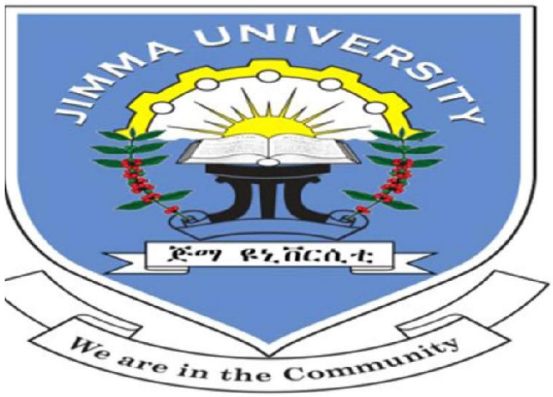

WOMEN'S AUTONOMY ON MATERNAL HEALTH CARE UTILIZATION AND ITS ASSOCIATED FACTORS IN HOMA DISTRICT, WESTERN ETHIOPIA, 2019.

BY: Aboma Diriba

A RESEARCH THESIS SUBMITTED TO FACULTY OF PUBLIC HEALTH, DEPARTMENT OF POPULATION AND FAMILY HEALTH, JIMMA UNIVERSITY; IN PARTIAL FULFILLMENT FOR THE REQUIREMENT OF MASTERS OF PUBLIC HEALTH IN REPRODUCTIVE HEALTH(MPH/RH).

May 2019

Jimma, Ethiopia

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ABSTRACT

Background: Women's autonomy has been a central concern for researchers and they agree that limited women's autonomy in Maternal Health Care is the main underlying causes of poor utilization of maternal health care, and associated with high maternal and children morbidity and mortality, low birth weight, and infertility. However, up to our search in Ethiopia little emphasis has been placed on assessing factors associated with women autonomy, despite of its importance in improving maternal well-being. In addition, since mixed method was recommended by researchers as their study limitation this research was fulfilled this gap.

Objectives; To assess magnitude of Women's Autonomy and its Associated Factors on Maternal Health Care utilization in Homa district, west Ethiopia,2019.

Methods; A community based cross sectional study with both qualitative and quantitative was employed. Stratified Multistage sampling method was used to select 468 mothers. Collected data were entered into Epi Data version 3.1 and exported to SPSS 21.0 for analysis. Bi-variable and multivariable logistic regression analysis was done to show factors significantly associated with women's autonomy.

Result: This study revealed that 66.2% of women had high autonomy on maternal health care utilization. Women who attended secondary and above education were 3 times more likely exercised high autonomy than women without formal education [AOR=3.2, 95% CI (1.395, 7.4)]. The odds of high autonomy 10 times high among Women from richest family than those from poorest family [AOR= 9.9, (95% CI (4.21, 23.082)]. The odds of having high autonomy 3 times higher among Women who have favourable attitude toward maternal health care have than women with un favourable attitude [AOR=3.3, 95%CI (1.891, 5.893)]. Being urban dwellers [AOR=2.5,95% CI (1.212, 5.046)], delay age at marriage 18 and above [AOR=3.3(1.887, 5.754)], and women's employment for payment [AOR=3.4, 95%CI (1.840, 6.233)] were more likely exercised high autonomy than their counter parts. Lack of education, lack of income, culture, religion and lack of awareness are factors addressed by qualitative study to supplement quantitative finding.

Conclusion and recommendation: This study revealed that majority of women in homa district had high autonomy. Over all the findings of this study imply that Women's who had formal education, living in households of high wealth status, women's employ for payment, delay age at marriage 18 and above, being reside in urban and women who have favorable attitude towards maternal health service were exercised high autonomy than their counter parts. So, enhancing economic status of women and household, improving their educational status, delay age at marriage, enhance attitude of women toward maternal health service can promote level of women autonomy.

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First I would like to express my gratitude to Jimma University, college of health science, department of population and family health for giving me interesting chance and support to do this thesis. I am also very thankful to pro. Abebe G/Mariam and Ms. Rahma Ali for their invaluable input from the inception of the proposal to the final compilation of this thesis. The meaningful cooperation provided by the study team and the study participants deserves special recognition. I extend my appreciation to the district administrators and Health Extension Workers for providing me the necessary information in study area and I appreciate all individuals those who support me throughout this research. Lastly my heartfelt thanks to my family for they were support me by materials necessary for this thesis.

ABBREVIATIONS AND ACRONYMS.

ANC: Antenatal care

CSA: Central Statistical Agency

EDHS: Ethiopian demographic health survey

ETB: Ethiopian birr

FDRE: Federal democratic republic of Ethiopia

FGD: Focus group discussion

HH: House hold

IDI: In-depth interview

JUERB: Jimma university institutional review board

LBW: Low birth weight

MDG: Millennium development

MHC: Maternal health care

MHS: Maternal health service

MoFED: Ministry of finance and development

MOH: Ministry of health

PI: Principal investigator

PNC: Postnatal care

SDG: Sustainable development goal

SPSS: Statistical Package for Social Sciences

SRH: Sexual and reproductive health

TV: Television

WHO: World Health Organization

1. BACKGROUND

1.1. Introduction

Autonomy means independence or freedom of the will or one's action(1), capacity to manipulate one's personal environment through control over resources and information in order to make decisions about one's own concerns or about close family members(2). Thus Women's autonomy means their ability to determine events in their lives, even though men and other women may be opposed to their wishes(2), women's degree of freedom relative to men, regarding control over financial resources, freedom of movement, opportunity to participate in decisions about maternal and child health care utilization (3).

United Nations asserted that women's autonomy is essential to human dignity and must be considered as basic human right and fully recognized as an integral part of sustainable human development paradigm(4). Also it is considered as crucial determinant of health, well-being, longevity of individuals and societies and becoming more widespread in the public health(5) and recognized as a key strategy to reduce gender inequalities and increase productivity in developing economies, especially in Africa(6,7). Despite of that, women spend part of their life cycle in a position inferior to that of men, they have double powerlessness and subordinated to men at any given point (8). In Ethiopia, even though major portion (71%) of married women participate in decision making (9), on economic dimension, Women hold only 18.7 % of agricultural land and head 20.1 % households. About 76 % of women have control over house hold assets, but even then, ownership and decision making remains in the control of men(10). women represent 47% of labor force in Ethiopia, with highly unequal participation: 68.5% of employed women were unpaid workers (11).

Regarding freedom of physical movement, for a large part of women in third world countries since there is profound gender discrimination, women's lives are highly restricted, they need a male permission for seeking healthcare for themselves and their children, going outside the family compound and visiting their relatives. This restriction of women's autonomy reduce access to key determinants of health which results higher levels of anxiety and depression, malnutrition, health risks from greater numbers of pregnancies and childbirth, and domestic violence against women(12).

Globally, maternal mortality fell by almost 44% from 1990 to 2015 (13,14). Recently Maternal health interventions have been successful in increasing access to and utilization of maternal health services,(15) however, limited women's autonomy in maternal health care are the main underlying causes of poor utilization of maternal health care utilization and high maternal morbidity and mortality in developing countries(16).

Since research into women autonomy in their health is an area of growing interest due to its importance from both a human rights and healthcare outcomes perspective (17) it is important to study factors associated with women autonomy on maternal health care utilization.

1.2. Statement of the problem

Recently women's autonomy is a focus of global development efforts because of it is an important determinant of women's health and wellbeing(18),associated with lower fertility, greater contraceptive use, lower ideal family size, and better maternal and child health(19,20). Also it's very crucial from health care seeking and utilization to choosing among treatment options, and considered as critical for the social, economic and sustainable development of any country but women in developing countries often have no or limited autonomy and control over their health (21–25).

Globally only 50% of women are exercising autonomy regarding their health care, sexual relations, and contraceptive use(26). Evidence from developing countries show that, women status within the society mostly limits their autonomy regarding their own lives. In Asian countries majority of women, 72.7% in Nepal, 54.3% in Bangladesh and 48.5% in Indian, have low autonomy over their health care(27). The same trends exist in African countries. In Egypt only 14.6% women make decisions about their health care alone without consulting anyone else(28), 75% of the Ghanaian women exercised autonomy on health matter, either alone (22%) or jointly with their partners (53%)(29).

Women's autonomy in health-care is considered as a prerequisite for improvements in maternal and child health, despite of that in Ethiopia less than half (41.4%) of women have high autonomy regarding their own and their children's health are, out of this only, 38.1% are able to use the money by their independent decision, 49.6% of women are autonomous to take their child to health facilities while 43.9% of women are free to go to health facility for their own health care service consumption which shows that high proportion of women are still exercising limited autonomy regarding their health(3).

When women exercise low status and autonomy their ability to obtain access to certain strategic resources (such as health services) declines, and in turn face various social and economic burdens(30), more likely to have a low birth weight child(31), risk of child death is greater (32), poor mental and physical health for women and higher morbidity and mortality for their children(12) and much less likely to receive antenatal care (ANC) and delivery care and postnatal(PNC) from a skilled provider (9).

Because of the socio-cultural constructions and practices, women are considered to be subordinate to men and second-class members/citizens both in the family and in the society(33). Also several socio-economic and cultural factors such as, women's age, and house hold income, (21) and deep rooted traditional attitudes, cultural values in community, low level of literacy, low commitments from concerned government bodies(34) that affect women's autonomy and hinder the full-fledged women's empowerment.

The federal democratic republic of Ethiopian (FDRE) constitution and the National Policy on Ethiopian women are basic in the national initiative towards gender equality. National Action Plan for Gender Equality, Ethiopian Women's Development and Change Package, Woreda based Core Plan and gender mainstreaming approach was designed as major strategies to implement international commitments and the national women's policy to improve women empowerment and gender equality (35) which contribute high for women autonomy in all aspects of life. But gender equalities progress is too slow and or reversing in some areas,(36) which may facilitate the existence of limited women autonomy. Different policies and legal frame work were designed by government to enhance gender equality and empower women, through increasing women's access to education and health care, access to land, credit, an increasing the number of women benefited from government programs and strategies had been considered as a key intervention for women's autonomy but their implementation is not as it was expected particularly in rural areas where majority of the people of the country reside and remain the most challenging(10,26,34,37,38).

Most of the previous studies gave an attention on potential impact of women's autonomy on maternal and reproductive health and they agree that women autonomy have great impact on Maternal and sexual and reproductive health service utilization (39–44) but very few studies concentrate on factors affecting women's autonomy on maternal health care services. There is scarce information regarding factors associated with women's autonomy on MHC utilization in West part of Ethiopia. In addition, despite of recent shift toward capturing population issues using qualitative and quantitative method (45) there is a research gap in Ethiopia to deal with such problem by mixed method. Therefore, this study was intended to assess factors associated with women's autonomy on maternal health care utilization in west part of Ethiopia and will provide important information for concerned bodies to help as an input for any possible intervention aimed at promote women autonomy on maternal health care.

1.3. Significance of the study

A better understanding of factors affecting women's autonomy can inform the design and implementation of health programmes and policy(42) to avert maternal health care problem due to low autonomy and status of women. So achieving 2030 Sustainable Development Agenda especially SDG5(achieve gender equality and empower all women and girls) (46) requires to make women are autonomous.

Thus, this study was assessed the level and factors associated with women's autonomy on maternal health care utilization among women in homa district, western Ethiopia. It is hoped that the findings of this study will provide an important perspective on factors associated with women's autonomy on MHC in the study area and provide important information for program managers of Homa district and policy makers at all levels to concentrate on the relevant factors of interest for possible intervention. Women affairs and gender office of the district will incorporate information provided by this study in their plan to intervene problem behind women autonomy on maternal health care utilization. Used to sensitize the community to make them to take a part with a government by identify what things have to be done at community level. It is expected that it will add an immense value to achieve SDG. Furthermore, the finding of the study will supply information for further research.

2. LITERATURES REVIEW

2.1. Definitions and measurement of Women's Autonomy.

It's acknowledgeable that women's autonomy is multidimensional concept which has contextual meaning and difficult to quantify. Fotso and his colleagues contextualize autonomy as the ability to decide and act upon decisions regarding personal matters(22) freedom from control of other people (47). It is something helps to increases access to material resources like food, land, income and social resources such as knowledge, power, prestige within the family and community(48). Nowadays it is considered as enacted ability of women to influence decision-making, control financial and physical resources and freedom of movement(3)(49).

Despite of women's autonomy is important for reproductive and maternal health service challenges have been existed in conceptualizing and measuring women's autonomy due to its multidimensionality. Earlier researchers prefer proxy indicators (socio economic) as an indirect indicator of women's autonomy on maternal health care(43). Autonomy cannot be measured, as it often was, using one-dimensional proxies, or indirect measures, such as women's education or labor force participation rates, as an approximate indicator of autonomy because it results highly imperfect measurement and have grave policy implications(50).

Recently, scholars have turned from using indirect proxies to quantify autonomy, choosing instead direct measures (combination of observable items or indicators) that are categorized into different dimensions of autonomy, such as Participation in decision making, access to and control over resource, extent of freedom of movement, attitudes toward wife beating, Attitudes toward refusing sex, Permission for healthcare services an large household purchases (3,40,49,51–55).

For the purpose of this study and considering context of study area, of the several indicators to measure women's autonomy relevant literatures reviewed(3,28,52,56–58) and three indicators: control over finance, decision-making power and extent of freedom of movement(mobility autonomy) are selected to measure women's autonomy.

Why these three dimension?

If women's autonomy is impaired through restrictions on movement, having limited or no decision making authority and being financially dependent, consequences are often, poorer mental and physical health for women and higher morbidity and mortality for their children(12), early age of marriage, and relatively low utilization of reproductive and maternal health care(59).

Women, who are autonomous, in this three dimension would be able to travel to health facility if needed, gain knowledge about MHC, spend money to pay for the travel and other health care utilization and make decisions if and when they need about their health(52) and able to seek health care services for themselves and their children(16,60).

Women autonomy in Control over decision-making and economic, enable women to improve their self-determination, control over resources, self-esteem, and would uplift the status and power relations within households, meeting the basic needs and altogether improving self-reliance, thereby reducing women's economic subordination(61) while freedom of movement outside the home for a woman gives an opportunity to enhance their knowledge and exposure towards world's phenomenon(62).

In addition to this all reason as various measures of autonomy are context based(63) I prefer these three dimensions of women autonomy since they are most relevant in developing countries(64) and in my study area context where women's have limited access and control over resources, lack of ability to make and execute independent decisions and freedom of mobility is under the guidance of husband or others.

2.2. Level of women autonomy.

Women's autonomy on their health care decision is vary from country to country and even there is a discrepancy within country itself. A Paper presented on International Population Conference in Session 184 report that in India only 56.6% of women are involved (either alone or with partner) in decisions regarding large household purchases and , only 41.4% of women had money that they can use without asking anyone(52). In Nigeria 6.2% of the women have independent decisions, and 32.7% have joint decision-making about their health care(65).

In Egypt only 14.6% women make decisions about their health care alone (28) and 75% of Ghanaian women reported exercising health care decision making autonomy either alone (22%) or jointly (53%)(29). In Ethiopia 58.6% of the women have lower autonomy while the remaining 41.4% had higher autonomy(3) regarding maternal and children health care utilization.

2.3. Factors Associated with Women's Autonomy.

women's autonomy is influenced by personal attributes of women as well as socio-cultural norms of the society(25). Study done in north Indian women shows that with closer ties to natal kin were more likely to have greater autonomy(66). Different studies in Nepal found that Women's education, rich women, age, employment, and number of living children,(48), ethnicity, and husband's education (67) are highly significant to women's autonomy in decision making on their health(48). Md. Morshedul Haque and his colleagues identify that Women's current age, place of residence, education, religion, media exposure are factors affecting women autonomy(61).Also studies done in Bangladesh conclude that age and higher educational attainment(68), occupation, gender-based awareness and income had a significant association on women's autonomy on their health care (69).

Empirical evidence from Nigeria found that place of residence, age above 35yrs, education, religion, occupation, home ownership and husband's occupation are factors independently associated with decision-making autonomy by the woman alone(42). Ghanaian researchers revealed that independent determinants of women's health care decision making autonomy were women's attainment of formal education, and having a partner who has attained formal education(29).

Community based cross sectional study done in south east Ethiopia shows monthly household income >1000 ETB, having employed husband, being in a nuclear family structure, being in monogamous marriage, mothers knowledge about MCH and having favorable attitude toward MCH care services were independently associated with an increased odds of women's autonomy(3). Other study done in Ethiopia, Adwa town, revealed those who attend secondary school, giving birth two and less (41) in SNNP of Ethiopia husband's education (25) wealth index, age, family size and, and occupation were factors significantly associate with women autonomy.

2.4. Conceptual frame work

This conceptual framework developed after a revision of pertinent literatures in similar topic(3,40,52,68,70).

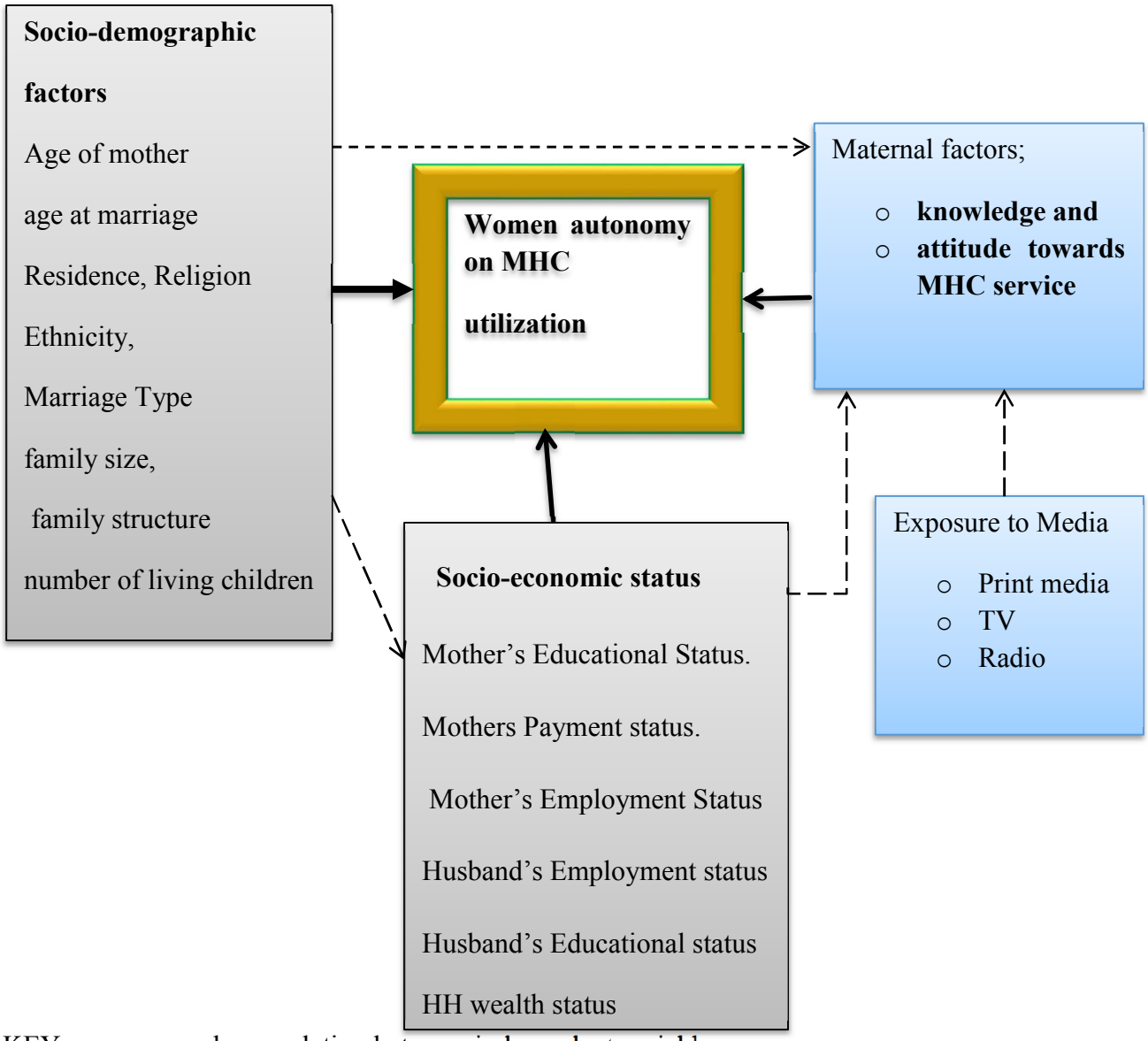

Figure 1 Conceptual framework of factors associated with women's autonomy on MHC utilization after reviewing of literatures.

3. OBJECTIVE

3.1. General objective

To assess status and factors associated with women autonomy on maternal health care utilization in Homa district, western Ethiopia, 2019.

3.2. Specific objectives

To assess status of women autonomy on maternal health care utilization in Homa district, western Ethiopia, 2019.

To assess factors associated with women autonomy on maternal health care utilization in Homa district, western Ethiopia, 2019.

4. METHODS AND MATERIALS

4.1. Study area and period

The study was conducted in Homa district, western Wollega zone, Oromia Regional state which is located at a distance of 496 km from Addis Ababa to the west of Ethiopia. The district has a total population of 52560, male 27560, female 25000 out of this 9,687 are women of Child bearing age group. The district has 3urban and 10 rural kebeles. In the district, there are 2 health centers and 13 health posts. The weather condition of the study area is 'woinadega'. The economy of the district is widely dependent on coffee production.

Study period was from march 1-30,2019.

4.2. Study design:

Community based cross sectional study with qualitative and quantitative method was employed to assess magnitude and factors associated with women's autonomy on maternal health care in homa district, western Ethiopia, 2019.

4.3. Population

4.3.1. Source population

All married women who had gave a birth in the past one year prior to the study, in Homa district were source population.

4.3.2. Study population

Women residing in selected kebeles who gave birth in the past one year in Homa district and meet eligibility criteria.

4.3.3. Study unit

Woman/individual.

4.4. Inclusion and Exclusion Criteria

4.4.1. Inclusion Criteria

Who gave birth in the past 12months and lived in the district for more than 6 months before data collection.

4.4.2. Exclusion criteria

Those who unable to communicate and un able to respond for different reasons.

Divorced.

For qualitative, those who participated in quantitative and including their husband.

4.5. Sample size determination and Sampling Technique

4.5.1. Sample size

Objective 1; The sample size was calculated by using a single population proportion formula by considering, 95% confidence level, 5% margin of error and 41.4% (p =0.414) estimated proportion of women autonomy on maternal and child health matters(3).

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

$n= (1.96)^2 \times 0.414(1-0.414)/(0.05)^2 = 373$,

Where: n = desired sample sizes.

$Z\alpha/2$ = critical value or normal distribution at 95% cl which equals to 1.96 (z -value at α=0.05),

P = proportion of women autonomy to decide on their own health matters(3).

D=margin of error (0.05) n_f =corrected sample size. N= size of source population

Objective -2

Table 1:sample size determination for factors associated with women's autonomy on maternal health care service.

Associated factors	CI %	Power (%)	Ratio (unexposed: exposed)	%outcome in unexposed	OR	Sample size	Reference
Type of marriage	95	80	0.3913	23.1	2.46	255	(3)
Husband's employment status	95	80	6.89	38.8	5.32	133	(3)
Age	95	80	1	15.7	3.47	128	(27)
HH monthly income	95	80	1	28.8	2.07	282	(3)

So, calculated sample size for objective one is large (373), it is selected to assure representativeness for both objective of the study.

Since the source populations are below 10,000 by applying finite population correction formula calculated sample size become **286**. Then calculated sample size, 286, multiplied by a design effect of 1.5 and 10% of the calculated sample size, 43, added for non-response. final sample size **472**.

For qualitative part, two FGD with 15 participants disaggregated by sex were selected purposively from husbands and wives and a total of 8 IDI with, 2 kebele managers, head of district administrator, district's gender office head, HEW, 2religious leaders, and 1Aba geda were held.

4.5.2. Sampling technique and procedure.

Stratified multi stage sampling technique was employed. At first all of the 13 kebeles in the district were divided in to urban and rural and then 54% of the kebeles were included in the study. From the total rural kebeles five and from the urban kebeles two were selected randomly. At kebeles level, sample size was distributed proportional to the size of the population in the selected kebeles to assure representativeness. To select study participants list of all women who gave birth in the past one year were obtained by reviewing health post registration of kebeles. Then sampling frame was done and study subjects were selected by simple random sampling technique (random number generated by computer).

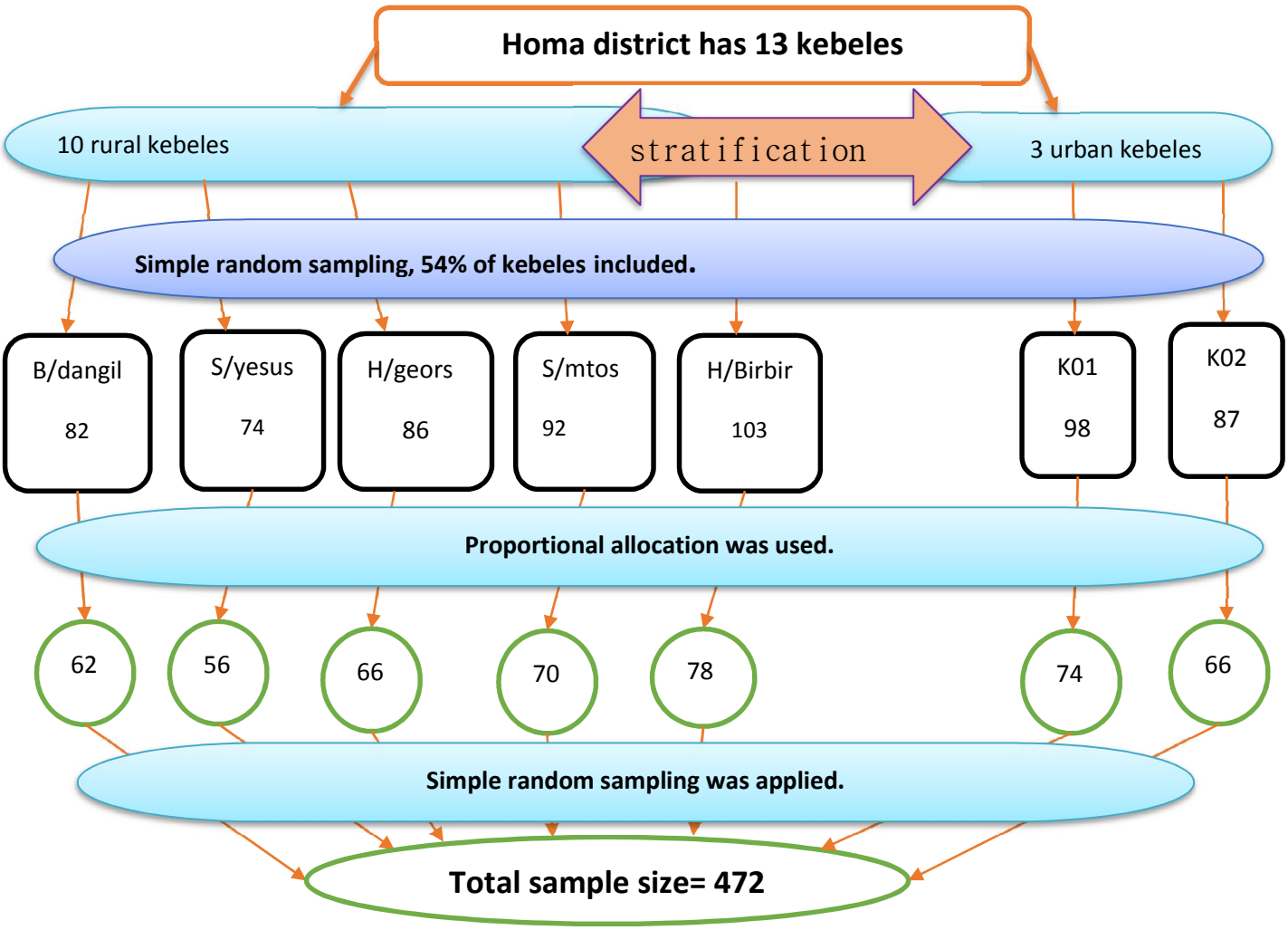

Figure 2:schematic presentation of sampling procedure.

4.6. Data collection procedure

4.6.1 Data collection instrument

After reviewing of relevant literatures (3,25,49,52,58,71–73)structured questionnaires were developed. The instrument contained socio demographic and socioeconomic characteristics of the respondents, Knowledge of women on MHC, attitude of women towards MHC, media exposure, and women autonomy indicators (control over finance, decision making power, extent of freedom of movement). For qualitative part FGD and IDI guide were used. The guide contains probing topics related with women's autonomy.

4.6.2 Data collectors

Data collection was conducted by three BSC and three diploma holders of female health care providers to address the women's safety and confidentiality of the information, and two health officers were assigned as supervisors. The principal Investigator along with two assistants were conducted the qualitative study.

4.6.3 Data collection technique

Data was collected by using interviewer administered pretested structured questionnaires. Data collection was carried out by house to house visit. Confidentiality was assured by excluding study participants name during the period of data collection. The study purpose procedure and duration, and benefits of the study were clearly explained for study participants. written consent was taken from the respondents before data collection and then data was gathered. Study participants who had not contacted were revisited twice to reduce non response rate. The main investigator was moderate the group discussion and the assistant moderator took detailed notes, tape record the discussion and handle any interruption to the focus group.

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4.8. Study variables

4.8.1. Independent variables

- Sociodemographic variables; Age, religion, Residence, Marriage Type, Ethnicity of Mothers.
- Socio economic variables: Mothers Educational Status, Mothers Employment Status, mothers Payment status, Husbands Employment status, Husbands Educational status, house hold wealth status.
- Maternal factors: Knowledge and Attitude of women towards maternal health care
- Exposure to media

4.8.2. Dependent variable

- Women autonomy on MHC utilization.

4.9. Operational definitions and measurements.

Maternal health care: a care given for one mother during prenatal, natal, post-natal including family planning services.

Women autonomy: women's authority to make independent decisions, freedom from constraint on physical mobility and the ability to freely control over financial resources.

A summary measure of Women autonomy was obtained from the composite index of the selected constructs of women autonomy: control over finance, decision-making power and extent of freedom of movement. The overall score of the three constructs is 24. An individual who scored mean and above were considered as having high autonomy. Accordingly, the sum value < 12 was categorized as low level of women autonomy and the value ≥ 12 was categorized as high level of autonomy and coded (0,1) respectively(3,74).

Decision making power: the ability of women to make decision regarding her own health where to seek for MHS such as prenatal, natal, post-natal care including family planning services.

Autonomy related to decision making was captured from the information on Who usually has final say on: her own health care, Number of children, Use of maternal health services such as contraception, antenatal care (ANC), preference of delivery site, and post-natal care (PNC). The possible responses for each items in decision making autonomy was respondent alone, respondent and husband/partner jointly, respondent and someone else, husband/partner alone & someone else. For each items the response was scored as: 2 if a woman made sole decision, 1 if she was involved with someone [husband/partner or someone else] and 0 otherwise.

The sum of the scores were represent an overall index of a woman decision-making power indicated by different studies(3,52). The maximum score on decision making autonomy was 12 and those who scored 6 and above were categorized as high decision making whereas those scored less than 6 were categorized as women with low decision making power.

Freedom of movement: the women's ability to move to health care facility without seeking permission from other adult (husband's/partner or someone else) for their own health care.

Autonomy regarding freedom of mobility was estimated from questions related to woman independent ability to leave the house without seeking permission from other adult (husband's/partner or someone else) to; 1. go to health facility for her own health care, 2. go out to visit family or relative, 3. go outside this village for public meeting and 4. go to market. These items are with binary responses (yes or no). Hence, those with 'yes' response scored 1 while those with 'no' response scored 0. The maximum score on freedom of movement is four. Those women who scored two and above were considered as high freedom of movement whereas those who scored less than two were categorized as low freedom of movement.

Control over financial resources: women's access to sources of money (her own earning, husbands/partner's earning and other sources) and ability to spend it without consulting anyone for their own health care concern.

The index for control over finance is composed of five items: 1. whether the woman had regular access to a source of money (including both wages earned and gifts or support from family, own land, house, jewelry, or other valuables which you can sell or use as you please".) and 2. whether she state that she could spend this money without consulting anyone, 3. who decides how the money she earned and 4. who decides how the money her husband's earnings are used, and 5. who decides on major house hold purchasing.

A possible response for the first two items binary responses (i.e. yes or no) was scored as 1 if yes and 0 other wise. A possible response for the last three items are respondent alone, respondent and husband/partner jointly, respondent and someone else, husband/partner alone & someone else. The response was scored as 2 if a woman made sole decision, 1 if she is involved with someone [husband/partner or someone else] and 0 otherwise. Since the total score on control over finance is 8, those women with a score of mean and above was considered as having high control over finance, while those women who scored less than mean had low control over finance.

Knowledge of women on maternal health care. A total of 19 questions about ANC, delivery, PNC and danger signs during pregnancy and childbirth were asked to assess women's knowledge on maternal health care service. After a composite score was done mothers who scored above 84% were considered as highly knowledgeable and Moderately knowledgeable if they scored between 50-84% and Poor knowledgeable mothers those who answered <50% (3).

Mothers attitude towards MHC service was measured by positively stated statements on attitude towards MHC with possible response of five Likert scale. The measurement scales were given for each item: 5 for strongly agree, 4 for agree, 3 for undecided, 2 for disagree and 1for strong disagree. Those participants who respond to attitude questions score mean and above mean value were considered as having favorable attitude and those who scored below the mean value were considered as unfavorable attitude(3) .

Media exposure: If an individual is exposed to TV, radio, or print media, every day, at least ones a week or less than a week. Media exposure of the study participant was estimated by the following three items. These assessed the frequency of; (1) reading print media (newspaper and magazines), (2) listening to the radio; and (3) watching TV. The response options: (1), almost every day (2) at least once a week, (3) less than once a week and (4) not at all. A value of 1 was assigned to response

1 through 3 and 0 for 4 (75). Then based on the overall score, those who scored zero are considered as no media exposure, those get 1 and 2 comes under the low and those who scored 3 point they come under the high exposure categories.

Wealth index: Households are given scores based on the number and kinds of consumer goods they own, ranging from a television to a bicycle or car, in addition to housing characteristics such as source of drinking water, and flooring materials(58).

Nuclear Family Structure; family consisting of a married couples & their children; the children can be born or adopted.

Extended Family Structure; nuclear family plus collateral kinship. i.e. father, grandfather, mother uncles, aunts, nieces, nephews etc.

4.10. Data Processing and Analysis.

The completeness and consistency of the data was checked then coded and double entered into Epi data version 3.1 and exported to SPSS version 21.0 for cleaning, processing and analysis. During analysis the variables were defined, categorized and recoded then descriptive statistics were presented using frequencies and graphs. Principal component analysis (PCA) was computed to see wealth status of households. From a total of 24 items included in the analysis three factors with eight items was created which could explain 65.3% total variance.

For all independent variables multi collinearity effect was tested using the Variance Inflation Factor and a maximum of 2.1 VIF was observed. Binary logistic regression analysis was used to compute crude odds ratio with its 95% CI and variables with P-value <0.25 were candidate for multivariable analysis. Finally, Multivariable analysis with Adjusted Odds Ratio (AOR) was used to control for possible confounders and to identify factors significantly associated with outcome variable. P-Value of < 0.05 was considered as the criterion for statistical significance. The goodness of the model was assessed by Hosmer and Lemeshow test(p=0.658)

Data from the qualitative part was transcribed, translated to English, coded and categorized accordingly to main thematic areas manually. Then after repeatedly read the data, finally the findings were triangulated with the quantitative findings.

4.11. Data Quality Management

The questionnaires were initially prepared in English and then translated in to Afan Oromo and then back into English to check for consistency. Before data collection, the instrument was pre-tested in 5%(24) of the total sample size in neighbor woreda, Ganji, two weeks before actual data collection to insure clarity, wording, logical sequence, skip pattern of the questioner. Cronbach's Alpha was computed for each of the three autonomy dimension separately and for an overall composite combining them. The estimated internal reliabilities for the control over finances 0.73, freedom of movement 0.83, and decision-making power measures were 0.88. The Cronbach's alpha coefficient for the three measures combined into a general index for autonomy was 0.73. Also, Cronbach's alpha coefficients were estimated for knowledge and attitude of mother towards maternal health care utilization and results internal reliability of 0.75, and 0.89 respectively.

All data collectors and supervisors were trained for two days by the principal investigator on objectives of the study, how to interview, measure and fill the questionnaires and how to maintaining confidentiality of study subjects.

During data collection, the administered questionnaires were checked for completeness and consistency on daily basis by supervisors and principal investigator, then timely corrections were made.

4.12. Ethical consideration

Before conducting the study, the proposal was reviewed by Ethical Clearance Board of Jimma University for possible ethical issues. The ethical approval letter was taken to different level of administrative bodies. An official letter of cooperation was given to concerned bodies. The Woreda health office and kebeles were asked for an official letter to get permission. Data collectors were trained on how to handle confidentiality and privacy by using consent form attached to each questionnaire. Confidentiality was assured by excluding their name during the period of data collection. Interview was made at appropriate place. The study purpose, procedure and duration, and benefits of the study was clearly explained for study participants and informed sign and consent was obtained from respondents. women who were not willing to engage in the study and those who want to stop interview at any time were allowed to do so.

4.14. Dissemination plan

The results of the study will be disseminated to relevant bodies such as Jimma University School of graduate study as partial fulfilment of master's degree in public health, woreda and zonal health office, Oromia health Bureau, MOH, etc. This will be done through submission of reports and presenting findings at appropriate seminars, workshops and conferences. Besides publication of the study findings on the reputable peer-reviewed local/international journal will be considered.

5. RESULTS

5.1 Socio demographic Characteristics of the Study participants

Of 472 randomly selected women, 468 participated in the study yielding a response rate of 99.15% with a mean (±SD) age of 26.78(±5.2) years. About 63.4% of the study participants were in the age ranges of 20-29 years. Ninety-seven percent of women were Oromo by ethnicity and 70.7% are protestant in religion. over 70% of study participants were from rural areas, nearly half of them had attended primary education and 82.9% of them reported that their husbands had formal education. Majority of the women (89.3%) were living in nuclear family structure, and 39.5% of them reported that they married at age of less than 18. The mean (±SD) number of children alive was 2.82(±1.402) and 4.97(±1.472) is the mean of family size. Regarding their payment status less than half of them reported that they are paid for their employment. Most (24.8%) of women were residing in a family with poorest quantiles of wealth index. (Table 2).

Table 2:Socio demographic profile of (n=468) and reproductive history of study participants in Homa district, west Ethiopia, March 2019.

Characteristics	Categories	Frequency(percent)
Age	<20	47(10)
	20-24	112(23.9)
	25-29	185(39.5)
	30-34	72(15.4)
	≥35	52(11.1)
Ethnicity	Oromo	455(97.2)
	Others®	13(2.8)
Religion	Protestant	331(70.7)
	Orthodox	95(20.3)
	Muslim	42(9)
Residence	Urban	139(29.7)
	Rural	329(70.3)
Wealth index	Poorest	116(24.8)
	Poor	76(16.2)
	Medium	88(18.8)
	Rich	81(17.3)
	Richest	107(22.9)
Educational Status of respondent	No formal education	95(20.3)
	Primary education	225(48.1)
	Secondary education (9-12)	96(20.5)
	College and above(12+)	52(11.1)
Employment status of respondent	Employed	300(64.1)
	Not employed	168(35.9)
Payment status of respondents	Paid	228(76.1)
	Not paid	72(23.9)
Educational Status of husband	No formal education	80(17.1)
	Primary education	197(42.1)
	Secondary education	106(22.6)
	College and above	85(18.2)
Employment status of husband	Employed	281(60.0)
	Not employed	187(40.0)
Marriage type	Monogamous	443(94.7)
	Polygamous	25(5.3)
Family Structure	Nuclear	418(89.3)
	Extended	50(10.7)
Number of children surviving.	≤2	246(52.6)
	3-4	160(34.2)
	≥5	62(13.2)
family size.	≤5	335(71.6)
	>5	133(28.4)

® represent Amhara and Gurage ethnic group

5.2 Women media exposure, knowledge and attitude towards maternal health care.

Out of mothers who had high media exposure 87.5% of them had moderate to high knowledge and 75.9% of them had favorable attitude towards maternal health care utilization. All of the women (100%) who had no media exposure were experienced low autonomy and from mothers with high media exposure, 89.3% of them had high autonomy.

5.3 Distributions of the responses to the women autonomy related questions.

Nearly half (54.5%) of women were decided about their own health care independently, and 77.8% of them had joint decisions regarding contraception use and 17.5% hadn't take part in decision over desired number of children.

This was also supported by the qualitative finding, even though at least joint decision making is become familiar in the community there is a situation in which women decision making power on maternal health care is still violated. Also they agree that it is impossible to say women are 100% free to decide on their health.

"There is mutual discussion and understand in my family to decide on FP, number of children desired, A NC utilization and other service" (35yrs husband, FGD).

"To share you a pain-full history of one mother, she is a mother of 7 children, and she decided to stop having any more children but her husband refused her decision. Since she had no option she conceived and finally she was died on giving her 8th birth at hospital. Still there is a believe "ijoolleen kennaa waaqaati (children are God's gift)" (26yrs HEW, IDI).

"For me more than 80% of our women are exercising their autonomy on their own health, but regarding decision on desired number of children, and contraceptive utilization, women autonomy is restricted in some religious area" (42 yrs district administration head, IDI).

"Due to the pressure from previous culture there is no sense of autonomy in the women. For instance, on FP even though she counseled by health care provider rather than deciding by herself, she give a high credit for husband to decide and prefer to be subordinate" (33yrs religious secretary, IDI).

Around two-thirds (67.1%) of women had regular access to a source of money, of which 35.5% of them reported that they are autonomous to use the money without consulting others. Nearly two

percent (1.9%) of women were decide alone about large item purchase for households and most (81%) of them had joint decision. **Table 3**

Participants in the qualitative study also mentioned that financial control of women in the area more in the hands of husbands(male). Especially women side agree that due *to* lack of means of income and control over house hold income their autonomy is limited, they are waiting for husband's final say to buy or sell things.

"I don't have my own income. Regarding large item purchasing he tells me after finishing the procedure of buying and selling (for the sake of informing me)" (24yrswoman, FGD).

"*Sometimes it's observable, when HH income is decided only by husband. Because the main source of income in this area is coffee and major part of coffee are in the hand of husband" (32yrs head of gender office, IDI).*

"Household and husband income is controlled by husband. To Purchase (buying and selling) big item for house hold they might discuss together but the final say is that of husband. If it is decided by wife, he feel that he is inferior in that society "(33yrs religious secretary, IDI).

Regarding freedom of movement (68.2%) of women were free to go to health facility for their own health care seeking without waiting for husband's or someone else permission. Table 4. Most participants of qualitative study agree that if women move without getting permission from husband the relation of the family might be disturbed, husbands might stop to take care of his family and their marriage would end up with divorce.

"Women should wait for husband's sound before going anywhere and they should keep God's principle. if they move without informing by saying we have the right to do so, it results a great problem even divorce" (44yrs man, FGD).

"the principle of our religion, ordered that husband is the head of the wife. So it is not allowed for women to move anywhere without getting permission from her husband. If she does so, it disturbs the family, divorce may happen." (33yrs religious leader, IDI).

Table 3: Percentage distribution of respondents by reported response to women autonomy related question Homa District, western Ethiopia. (n=468)

Autonomy questions	Frequency(percent)		
	Independent decision	joint decision	not involved in decision
final say on your Health care	255(54.5)	185(39.5)	28(6.0)
final say on desired number of children	43(9.2)	343(73.3)	82(17.5)
final say on your contraception utilization	35(7.5)	364(77.8)	69(14.7)
final say on ANC utilization	229(48.9)	227(48.5)	12(2.6)
final say on preference of delivery site	100(21.4)	315(67.3)	53(11.3)
final say on PNC utilization	245(52.4)	212(45.3)	11(2.4)
On the use of wife's money	70(22.3)	220(70.1)	24(7.6)
On the use of husband's money	5(1.1)	332(70.9)	131(28)
Major household sales & purchases	9(1.9)	379(81.0)	80(17.1)
	Yes	**No**	
Freedom to go health facility for your own health care	319(68.2)	149(31.8)	
Freedom to visit family or relative	235(50.2)	233(49.8)	
Freedom to go market places	307(65.6)	161(34.4)	
Freedom to go for public meeting	169(36.1)	299(63.9)	

5.4 Dimensions of women's autonomy

The mean (±SD) score of women on decision making power index was 7.4(±2.5) out of a possible maximum of 12. The mean (±SD) score of women on freedom of movement was 2.2(±1.2) out of 4. The mean (±SD) score of women on control over financial resource was 3.37(±1.753) out of 8.

The mean(±SD) score of overall index women's autonomy was 12.97 (±4.54) out of a possible maximum of 24 score and 66.2% of the women had higher autonomy (Figure 1).

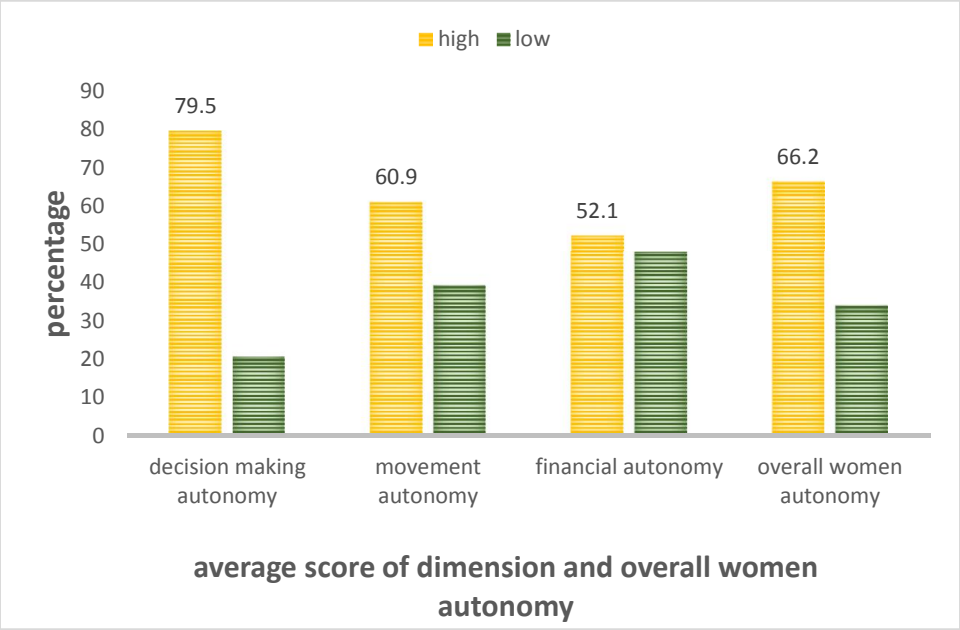

Figure 3. Dimension of Women's autonomy in Homa district, western Ethiopia,2019

5.5 Logistic regression estimates of Factors associated with women autonomy

Binary logistic regression analysis was done to identify candidate variables for multivariable logistic regression at P-value <0.25 and 11 variables (current age, age at marriage, place of residence, wealth index, educational status of respondents, employment status of couples, payment status, knowledge and attitude towards maternal health care) were taken to multivariable logistic regression. After adjusted for confounders in the final model six variable; educational status of respondent, age at marriage, place of residence, payment status, wealth index, and attitude towards maternal health care were found to be positively and significantly associated with high level of women autonomy (Table 4).

Women who attended secondary and above education have 3.2 times higher odds of high autonomy than those who haven't formal education [AOR=3.221, 95% CI (1.395, 7.439)]. Women who have primary school have 2.6 times higher odds of having high autonomy than women's who doesn't have formal education [AOR=2.618(1.351, 5.071)].

"Lack of education especially on women side and culture of interrupting education at low level (school dropout), lack of awareness on women autonomy or gender equality affecting autonomy of women in our district" (23yrs kebele manager, IDI).

"some of our women, especially those who haven't education still a victim of the past culture, due that they are not confident enough to exercise autonomy at required level, rather they prefer to be husband subordinate" (42 yrs district administration head, IDI).

Women who have favorable attitude towards maternal health care services were 3.3 times more likely to be highly autonomous than mothers with unfavorable attitude [AOR:(3.338, 95%CI (1.891, 5.893)].

"Women by themselves are one factor. Because they are not attending women conference, public meeting, and other opportunity created by government to improve their knowledge, attitude towards maternal health care, build their self-confidence. This could affect their level of autonomy on maternal health care utilization" (26yrs HEW, IDI)

Women who reside in urban have 2.5 times higher odds of having high autonomy than their counterparts in rural areas [AOR: 2.473,95% CI (1.212, 5.046)]. Women who married at age of eighteen and above had 3.3 times higher odds of high autonomy than those married at early marriage [(AOR= 3.296 95% CI (1.887, 5.754)].

Women in the families of richest quantiles have 10 times [AOR= 9.858, (95% CI (4.21, 23.082)], women from rich family have 7 times [AOR=7.330 (95%CI (3.220, 16.686), women from medium wealth quantiles have 5 times [AOR= 4.832 (95%CI (2.245, 10.400), and women from poor wealth quantiles have 2 times [AOR=2.336(95%CI (1.089, 5.011)] higher odds of having high autonym than women living in poorest families respectively.

Women who paid for their employment have 3.4 times higher odds of having high autonomy than women who doesn't paid for their employment [AOR=3.386(95%CI (1.840, 6.233). (**Table** 4)

High proportion of women in our district are house wives, due that they are not participating in income generating activities. This made them to be dependent financially on husbands (24yrs kebele manager, IDI).

Both of us are government employee and we are running our life by plan. We are collecting our income on the same bank account and we discussed together if we want to spend it (28 yrs old male teacher, FGD).

Table 4: Results of Bivariable and multivariable logistic regression.

Variables	Women autonomy		Crude OR(95%CI)	AOR (95%CI)
	Low n=158	High n=310		
Age of respondents				
<20	22(13.9)	25(8.1)	1	
20-24	61(38.6)	51(16.5)	0.736[0.372, 1.457]	.341(0.129, 0.899)
25-29	51(32.3)	134(43.2)	2.312 [1.198, 4.462]*	.232(0.082, 0.658)
30-34	14(8.9)	58(18.7)	3.646[1.609, 8.260]*	.492(0.146, 1.653)
≥35	10(6.3)	42(13.5)	3.696[1.508, 9.060]*	.453(0.116, 1.770)
Age at marriage				
<18	84(53.2)	84(27.1)	1	1
≥18	74(46.8)	226(72.9)	3.054[2.046, 4.558]**	3.296(1.887, 5.754) **
Residence				
Rural	142(89.9)	187(60.3)	1	1
Urban	16(10.1)	123(39.7)	5.838(3.319-10.268)**	2.473(1.212, 5.046)*
Wealth index				
Poorest	70(44.3)	46(14.8)	1	1
Poor	34(21.5)	42(13.5)	1.880[1.047,3.376]*	2.336(1.089, 5.011)*
Medium	23(14.6)	65(21.0)	4.301[2.351, 7.866] **	4.832(2.245, 10.400) **
Rich	17(10.8)	64(20.6)	5.729[2.986,10.990] **	7.330(3.220, 16.686) **
Richest	14(8.9)	95(30.0)	10.109[5.153,19.831]**	9.858(4.211, 23.082)**
Educational Status of respondent				
No formal education	58(36.7)	37(11.9)	1	1
Primary education (1-8)	79(50.0)	146(47.1)	2.897[1.766, 4.752] **	2.618(1.351, 5.071)*
Secondary and above(9+)	21(13.3)	127(41.0)	9.480[5.105, 17.606]**	3.221(1.395, 7.439)*
Employment status of respondent				
Not employed	100(63.3)	68(21.9)	1	1
Employed	58(36.7)	242(78.1)	6.136[4.029, 9.345]**	0.655(0.268, 1.596)
Payment status of respondents				
Not paid	30(51.7)	42(17.3)	1	
Paid	28(48.3	201(82.7)	5.128[2.778,9.466]**	3.386(1.840, 6.233)**
Employment status of husband				
Not employed	102(64.6)	85(27.4)	1	1
Employed	56(35.4)	225(72.6)	4.821[3.198, 7.269]**	0.820(0.378, 1.781)
Family Structure				
Nuclear	134(84.8)	284(91.6)	1.956[1.083, 3.535]*	1.719(0.757, 3.903)
Extended	24(15.2)	26(8.4)	1	1
Knowledge about MHC				
Poor	85(53.8)	47(15.2)	1	1
Moderate	53(33.5)	154(49.7)	5.255[3.272, 8.439] **	1.469 (0.715, 3.015)
High	20(12.7)	109(35.2)	9.856[5.435, 17.873]**	2.357(1.025, 5.418)
Attitude towards MHC				
Unfavorable	115(72.8)	73(23.5)	1	1
Favorable	43(27.2)	237(76.5)	8.683[5.605, 13.451]**	3.338(1.891, 5.893)**

* P<0.05 ** P<0.001 at 95 % CI, ®: represent, Gurage and

6. DISCUSSION

This study showed, a large proportion of women (79.5%) have high autonomy in decision making, nearly half (52.1%) them had high financial autonomy and 60.9% of them had high movement autonomy. This finding is higher than finding of studies done in kapilvastu district of Nepal, which indicate 50.18% of women had high decision making autonomy, 50.67% of them have freedom of movement autonomy and 37.24% of women had high financial autonomy(76). This difference might be due to variation between socio-economic and cultural belief of the two districts community, and variation of items used to measure dimension of autonomy. The other plausible reason for this difference could be time gap, due that the possible measures taken to remove gender gaps and inequalities by the countries may vary.

This study revealed that out of women who had access to money (67.1%), only 35.5% of them reported that they are autonomous to use the money without consulting others. This finding is nearly similar with results of studies done in Bale zone, Ethiopia, out of women those who had access to money, 38.1% of them were autonomous to use the money without consulting others(3). Also comparable result was presented on international population conference that in India 41.4% of women had money that they can use without asking anyone(52) . The similarity of these finding might be due to the fact that economic problem of women in developing country is related to gender disparity(77).

In this study 54.5% of women had independent decision on their own health care. In India 47.1% of women were decide on own health care (48), in Egypt 14.6%(28) and in Nigeria only 6.2%(65) women make decisions about their health care alone without consulting anyone else. This finding suggest that decision making power of women on their own health care is slightly higher than that of India and much higher than that of Egypt and Nigeria. This might be due to gender mainstreaming to different sectors by Ethiopian government(38), and currently the government is working on gender equality and women empowerment to achieve SDGs(78). This all efforts may provide information, improve behavioral change and decision making power of women on utilization of maternal health care.

Over all this study show that 66.2%, of women were experienced high autonomy and 33.8% them were practiced low autonomy. This finding higher than previous study done in, south east Ethiopia, in which 41.4% of women had high and 58.6% had low autonomy(3)(25)(25) but similar with studies conducted in Nepal(79) which showed that about 33% of women had low autonomy. This difference might be since there is a time gap between the study, measures taken to promote the fulfilment of girls and women potential through education, commitment of government, stake holders and awareness of communities to promoting full respect for human dignity, achieving women empowerment and gender equality (34,36,37) are become strengthened over the time.

This study revealed that women who had formal education were more likely to have high autonomy than women without formal education. Studies done in Dabat of Ethiopia(74), Nepal(48,67), Nigeria(42) and Ghana(29) reported consistent findings. This is mainly due to the fact that educated women are more aware of their right to free choice and might be more capable of exercising their will as far as health care decision is concerned, either alone or with their partners(29), education may impart feelings of self-worth and self-confidence, which are more important features in bringing about changes in health-related behavior than exposure to relevant information(69), and also women's education increases the income of women and women's empowerment(80).

In this study women who married at age of 18 and above were more likely had high autonomy than women married at age of less than 18 years. This higher in strength than studies done in Egypt(73), and contradict with report from Albania(81). The possible reason for this contradictory finding might be age at marriage classification means in this study and Egypt, those who married before age 18 were considered as a reference group but the Albanian researchers used those who married before age 20 as a reference group. This finding imply that later age at marriage provides more opportunity for education, employment, and participation in the choice of a husband, which can enhance women's power within the households, her ability to negotiate with husbands and other household members and her involvement in decision-making after marriage(82).

In this study women who paid for their employment were more likely exercised high autonomy than those who not paid for their work. The study done in south Asia(27) and Nepal (48) report consistent findings. This might be due to the fact that women, who work for incomes are more likely to be exposed to a wider range of ideas and social roles which may change their views about what they should be able to do(83), increases her threat utility and therefore increases her level of bargaining power relative to her husband(84). This finding imply that employ for payment gives women the opportunity of living independently of men, and being able to make highly autonomous regarding their own health care.

The present study also found that women have favorable attitude toward maternal health service utilization were more likely experienced high autonomy on MHC utilization than women with unfavorable attitude. This finding is higher in strength than study done in Ethiopia (3). This might be due to the proportion of study participants who have formal educations are higher in my study. The other possible reason might be currently the government is working on the achievement of the SDGs through improving maternal health and women empowerment(78) and expansion of HEW may provide information and behavioral change on utilization of maternal health. This result imply that women who had favorable attitude towards maternal health care services could easily influence their husbands and significant others(3).

Recently Household wealth status has emerged as a significant factor for women's involvement in health care decision making. Accordingly, in this study Women from the richest, rich, medium and poor quintile of wealth index were more likely to be highly autonomous than women from poorest quintile households respectively. This finding is higher in strength than a report of studies done in Ethiopia(3)(74), Bangladesh (27) and contradict with studies done in South Ethiopia(25), Nepal(48) and Egypt(73). The possible reason for this variation might be, the previous Ethiopian research focuses on monthly income to measure relative socioeconomic status of households. The other explanation for the study of Bangladesh might be dimensions used to measure autonomy (only focus on decision making) and a large scale data of that countries were used for analysis. The contradictory finding of this study with that of south Ethiopia might be variation in house hold wealth index classification. In that of Egypt and Nepal, large sample size was used, socio-economic and cultural difference between population of study area might be a possible reason for this inconsistent finding.

This study indicates that women who reside in urban were more likely to be highly autonomous than their counterparts in rural area. This finding is lower in strength than the finding of studies done in north west Ethiopia (74) and higher in strength than that of Asian country(27). But this finding is contradict with that of Bangladesh(61). The possible reason behind women in urban of my study area exercise high autonomy less than that of Dabat is all urban kebeles of that study area, Dabat, are a site for Team Training and done as project area for Gondar University. so the basic infrastructure might be higher than that of my study area, community may get information about the importance of health care utilization through an outreach program and provision of regular information during data collection for the surveillance which could directly or indirectly contribute for level of women autonomy. The possible reason for contradictory finding in Bangladesh might the variation between analysis method and the way they measure autonomy.

Quantitative findings such as education, and income related factors were supported by qualitative study. Also qualitative study addressed that previous culture, women less concern to use available opportunity to enhance gender equality, religion and misperception around it, lack of equal awareness on gender equality and lack of public meeting on gender equality, women empowerment and autonomy that offer both husband and wife made women are less likely to be highly autonomous on MHC utilization.

6.1 Strength and limitation of the study

The main strengths of this study are the use of qualitative methods to supplement quantitative findings. There was a high response rate for the study. A relative measure of socio-economic status (wealth index) was computed.

Women's autonomy is a sensitive issue that is often hidden by the women and underreporting or overexploiting is possible(85). The quantitative study didn't include men and all information are taken from one side. Even though it was tried to be minimized by appropriately selecting source population, still there is a possibility of recall bias.

7. CONCLUSION AND RECOMMENDATIONS

7.1 conclusion

Women in homa district have relatively high autonomy. Educational status of women, women's employ for payment, wealth index of house hold, age at first marriage, attitude towards MHC and place of residence are factors significantly associated with women autonomy on MHC utilization in the study area. Qualitative study addressed, being victim of previous culture, religion and misperception around it, women's lack of their own means of income, lack of education (school dropout at low level), lack of equal awareness on gender equality as factors contributing in women autonomy on MHC utilization.

7.2 Recommendations

For government and woreda administrator: Facilitate means to improve women's opportunity to employ for income and on how to increase economic status of households such as women centered credit association and establish small and microenterprise for women.

For gender office and educational bureau of the district: Working with community, for instance by using local media or establish public meeting for both men and women to discuss on how to improve female education at least to primary level, importance of delay age at marriage in line with women autonomy, what things to be done at community level to create income generating activities to increase economic status of women and households.

For woreda health bureau and health care providers at all level: Since attitude of mothers toward MHC service is a double advantage we encourage you to invest your maximum effort to change the attitude of all women and teach them about the consequence of early marriage by facilitating different programmes such as women conference regularly and also delivering information via local media.

For community: We encourage a large community, in the area to take part in enhancing women autonomy by improve educational status of female, involving women in income generating activities despite of gender role and considering marriage after age 18 as a culture.

For researcher: Incorporate male side information to compare couple responses and to see an extent to which male characteristics affect women's autonomy on MHC utilization.

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Annex I: participant information sheet and informed consent form (English version)

My Name is----------. I am working as a data collector for the study being conducted in this community on the assessment of factors associated whith women's autonomy regarding maternal health care for who studying it as part of the requirement to graduate his masters' degree in public health / Reproductive health from Jimma university. I would like to ask you some questions related to this study and all information you give will be confidential and will be used to make a general report. No names will be included in the report and there will be no way to identify you as one of the people who gave information. Your inclusion in the study is voluntary and you are free to withdraw from the study if you are not willing to participate. If you have any questions about the study, feel free to ask me. The interview will take 30-40 minutes,so kindly request you to give attention this time for the interview. If you need to get the investigator you can contact through the following address: -

Name – Aboma Diriba

Address: Email – abomadir96@gmail.com, Phone- 251-920 862296

8.2 Informed Consent Form

I have been well aware of that this research undertaking is for a partial fulfillment of MPH degree which is fully supported and coordinated by the JU, College of Health Sciences, Department of PFH and the designate principal investigator is Aboma. D. I have been fully informed in the language I understand about the research project objectives. I have been informed that all the information I shall provide to the interviewer will be kept confidential. I understood that the research has no any risk and no composition. I have assured that the right to ask information that is not clear about the research before and or during the research work and to contact Jimma University, College of Health Sciences IRB Office: Tel. _____

Principal Investigator's Name: Aboma Diriba Tel: _____

Advisors Name 1. _____ Address: _____

2. _____ Address; _____

I have read this form, or it has been read for me in the language I comprehend and understood the condition stated above, therefore, I am willing and confirm my participation by signing the consent.

Agreed to participate in the study: Yes _____No____Time started _____Time finished_____

8.3: Annex III: Data collection Instrument

This questionnaire is prepared for collecting information on assessment of factors associated whith women's autonomy regarding maternal health care utilization, in Homa districts, west Wollega Zone, Oromia region, West Ethiopia, 2019.

Kebele: _____ House code_____

Name of Data Collector: _____ Signature_____ Date: _____

Name of Supervisor: _____ Signature_____ Date: _____

Instruction: Encircle the response/s in response column

Part one: socio-demographic characteristics of the respondents

	Question	Response option	Code	Skip
101	Age of the respondent?	----------(in completed years)		
102	Age at marriage	----------(in completed years)		
103	What is your Ethnicity?	1.Oromo 2. Gurage 3. Amhara 4.Others(Specify)_____		
104	What is your Religion?	1. Protestant 2. Orthodox 3. Muslim 4.Others (specify)_____		
105	Residence of the respond-ent?	1.Urban 2.Rural		

106	Educational Status of respondent	1. Unable to read and write 2. only able to read and write 3. Primary education 4. Secondary education 5. College and above		
107	Aside from your own housework, have you done any work in the past 12 months?	1.yes 2.No		
108	Are you paid, in cash/kind, for this work?	1.Paid 2.Not paid		
109	What is your Husband Educational Status?	1.Unable to read and write 2. only able to read and write 3. Primary education 4. Secondary education 5. College and above		
110	Has your husband done any work in the past 12 months?	1.yes 2.no		
111	What is your Marriage Type?	1.Monogamous 2.Polygamous		
112	Family Structure	1.Nuclear 2.Extended		
113	Number of children surviving.	In number_____		
114	family size.	In number_____		
	HOUSE HOLD CHARACTERISTICS			

115	What is the main source of drinking water for member of your house holds?	1. Piped water 2. Protected well 3. Protected spring 4. Unprotected well 5. Unprotected spring 6. river/lake 7. other specify			
117	What is the Floor of your house made of?	1. Mud 2. Sand 3. Wood 4. Cement 5. Other (specify)			
118	What is the roof of your house made of?	1. Grass 2. Corrugated iron/metal 3. Cement 4. Other			
119	What is the wall of your house made of?	1. Wood and mud 2. Cement block 3. Sand and stone 4. Bricks 5. Other			
120	**Does your house hold have**	**Yes= 1**	**No= 0**		
	Electricity				
	Electric mitad				
	A television				
	Refrigerator				
	A radio?				
	Mobile phone				

	Non-mobile telephone				
	Watch				
	Table				
	Chair				
	Bed with cotton/sponge/ spring mattress				
	Automobile like car, Bajaj, trunk motor cycle				
	Animal-drawn cart				
	agricultural land				
	Milk cows, oxen or bulls?				
	Horses, donkeys, or mules?				
	Sheep				
	Goats				
	Chickens or other poultry				
	Beehives				

part 2 questions related to media exposure.

No	Question	Response option	Skip
121	Do you read prints media such as news-paper ?	1. almost every day 2. at least once a week 3. less than once a week 4. not at all	
122	Do you listen a radio ?	1. almost every day 2. at least once a week 3. less than once a week 4. not at all	
123	Do you watch TV?	1. almost every day 2. at least once a week 3. less than once a week 4. not at all	

Part three: women's knowledge about maternal health care service

124	Do pregnant women need to go for ante-natal check-up?	1. Yes 2. no	If no skip to Q128
125	How many times mothers should get ANC service during their pregnancy?	1. Once 2. Twice 3. Three times 4. Four and above	
126	is it required to go for ANC even if there is no complication during px?	1. Yes 2. No	
127	Do pregnant woman need to take extra food as compared to non pregnant state?	1. Yes 2. No	

128	Birth preparedness and complication readiness is good practice for px mother.	1. Yes 2. no	
129	Who is the right person to give delivery service?	1. Skilled birth attendant 2. TBA 3. Relatives 4. Others(specify)	
130	Do you know danger sign of pregnancy and or delivery?	1. Yes 2. No	If no skip to Q 132
131	Can you mention them?	1. Convulsion 2. Blurring of vision 3. Severe head ache 4. Reduction or Absence of fetal movement 5. Vaginal bleeding 6. Severe lower abdominal pain 7. Others	
132	HF is the ideal place a mother should get ANC, natal and PNC	1. Yes 2. no	
133	How many times mothers should get PNC service?	1. One 2. two 3. 3. three and above	
134	Is it recommended to go for PN visit If there is no complication.	1. 1.yes 2. 2. no	

Part four: women's attitude towards maternal health care service

s/no	Questions	Strongly disagree (1)	Disagree (2)	Unde-cided(3)	Agree (4)	Strongly agree (5)	Skip
135	Pregnant mother should go for antenatal booking within the first third month of pregnancy.						
136	Women having danger signs should seek medical help.						
137	Antenatal follow up is good to monitor mother's and fetus' health						
138	Vitamin and iron sulfate supple-ment is good for health of mother and the fetus						
139	Giving birth at HF minimizes ma-ternal and new born morbidity and mortality						
140	All pregnant mothers are at risk of pregnancy and delivery complica-tion						

Part five; women's autonomy on decision making power

No	Question	Response option	Skip
141	who in your family usually has the final say on your Health care ?	1. respondent alone 2. Respondent and husband/partner jointly, 3. Respondent and someone else, 4. husband/partner alone 5. someone else	
142	who in your family usually has the final say on desired number of children?	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. someone else	
143	who in your family usually has the final say on your contraception utilization?	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. someone else	
144	who in your family usually has the final say on ANC utilization	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. someone else	
145	who in your family usually has the final say on preference of delivery site?	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. someone else	
146	who in your family usually has the final say on PNC utilization	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. someone else	

Part six: women's autonomy on control over finance

No	Question	Response option	Skip
147	Do you have regular access to a source of money (wages earned and gifts or support from family)?	1. Yes 2. No	If no skip to Q,150
148	Can you spend this money without consulting anyone?	1. Yes 2. No	
149	who decides on how to use the money you earned?	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. someone else	
150	who decides on how to use the money your husband earned?	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. 5.someone else	
151	Who decides about making major household purchases?	1. respondent alone 2. respondent and husband/partner jointly, 3. respondent and someone else, 4. husband/partner alone 5. .someone else	

Part seven: women's autonomy on freedom of movement

152	Can you leave the house without asking permission of other adult (husband's/partner or someone else) to go to health facility for your own health care?	1. Yes 2. no	
153	Can you leave the house without asking permission of other adult (husband's/partner or someone else) to visit family or relative?	1. Yes 2. No	
154	Can you leave the house without asking permission of other adult (husband's/partner or someone else) to go to market places outside this village?	1. yes 2. no	
155	Can you leave the house without asking permission of other adult (husband's/partner or someone else) to go for public meeting?	1. Yes 2. No	

ANNEX C: Consent form focus group discussion (English version)

A study on the assessment of factors associated whith women's autonomy regarding maternal health care among married women in Homa district. for who studying it as part of the requirement to graduate his masters' degree in public health /Reproductive health from Jimma university.

Group name (code) _____ Name of Moderator _____

Name of note taker(s) _____ _____

Date _____ Total time taken ____ Code number of tape recorded _____

Hello, thank you for taking your time to talk to us, we are _____ (the moderator) and

_____ (the note takers).

We are working on a research approved by Jimma University, institute of health to be conducted in partial fulfillment of master's degree in Reproductive Health. We are here to learn from you about factors associated whith women's autonomy regarding maternal health care which will contribute to provide important information for program managers and policy makers at all levels to concentrate on the relevant factors of interest for possible intervention.

We would like to tell you some rules considered in our meeting

1. The discussion will last about 1 -1:30 hours

2. Everything you say will remain confidential

3. Your name will not be used when reporting on the findings and your participation is voluntary.

5. A tape recorder will be used only to facilitate the recording and analysis of the discussion and all tapes will be destroyed after they have been transcribed.

Permission to tape record the discussion? Yes_____ No _____

Focus group discussants:

Characteristics of the group.

S/No	Sex	Age	Educational level
1			
2			
3			
4			
5			
6			
7			
8			

Discussion points: women autonomy on maternal health care utilization.

1. What does it mean women autonomy for you?

❖ does women in your community are autonomous? Why? In line with maternal health care utilization

2. who in your family usually has the final say on mother's own health care, Number of children, contraception services, ANC, preference of delivery site, and PNC? Why?
3. How do you explain authority of women in this community on control over the finance?

❖ who decides how the money women earnings are used/ can she spend it without consulting any one? Why?

❖ Can women's decide on how the money husband's earnings are used? Why?

❖ Who usually makes decisions about making major household purchases? For instance, land, coffee, TV, Ox

4. In this community is it acceptable if women to go to health facility, visit family and market or to attend public meeting out of this village without informing their husband or others? What kinds of other places do you need your husband's or other family member's permission to go?

❖ What happens if women don't ask permission or tell husband/others before they go?

5. In your opinion, what factors can influence women's autonomy on maternal health care? How they affect their decision-making roles, freedom of movement, and control over economy?

Questions/Guide for the 'Key Informants Interview.

1. What does it mean women autonomy for you? How do you see the autonomy of women in this community (autonomous or not)? Especially in line with maternal health care utilization? If no, Why?
2. In your opinion in this community who usually has the final say on mother's own health care, Number of children, contraception services, ANC, preference of delivery site, and PNC? Why?
3. How do you explain authority of women in this community on control over the finance?

❖ who decides how the money women earnings are used/ can she spend it without consulting any one? Why?

❖ Can women's decide on how the money husband's earnings are used? Why?

❖ Who usually makes decisions about making major household purchases? For instance, land, coffee, TV, Ox

4. Do you think that it is acceptable, if women to go to health facility, visit family and market or to attend public meeting out of this village without informing their husband or others? If yes, is it uniformly applicable throughout the community? If no, why?

❖ What kinds of things may happen if women don't ask permission or tell husband/others before they go?

5. In your opinion, what factors can influence women's autonomy on maternal health care? How these factors can affect their decision-making roles, freedom of movement, and control over economy

Appendix II: participant information sheet and informed consent form for selected study participant (afan oromo version)

Akkam bultan/ooltan! Maqaan koo _____ jedhama. Anis sassaabduu ragaa qo'annoo ganda keessan keessatti qorannoo dhimmi of hoggansidubartootaa gama tajaajila fayyaa haadholii irratti maal fakkaata kan jedhuu fi walitti dhufeenya inni wantoota biraa waliin qabu qorachuuf bara 2018/19 barataa digrii lammaffaa Yuniversitii jmmaa kan tahe Abboomaa Dirribaatiin geeggeeffamuuti. Isinis garee qo'annoo keenyaa taatanii waan filatamtaniif waa'ee qo'annoo kanaa isinii ibsuuf gurra fi qalbii keessan akkanaaf ergiftan kabajaan nan gaafadha. Odeeffannoon isin nutti himtan hundi iccitiin qabama. Gaaffiin enyuumma keessan fi maqaa keessan ibsu hin jiru. Argannoon qo'annaa kanaa hawaasa qo'annaa kana irratti hirmaatan akka walii galaatti kan ibsu yoo tahu, karaa kamiinuu dhimma nama dhunfaa hin calaqqisiisu.

Rakkinni qo'annoo kana keessatti hirmaachuu keessaniin isin quunnamu yoo jiraate, yeroo keessan muraasa (daqiiqaa 30-40) qofaa fudhachuu taha. Qo'annoo kana irratti hirmaachuu keessaniin kaffaltiin kaffalamu tokko iyyuu hin jiru. Garuu bu'aan qo'annoo kanaa ragaawwan haarawaa waajjira fayyaa naannoo keessaniifi qooda fudhattoota biroof ni argamiisa.

Hirmaachuuf fedhii qabdu yoo tahe gaffiiwwan garaa garaa qo'annoo kanaaf qopha'an isiniifan dubbisa.

Hirmaannaan qo,annoo kana keessatti gootan guutuummaan guutuutti fedhii irratti kan hundaa'e. Mirga hirmaachuu fi hirmaachuu dhiisuu ni qabdu. Hirmaachuuf yoo murteessitsn, mirga yeroo barbaaddanitti qo'annoo kanaa keessaa bahu yommuu qabaattan kana gochuu keessaniifis faayidaan isiin argachuu qabaattanii dhabdan tokko iyyuu hin jiru. Gaaffii deebisuu hin barbaadne deebisuufis hin dirqamtan.

Teessoo

Gaaffii yookiin qeeqa qo'annoo kana ilaallatuu kamiifuu, teessoo armaan gadiin gaafachuu fi quunnamuu ni dandeessu.

Qo'ataa muummee: obbo Abboomaa Dirribaa, lakk. bilbila mobayilii: *+251920862296* yookiin E-mayilii, abomadir@gmail.com

Waajjira dhimma naamusaa qo'annaa fayyaa dhaabbatichaa (JUERB) lakk. Bilbilaa _____ Yookiin lakk.Poostaa _____, Jimma.

Unkaa walii galtee fedhii irratti hundaa'ee:

Qorataan muummee qo'annochaa obbo Abboomaa.D ta'uu,qorannichi guutuummatti Jimmaa univesiitiin kan deeggaramuu ta'uu fi kaayyoon qo;annochaa ragaa barnootaa digrii lammaffaa saayinsii fayyaa ha-waasaa argachuuf akka ta'e haalaan hubadheen jira.

Unkaan walii galtee hirmaattootaa afaan ani hubachuu danda'uun naa dubbifameera. Kaayyoo qo'annichaa, faayidaa fi midhaa, dhimmi iccitii eeguu, mirga hirmaachuu fi teessoon qo'ataa illee natti himamee jira. Wanta ifa hin taane akkan gaafadhuuf carraan naaf keennamee jira. Akkan yeroo barbaade qo'annicha adda kutee bahuu dandahu yookiin gaaaffii deebisuu hin barbaannee deebisuu hin dirqamnes natti himameera. qorannichaan wal qabatee waan ifaa naaf hin taane kamiinuuu gaafachuuf Waajjira dhimma naamusaa qo'annaa fayyaa dhaabbatichaa (JUERB) akkan quunnamuuf teessoon isaanii naaf laatameera. lakk. Bilbilaa _____ Yookiin lakk.Poostaa _____, Jimma.

Kanaafuu, akkan qo'annaa kana irratti feedhii kootiin hirmaadhe mallattoo koo armaan gadiin nan mirkanneessa.

qorannichatti hirmaachuuf itti walii galtee?: eeyyee _____lakki_____

Mallattoo hirmaattuu_____. Mallattoo odeeffannoo sassaabduu_____.

guyyaa _____

yeroo itti eegale _____yeroo itti xumurame_____

maqaa daataa sassabduu _____mallatoo _____

Hub: Waliigalteen kun fuul-dura hirmaataa qo'annoo fi odeeffannoo sassaabduu itti malleettaffamuun, koopppiin isaas hirmaataa/ttuf kennamuu qaba.

Galatoomaa!

APPENDIX C II: Guca gaaffilee afaan oromoon qophaa'e

gucni gaafilee kun kan qophaa'e qorannoo tajaajila fayyaa haadholii irratti of hoggansi /ofiin murteeffa-chuun dubartootaa maal fakkaata kan jedhuu fi walitti dhufeenya inni wantoota biraa waliin qabu beekuuf odeeffannoo sassaabuuf gargaaru dha.

ganda: _____ lakk.manaa_____

odeeffanoo sassaabduu ----------mallattoo ----------

maqaa to'ataa/ttuu ----------mallattoo ----------

guyyaa ----------sa'atii ----------

kutaa 1ffaa : gaaffilee hawasummaa fi diinagdee hirmaattotaa.

t/l	gaaffii	deebii	Irra darbi
101	Umuriin kee meeqa?	----------(waggaa dhaan)	
102	Umuriin ati itti eerumte meeqa?	_____waggaadhaan	
103	Qomoon kee maali?	1.Oromo 3. Amhara 2. Gurage 4.kan biraa(ibsi)_____	
104	Amantaan kee maali?	1. Protestant 3. Muslim 2. Orthodox 4.Others (specify)_____	
105	Bakka jireenyaa?	1.magaalaa 2.baadiyyaa	
106	Sadarkaaa barnootaa gaafatamtuu	1. dubbisuuf barressuu kan hin dandeenye 2. dubbisuuf barreessuu kan danda'u 3. sadarkaa tokkoffaa 4. sadarkaa lammaffaa 5. kolleejjii fi isaa ol	
107	Jioota 12,n darban keessa hojii mana keessaa hojjettun ala hojii biraa hojjettee beektaa?	1.hojjedheera 2.hin hojjenne	Skip
108	Hojii dabalataa hojjettu kanaaf wanti siif herregamu jiraa?	1.naaf herregama 2.naaf hin herregamu	

109	Sadrkaa barnootaa abbaa manaa?	1.dubbisuu fi barreessuu kan hin dandeenye. 2.dubbisuu fi barreessuu n I danda'a 3. barnoota sadarkaa 1ffaa 4. barnoota sadarkaa 2ffaa 5. kolleejjii fi isaa ol	
112	Abbaan manaa kee hojii hojjechaa jiru qabaa?	1.hojjechaa jira 2.hojjechaa hin jiru	
111	Abbaan manaa kee sim alee haadha manaa kan biraa qabaa?	1.ana qofa 2.haadha manaa biraa qaba.	
112	maatiin kee eenyufaa of keessatti ammata	1.abbaa manaa fi ijoollee 2.abbaa manaa,firootaa fi ijoollee	
113	Ijoollee meeqa qabdu.	Laakk,n_____	
114	Baay'inni nama maatii kana keessa jiraatanii meeqa?.	Lakk,n_____	
	Haala fi qabeenya manichaa		
115	Maatiin keessan bishaan dhugaatiif tau eessaa argattu?	1. bishaan boonoo(buambuaa) 2. bishaan boollaa eegamaa tae 3. bishaan burqituu eegumsa 4. bishaan burqituu eegumsa hin qabne 5. bishaan boollaa eegamaa hin taane 6. haroo /laga 7. kan biraa, ibsi	

117	Manni keessan lafti isaa maaliin hojjetame?	1. biyyee 3. muka 2. ashawaa 4. simmintoo 4,ka biraa yoo tae ibsaa		
118	Baaxiin mana keessanii maalirraa hojjetame?	1. caffee/marga 3. simmintoo 2. qorqorroo 4. ka biraa		
119	Dagaleen mana keessanii maalir-raa hojjetame?	1 mukaa fi biyyee 3. cirrachaa fi dhakaa 2. blokeetii simmintoo 4. ka biraa		
120	**Wantoota armaan gadii maatiin keessan qabuu**	**Eeyyee=1**	Lakki=0	
	Elektrikii			
	Eelee elektrikaa			
	Televejiinii			
	Diidalleessituu			
	Raadioo			
	Moobayilii sochootuu			
	Telefoona manaa			
	Sa'aatii			
	Barcuma			
	Xarapheezzaa			
	Siree firaashii cidii/spoonjii waliin			
	Geejjiba manaa kan akka Makiinaa,bajaajii,dofdoqqee ,biskiliitii fi kkf			

	Makiinaa beeyladootaan karki-famu(gaarii)			
	Lafa qotiisaa nii qabduu			
	Horii aannanii, sangaa, korma			
	Farad, harree, gaangee?			
	Hoolota			
	re'oota			
	Lukkuu			
	Gaagura			

kutaa 2ffaa:sabquunnamtii hawaasaan gaaffiwwan wal qabatan.

T/L	gaaffii	Deebii	Irra darbi
121	Barruulee garaa garaa nii dub-bistaa ?	1. eeyyee yeroo hunda 2. xiqqate torbanitti yeroo tokko 3. torbanitt yeroo tokkoo gadi 4. dubbisee hin beeku	
122	Raadiyoona nii dhaggeeffattaa	1. eeyyee yeroo hunda 2. xiqqate torbanitti yeroo tokko 3. torbanitt yeroo tokkoo gadi 4. goonkumaa	
123	Televejiinii nii daawwattaa?	1. eeyyee yeroo hunda 2. xiqqate torbanitti yeroo tokko 3. torbanitt yeroo tokkoo gadi 4. goonkumaa daawwadhee hin beeku	

Part three: tajaajila fayyaa haadholiirratti hubannoo dubartootni qaban.

124	Haati ulfaa tokko hordoffii mana yaalaa qabaachuu qabdi.	1. Eeyyee 2. lakki	Lakki, gara gaaffii 127tti darbi
125	Haati ulfaa tokko tajaajila yeroo ulfa duraa kennamu al meeqa argachuu qabdi?	1. tokko 3. sadii 2. lama 4. afurii fi isa ol	
126	rakkoon yoo hin jiraatne tajjajilli yeroo ulfa duraa kennamu barbaachisaadhaa?	1. Eeyyee 2. Lakki	
127	Haati ulfaa tokko nyaata dabalataa nii barbaaddii?	1. Eeyyee 2. Lakki	
128	Haadha ulfaa tokkof qophiin isheen yeroo da'umsaa fi rakkoolee mudachuu danda'anif gootu shaakala gaariidha.	3. Eeyyee 4. Lakki	Lakki yoo tae gara G-125
129	Tajaajila yeroo da'umsaa kan kennu qabu eenyu?	1. ogeessa fayyaa 3. Firoota 2. deessistuu aadaa 4. kan biraa(ibsi)	
130	Mallattoo hamaa kan yeroo ulfaa fi da'umsaa nii beektaa?	1. Eeyyee 2. lakki	Lakki yoo ta'e gara G 132
131	Maalfaadha? Ibsi	1. Of wallaaluu 2. dhiiga baayinaan karaa qaama hormaataa ba'u. 3. Ija dora nama maruu3. 4. Mataa dhukkubbii jabaa tae 5. hiddi handhuuraa dursee dhufuu 6. akkaataa taumsa mucaa sirrii ta'uu dhabuu	

		7. dha'atnaan onnee mucaa hir'achuu/dhaabbachuu 8. others. 9.miixuu yeroo dheeraa	
132	Bakki sirriin dubartootni itti tajaajila fayyaa kan yeroo ulfaa, da'umsaa,fi da'umsa boodaa argachuu qaban mana yaalaa/buufata fayyaati.	1. Yes 2. No	Lakki yoo ta'e gara G 135
133	Haati tokko tajaajila yeroo da'umsa boodaa al meeqa argachuu qabdi?	1. tokko 2. lama 3. sadii fi isaa ol	
134	rakkoon yoo hin jiraatneyyuu tajaajila yeroo da'umsa boodaa argachuun barbaachisaadhaa.	1. Eeyyee 2. lakki	

kutaa 4ffaa: tajaajila fayyaa haadholiif kennamu ilaalchisee ilaalcha dubartootni qaban.

135	Haati tokko ulfooftee ji'a 3 gidduutti hordoffii eegaluu qabdi.	1. haalaanan itti walii gala 2. ittan walii gala 3. murteessuuf rakkisaa dha 4. itti walii hin galu 5. haalaanan itti walii hin galu.	
136	Haati mallattoo hamaa ta,e of irratti argite tokko mana yaalaa deemuu qabdi.	1. haalaanan itti walii gala 2. ittan walii gala 3. murteessuuf rakkisaa dha 4. itti walii hin galu 5. haalaanan itti walii hin galu.	
137	Hordoffiin yeroo ulfaa godhamu fayyaa haadholii fi daa.imaaf gaariidha.	1. haalaanan itti walii gala 2. ittan walii gala 3. murteessuuf rakkisaa dha 4. itti walii hin galu 5. haalaanan itti walii hin galu.	

138	Fayyaa haadhaa fi daa'imaaf vaayitaaminni A fi kininni hir'ina dhii-gaaf kennamu baay'ee barbaachi-saadha.	1. haalaanan itti walii gala 2. ittan walii gala 3. murteessuuf rakkisaa dha 4. itti walii hin galu 5. haalaanan itti walii hin galu.	
139	Mana yaalaatti da'uun miidhaa fi du'aatii haadholii fi da'immanii nii hir'isa.	1. haalaanan itti walii gala 2. ittan walii gala 3. murteessuuf rakkisaa dha 4. itti walii hin galu 5. haalaanan itti walii hin galu.	
140	Haati hundi yeroo ulfaas tae da'umsaa rakkoof saaxilamoodha.	1. haalaanan itti walii gala 2. ittan walii gala 3. hin murteessine 4. itti walii hin galu 5. 5. haalaanan itti walii hin galu.	

kutaa 5ffaa; gaaffilee dubartootni gama tajaajila fayyaa haadholii irratti murtoo murteeffachuuf qaban.

No	Gaaffii	Deebii	Irra tari
141	Tajaajila fayyaa ati argachuu qabdu irratti maatii kee keessaa yeroo baay'ee murtii dhumaa kan dabarsu eenyu?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	
142	Maatii kee keessaa baay'ina daa'ima argachuu barbaaddanii kan murteessu eenyu?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	

143	Mala ittisa da'umsaa fayyada-muu irratti yeroo baayee murtoo dhumaa kan murteessu eenyu?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	
144	Hordoffii yeroo ulfaa akka ar-gattuuf maatii kee keessaa eenyutu murtii dhumaa laata?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	
145	Bakka da'umsaa filachuurratti kan murtii dhumaa laatu eenyu?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	
146	Hordoffii yeroo daumsa boodaa akka argattuuf maatii kee kees-saa eenyutu murtii dhumaa laata?	6. deebi-deebistuu qofa 7. deedi-deebistuu fi abbaa manaa/maatii waliin 8. deebi-deebistuu fi nama kan biraa. 9. abbaa manaa/maatii qofa 10. nama kan biraa	

kutaa 6ffaa: gaaffilee oluntummaan dubartootaa maallaqa/qabeenyaa toachuu irratti maal fakkaata

T/L	Gaaffii	Deebii	Irra tari
147	Madda galii dhaabbataa ta'e nii qabdaa (miindaa and kennaa ykn gargaarsa maatii irraa)?	1. Eeyyee 2. lakki	Lakki yoo tae G150
148	Nama kamiin osoo hin mariisisin maallaqa kana baasuu ni dan-deessaa?	1. Eeyyee 2. lakki	
149	Maallaqa argatte kana akkaataa itti fayyadamtu irratti eenyutu murteessa?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	
150	Akkaataa itti fayyadama maallaqa abbaan manaa kee argatu irratti kan murteessu eenyu?	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. nama kan biraa	
151	Qabeenyaa gurguddaa,kan lafaa ,buna,bineeldota,TV fi kkf bituu fi gurguruu irratti eenyutu mur-teessa	1. deebi-deebistuu qofa 2. deedi-deebistuu fi abbaa manaa/maatii waliin 3. deebi-deebistuu fi nama kan biraa. 4. abbaa manaa/maatii qofa 5. 6. nama kan biraa	

kutaa 7ffaa: gaaffilee mirga bakka barbaadan deemuu dubartootaa.

152	Nama kamiiniyyuu eeyyama utuu hin gaafatin tajaajila fayyaa ofii kee argachuuf gara mana yaalaa deemuu ni dandeessaa?	1. eeyyee 2. lakki	
153	Maatii ykn firoota kee daawwachuuf eeyyama nama kamiiniyyuu utuu hin gaafatin manaa deemuu nii dandeessaa?	1. eeyyee 2. lakki	
154	Gabaa ganda kanaan alaa kan tae deemuuf eeyyama nama kamiinuu ala manaa deemuu nii dandeessaa?	1. eeyee 2. lakki	
155	Walgahii uummataa hirmaachuuf eeyyama nama ka-mii utuu hin gaafatin manaa deemuu nii dandeessaa	1. eeyyee 2. lakki	