and programs, reproductive rights and reproductive behavior. Furthermore, the UNFPA gives male involvement two dimensions: One, men as supportive partners in women´s reproductive health needs, choices and rights and two, men´s own reproductive and sexual behavior. Accordingly, male involvement can mean different strategies from education and awareness rising to actual participation. Involving men in reproductive health programs is considered beneficial in many ways, and this perspective has been justified for example through men´s various roles as sexual partners, husbands, fathers, family and household members, community leaders and many times as gatekeepers to

health information and services. [4] It is believed that when male and female aware of each other's health needs, they are more likely to receive needed services. [5]

A number of factors have been reported by several researchers as being responsible for influencing male involvement in maternal health care services such as, Cultural factors, Socio –demography, Health service factors and other.

In Ethiopia there is an effort to improve male partner involvement on maternal health care service, But the goal desired remain un achieved which is low as study done in Ethiopia showed.**[6]**

1.2 statement of the problem

Men's accompanying their wives in routine ANC and other maternal health services is an important factor in contributing to the reduction of maternal morbidity and mortality. [7]Maternal mortality is considered the main indicator of maternal health [8]. Although not a wide public health problem in high-income countries, maternal mortality continues to be unacceptably high in many low-income settings. In fact, in the poorer countries pregnancy and childbirth are still the leading causes of death and disability among women of reproductive age [9]. Nearly all, 99 % of maternal deaths take place in developing countries; more than half in sub-Saharan Africa and about one third in South Asia [10].

Improving maternal health is one of the Millennium Development Goals (MDGs) launched in 2000 and it is the goal lagging most from its target. The countries of the international community have engaged to reduce maternal mortality by three quarters from 1990 to 2015. In 2010 there were about 287 000 maternal deaths worldwide which is nearly half of that in 1990 but the target is still very far for many regions too far to be reached by 2015 [11]. In addition, the progress has been uneven, the slowest change having taken place in regions with initially highest burden of deaths, except of southern Asia. The maternal mortality ratio (MMR), the number of maternal deaths per 100 000 live births, was 15 times higher in developing regions compared to developed regions in 2010, sub-Saharan Africa having the worst figure, 500 per 100 000 live births. One important difference between the areas in the opposite ends of the scale is the coverage of skilled attendants at birth: In the areas with highest mortality, the coverage of births attended by skilled personnel is the lowest. [12] For Ethiopia, the MMR estimates is 676 in 2011 [13].

According to the latter EDHS data, the ratio has remained effectively the same since 2000.[13]Globally, 80 % of the maternal deaths occur due to complications arising during pregnancy, delivery or the puerperium. Those complications; severe bleeding, infections, high blood pressure and unsafe abortion are largely preventable and treatable and thus, most maternal deaths could be avoided.

Good quality maternal health care, comprising of antenatal, delivery and postnatal services, essentially promotes mother´s and child´s wellbeing and helps to prevent severe complications and illnesses, even death . [14]

Research done in Uganda suggest that male involvement is a very significant factor to consider in finding a solution to the three main factors responsible for many of the maternal death: 1) the delay in decision-making to refer the patients to the appropriate health facility where proper treatment could be taken; 2) lack of a system for emergency transport to ensure that women who experience obstetric complications receive timely treatment; and 3) delay in receiving treatment within the health care facility, which is sometimes related to covering the costs associated to such emergencies.[7]

Antenatal care (ANC) is seen as an important opportunity for many health interventions and health education as well as for promoting the use of skilled attendance at birth .[15] Moreover, it connects the woman and her family with the health system .[16]

ANC utilization is nearly universal in most high- and middle-income countries today [9].Across most developing regions, the coverage has been on rise during the last two decades. Eighty percent of women had at least one antenatal visit in 2010 compared to 63 % in 1990. However, almost half of pregnant women in developing countries remained without the recommended care, minimum four visits, in 2010. Furthermore, in sub-Saharan Africa there has been a fall from 50 to 46 % between 1990 and 2010 (four visits or more). What comes to deliveries attended by skilled health personnel, the coverage is more than 95 % in most Northern American, European and Eastern Asian countries compared to 65 % in developing regions where the progress has been varying since 1990 [10]. No advance has taken place in the Caribbean and only little in sub-Saharan Africa, from 42 to 45 % in 2010. [12]

In Ethiopia, maternal health care utilization is alarmingly low, even in relation to other low-income countries. According to the WHO´s statistics, only 12 % of women had the recommended four antenatal visits in 2005 (*attention: by any, not necessarily skilled provider*) while the average for low income countries was 36 %.[16]

The study done in Uganda, revealed about 43% of the men accompanied their partners to the health facility during ANC, 43% accompanied their partners during delivery and nearly 32% accompanied partners for postnatal care. This study have shown that most women attend ANC only once instead of the recommended minimum of four times, and never return for delivery. This has been attributed to a number of factors, the notable one among many is husbands deciding when and where a woman is to get ANC and delivery care. [7]

Twenty-eight percent of Ethiopian women had at least one visit the same year and got attended by a skilled provider. Furthermore, in only 6 % of the deliveries there was a skilled attendant compared to 46 % for the countries in the same income group. [16] The more recent figures of the EDHS 2011 show some improvement: the antenatal care coverage for four visits was 19 % (34 % for one visit from a skilled provider) and there was also a slight increase in proportion of deliveries attended by skilled personnel, to 10 % .[13] The births attended by skilled personnel are usually those taking place in hospitals or other health institutions. Thus, the vast majority of Ethiopian women delivers at home with assistance of traditional birth attendants (28%) or relatives (57 %), or alone (4 %) [13]**.** Quality postnatal care has an essential part in maternal health care in recognizing and managing above mentioned complications as well as in improving neonatal survival [16]. Still, postnatal care is a neglected area in Africa and research on postnatal care in developing countries is scarce[17]. Li, et al. (1996) found that more than 60 % of maternal deaths occur within six weeks after delivery and 80 % of postpartum deaths can be attributed to obstetric factors, which findings emphasize the importance of good delivery and postnatal care for the mother. A number of factors have been reported by several researchers as being responsible for influencing male involvement in maternal health care services.

Study done in Uganda showed Factors that predicted male involvement in maternal health care services included; providing invitation letter (25%) and communication with the partner concerning place of delivery .

Factors associated with low male involvement included; low education level of the husband, Male perception of maternal health services being accessible and health workers demanding for more money. [7] study have identified ANC opening hours as a limiting factor for male involvement .[18]

Despite of the increasing efforts to target men, the research over factors associated with male partner involvement on maternal health care service and maternal health care service utilization in Ethiopia is still scarce. More knowledge about factors associated male partner involvement on maternal health care is needed to have a wider selection of instruments for promoting safe pregnancy and motherhood in Ethiopia. So this study will contribute to better understanding of the factors that make men get involved in ANC, delivery and postnatal care.

Chapter two: Literature review

2.1 Literature review

The awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband. The husband is often the primary decision maker, and wife's economic dependence on her husband gives him greater influence on major household decisions, as was reported in Nepal by Britta and others where 50% of the women had the final decisions. Studies have suggested that male involvement in maternal health results into positive outcome for not only the pregnant woman but also for the unborn child [19].

Antenatal care service

Societal allocation of roles to the men and women especially decision making influences utilization of ANC. It is therefore important for men to understand and appreciate the importance of attendance of ANC, delivery at a health facility and postnatal care services. A study done by Britta et al in Nepal revealed that husbands accompanied only 40% of their women attending ANC for the first time and that greater decision-making power for women was associated with lower husband accompaniment to ANC and lower overall male involvement. In effect men's involvement in the maternal health care system often stops at the doors to the clinic, yet to exclude men from the information on the benefits of antenatal care, counseling and services is to ignore the important role men's behaviors and attitudes may play in a woman's maternal health choices. [20] It is not uncommon in most African societies for men to decide as to when and how a woman should seek care. For example in Kano Nigeria, 17.2 % of women did not attend regular ANC because of husband denial .[21]

In Uganda, despite of health facilities being in walk able distances in many districts, women having income and improvement in the quality of care, women continue to report late for ANC and deliver outside the health facilities [22].

This fact of male's affecting utilization of ANC and delivery care in Uganda is supported by the findings of the study done by Tororo in which she observed that some pregnant women when asked to come with their partners during the next ANC visit dropped out and also the study by Kasolo and Ampaire in which they argued that poor knowledge of what is done at the health facility coupled with poor communication among spouses and the low status of women in the community greatly affect women's utilization of ANC services in Uganda.[22, 23] In order for women to be able to access and utilize ANC services, male involvement needs to be emphasized at all levels of ANC delivery.

Delivery care service

Studies have also shown that the presence of husbands in the labour room shortens the labour, reduces pain, panic and exhaustion of the women **.[24]** However, it is widely recognized that men are often marginalized by the maternal health care provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to promote their own health as well as that of their families. Koisa reported that most men do not actually accompany their partners to antenatal care consultations or during labour or delivery[25]. Part of the reason for the low male involvement have come a long way with the traditional approach of health workers, coupled with notices in the health care premises, for example "men are not allowed in the labor ward" which discourage men from giving support to their wives in ANC and labor [26].

Ethiopia where conservative gender norms prevail, the husband is the one to have the most powerful say even to woman´s health care use .[15] According to the study by Warren , also the decision about the location for the birth is usually made by the husband (or partner). In addition, other extended family members like mother-in-law and sister-in-law might get involved in the decision-making[27].

Postnatal care service

In Ethiopia according to EDHS 2011 Just 7 percent of women received postnatal care in the first two days after their last delivery in the two years before the survey. The most important barrier to access to health services that women mention is taking transport to a facility (71 percent), followed by lack of money (68 percent) and distance to a health facility (66 percent).[13]

Study done in Uganda showed 74 percent of the women who deliver in Uganda receive no postpartum care at all .([28], [7]) If men are well sensitized about postnatal care services and their concerns addressed, the number of mothers seeking post natal care is likely to increase.

It is important therefore for all stakeholders to realize that maternal health is not just a woman's issue because a mother's health has a direct bearing on the health of her newborn.

Factors affecting Male Involvement in Maternal Health Care Services

A number of factors have been reported by several researchers as being responsible for influencing male involvement in maternal health care services. Some of which are noted in the paragraphs that follow in this segment.

Socio demographic factors A cross-sectional study covering 380 male partners and their spouses was conducted in Busia district in Western Kenya to establish demographic, socio-economic and cultural factors that affect male partner participation in promoting deliveries by skilled attendants. The studies showed a significant relationship between level of education, occupation and level of income of the male partner and his support for skilled delivery. [26, 29, 30]

Most studies reported that older age and cohabiting were associated with male involvement. [31] A study in Uganda found that men who had completed 8 or more years of education were twice more often involved compared with those with less than 8 years of education . [32]

Study conducted in Kinshasa and Tanzania found male involvement was 1.2 times higher among men whose female partners were 25 years or older.[33] Another study done in Ethiopia showed there is an association between number of children and male partner involvement on maternal health care service. [6]

Cultural factors: Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a nurse or doctor is viewed as a sign of weakness. Many men feel it is their right to refuse contraception, to allow their partners or even discuss FP [1]. Communication: Poor communication between men and their female partners was associated with poor male involvement **Error! Reference source not found.**.

Study done in Kinshasa revealed that Monogamous partners and co-habiting men were twice and 1.6 times respectively more likely to be involved [33].

Yet in many situations in Africa where the man is economically in position to provide the basic necessities of life he tends to have more than one wife, which also negatively affects his willingness and ability to escort the wife to seek care. Multiple partner relationships promotes different interests for the man and his partners and this will hamper possibilities for transparent decision making on maternal health service issues in addition to involvement in maternal health services of all his wives when needed [6].

Health service factors: Generally research shows that service related factors are more important than user related factors in affecting male involvement in maternal health care services. The most important ones pointed out include, long physical distance from the health unit, lack of transportation, inconvenient clinic hours, long waiting time at the clinic, poor technical and interpersonal skills. The situation is worsened by the fact that information received from health workers on maternal health care is primarily aimed at women as was reported by UNFPA in several developing countries that women not men were the targets of reproductive health programs yet most of them are not financially or culturally positioned to make decisions about these issues without consulting their husbands. This may actively discourage men from participating in maternal health care services by the structure of services or by attitudes of health care workers [12, 37].

Financial constraints of clients and health facilities have been identified as impacting health services uptake and male participation [34]. Frequently women have to wait for a long time before receiving ANC services because of burdensome administrative procedures which result in poor patient/client through-put in health facilities. Men, who frequently are in the paid workforce, are often not in a position to spend virtually the entire day participating in ANC services [32].In Turkey, it was observed that health care workers were not supporting men who wanted to join in maternal health services, the same study noted that a lot of men come to the clinic with their wives ‘but it stops at the door [33].

However despite the benefits of male involvement in maternal health care services, the majority of studies on maternal health care such as pregnancy and child birth in most countries have been exclusively focused on women. Yet it is important to assume that for all the steps leading to maternal survival there is always a man standing by the side of every woman knocking at the gate, before, during and after each pregnancy.

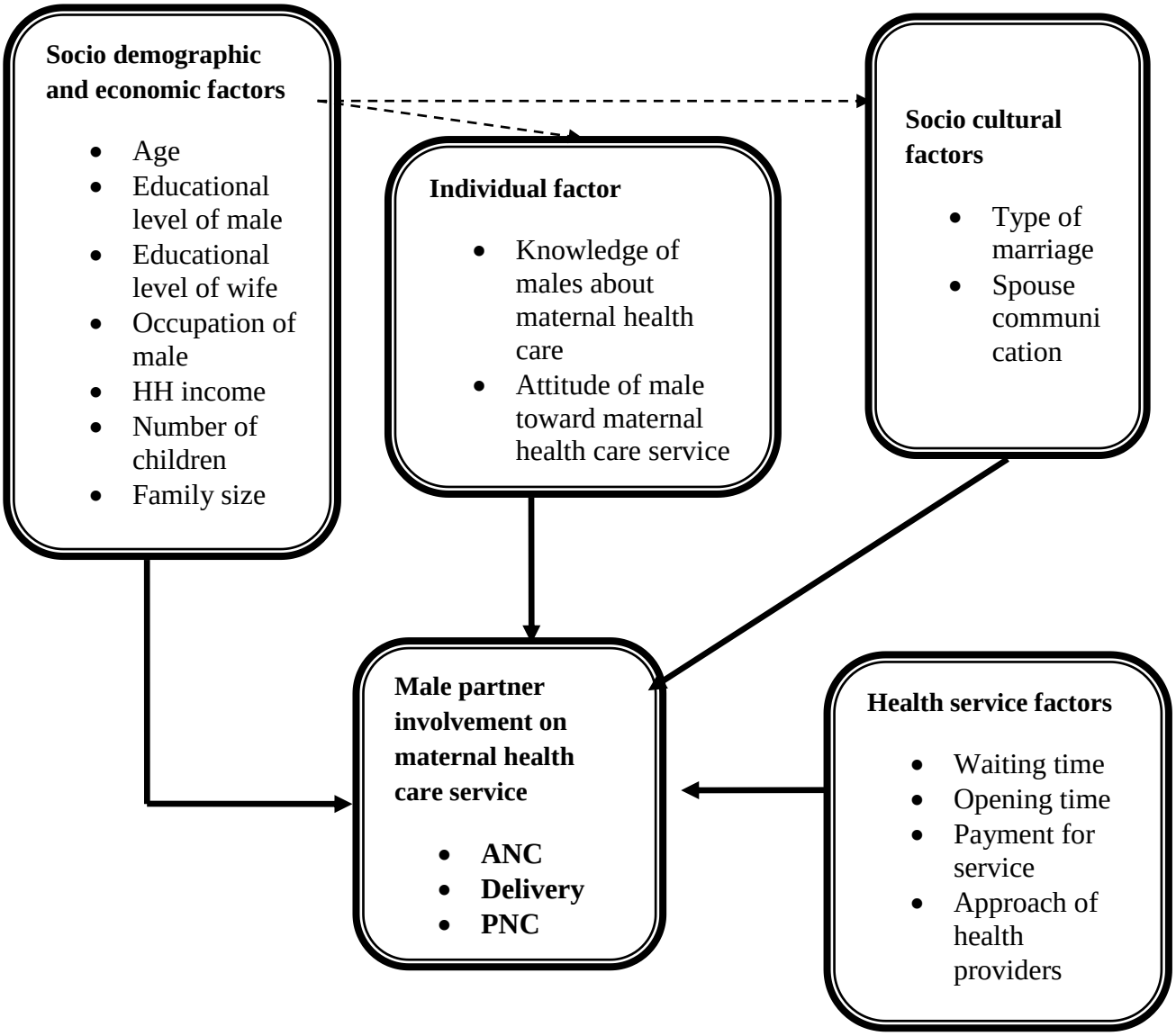

Figure 1 conceptual frame work of factors associated with male partner involvement on maternal health care service in Shashemene town,2014

Significance of the study

Although pregnancy is not an illness, it creates a lot of physical and emotional demands on the mother. The husbands as well as other family members need to understand and appreciate the discomfort and tiredness that pregnancy may cause to the pregnant woman.

With high levels of maternal mortality persisting in developing countries, especially in Africa, there is increasing interest in identifying ways through which women can access appropriate care to prevent deaths during pregnancy. Although the emphasis in global reproductive health programming in developing countries has mainly focused on educating women about issues such as maternal health care, there is increasing interest in involving men in maternal health care. There is a growing belief that the role of men in the access of care is very relevant given their large role in family decision making.[38]

The aim of this study is to contribute to better understanding of the factors that make men get involved in ANC, delivery and postnatal care service. Information generated will be used by Shashemene town health office and other partners working on maternal health care to provide decision-making and actions that will lead to increased male involvement in maternal health care services. Increased male involvement in maternal health care services will subsequently, lead to increased utilization of maternal health services by the pregnant women, mothers and their children. This will contribute to reduction in maternal and infant mortality in shashemenne town.

Chapter three: Objective

General Objective

To assess male involvement in maternal health care service and associated factors in Shashemene town, Oromia region,2014.

Specific Objective

- To determine the proportion of males who involve in antenatal care service in shashamane town
- To determine the proportion of males who involve in delivery care service in Shashemene town.
- To determine the proportion of males who involve in post natal care service in Shashemene town.
- To identify factors related with the males partner involvement in maternal health care services in Shashemene town.

Chapter four: Method and materials

4.1 Study area and period

The study was carried out in Shashemene town, Oromia region which is located in the southern part of Ethiopia about 250 kilometers (Km) from the capital city of Ethiopia. The study was carried out in urban part. The town has eight kebeles with total population of 134,344.In Shashemene town there are more than 41 health facilities. Among this five (3=health center, two hospitals) of them are governmental.

Maternal health care services in the town are delivered through a network of a total of 15 health units some of which are owned by Non Governmental organization and the other are government owned.

This study was conducted from April 1-30/2014.

4.2 Study design

Cross sectional community based design was used .The study was employed quantitative method.

4.3 Source population

The source population was comprised of all men in the study area, who were married or had ever been married and their wife had at least one history of pregnancy.

4.4 Study population

Men those full fill inclusion criteria and selected as sample in the study area

4.5 Inclusion criteria

Male who was consented to participate in the study and had fathered at least one child in the one year preceding the study, to cater for recall period, and his wife had at least one follow up at health institution during pregnancy/delivery/PNC and residents for six months or more to cater for familiarity and knowledge of the services provided was requested to participate in the study.

4.6 Exclusion criteria

Study participant who are sick and unable to sustain an interview.

4.7 Sample size

To determine sample size, proportion (p) from male partner involvement on ANC, delivery & PNC were identified from literature and p that give large sample size (p of male partner involvement on ANC which is 43% from the study done in Ethiopia [6]was used.

The sample size was calculated using

$n = \frac{z^2 \times p \times q}{d^2} = \frac{(1.96)^2 X (0.43)(0.57)}{0.05^2} = 376$

z =1.96= z value for 95% confidence limits

p=0 .43 = proportion of men involved in maternal health care.[6]

q = 1-p = 1-0.43 = 0.57

d = 0.05 is the acceptable error of the estimator at 95% confidence level.

Since target population is less than 10,000 by using correction formula n/1+n/N=329

Adjustment for possible non-response

10% non respondents , (329 x0.1)+329 = **362**

4.8 Sampling procedure

In this community based study multistage sampling technique was used.

Out of the 8 kebeles in the town 4 (50%) of them selected by using simple random sampling. The decision to sample 4 kebele is guided by the assumption that information generated from the kebeles will representative of the whole town. The process was involved writing the names of the kebeles on pieces of paper, folding papers putting them in a container and vigorously shaking the container after which one piece of paper was picked without replacement until four kebeles selected. A total number of male partner(1508) full fill inclusion criteria of the study in four selected kebele was identified by census. And number of males included on the interview was allocated proportionally for selected kebeles and Finally participants was selected by using simple random sampling technique which was lottery method.

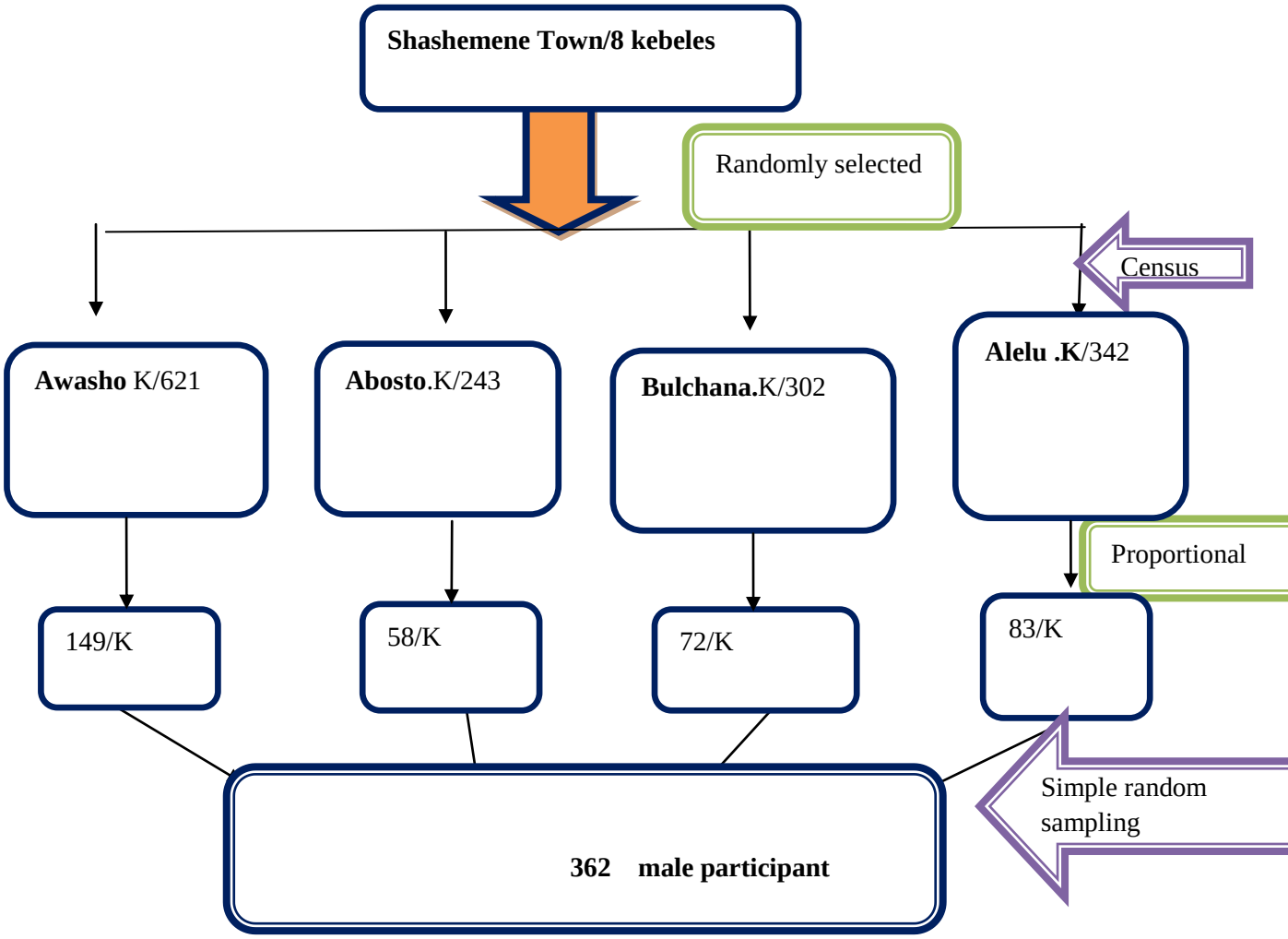

Figure 2 Sampling procedure that used on the study of male partner involvement in maternal health care service and associated factors in Shashemene town , 2014

4.9 Study variables

4.9.1 Dependent variable

Male involvement in maternal health care service

4.9.2 Independent variables

Socio -demographic characteristics ; age of the man, education level of the male, number of children, Family size, occupation of male, educational level of wife and HH income.

Individual factors:-Male knowledge and Attitude on maternal health care services.

Socio -Cultural factors :-type of marriage, spousal communication.

Health service factors includes:-Approach of health workers, waiting time, payment for service, and opening time.

4.10 Data collection tool and technique

The study instruments included, individual structured questionnaires which have three parts Socio demography, male partner involvement on maternal health care, and factors(cultural, knowledge, health service and 5 likert scale question was used to measure perception of male toward maternal health care. The instrument is adapted from literatures.[6, 7, 26]

This was used for quantitative data and a face to face interview method of data collection was employed.

4.11 Quality control

Data collection was done by eight male nurses with two environmental health supervisors. Research Assistants were trained for one day such that they became familiar with the statement of the problem, objectives of the study, sampling procedure, data collection tools and plan for data collection. The training was also include interviewing techniques such as asking questions in a neutral manner, not showing by word or actions what answer they were expecting. Questioner was translated to local language in Afan Oromo and Amharic version and back translated to English version by other person.

Pre test was carried out on 5% of total sample size in Shashemene town Burka Gudina kebele which is out of selected kebele . After pre test necessary modification was done. The Research Assistants was participated in pre testing of the study tools. This was served two purposes: the training of the interviewers and a test for clarity of the questionnaires.

Each questionnaire had code and the respondent's number written on it for proper identification and storage. Data collection process was strictly followed by supervisors .The data was checked by the research assistants before closing the day's activities.

4.12 Data analysis

Data was entered, cleaned and checked by using epi- data version 3.1 and later analysis was done by using SPSS version 16.Univariate analysis was conducted for frequency and percentage. Logistic regression with enter method was applied in order to analyze association between dependent and independent variables. Bivariate analysis was employed to select candidate for multivariable analysis, variables those have p-value ≤ 0.25 were selected.

Multivariable analyses was carried out in order to assess the association between dependent and independent variables and variables which have p-value ≤ 0.05 were identified as a predictors. Adjusted odds ratios and 95% confidence intervals were calculated for each of independent variables in logistic regression to observe the strength of association.

Factor analysis was employed For likert scale questions to extract factor represented each of the scale which facilitate treatment of variable as continuous during further analysis. Assumptions are checked, correlation between variables were >0.3,Kaiser-Meyer-Olkin(KMO) measure of sampling adequacy was >0.5 and bartlet test of significance was significant at $p<0.05$ .Eigen value ≥ 1 was taken to select components. All variables were checked for their communality value that is proportion of the variance in the original variables that is accounted for by the factor solution at >0.5 and variables those had <0.5 value was removed from analysis. At the end pattern of factor loading was examined to identify variable that had complex structure, and variable had high loading or correlation ≥ 0.4 on more than one component were removed from analysis. Finally variables were reduced to one component to measure attitude of males toward maternal health care service with chronbachs alpha(reliability coefficient) value of 78% Data was presented by using simple frequency tables and graphs .

4.13 Ethical Consideration

The study was approved by the Jimma University Ethical committee and official letters was written to Shashemene town administrative health office. At the town level, permission to conduct the study was obtained from the local leaders and the town Health Office before conducting the study. Informed consent of each individual participant was obtained at the start of the study. Respondents were read an informed consent form that explained the following 1) the purpose of the study, 2) what participation in the study will involve, 3) How confidentiality and anonymity to be maintained, 4) The right to refuse to participate in the study or to withdraw from the study without any penalty, 5) the benefits and risks of participating in the study. The research team were urged and required to respect the culture of the respondents during the data collection process. Confidentiality and anonymity was maintained by the use of code numbers on the questionnaire other than names. Information obtained were only used for the purposes of this study. The data collected were accessible only to the people involved in the study and the principal investigator stored the questionnaires and other study tools in a lockable filing cabinet.

4.14 Operational definition

Maternal health care service: for purposes of the study refer to antenatal care service, delivery care service and postnatal care service

ANC: Ante-natal care service is care given to a mother and partner during pregnancy

Delivery care : Delivery care service is care given to the pregnant mother after onset of labor until complete expulsion of the baby, placenta and membranes.

Postnatal care: Postnatal care service is health care given to the mother and baby after childbirth up to six weeks..

Male involvement in maternal health care service: is when male partner involved in one of ANC, Delivery, and PNC service.

Male involvement in ANC service: When male accompany his wife at least once during follow up of ANC.

Male involvement in delivery service: When male accompany his wife during delivery service.

Male involvement in PNC service:- When male accompany his wife at least once during follow up.

Knowledgeable about maternal health care service:-When respondents respond greater than median score of knowledge question which included about availability of service, importance of service, and component of service.

Good approach:-when health workers allow males partner to enter to service room.

Long waiting time:-Waiting time >45 minutes to get service.

Good spouse communication:-If spouse discuss and shared decision on maternal health care service

4.15 Dissemination of the study findings

The final report of this study will be presented to the Jimma University collage of Public Health department of population and family health in partial fulfillment for the award of Masters of Public Health in reproductive health of Jimma University. The findings of the study will be presented to Shashemene town health office. Besides, organizations working in this area will be informed to use the findings. Attempts will be made to present the results on scientific conferences and to publish the results of the study on pear reviewed journals.

Chapter Five: Result

5.1 Socio-demographic and economic characteristics

From the total of 362 households, 355 gave complete response to the interview yielding a response rate of 98%.

The mean age of studied men was 36 with (±SD6.4).Majority of respondents 156(43.9%) were 30-39 years of age. 328 (92.3%) of them had monogamous relationship. Nearly 196(55.2%) had education level of primary and above, followed by primary level education 159(44.8%), majority of them 187 (52.7 %) reporting having spouses with primary level of educational status. Majority of them were merchant by occupation, followed by government employed 116(32.7%).Among the respondents 242 (68.2%) of them reported having income of ≥1000.Regarding their religions, most of respondents were orthodox religion followers, followed by Muslim 102(28.7%) and protestant 76(21.4%). The number of children reported by respondent was varied from 1-7, But half of men had 3-4 children 179(50.4%) and followed by ≤2. 136 (38.3). Majority of them responded as having ≤5 family size (**Table** 1).

Table 1 Socio demographic and economic characteristics of respondents and their wife in Shashemene town ,2014

Characteristics	Frequency	Percentage(%)
Age of respondent		
≤29	61	17.2
30-39	156	43.9
≥40	138	38.9
Occupation		
Merchant	133	35.7
Government employed	116	32.7
NGO	51	14.4
Private organization	40	11.3
Other	15	4.2
Educational level of respondent		
Primary level	159	44.8
Post primary level	196	55.2
Educational level of wife		
Primary level	187	52.7
Post primary level	168	47.3
Religion		
Orthodox	128	36.1
Muslim	102	28.7
Protestant	76	21.4
Catholic	40	11.2
Others	9	2.5
HH income		
<500	39	11.0
500-1000	74	20.8
≥ 1000	242	68.2
Number of children		
≤2	136	38.3
3-4	179	50.4
≥5	40	11.3
Family size		
≤5	190	53.5
>5	165	46.5
Type of marriage		
Monogamy	328	92.3
Polygamy	27	7.7

5.2 Male involvement in maternal health care service

The study showed that from 326(91.8%) wife of respondent followed ANC service, 129(39.6%) of the men involved on service, from 333(93.8%) institutional delivery, 199(59.8%) of men involved on service, and among 199(56.1%) of wife of respondent followed PNC service 41(20.6%) of men involved on service. When we saw as general 212 (59.7%) of respondents involved in maternal health care service (**Fig 3**)

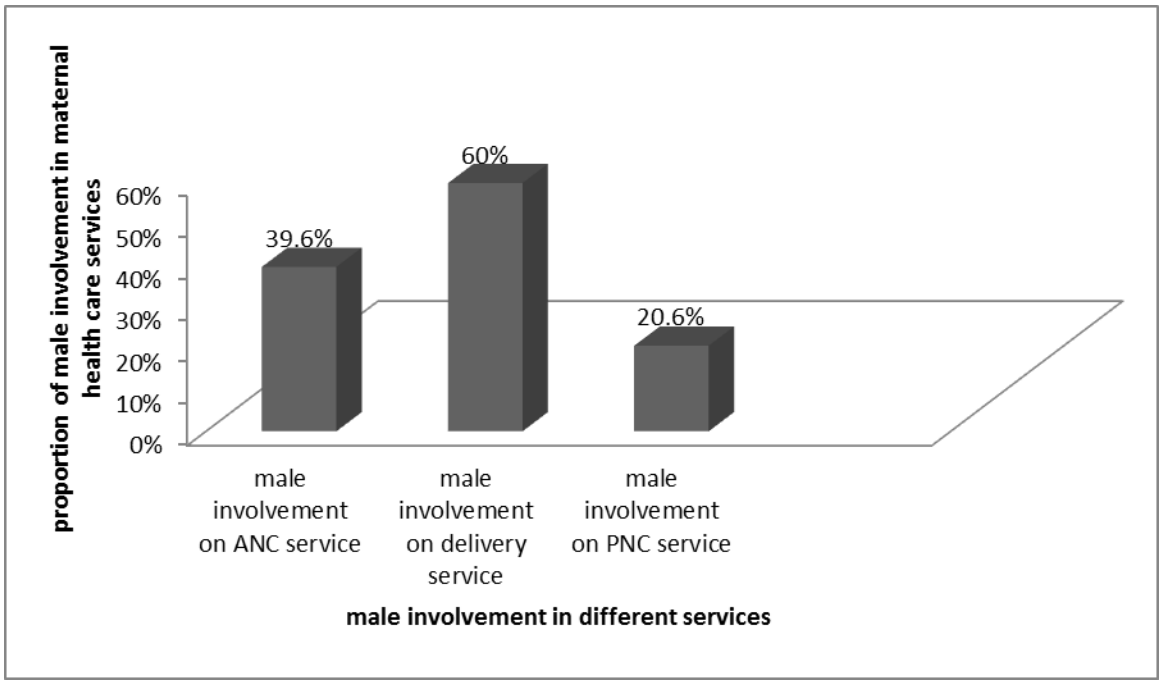

Figure 3 Proportion of Male involvement in maternal health care service in Shashemene town „2014

Joint couple decision-making on maternal health care service was 210(63.1%) for delivery service, 140(42.9%) for antenatal care service and only 49(24.4%) for post natal care service. (**Fig 4)**

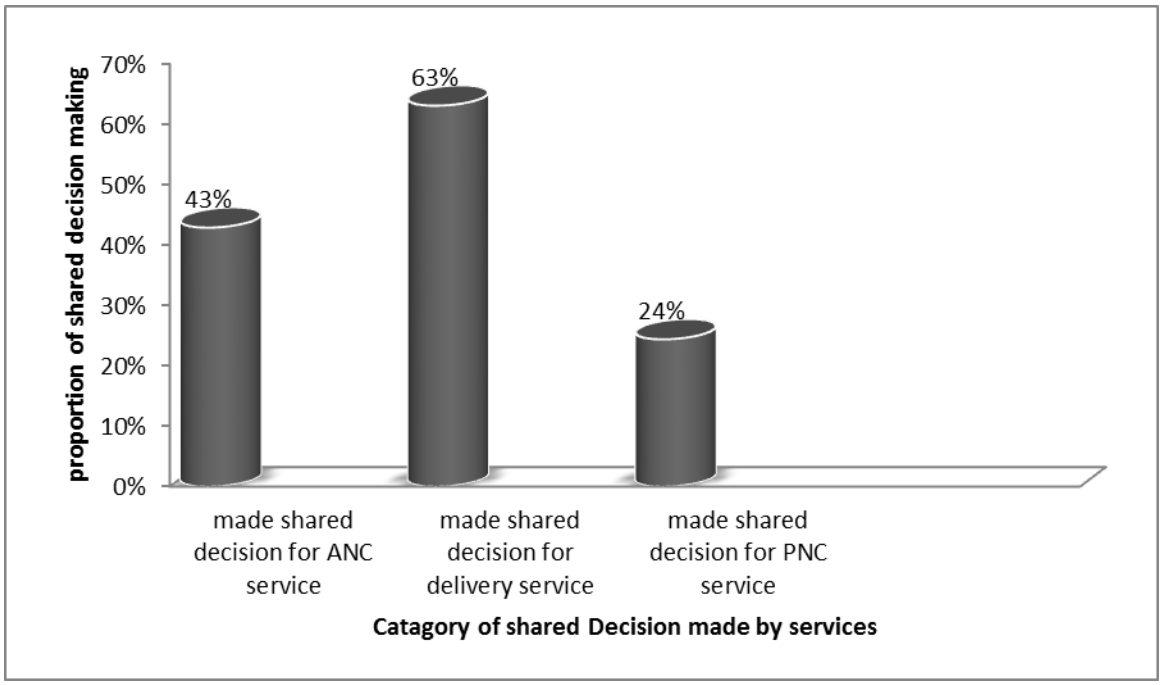

Figure 4 Proportion of respondents made shared decision on maternal health care service in Shashemene town,2014

Regarding financial support made by male to their wife for maternal health care service ,majority of them 286(85.9%) were made support during labor or delivery service, followed by during ANC service 259(79.4%) and PNC service 108(54%).(**Fig 5)**

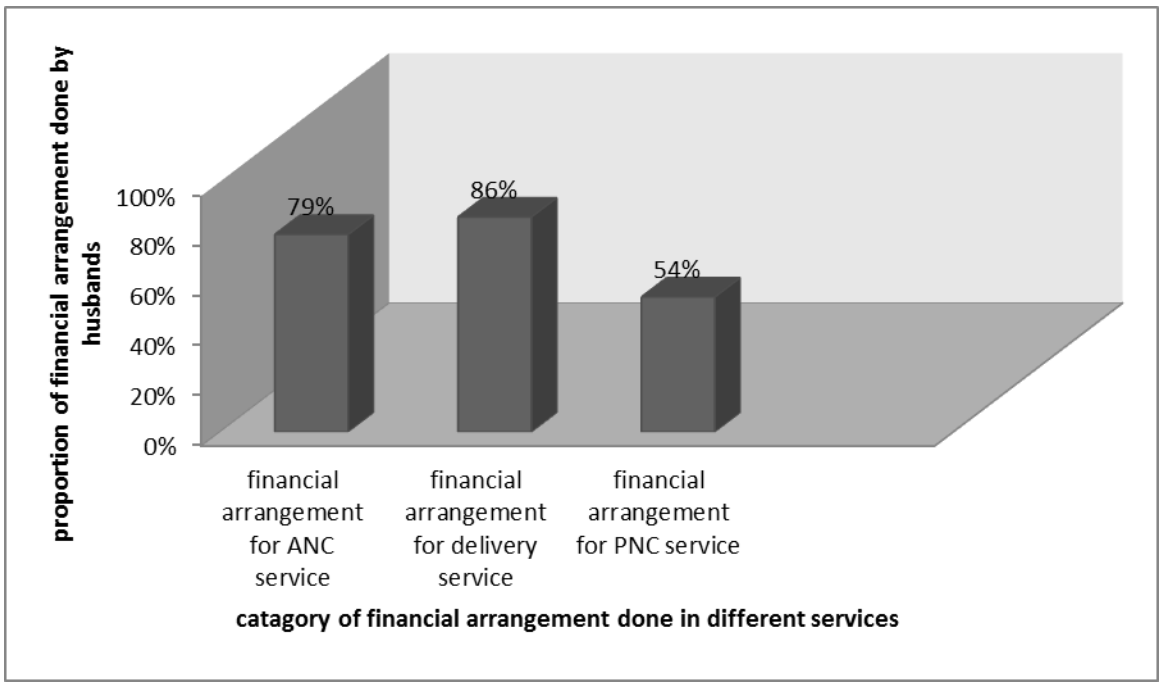

Figure 5 Proportion of respondents made financial arrangement on maternal health care service in Shashemene town,2014

5.3 Knowledge about maternal health care service

The percentage of males who were knowledgeable about services offered during ANC was 176 (49.6%) and 107 (30.1%) during delivery. The percentage of males found to be come knowledgeable about services offered during postnatal were only 95(26.8%).Among these respondents majority of them 327(94%) heard about maternal health care service from health professionals and media. Among respondents about 146(41.1%) of them were knowledgeable about maternal health care services**.** (**Fig 6**)

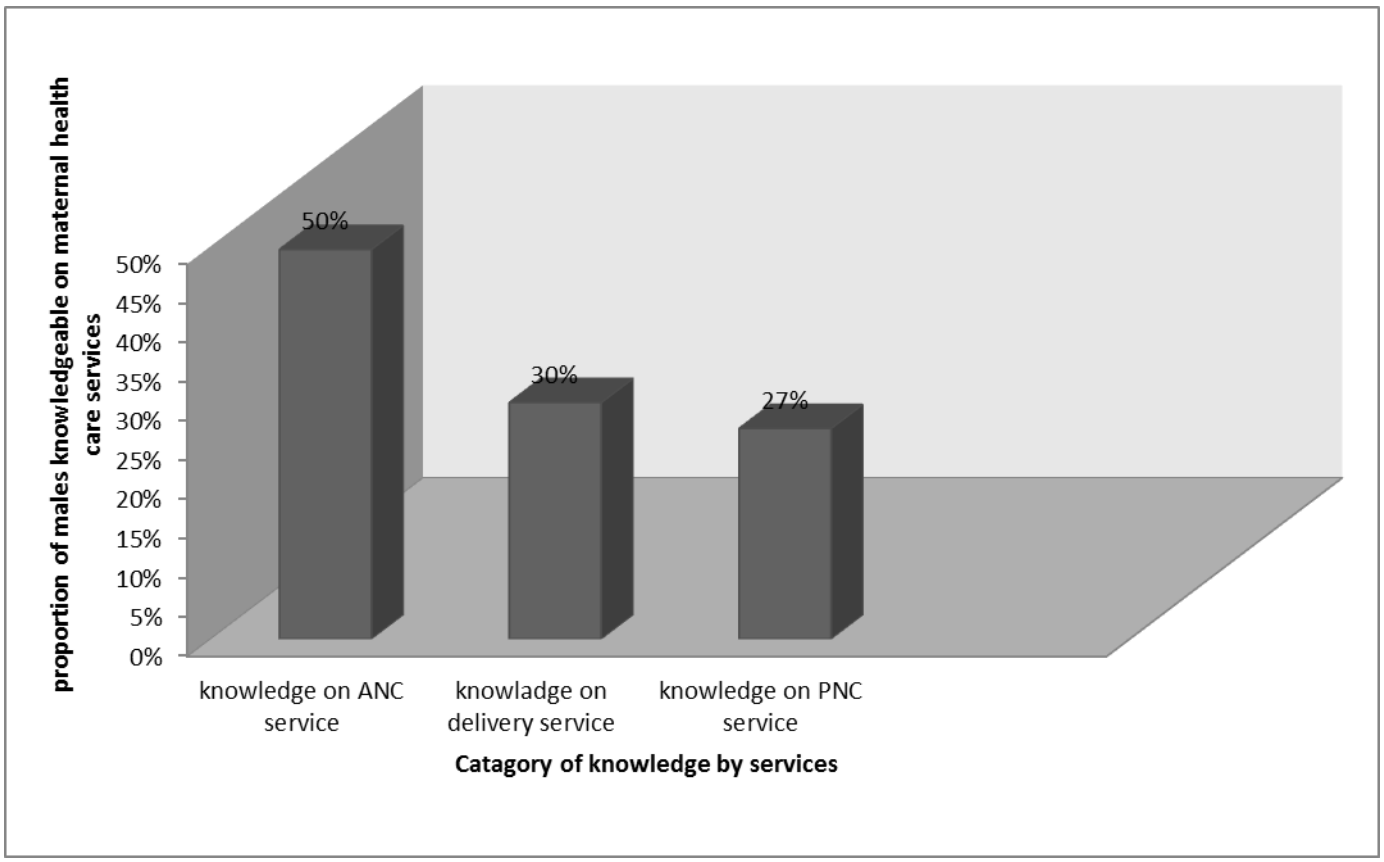

Figure 6 Knowledge of respondents about maternal health care service in Shashemene town,2014

5.4 Attitude toward male involvement on maternal health care service

On Attitude of males toward maternal health care service about 67(18.9%) of them strongly agree and 106(29.9%) of them agree on the idea said pregnancy is natural phenomena no need of male involvement,33(9.3%) were strongly agree and 60(16.9%) were agree on the idea said delivery should takes place at home, on the idea said accompanying wife for service indicates ruled by wife,23(6.5%) of them were strongly agree and 23(6.5%) were agree,68(19.2%) and 48(13.5%) were strongly agree and agree respectively on the idea support women should not go outside after delivery for 45 days and 35 (10%) of respondents were agree on idea support delivery should attended by family member only.

5.5 Health facility factors

About maternal health care service provided in health facilities, majority of respondents 229(64.5%) responded presence of long waiting time before service and also 183 (51.5%) of them responded there is payment for service, As majority of them (73.2%) responded this payment is not affordable. Among respondents 194(54.6%) responded as opening time was not convenient for them. In addition to this most of respondents 237(66.8%) said health providers did not allow for male partners to enter in service room. (**Fig 7)**

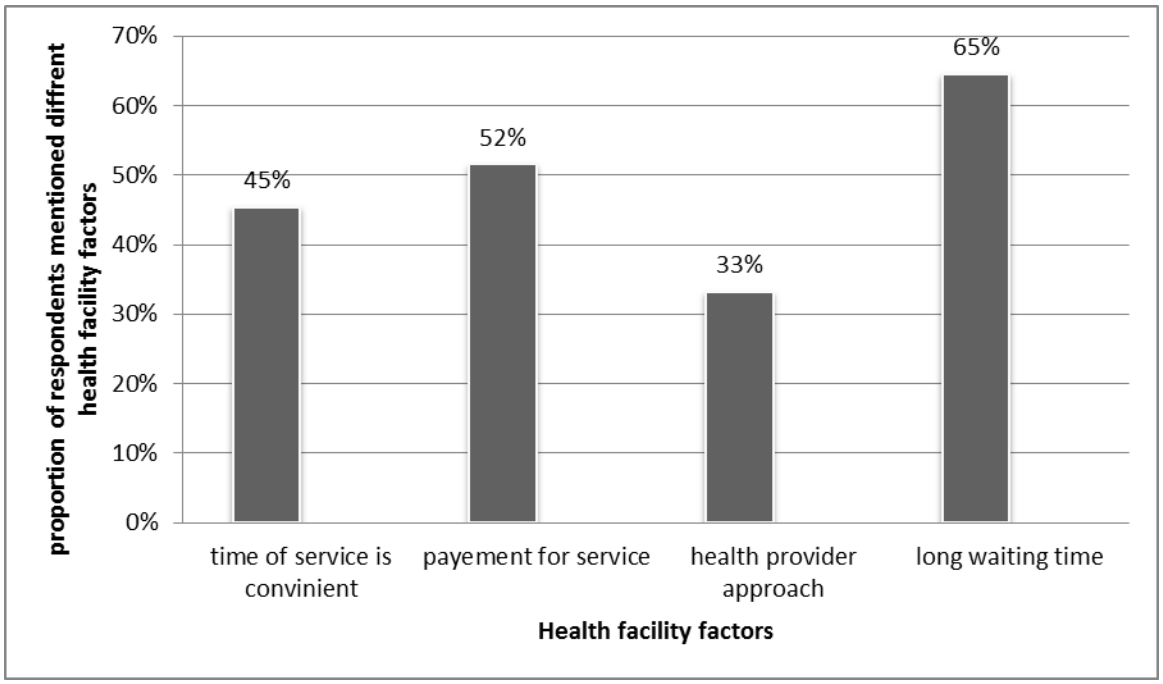

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Figure 7 Health facility factors mentioned by respondents about maternal health care service in Shashemene town , 2014

5.6 Challenges reported by respondents to involve on maternal health care service

Different challenges to involve on maternal health care service were responded by respondents such as:- health professionals forced us for HIV test 125(35.2%),high service payment 72(20.3%),health provider approach 210(59.2%),cultural taboo 76(21.4%),distance of health facility 94(26.5%),long waiting time 224(63.1%), opening time of service is not convenient 270(76.1%).

5.7 Factors associated with male involvement in ANC service

In the bivariate analysis , educational level of respondent, educational level of wife, spouse communication, health facility waiting time, opening time, payment for service , health provider approach, knowledge about ANC service and Attitude of male toward maternal health care service were associated with male involvement in ANC service at significance value of $\leq$0.25. Age of respondents, HH income, Type of marriage, Family size and number of children were not candidate for multivariable analysis. When selected variables adjusted with other variables on multivariable analysis all selected variables were significantly associated with male involvement in ANC service at significance value of <0.05.

The odds for male involvement on ANC service was 8 fold among males educated to more than primary level compared to males educated up to primary level (AOR=8.0,CI:3.5-15.1).Wife educational level appeared as one of predictor for male involvement on ANC service, husband of women educated to more than primary level were 7 times more likely to involve on ANC service in comparison with husband of women educated to primary level (AOR=6.9,CI:3.0-12.7).In addition to this males having good communication with their wife were 3 times more likely to involve on ANC service as compared with those having good spousal communication (AOR=3.4,CI:1.5-7.7). Males who were knowledgeable on ANC service were 8 times more likely to involve on ANC service (AOR=7.8,CI: 3.4-15.0). Regarding Attitude of males to ward service, as negative Attitude increase by one male involvement in ANC service was reduced by 45%.(AOR=0.45,CI:0.2-0.9).Service opening time(AOR=2.6,CI:1.1-6.6),waiting time (AOR=3.4,CI:1.6-7.5),payment for service(AOR=3.9,CI:1.7-8.9) and health provider approach(AOR=11.7,CI:4.7-24.0) were predictive of male involvement in maternal health care service (**Table 2**).

Table 2 Factors associated with male involvement in ANC service in Shashemene town ,2014

	Male involvement in ANC service N(%)			
	Yes	**NO**	**COR(95%CI)**	**AOR(95%CI)**
Educational status of respondent				
Primary level	33(23)	110(77)	1	1
Post primary level	96(52.4)	87(43.2)	3.6(2.2-5.9)	8.0(3.5-15.1)**
Wife education level				
Primary and below	32(19)	136(81)	1	1
Post primary	97(61.3)	61(38.7)	6.7(4.0-11.1)	6.9(3.0-12.7)**
Spouse communication				
Poor	33(23.4)	108(76.6)	1	1
Good	96(51.9)	89(48.1)	3.5(2.17-5.7)	3.4(1.5-7.7)*
Opening time				
Not Convenient	93(60.4)	61(39.6)	1	1
convenient	36(21)	136(79)	5.7(3.5-9.3)	2.6(1.1-6.6)*
Waiting time				
Long	58(27.9)	150(72.1)	1	1
Short	71(60.1)	47(39.9)	3.9(2.4-6.2)	3.4(1.6-7.5)*
Payment for service				
Yes	45(25.9)	129(74.1)	1	1
No	84(55.2)	68(44.8)	3.5(2.2-5.6)	3.9(1.7-8.9)**
Health provider approach				
Poor	53(23.5)	172(76.5)	1	1
Good	76(75.2)	25(24.8)	9.8(5.7-17.0)	11.7(4.7-25.0)*
Knowledge about service				
Not Knowledgeable	40(25)	120(75)	1	1
Knowledgeable	89(53.6)	77(46.4)	3.4(2.1-5.5)	7.8(3.4-15.0)**

is p<0.05,P<0.001, Overall relationship model chi-square was significant P<0.001,Husmer and Lemeshow goodness of fit=0.71,at p value>0.05.*

5.8 Factors associated with male involvement in delivery service

In the bivariate analysis educational level of respondents, educational level of wife, type of marriage, spouse communication, Health facility opening time, health provider approach, knowledge about delivery care service and Attitude of male toward maternal health care service were significantly associated with male involvement in delivery service at significance value of ≤0.25. On multivariable analysis adjusting for other significant factors altered the picture, and educational level of wife, spousal communication, Type of marriage, health provider approach , knowledge about service and Attitude toward delivery service could be interpreted as predictors for male involvement on delivery service at p-value of <0.05.

Respondents having wife educated to more than primary level were 6 times more likely to involve on delivery service than those having wife educated to below primary level(AOR=5.8,CI:3.0-10.1).Study revealed that respondents having good spousal communication were 4 times more likely to involve in delivery care service (AOR=3.6,CI: 1.9-6.5).Respondents who had monogamy relation were 4 times more likely to involve in delivery care service as compared with those had polygamy relation (AOR=3.9,CI:1.2-12.7). Health provider approach (AOR= 6.2, CI:3.1-12.4) was the factor associated with increase likely hood of male involvement on delivery care service. Looking at knowledge and Attitude toward delivery care service, respondents who were knowledgeable on delivery care service were 4 times more likely to involve on delivery care service as compared with those not knowledgeable (AOR=3.6,CI:1.8-7.3), And as negative Attitude increase by one, male involvement on delivery service was decrease by 6.3%(AOR=0.063,CI:0.008-0.48**).(Table 3)**

Table 3 Factors associated with male involvement in delivery care service in Shashemene town,2014

	Male involvement in Delivery service N(%)			
	Yes	**NO**	**COR(95%CI)**	**AOR(95%CI)**
Educational status of respondent				
Primary level	77(51.3)	73(48.7)	1	1
Post primary level	122(66.6)	61(33.4)	1.8(1.2-2.9)	1.5(0.8-2.8)
Wife education level				
Primary and below	72(41.6)	101(58.4)	1	1
Post primary	127(79.3)	33(20.4)	5.4(3.3-8.7)	5.8(3.0-10.1)**
Spouse communication				
Poor	61(41)	88(59)	1	1
Good	138(75)	46(25)	4.3(2.7-6.9)	3.6(1.9-6.5)**
Type of marriage				
Polygamy	6(23)	20(77)	1	1
Monogamy	194(63.4)	112(36.6)	5.6(2.2-14.4)	3.9(1.2-12.7)*
Health provider approach				
Poor	105(45.6)	125(54.3)	1	1
Good	94(91.2)	9(8.8)	12.4(5.9-25.9)	6.2(3.1-12.4)*
Knowledge about service				
Not Knowledgeable	76(47.2)	85(52.8)	1	1
Knowledgeable	123(71.5)	49(28.5)	2.5(1.4-4.3)	3.6(1.8-7.3)**

is p<0.05,P<0.001,Overall relationship model chi-square was significant P<0.001, Husmer and Lemeshow goodness of fit=0.8,at p value>0.05.*

5.9 Factors associated with male involvement in post natal care service

In the bivariate analysis educational level of respondents, educational level of wife, spouse communication, payment for service ,knowledge about PNC service and Attitude of male toward maternal health care service were selected as candidate for multivariable analysis at p $\leq$0.25. On multivariable analysis educational level of respondents, educational level of wife, , knowledge about service and Attitude could be interpreted as predictors for male involvement in PNC service at p-value of <0.05.

Respondent with post primary educational level were 5 times more likely involved in PNC service as compared with primary level(AOR=6.1,CI: 2.3-15.4).Males having wife educated to more than primary level were 6 times more likely to involve in PNC service than those having wife educated to below primary level(AOR=7.6,CI:2.5-21.0).Knowledge about service(AOR=2.4**,**CI:1.1-5.4) and Attitude toward service (AOR=0.7,CI:0.4-0.9) were factors found to be predictive for male involvement in post natal care service.(**Table 4**)

Table 4 Factors associated with male involvement in post natal care service in Shashemene town, 2014

	Male involvement in PNC service N(%)			
	Yes	**NO**	**COR(95%CI)**	**AOR(95%CI)**
Educational status of respondent				
Primary level	7(4.6)	86(95.3)	1	1
Post primary level	37(31.6)	76(68.3)	5.4(2.3-13.1)	6.1(2.3-15.4)**
Wife education level				
Primary and below	5(5.4)	87(74.4)	1	1
Post primary	36(32.4)	75(67.6)	8.3(3.1-22.3)	7.6(2.5-21.0)**
Spouse communication				
Poor	30(25.6)	87(74.4)	1	1
Good	11(12.8)	75(87.2)	2.3(1.1-5.0)	2.0(0.8-4.7)
Payment for services				
Yes	16(15)	89(85)	1	1
No	25(25.5)	3(74.5)	1.9(0.9-3.8)	1.0(0.4-2.2)
Knowledge about service				
Not Knowledgeable	19(14.5)	11(85.5)	1	1
Knowledgeable	22(30.5)	50(69.5)	2.5(1.2-5.2)	2.4(1.1-5.4)*

is p<0.05,P<0.001,Overall relationship model chi-square was significant P<0.001, Husmer and Lemeshow goodness of fit=0.65,at p value>0.05.*

5.10 Factors associated with male involvement in maternal health care services

In the bivariate analysis , educational level of respondent, educational level of wife, spouse communication, type of marriage, health facility waiting time, opening time, payment for service, health provider approach, knowledge about maternal health care service and Attitude of male toward maternal health care service were associated with male involvement in maternal health care service at significance value of $\leq$0.25. When selected variables adjusted with other variables on multivariable analysis except educational level of husband, payment for service and waiting time, all selected variables were significantly associated with male involvement in maternal health care services at significance value of <0.05.

Respondents who had wife educated to more than primary level were 6 times more likely to involve in maternal health care service than those having wife educated to below primary level(AOR=6.5,CI:3.5-11.9).Males had monogamy relation were 3 times more likely to involve in maternal health care services as compared with those had polygamy relation(AOR=3.1,CI:1.1-9.6).In addition to this males who had good spouse communication were 3 times more likely involve in maternal health care service (AOR=3.2,CI;1.8-5.8).Health facility factors such as opening time(AOR=2.4,CI:1.2-4.6) and health provider approach(AOR=4.7,CI:2.3-9.6) were predictive variables for male involvement in maternal health care service.Knowledge about service (AOR=2.7**,**CI:1.4-5.2) and Attitude toward service (AOR=0.7,CI:0.5-0.8) were factors found to be predictive for male involvement in maternal health care service (**Table 5).**

Table 5 Factors associated with male involvement in maternal health care service in Shashemene town,2014

	Male involvement in maternal health care services N(%)			
	Yes	**NO**	**COR(95%CI)**	**AOR(95%CI)**
Educational status of respondent				
Primary level	79(49.6)	80(50.4)	1	1
Post primary level	133(67.9)	63(32.1)	2.1(1.4-3.2)	1.3(0.7-2.4)
Wife education level				
Primary and below	74(39.5)	113(60.5)	1	1
Post primary	138 (82.1)	30(17.9)	7.0(4.2-11.4)	6.5(3.5-11.9)**
Type of marriage				
Polygamy	6(23)	20(77)	1	1
monogamy	206(62.6)	123(37.4)	5.5(2.1-14.2)	3.1(1.1-9.6)*
Spouse communication				
Poor	66(42.9)	88(57.1)	1	1
Good	146(72.6)	55(27.4)	3.5(2.2-5.5)	3.2(1.8-5.8)**
Opening time				
Not Convenient	86(44.3)	108(55.7)	1	1
convenient	126(78.3)	35(21.7)	4.5(2.8-7.2)	2.4(1.2-4.6)*
Waiting time				
Long	118((50.2)	111(49.8)	1	1
Short	94(74.6)	32(25.4)	2.7(1.7-4.4)	1.6(0.8-3.1)
Payment for service				
Yes	96(52.4)	87(47.6)	1	
No	116(67.4)	56(32.6)	1.8(1.2-2.8)	1.6(0.3-1.9)
Health provider approach				
Poor	112(47.3)	125(52.7)	1	1
Good	100(84.7)	18(15.3)	6.2(3.5-10.8)	4.7(2.3-9.6)**
Knowledge about service				
Not Knowledgeable	97((46.4)	112((53.6)	1	1
Knowledgeable	115(78.8)	31(21.2)	4.2(2.6-6.9)	2.7(1.4-5.2)**

is p<0.05,P<0.001,Overall relationship model chi-square was significant P<0.001, Husmer and Lemeshow goodness of fit=0.76,at p value>0.05.*

Chapter Six: Discussion

6.1 Male involvement in maternal health care service

The study revealed that the proportion of males who involve on ANC service, delivery and postnatal care service was relatively low at 39.6 % , 59.8% , 20.2% respectively.

This study is consistent with recent studies that have shown low male involvement in maternal health care services. The study done in Uganda revealed that 42.7% of the males involved during ANC service[7] and 43% on recent study done in Ethiopia at national level[6] , but male who involved for delivery service in our study is relatively higher compared to 43.4% reported in Uganda and 27.1% reported in Nigeria[7, 36]. This is may be due to our study was focus on only urban area. However the proportion of males who accompanied the wife for PNC in this study was lower than in Uganda [7].This may be due to lower awareness and utilization of PNC service in this study when compared with study done in Uganda.

According to this study, joint couple decision-making is high for delivery service and ANC, while low for PNC service at 24.4%. The findings differ from findings of Uganda, Nepal and India[7, 19] [35]In the study conducted in Uganda reported a 62.7% joint decision-making on ANC service,32.5% on delivery service and 66.6% on PNC service ,[7] while in Nepal 75% of the sampled women reported discussing with their husbands on ANC service[19] and in India a 71% joint couple decision-making on maternal health issues was reported[35] . Comparatively lower level of male involvement in decision-making on maternal health care services in this study, contrasts with that in Uganda, Nepal and India. This is probably due to the low level of wife education of respondents and cultural difference between countries.

6.2 Knowledge of males toward maternal health care service

Regarding knowledge of male about maternal health care service, majority of them had awareness on maternal health care service, But only 41.1% of respondents had comprehensive knowledge, which was 49.6% for ANC,30% for delivery service and only 27 % for PNC service. This finding is not different from recent study done in Nigeria which was 46% comprehensive knowledge on maternal health care[36, 39] and study done in Kenya revealed that 25% knowledge on delivery service this also relatively the same with this study**[26].**

6.4 Health facility factors

Regarding maternal health care service provided in health facilities, majority of respondents 64.5% responded presence of long waiting time before service, which is higher compared with the study done in Uganda 45%**[7],** this is may be due to load difference in urban and rural setting. And also 51.5% of them responded there is payment for service, As majority of them 73.2% responded this payment is not affordable. This finding is relatively lower when we compared it with 61% in the study done in Kenya **[26]**.This is may be due to starting of free service for maternal health care services in Ethiopia. In this study 54.6% of respondents said that opening time was not convenient for them. This is may be majority of them were merchant and This finding also consistent with the study done in Cameron which was 58% **[29].**

6.5 Factors associated with male involvement in maternal health care service

6.5.1 Factors associated with male involvement in ANC

The study revealed Male involvement in ANC was significantly associated with educational level of husband. Husbands educated to more than primary level were 8 times more likely to involve in ANC service. Education also enables men to discard the negative attitudes and cultural beliefs, and it is also likely that men with high level of education have some formal employment which enables them to raise funds that they can use to pay bills for services. This finding was agree with the study done in Uganda and Ethiopia [6, 7] **.** Wife educational level appeared as one of predictor for male involvement in ANC service. This finding was similar with the study done in Ethiopia ,Uganda and Nepal [6, 7, 19]. In addition to this males involvement on ANC service was associated with spouse communication, having good communication with their wife were 3 times more likely to involve in ANC service. This finding was agree with study done in Uganda . **[7].** According to this study, waiting time at the health facility of more than 45 minutes was associated with male involvement in ANC service. This is also similar with the study done in **,** Laumu county and Omoro county and Uganda. Study in Uganda revealed that short waiting time at the health facility was predictive of increased male accompanying the wife for Antenatal care (AOR 3.28, 95%CI 1.83-5.87). **[7, 28, 30] .** It is possible that if waiting time at the health facility were reduced it will result in increased male accompanying the wife for Antenatal care. This is because many men have long working hours and long waiting time makes it difficult to find time off to attend maternal health services. Payment which is not affordable was found to be another predictor for male involvement in ANC service. This also similar with the study done in Uganda and laumu county[7, 28].This is may imply Husbands could have fear of being embarrassed in case they fail to pay for supplies and drugs during service. Service opening time also significantly associated with male involvement in ANC service this is similar with the study done Cameron[37]. Health provider approach was predictive of male involvement on maternal health care service. This is consistent with the study done in India According to the study harsh, critical language directed from skilled health professionals was a barrier to male participation. This study

also suggested Harsh treatment of men by health providers discouraged them from returning or participating in service, Furthermore , some providers did no t allow men access to AN C settings[35]. Male's knowledge about ANC service were significantly associated with male involvement in ANC service. This is may be due to as males could understand complication related to pregnancy and advantage of ANC service they could involve in service This is similar with the study done in Nigeria [36] **.**In this study occupation, Religion, Age of husband, Number of children and family size were not significantly associated with male involvement in ANC service ,But these variables were significantly associated in the study done in Ethiopia and Uganda [6, 7] .This is may be due to difference on source population this study did not include rural and selected males who had <1 infants.

6.5.2 Factors associated with Male involvement in delivery service

Educational level of wife was significantly associated with male involvement in delivery service, males having wife educated to more than primary level were 6 times more likely to involve on delivery service than those having wife educated to below primary level. Educated women could have higher receptivity to new health-related information, access to financial resources and , more control over resources within the household and wiser spending, better communication with the husband and more decision-making power that help them to discuss and made couple decision and increase husband involvement in service as compared with women educated to lower level. This finding is consistent with the study done in Uganda [7] .Educational level of males were not significantly associated with male involvement in delivery service ,But it significantly associated in study done in Kenya Busia district [26] **.**This is may be due to difference of sample size**.** Also occupation was not significantly associated with male involvement in delivery, this is consistent with study done in Uganda [7]

Spouse communication was associated with increased likely hood of male involvement in delivery service. This is relatively the same with the study done in Uganda which was male involvement increased in males having good communication with their wife [7]**.** The positive associations between joint decision-making and male involvement imply

that couple Communication and shared negotiation strategies can improve health practices. According to this study, the fact that health workers don't allow men entry into the delivery room was responsible for some men not accompanying their partners for delivery care service. Similar findings were reported in the study carried out in South Africa. In South Africa, some men indicated that even when men accompanied their partners to the clinic, they generally waited from outside[29].

Age of males was not significantly associated with male involvement, this finding was agree with study done in Kenya [26]. This study revealed that Type of marriage was associated with male involvement in delivery service, males had monogamy relation were 4 times more likely involve in delivery service ,this result is in line with the study done in Uganda and south Africa [7, 29].study in South Africa revealed that men in polygamy relationships are always detached from their wives because they are supposed to remain impartial across their marriages.

6.5.3 Factors associated with male involvement in PNC

Educational level of male, educational level of wife, knowledge about service) and perception toward service were factors found to be predictive for male involvement in post natal care service. study done in Uganda revealed similar result which was educational level of male and wife were significantly associated with male involvement in PNC service [7] **.**

Limitation of the study

- Due to limited number of literatures some variables were not discussed or compared with other studies.
- Male involvement in maternal health care service and associated factor was not discussed due to absence of similar study and for comparison purpose the three services were analyzed independently.

Chapter Seven: Conclusion and Recommendation

Conclusion

Although a high proportion of males in the study made financial arrangement for maternal health care service, the number of males who discuss and make joint couple decision on maternal health care service and who accompany their partners for ANC, delivery and postnatal care was low.

Factors that were found to be associated with male involvement in ANC were, educational level of husband, educational level of wife, spouse communication, health facility waiting time, opening time, health provider approach, knowledge about ANC service and attitude .Factors associated with male involvement in delivery service were, educational level of wife, spousal communication, Type of marriage, health provider approach, knowledge about service and Attitude toward delivery service. Educational level of respondents, Wife educational level, knowledge about service and Attitude toward PNC service were identified as predictors for male involvement in PNC service.

Factors that were found to be associated with male involvement in maternal health care service were, educational level of wife, Type of marriage, spouse communication, health service opening time, , health provider approach, knowledge about service and Attitude .

Recommendations

Health centers should

- Take steps to raise knowledge and change attitude of males on the maternal health care services and benefits of male involvement in maternal health care services.

- Strengthen health education on male involvement on maternal health care service and harm full traditional practice (like: polygamy).

- Send invitation letter to husbands of mothers who came for maternal health care services to improve spouse communication and male involvement in maternal health care service.

Town health office should

- Sensitize health professionals on maternal health care service provided to men who accompany their partners.

- Follow health facilities for full implementation of free service for all maternal health care services.

- Ensure presence of sufficient number of health professional as needed in facilities to reduce waiting time.

Town Education office should

- Should be encouraged both girls and boys to stay in school beyond the primary level for sustainability of increased male involvement in maternal health care services.

For researchers

- In the presence of urban health extension professionals, Knowledge of males toward maternal health care was poor. Establishing the contributing factors to this finding need to further be investigated to establish the messages health workers give to the men at household level and health facility.

References

1. Health, E. Men as partners Johannesburg 2008 [cited 2014 March 25].
2. International, F.C., The safe motherhood Action Agenda; priorities for the next decade, report on safe motherhood technical consultation Colombo. Sri Lanka October 1992. 18-23.
3. Kakaire, O., Kaye, D.& Osinde, O. , Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. . Reproductive health, 8, 12. , 2011.
4. UNFPA, Investing in people: National progress in implementing the ICPD Program of action. 1994-2004.
5. (ICPD)cairo, Frameworks on Male Involvement in Reproductive Health. 1994.
6. Paavilainen, M., men´s socio-demographic background and maternal health care utilization in ethiopia. Aug,2013.
7. Peter, N.D., Factors Associated With Male Involvement In Maternal Health Care Services In Jinja District, Uganda. 2011.
8. Geller, S., Cox, S., Callaghan, W. & Berg, C, Morbidity and mortality in pregnancy: laying the ground work for safe motherhood (review). Women´s Health Issues 2006. 16(4).
9. WHO, The world health report 2005, World health organization: Geneva.
10. WHO, Maternal mortality. May 2012, World health organization.
11. WHO, World Health Statistics 2011, world health organization: Geneva.
12. UNFPA, State of world population 2012: Newyork.
13. (ICF), C.E.I.I., Ethiopia demographic and health survey. 2011, Central Statistical Agency Addis Ababa and Calverton.
14. tretz, S.p.a.k., Improving health of women and adolescent. 2013, UN: Washington DC.
15. Wang, W., Alva, S., Wang, S. & Fort, Levels and trends in the use of maternal health services in developing countries DHS Comparative Reports 2011.
16. WHO, Global health observatory data repository. Ethiopia statistics summary (2002 - present). 2013c
17. WHO, Opportunities for Africa's newborns: practical data, policy and programmatic support for newborn care in Africa. 2006.
18. Msuya SE, M.E., Hussain A, Uriyo J, Sam NE, Stray-Pedersen B, Low male partner participation in antenatal HIV counselling and testing in northern Tanzania: implications for preventive programs AIDS Care 2008 ,20(6): p. 700-709
19. Britta C. (Beenhakker) Mullany, P., Women's autonomy and male involvement in antenatal care: associations and tensions in Nepal. 2004.
20. WHO, Women 's Health in the WHO Africa Region: A call for action. Report of Regional Director. , C.-. Fifth-eighth session Yaunde, Editor. September ,2008: Cameroon.
21. Adamu, Y.S., H, Barriers to the use of antenatal and obstetric care services rural Kano, Nigeria Journal of Obstetrics & Gynecology, 2002 22(6): p. 600-603.
22. Ampaire, K.a., Knowledge, Attitudes and Practices of women and men towards safe motherhood in rural settings. A study done on behalf of Delivery of Improved Service for Health (DISH II) project. 2002.

23. Nyane, Factors associated with Antenatal care dropout among pregnant women in Tororo district. MPH dissertation Makerere University School of Public Health. 2008.
24. WHO, Accelerating progress towards the attainment of international reproductive health. 2006.
25. Koisa, Opportunities and Challenges for men's involvement: the regional reproductive strategy. , in Paper presented in the meeting of Regional adviser in Reproductive Health WHO/PAHO. 5-7 September 2002: Washington DC. USA
26. Mildred Nanjala, D.W., Determinants of Male Partner Involvement in Promoting Deliveries by Skilled Attendants in Busi, Kenya. Global journal of health science, 2012. 4(2).
27. Warren, C., seeking for maternal health: challenges remain for poor women. Ethiopian Journal of Health Development2010. 24(1): p. 100-104.
28. Ndunge, A., Determinant of male involvement in the utilization of maternal and child health service in Lamu county. 2011.
29. Mullick Saiga, B.K.a.M.W., Involving men in maternity care:Health service delivery issues. 2005.
30. Tweheyo.R, Determinants of male participation in skilled antenatal and delivery care in Amoro County Gulu district, MPH dissertation Makerere University School of Public Health. 2009.
31. Antelman G, S.F.M., Kaaya S, Mbwambo J, Msamanga GI,Hunter DJ, Fawzi WW, Predictors of HIV-1 serostatus disclosure: a prospective study among HIV-infected pregnant women in Dar es Salaam, Tanzania. AIDS 2001 2001. 15:1865-1874.
32. Byamugisha R, A.A., Ndeezi G, Karamagi CA, Tylleskar T, Tumwine JK, Male partner antenatal attendance and HIV testing in eastern Uganda. J Int AIDS Soc 20112011. 14(1):43.
33. Ditekemena J, M.R., Koole O, Colebunders R, Kashamuka M, Tshefu A,Kilese N, Nanlele D, Ryder R, Male partner voluntary counselling and testing associated with the antenatal services in Kinshasa, Democratic Republic of Congo. Int J STD AIDS 20112011. 22(3):165-170.
34. Matovu JK, M.F., Expanding access to voluntary HIV counseling and testing in sub-Saharan Africa: alternative approaches for improving uptake. Trop Med Int Health 2007. 12: p. 1315-1322.
35. Alka Barua, R.P.P., Kerry Mac Quarrie and Sunayana Walia Husbands' involvement in maternal care among young couples in India. 2005.
36. Olugbenga-Bello Adenike I., A.-O.E.O., Adewole Adefisoy, Adeomi Adeleye A.and Olarewaju Sunday O. and Perception, attitude and involvement of men in maternal health care in a Nigerian community Journal of Public Health and Epidemiology June 2013. Vol. 5(6) p. pp. 262-270,.
37. Nkuoh GN, M.D., Tih PM,NKfusai J, Barrier to men participation on antenatal and prevention of mother to child transmission care in Cameron. Africa mid wifery women health, 2010. 55(4):363-369.
38. Cohen, S., Burger, M Partnering: A New Approach to Sexual and Reproductive HealthTechnical Paper no. 3 2000, United Nations Population Fund: New York.

39. Mullany, B.C., Barriers to and attitudes towards promoting husbands involvement in maternal health in Kathmandu. journal of Social science and medicine, , 2006. 62(11) p. 2798-2809.

Annex-1 Consent form

Title of the study: Male involvement in Maternal health care service and associated factors in Shashemene town,Oromia region,Ethiopia

I am----------. Coming from Jimma University. I am carrying out a study on male involvement in Maternal Health care service in Shashemene town

Reason for the study. I would like to find out the reasons why most men in the town are not actively involved in maternal health services especially regarding accompanying their partners to the health unit to seek antenatal care, delivery and postnatal care services. The study will provide an opportunity to obtain a comprehensive picture on male involvement in maternal health care services and the factors that hinder or promote male involvement in maternal health.

Benefits of the study. The Findings of the study will provide information on how best to involve men in maternal health care service and to improve the health of both men and women as a whole.

Risks of the study. No invasive procedures that will be performed on you during this study. However some of the questions I will ask are sensitive and are of a private nature, and may make you feel uncomfortable. Please be assured that this discussion is strictly confidential, and names will not be recorded. The findings of the study will be generalized and not linked to the individual

Participation in the study. Participation in the study is voluntary, if you do not want to answer particular questions that is okay. There are no right or wrong answers to the questions that we will be asking you. Please feel free to answer exactly as you feel. You are free to withdraw from the interview at any time without the need to justify your decision

I would like to seek your consent before I proceed. Are you willing to allow me continue with the interview?

1. Yes 2. No

If the Respondent agrees to continue, ask if he has any questions. Respond to the questions as appropriate, and then start discussion.

If the Respondent does not agree to continue, thank him and go to the next interview.

Annex 2

Questionnaire

Questioner code

Household code_____

Name of kebele_____

Name of interviewer_____

Data collection date _____

Part one

Socio demography and economic questions

Q.no	Question	Option	Skip	code
101	How old were you at your last birth day?	**_____years**		
102	Occupation	1.merchan 2.government employed 3.NGO 4.private employed 5.un employed 6.Other----------		
103	what is your highest level of education?	1.Can't read and write 2. write and read with out formal education 3.If formal education highest grade achieved_____		
104	what is the highest level of education of your wife?	1.Can't read and write 2. write and read with out formal education 3.If formal education highest grade achieved_____		

105	what is your religion?	1.Muslim 2. Orthodox 3 Protestant 4. Catholic 99.Other ___		
106	household income/month	**_____birr**		
107	Number of children	_____		
108	Family size	_____		

Part Two

201	Have you heard about maternal health care service?	1.yes 2.No ⟶	**203**	
202	If yes for Q 201,from where?	1.Radio 2.Health professional 3.posters 4.News paper 5.wife partner 6.Other(specify)__		
203	Have you heard about ANC	1.Yes 2.No		
204	What is importance of ANC? **Multiple answer is possible ,Don't read options**	1.To follow maternal health 2.To follow fetal condition 3.To prevent complication 4.For PMTCT 5.Other_____ 6.I don't know		
205	What is the recommended minimum number of times a pregnant woman is to attend ANC?	1.Twice 2.Three times 3.Four times 4.I don't know		

206	What services are offered to pregnant woman and her husband during ANC? **Multiple response is possible** **Don't read options**	1.Tatanus toxoid vaccination 2.waight measurement 3.checking for Blood pressure 4.checking for Fetal heart beat 5.screening for STI 6.Animia screening 7.HIV testing for mother and her partner 8.prevantion and treatment of malaria 9.I don't know 99.Other (specify)_____		
207	Which services are offered to pregnant women during labor and delivery at the health unit? **Multiple response is possible** **Don't read option**	1.follow progress of labor 2.Follow maternal condition 3.Follow fetal condition 4.manage complication 5.PMTCT 6.I don't know 99.other(specify)_____		
208	What problems can happen if your wife delivered at out of heath facility? **Multiple answer is possible** **Don't read option**	1.Bleeding 2.Infection 3.Fetal distress and death 4.maternal death 5.I don't know 99.other (specify)_____		
209	What are some of the services offered to the mother and her baby during the first 6 week after delivery? **Multiple response is possible** **Don't read the option**	1.check for infection 2.check for nutrition 3.vit–A supplementation 4.check for breast feeding 5.I don't know 99.other (specify)_		

Part three: Male involvement in maternal health care

Q.no	Question	Option	skip	Code
301	Did your wife had ANC follow up at health facility during the last pregnancy?	1.Yes 2.No →	**305**	
302	Who makes the final decision of where your wife should attend ANC?	1.The woman decides 2. The husband 3. Make a decision as a couple		
303	Did you accompany your wife for ANC at least once during her last pregnancy?	1.Yes 2.No		
304	Have you made any financial arrangement for your wife for ANC follow up during the last pregnancy?	1.Yes 2. No		
305	Did your wife delivered at health facility on the last delivery?	1.yes ~~2.No~~ →	**308**	
306	If yes for qn 305 did you accompany your wife to the health unit during labour for the most resent delivery	1. Yes 2. No		
307	Have you made any financial arrangement for your wife for delivery purpose?	1.Yes 2. No		

308	Who makes the final decision of where your wife is to deliver?	1. Make a decision as a couple 2. Wife decides 3. Husband decides 4.Mother in law 5.Other_____		
309	Did your wife follow post natal care in health facility after delivery up to 45 days?	1.Yes 2.No ⟶	**401**	
310	Did you discuss and made a joint decision on postnatal care services with your wife for the last pregnancy?	1.Yes 2. No		
311	Did you accompany your wife to seek care in health unit within 6 weeks after delivery of your youngest child?	1.Yes 2.No		
312	Have you made any financial arrangement for your wife for Postnatal care purpose?	1.Yes 2. No		

PART Four-4.1 socio cultural factor

Qn.no	Question	Option	Jump	Code
401	What is your marriage relationship?	1.Monogamous Relationship 2. Polygamous relationship		

4.2 Health facility factors

Qn no	Question	Option	Skip	Code
402	How long does the woman on average spend in the health facility when she goes for ANC or postnatal care.	_____ _____ __		
403	Is the time of service convenient for you?	1.yes 2.No		
404	Is there any payment for the service?	1.yes 2.No ⟶	**406**	
405	If yes for Qn 406 is it affordable for you?	1.Yes 2.No		

406	Did Health workers allow you to enter with your wife during visit?	1.yes 2.No		
407	Have you ever received an invitation letter from a health worker inviting you to discuss pregnancy issues of your wife?	1.Yes 2. No		
408	what challenges do you face in escorting your wife to the health facility for ANC, delivery and postnatal care?	1.Time of service is not convenient for me 2.Long waiting time at the health facility 3.Concurrent job demand 4.Long distance to the health facility 5.It is a cultural taboo 6.Health professional approach 7.cost they asked is high 8.Helth providers forced as for HIV test 9.We are not living to gather 99.Other (specify)……		

Attitude

	Questions	Strongly agree(5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly disagree (1)
1	Pregnancy is a natural phenomena no need of male involvement					
2	Delivery should take place at home to ensure that the placenta is safely buried					
3	Accompanying wife for maternal health care service is indicate male ruled by his wife					
4	Women should not go out of home including health institution after delivery for 45 days.					
5	Attending delivery by individual out side of family member is cultural taboo					

Thanks very much for your time

Guuca hayyamaa fi gaffilee afaaniin gaafataman Afaan Oroomoo tiin

Yaada walii galtee gaaffiif deebii qorannoo hirmaannaa dhirootaaa fayyaa haadhoolee irrtti fi sababoota isaa magaalaa Shaashamannee tti.

Maqaan koo _____ragaa Sassaabaa qorannoo hirmaannaa dhiraa tajaajila haadholee irratti fi sababa isaa barattuu maastersii jimmaa yuuniversitii tiin hajjatamu dha.Barbaachisummaan qurannoo kanaa sababa dhiroonni tajaajila haadholee irratti hin hirmanne adda baasuuf qaamonni dhimma kana irrati hojjatan odeefannoo kana fayyadamuun hirmaannaa dhirootaa dabaluuf akka hojjataniif gargaara.Yeroo qorannoo kana kessatti hirmaattanitti gaaffii dhimma dhunfaa kessan waliin wal qabatee isiin gaafachuu ni danda'a garu,Dhimmi kun iccitii dhaan kan qabamu ta'uu isaa fi waraqaa gaaffii irrattti maqaan kessan kan hin barroofna waan ta'eef,namni kan biraa beekuu hin danda'u.Ragaan kuniis qorannoo qofaaf kan fayyadu ta'u isinif ibsa.Dabalataaniis gaaffilee kana gutummaa gututti yookaan giddutti addaan kutun mirga kessani.Gaaffileen kun daqiqaa 20-30 ni fudhata.

Kanaaf gaaffilee itti anuu itti fuufuu f walii galtanii?

1.Walii galeera

2.Walii hin galle

Lakk.gaaffii_____

Lakk.manaa_____

Maqaa gandaa_____

Maqaa raga sassaabaa_____

Guyyaa ragaan itti sassaabame_____

Kutaa tokkoffaa -Haala waliigala haawaasaa

Lakk	Gaaffii	Filannoo	Irra darbi	Lakk.dhoksaa
101	Umuriin kessan meeqa?	Waggaa----------		
102	Goosti hojii kessan maali?	1.Daldalaa 2.Hojjataa mootummaa 3.dhaabata mitii motummaa 4.dhaabata dhunfaa 5.Hojii hin qabu 6.kan biro----------		
103	Sadarka an barumsaa kessan haagam?	1.barreessu fi dubbisuu kan hin dandenye 2.barumsa idilee osoo hin baratiin barressuu fi dubbisuu kan danda'u 3.barumsa idilee yoo baratee haanga meeqaa_____		
104	Sadarkaan barumsaa kan haadha manaa kessanii haangam?	1.barreessu fi dubbisuu kan hin dandenye 2.barumsa idilee osoo hin baratiin barressuu fi dubbisuu kan danda'u 3.barumsa idilee yoo baratee haanga meeqaa_____		
105	Amantaa kam hoordoftu?	1.Muslima 2.Ortoodoksii 3.prootestaantii 4.katoolikii		

		5.kan biro_____		
106	Galiin walii gala kan ji'aa meeqa?	_____birr		
107	Lakkofsi daa'imman qabdan meeqa?	_____		
108	Baayina maatii mana kessanii meeqa?	_____		

Gaaffii safarttuu beekumsaa waa'e tajaajila fayyaa haadhoolee				
201	Waa'ee tajaajila fayyaa haadholeef kennamu dhageessanii beektuu?	1.Dhagaheera 2.Hin dhageenye →	**203**	
202	Yoo dhageessan essaa dhagessan? **Deebiin tokko ol ni haayyamama**	1.Radio 2.Ogessa fayyaa 3.Postarii 4.Gaazeexaa 5.Haadha manaa koo irraa 5.kan biro_____		
203	Waa,e tajaajila hordoffii da,umsa duraa dubartoota ulfaaf kennamu dhageessanii	1.Dhagaheera 2.Hin dhageenye →	**207**	

	bektuu?			
204	Tajaajilli da'umsa duraa faayidaa maal qaba? **Deebiin tokko ol ni haayyamama** **Filannon hin dubbifamu**	**1**.Fayyaa haadha ulfaa hordoofuu dhaaf 2.Fayya daa'ima garaa jiruu hordofuu 3.Rakkoo fayyaa cima ulfa waliin qabatee dhufu ittisuuf 4.Tajaajila ittisa HIV haadha irraa gara daa'imaatti akka hin dabarre godhu kennuuf 5.Kan biro_____		
205	Haati ulfaa tokko yeroo ulfaa kessatti haarka meeqa dhaabata fayyaatti ilaalamuu qabdi?	1.Haark lama 2.Haarka sadii 3.Haarka afuur 4.Hin beeku		
206	Tajaajilli haadha ulfaa tokkof yeroo hordoffii ishee kessatti kennamu maal fa'i? **Deebiin tokko ol ni hayyamama** **Filannon hin dubbifamu**	1.Tajaajila ittisa dhukkuba tetaanasii 2.Ulfaatinni qaamaa ishee ni hordafama. 3.Dhibbaan dhigaa ishee ni hordafama 4.Rukuttaan onnee daa'ima garaa kessaa ni hordafama 5.Sakatta'insi dhukkuba wal qunnamttii saalaa 6.Qorannoo haanqina dhigaa 7.Qorannoo HIV haadhaa fi abbaa manaa isheef 8.Ittisaa fi yaala dhukkuba busaa 9.Hin beeku		
207	Tajaajilonni haadha tokkof	1.Halli cininsuu ni		

	yeroo da'umsaa kennamu maal fa'i? **Deebiin tokko ol ni hayyamama** **Filannon hin dubbifamu**	hordafama 2.Nageenyi haadhaa ni hordafama 3.Haalli nageenya daa,ima garaa kessaa ni hordafama 4.Rakkoon cimaan yoo umama tarkaanffii haarifachisaan ni fudhatama. 5.Tajaajilli ittisa HIV haadh irraa gara daa'imaatti hin dabarre godhu ni kennama 6.Hin beeku 7.Kan biro_____		
208	Haati tokko manatti yoo desse maaltu ishee mudachuu danda'a? **Deebiin tokko ol ni hayyamama** **Filannon hin dubbifamu**	1.Dhangala'uu dhigaa 2.Infeekshinii 3.Daa'imni ukkaamamuu fi du'u 4.Du'aatii haadhaa 5.Hin beeku 6.Kan biro_____		
209	Tajaajilonni haadha tokkof yeroo da'umsaa booda haanga guyyaa 45 kennamu maal fa'i? **Deebiin tokko ol ni hayyamama**	1.Sakata'insa dhukkuba adda addaa 2.Sakatta'insa sirn nyaataa 4.Vit-A ni kennama 5.Haalli itti haarma itti hoosisan ni ilaalama 6.Hin baaku 7.Kan biro_____		

	Filannon hin dubbifamu			

		Gaaffii hirmaannaa dhirootaa		
301	Haati manaa kessan yeroo ulfa dhumaa irratti hordoffii da'umsa duraa dhaabata fayyaa ttii hordoofteettii?	1.Hordoofteetti 2.Hin hordoofna ⟶	**305**	
302	Filannoo bakka haati manaa kessa hordoffii gotu irrattii murtee dhumaa kan kennu enyu?	1.Haadhamanaa qoofa 2.Abbaa manaa qofa 3.Mariyannaa waliin murteessina 4.kan biro----------		
303	Isin hadhamanaa kessan waliin yeroo hordooffii da'umsa duratti yoo xiqqaate al tokko dhaabta fayyaa deemtanii bektuu?	1.Deemera 2.Hin deemne		
304	Yeroo hordooffii da'umsa duraa kessaattii baasii tajaajilaaf barbaachisuf haala mijeessitanii turtanii?	1.Haala mijeessera 2.Hin mijeessine		
305	Haati manaa kessan da'umsa dhumaa irraatti dhaabata fayyaa kessatti dessee?	1.Eyyee 2.Lakki ⟶	**308**	

306	Yoo dhaabata fayyaatti desse yeroosanattii isin waliin deemtanii turtanii?	1.Deemera 2.Hin deemne		
307	Yeroo da'umsa daa'ima dhumaa irratti baasii tajaajilaaf barbaachisuf Haala mijeessitanii turtanii?	1.miijessera 2.Hin miijeessine		
308	Bakka da.umsaa filachuuf murtee dhumaa enyutu kenna?	1.waliin mariyannee murteessine 2.Haadha mana qofatu murtesse 3.Abbaa manaa qofatu murtesse 4.Haadha koo 5.Kan biro_____		
309	Haati manaa kessan da'umsa booda haanga guyyaa 45 gidduutti hordoffii dhaabata fayyaa tti qabdi turtee?	1.Eyye 2.Lakki ⟶	**401**	
310	Waa'e tajaajila da'umsa boodaa haanga guyyaa 45 tti kennamu irratti mariyatanii tuurtanii?	1.Mariyannerra 2.Hin mariiyanne		
311	Tajaajila da'umsa boodaaf haadha manaa kessan waliin dhaabata fayyaa dhaqxanii turtanii?	1.Dhaqeera 2.Hin dhaqne		
312	Basii tajaajila da'umsa boodaa argachuuf barbaachisuuf haadha manaa kessaniif mijeessitanii turtanii?	1.Mijeessera 2.Hin mijeessine		

Sababa Adaa fi dhaabilee fayyaa waliin wal qabatu				
401	Goosa gaa'ilaa	1.Hadha manaa tokko 2.Haadha manaa tokko ol		
402	Hati manaa kessan tajaajila argachuuf dhaabata fayyaa edda gesse booda tilmaamaan daqiiqaa meeqa egdi?	_____daqiiqaa		
403	Saa'aatiin tajaajilli fayyaa haadholeef itti kennamu isiniif mijaa'aa dhaa?	1.mijaa'aa dha 2.mijaa'aa miti		
404	Dhaabata fayyaa kessa kaffalttiin tajaaila haadhoolee argachuuf kaffalamu jiraa?	1.Jira 2.Hin jiiru ⟶	**406**	
405	Yoo kaffa lttiin jira ta'e human kessan waliin wal gitaa?	1.Ni gita 2.Hin giitu		
406	Yeroo tajaajila da'umsa duraa,da'umsaa fi da'umsa boodaaf argachuuf haadha manaa kessan waliin dhuftanitti ogeessonni fayyaa kutaa tajaajilaa akka galtaniif isinii haayyamuu?	1.Ni hayyamu 2.Hin haayyaman		
407	Yeroo haatimanaa kessan hordoffii tajaajila hadholee argachuuf gara dhabata fayyaa dhaqanitti ogeesoonni fayyaa waraqaa	1.Eyyee 2.Lakki		

	waamichaa isiniif erganii beekuu?			
408	Haadha manaa kessan waliin tajaajila haadholeef gara dhaabata fayyaa deemuuf rakkoo isin mudate maali?	1.Sa'aa tiin tajaajilaa mijaa'aa mit 2.Dhaabataa fayyaa kessa sa'aatii dheraa turutu jira 3.Haala hojii waliin naa hin mijatu 4.dhaabanni fayyaa bakka jireenyaa koo irraa fagoo dha. 5.Adaa dhaan safuu dha. 6.Simannaan ogeessota fayyaa gaarii miti 7.Kaffalttiin tajaajilaa baay'ee dha 8.Ogeessoonni fayyaa qorannoo HIV dhaaf nama dirqisiisu 9.haadha mana koo waliin bakka tokko hin jiraannu 10.Kan biro_____		

Ilaalcha

		Sadarkaa walii galtee				
Lakk		Sirritti deeggara (5)	Nan deeggara (4)	Yaada hin qabu (3)	Hin deegaru (2)	Sirritti hin deeggaru (1)
1	Ulfa ta'uun kennaa umamaa ti hirmaannaa dhirootaa hin barbaachisu					
2	Dubartiin ulfaa mana tti da'uu qabdi obbaatiin sirriitti akka awwalamuuf					
3	Abbaan manaa haadha mnaa isaa waliin dhaabbata fayyaa deemuun mo'amuu isaa muldhisa.					
4	Dubarttin tokko deesee haanga guyyaa 45 tti dhaabata fayyaa dabalatee manaa ba'uu hin qabdu.					
5	Dubarttin ulfaa nama maatii ala ta'ee haarkatti da'uun safuu dha.					

Galatoomaa

የጥናት መረጃ መስጫ የስምምነት ቅጽ

ጤና ይስጥልኝ ስሜ---------- ይባላል፡፡የምሰራዉ ለጅማ ዩኒቨርስቲ የህብረተሰብ ጤና እና ህክምና ሳይንስ ኮለጅ ድህረ-ምረቃ ተማሪ ለሆነችው እንዴ ጊዜያዊ መረጃ ሰብሳቢ በመሆን ነው፡፡

የጥናቱ ዓላማ፡-

የዚህ ጥናት ዋና ዓላማው የ ወንዶች ተሳትፎ በ እናቶች ጤና አገልግሎት ና ምክንያት ልሆኑ ይችላሉ ተብሎ የሚታሰቡ ችግሮችን በጥናቱ ለመለየት ነዉ፡፡

በዚህ ቃለመጠይቅ ወቅት ለጥናቱ ይጠቅማሉ ተብለዉ የተለዩ የግል ህይዎቶን በሚመለከት የተዘጋጁ ቃሌ መጥይቆች የተካተቱ ጥያቄዎችን ይጠየቃሉ፤ መልሶትም ለጥናቱ በተዘጋጀዉ የመጠየቂያ ቅጽ ላይ ይመዘገባል፡፡ አንድ አንድ ግላዊ ጥያቄዎችን በሚጠየቁበት ወቅት መጥፎ ስሜት ሊሰማዎት ይችላል፤ ነገር ግን በዚህ መጠይቅ ውስጥ ስም ና እርሶን ለመለየት የሚያገለግል ነገር አይፃፍም፡፡ ሁሉም መረጃ የቁጥር ኮድ በመጠቀም በጥንቃቄ እንደሚያዝ ልገልጽሎት እወዳለሁ፡፡

በዚህ ጥናት ላይ የሚያደርጉት ተሳትፎ ሙሉ በሙሉ በፍቃደኝነት ላይ የተመሰረተ ነው፡፡ ከዚህ ጥናት የምናገኘዉ መረጃ

በ እናቶች ጤና ዙርያ ለ ሚስሩት አካላት፤ የጤና ባለሙያዎች ስለ ወንዶች ተሳትፎ በ እናቶች ጤና አገላግሎት ላይ ና እንደሁም ምክንያቶቹ እንድያዉቁ በማድረግ የእናቶችን ጤና ለማሻሻል እንደ ግበአት ለመጠቀም ይረዳል፡፡ መጠይቁ የሚካሄደዉ በግል ስሆን ከ20-30 ደቂቃ ይፈጃል፤ መመለስ ያልፈለጉትን ጥያቄ እንዲመልሱ አይገደዱም፡፡ በሂደቱ ላይ በጥናቱ ላለመካፈል በማንኛውም ወቅት መወሰን ይችላሉ፡፡ ነገር ግን ሁሉንም ጥያቄዎች እንዲመልሱልን እናበረታታለን፡፡ ግልፅ ያልሆነ ነገር ካለ ሊጠይቁን ይችላሉ፡፡ ስለትብብርዎ በጣም አመሰግናለሁ፡፡

ተጠያቂው ተስማምቷል?አዎ አልስማማም

የጠያቂው ፊርማ----------ቀን----------

ስነ ህዝባዊ፤ ና ኢኮኖሚ፤ ጥየቄዎች				
ተ.ቁጥር	ጥያቄ	ምርጫ	ዝለል	ሚስጥር ቁጥር
101	ዕድሜዎት፤ ስንት ነው	----------		
102	የመተዳደሪያ፤ ስራዎት ዐይነት	1.ነጋዴ 2.የመንግስት ሰራተኛ 3.መንግስታዊ ያልሆነ ድችጅት ሰራተኛ 4.የግል ድርጅት ሰራተኛ 5.ስራ የለኝም 6.ሌላ መልስ----------		
103	የትምርት፤ ደረጃ	1.መጻፍ ና ማነበብ የማይችል 2.የመደበኛ ትምህርት ሳይከታተል.መጻፍ ና ማንበብ የሚችል 3.መደበኛ ትምህርት ከተከታተሉ ዕስከ ስንት----------		
104	የባለቤትዎት፤ የትምርት ደረጃ	1.መጻፍ ና ማነበብ የማይችል 2.የመደበኛ ትምህርት ሳይከታተል.መጻፍ ና ማንበብ የሚችል 3.መደበኛ ትምህርት ከተከታተሉ ዕስከ ስንት----------		
105	የሚከተሉት፤ ሃይማኖት	1.ሙስሊም 2.ዖርቶዶክስ 3.ፕሮቴስታንት		

		4.ካቶሊክ 5.ሌላ----------		
106	ከቤተሰብ ዐባል ሰርቶ፤ የመተዳደርያ ገቢ፤ ለቤት የሚያመጣው ማነው	1.ባለቤት /ባል ብቻ 2.ባለቤት /ሚስት ብቻ 3.ሁለቱም ይሰራሉ 4.ሁለቱም አይሰሩም 5.ሌላ----------		
107	ጠቅላላ ወርሃዊ ገቢ	----------ብር		
108	የልጆች፤ ቁጥር	----------		
109	ጠቅላላ፤ የቤተሰብ አባል ቁጥር	----------		

ክፍል ሁለት--የ እውቀት መለኪያ ጥያቄዎች

201	ስለ እናቶች፤ ጤና አገል ግሎት ሰምተው፤ ያውቃሉ	1.አዎ 2.አይ ⟶	**203**	
202	ጥያቅ ፤ቁጥር 201 መልስ፤ አዎ ከሆነ ከየት ነው የሰሙት **ከ አንድ በላይ መልስ ይቻላል**	1.ሬድዮ 2፣ከ ጤና፤ ባለ ሙያ 3.ፖስተር 4.ጋዜጣ አንብቤ 5.ባለቤቴ/ሚስቴ ነግራኝ 6.ሌላ---------		
203	ስለ ቅድመ፤ ወሊድ አገልግሎት ፤ሰምተው ያውቃሉ	1.አዎ 2.አይ ⟶	**207**	

204	የ ነብሰ ጡር፤ እናቶች፤ ቅድመ ወሊድ፤ ክትትል፤በጤና ድርጅት ማድረግ፤ምን ይጠቅማል **ከ አንድ በላይ መልስ ይቻላል** **ምርጫ አይነበብም**	1.የ እናትየውን፤ ጤና ለመከታተል 2.የ ሽሉን፤ ጤንነት ለመከታተል 3.አደገኛ ፤የጤነ ችግር እነዳይከሰት፤ቀድሞ ለመከላከል 4.HIV ፤ከእናት ወደ ልጅ እንዳይተላለፍ፤ ለመከላከል 5.ሌላ------ 6.አላውቅም		
205	አንድ፤ እናት፤ በእርግዝና ፤ወቅት፤ስንት ግዜ፤በጤና ድርጅት የ ቅድመ ወሊድ ክትትል ማድረግ አለባት	1.ሁለት ገዜ 2.ሶስት ግዜ 3.አራት ግዜ 4.አላውቅም		
206	ለነብስ ጡር እናት፤በጤና ፤ድርጅት፤ክትትል በምታደረግበት ግዜ፤የ ሚሰጡት አገልግሎት፤እነማን፤ናቸው **ከ አንድ በላይ መልስ ይቻላል።።** **ምርጫ አይነበብም**	1.የ ቴታነስ ማከላከያ ክትባት 2.ክብደት መመዘን 3.የ ደም ግፊት መጠን ክትትል 4.የ ሽሉ የ ልብ ምት ክትትል 5.የ አባላዘር በሽታ ምርመራ 6.የ፤ደም ማነስ ምርመራ 7.HIV ምርመራ ለዕናት ና ለ ባልዋ 8.የ ወባ በሽታ መከላከል ና ህክምና 9.ሌላ---------- 10.አላውቅም		
207	ለእናቶች ፤በጤና፤ ድርጅት ውስጥ፤በ፤ወሊድ ግዜ የ ሚሰጡ፤ አገላግሎቶች አነማን ፤ናቸው	1.የ፤ ምጡ ሁኔታ ክትትል ይደረጋል።። 2.የ እናትየው፤ የ ጤና፤ ሁኔታ ክትትል፤ ይደረጋል።።		

	ከ አንድ፤ በላይ መልስ፤ ይቻላል።። **ምርጫ አይነበብም**	3.የ ሽሉ፤ የጤና ሁኔታ ፤ክትትላ ይደረጋል።። 4.አደገኛ፤ የ ጤና ፡ችግር ከተከሰተ፤አፋጣኝ፤እርምጃ ይወሰዳል።። 5. HIV፤ ከእናት ወደ ልጅ እንዳይተላለፍ፤ ለመከላከል 6.ሌላ--------- 7.አላውቅም		
208	ነብሰ ጡር ፤እናት በቤት ውስጥ፤ ብትወልድ ምን፤ ችግር ሊገጥማት ይችላል **ከ አንድ በላይ መልስ ይቻላል** **ምርጫ አይነበብም**	1.የ ደም መፍሰስ 2.ተጓዳኝ የ ጤና ችግሮች 3.የ ሽሉ መታፈን ና መሞት 4.የ፤ እናት ፤መሞት 5.ሌላ---------- 6.አላውቅም		
209	ድህረ ወሊድ፤ እስከ ስድስት ሳምንት፤ ድረስ ለ እናቶች የ ሚሰጥ፤ አገልግሎቶች እነማን ናችው **ከ አንድ በላይ መልስ ይቻላል** **ምርጫ አይነበብም**	1.ለ ሌሎች በሽታ ምርመራ ይደረጋል 2.የ አመጋገብ ሁኔታ 3.Vit-A ይሰጣል 4.የ፤ህጻኑ የጡት አወሳሰድ ይታያል 5.ሌላ---------- 6.አላውቅም		

ክፍል ሶስት፤

የ፤ ወነዶች፤ ተሳትፎ

301	ባለቤቶት፤ በ መጨረሻው እርግዝና ወቅት፤የ ቅድመ ወሊድ ክትትል፤ በ ጤና ድርጅት አድርገው ነበር	1.አዎ 2.አይ ⟶	**305**	
302	የ ቅድመ ወሊድ ክትትል ለ ማድረግ ቦታ ለመምርጥ፤የመጨረሻ፤ውሳኔ፤ማነው፤ሚሰጠው	1.ሚስት ብቻዋን 2.ባል ብቻውን 3.በ ጋራ ተማክረን አንወስናለን 4.ሌላ----------		
303	ባለቤቶት የ ቅድመ ወሊድ ክትትል በሚያደርጉበት ግዜ፤የ ጤና ድርጅት አብረው ሄደው ነበር	1.አዎ 2፣አይ		
304	308	የ ወሊድ ቦታ ለ መምረጥ፤ ከ እርሶ ና ከ ባልቤትዎ የ መጨረሻውነ ውሳሜ ሚሰጥ ማነው	1.በ አንድ ላይ በመመ ካከር 2.ሚስ ት ብቻዋን 3.ባል ብቻው ን 4.የ ባል እናት 5.ሌላ--------	
305	ባለቤቶት፤በ መጨረሻው እርግዝና ወቅተ፤በ ጤና ድርጅት ነው የወለዱት	1.አዎ 2.አይ ⟶	**308**	

306	መልስዎ አዎ ከ ሆነ እርስዎ አብረው ሄደው ነበር	1.አዎ 2.አይ		
307	በ ጤና ድርጅት የ ወሊድ ፤አገልግሎት ፤ለ ማግኘት፤የሚያስፈልገውን፤ወጪ፤አመቻችተዋል	1.አዎ 2.አይ		
309	ባለቤቶት፤ ከ ወሊድ ቦሃላ ባሉት አርባ አምስት ቀናት ውስጥ በጤና ድርጅት ክትትል አድርጋ ነበር	1.አዎ 2.አይ ⟶	**401**	
310	በ ድህረ ወሊድ አገልግሎት፤ ማግኘት ላይ፤ ከ ባለ ቤቶት ጋር ተማክረው፤ ና ወስነው ነበር	1.አዎ 2.አይ		
311	በ ድህረ ወሊድ አገልግሎት ወቅት፤ወደ ጤና ድረደጅት፤ ከ ባለ ቤቶት ጋር ሄደው ነበር	1.አዎ 2.አይ		
312	በ ጤና ድርጅት የድህረ፤ ወሊድ ፤አገልግሎት ፤ለ ማግኘት፤የሚያስፈልገውን፤ወጪ፤አመቻችተዋል	1.አዎ 2.አይ		

ክፍል አራት- ባህላዊ ና የጤና ድርጅት ምክንያት ጥያቄዎች

401	የ፤ጋብቻ፤አይነት	1.አንድ ሚስት 2.ከ አንድ ሚስት በላይ		
402	ባለቤቶት ፤ለ ቅድመ ወሊድ ከክትትል የ ጤና ድርጅት ሄዳ አገልግሎት ለ ማግኘት ፤በ ጤና ድርጅቱ ውስጥ ምን ያክል ትቆያለች	----------ደቂቃ		
403	አገል›ግሎት፤ የሚሰጥበት ሰአት፤ ለ አርሶ አመቺ ነው	1.አዎ 2.አይ		
404	አገልግሎት ፤ለ ማግኘት ከፍያ አለ	1.አዎ 2.አይ ⟶	**409**	
405	መላስዎ አዎ ከ ሆነ፤ አቅሞትን ያገናዘበ ነው	1.አዎ		

		2.አይ		
406	አገልግሎት ለማግኘት የ ጤና ድርጅት በ ሄዱበት ወቅት፤ የ ጤና ባለ ሙያዎች፤ ወደ፤አገልግሎት ክፍል፤ከ ባለቤቶት ጋር ፤እንዲገቡ ፈቅደውሎት ነበር	1.አዎ 2.አይ		
407	የ ጥሪ ወረቀት ፤በ ባለቤቶት አማካኝነት ፤ከ ጤና ባለ ሙያ ፤ስለ ባለ ቤቶትእነዲሁም ስለ ራስዎት ጤና ለ መወያየት ፤ደቸሶዎት ያውቃል	1.አዎ 2.አይ		
408	ባለቤቶት ለ አናቶች ጤና አገልግሎት ለ ማግኘት ወደ ጤና ድርጅት ፤በ ሚሄዱበት ወቅተ፤እርሶ አብረው እነዳይሄዱ ፤አንቅፋት የሆነቦት ፤ምንድነው	1.የ አገለግሎት መስጫ ሰአቱ ምቹ አይደልም 2.በ ጤና ድርጅት ውስጥ ረጅም ሰአት የቆያሉ 3.ከ ስራ ጋር አይመቸኝም 4.የ ጤና ድርጅት የ ለበት እሩቅ ነው 5.በ ባህል አስነውሪ ነው 6.የ ባለሙያዎች አቀባበል 7.ለ አገልግሎቲ የሚጠይቁት ክፍያ ትልቅ ነው 8.ባለ ሙያዎች የ HIV ምርመራ አነድናደረግ ያስገድዱናለ 9.እኔ ና ባለቤቴ አብረን አንኖርም 10.ሌላ----------		

አመለካከት

ሀሳብ	**በጣም እስማማለሁ** **(5)**	**አስማማለሁ** **(4)**	**ሀሳብ የለኝም** **(3)**	**አልስማማም** **(2)**	**በጣም አልስማማም** **(1)**
እርግዝና የ ተፈጥሮ ጉዳይ ነው፤የ ወነዶች ተሳትፎ					

አያስፈልገውም።					
ወሊድ በ ቤት መሆን አለበት ፤እንግዴ፤ልጅ በ ትክክል እንዲቀበር።					
ወንድ ባለ ቤቱን ፤ለ እናቶች ጤና አገልግሎት፤የዝዋት ጤነ ድርጅት መሄድ ማለት ፤መሸነፉነ የሳያል።					
የ ወለደች እናት 45 ቀን ስኪሞላት ድረስ የ ጤና ድርጅት ጨምሮ ከ ቤት መውጣት የለባትም።					
ሴትን ከቤተሰብ አባል ውጭ ፤ሌላ ሰው፤ካዋለዳት፤ነውር ነው።					

ስለ ትብብሮ አመሰግናልሁ