A WOMAN'S AUTONOMY ON MATERNAL HEALTH SERVICE UTILIZATION AND ASSOCIATED FACTORS IN AMBO TOWN, WEST SHOWA ZONE, ETHIOPIA

BYTADELE YADESSA (BSC)

A RESEARCH THESIS SUBMITTED TO SCHOOL OF NURSING AND MIDWIFERY, INSTITUTE OF HEALTH SCIENCES, JIMMA UNIVERSITY FOR PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE MASTERS OF SCIENCE DEGREE IN MATERNITY HEALTH NURSING.

JIMMA,ETHIOPIA
JUNE, 2018

A WOMAN'S AUTONOMY ON MATERNAL HEALTH SERVICE UTILIZATION AND ASSOCIATED FACTORS IN AMBO TOWN, WEST SHOWA ZONE ETHIOPIA.

ByTadeleYadessa (BSc)

Advisors: 1.Mr FekaduYadessa (BSc, MSc, Ass.professor).

2. Mr. Adugna OLani (BSc, MSc)

JIMMA, ETHIOPIA
JUNE, 2018

ABSTRACT

*Background**:**women's autonomy encompasses the ability to obtain information and make decisions about one's own concerns, have some control over finances and freedom of movement. Women's autonomy in health-care decision making is central to the improvements of maternal and child health. Little is known about women's autonomy and its influencing factors on maternal and child health care service utilization in Ambo town, West showa zone Oromia region as well as in Ethiopia.*

***Objectives**: The objective of this study was to assess the women's autonomy of deciding on their maternal health service utilization &associated factors in Ambo Town, Ethiopia.*

***Methods:** Community based cross-sectional study was conducted on 381 women of having under five childrenfrom March 3- April 3 2018. Face to face interview was carried out to collect data using structured questionnaires adapted from different literatures. Four BSc mid-wives who have lived in Ambo town for at least one year were recruited from Ambo general hospital andtrained for two days for data collection. Women's autonomy was measured by using the composite index of the three constructs of women's autonomy: control over finance, decision-making power and extent of freedom of movement. Proportional and Systematic sampling method was used to get required sample. Descriptive statics, binary andmultiple logistic regression analysis was conducted by using SPSS version 22 analytical software to identify factors associated with autonomy of women. The explanatory variables having P value <0.05 inmultiple logistic regression analysis was taken as significant association and reported using p-value and adjusted odd ratio.*

***Result**: Out of 381 women, more than half (55.6%) had higher autonomy regarding their maternal health service utilization. In the multiple logistic regression models, after adjusting for the potential confounders; being in 3-4 Parity, adjusted odds ratio [(AOR):0.*28(95% C.I:.10-.76)],having 3-4 *living children[(AOR):6*(95% C.I: 2.42-14.94)], *being in tertiary Educational status (Women's) [(AOR):0.* .007(95% C.I:.00-.27)], *having exposure to media [(AOR):0.*008(95% C.I:. 001-.079)],*Being in monogamy marriage type and having >=18year age at marriage [(AOR):0.*038 (95% C.I:.003-.42)],*were the final predictors of women's autonomy.*

Conclusion: In improving MHSU, women's autonomy of decision making plays a central role and needs strong focus.Socio-demographic and socio cultural factors were found to influence women's autonomy.

***Recommendation**: Interventions targeting women's autonomy with regards to deciding their maternal health service utilization should get focus equal to that of expanding health institution and health professionals and priority should be given to women with a lower socioeconomic status*

Key words:Ambo town,Maternal health care utilization,Women, Autonomy.

ACKNOWLEDGEMENT

First of all I would like tothank Almighty GOD for his endless love,next JU for giving me this chance and for its support by funding, libraries and websites for preparing this material I would also like to express my deepest gratitude and appreciation to my advisors Mr.FekaduYadessa(BSc, MSc,Ass.professor) and Mr.Adugna OLani (BSc, MSc) for their genuine and constructive comments. Studysubjects, datacollectors, supervisor's health extension worker and kebele leaders have great thanks on behave of me for their patience and collaboration. Last but not least I would like to thank my families and friends.

Contents

LIST OF FIGURES

LIST OF TABLES

ABBREVIATION AND ACRONOMIES

ANC Antenatal care

ETBEthiopian Birr

EDHSEthiopian Demographic and Health Survey

FSFinal Say

ICPDInternational Conference on Population and Development

HFDHealth Facility Delivery

MMRMaternal Mortality Rate

MHSU Maternal health service utilization

PNCPostnatal care

SSASub-Saharan Africa

WHOWorld Health Organization

DECLARATION

The undersigned agreed to accept responsibility for scientific ethical and technical conduct of the reaserchs project and for provision of required progress reports as per terms and conditions of the institute of health in effect at the time of grant is forwarded as the result of this application.

Name of the investigator:----------
Signature:----------
Name of the institution:----------
Date of submission:----------

Name and signature of internal examiner

Approval of the advisors

Name and signature of Major advisors

Name and signature of co-advisor

CHAPTER ONE: INTRODUCTION

1.1.Background of the Study

Autonomy is multidimensional concept and difficult to quantify. It refers to independence or freedom of the one's action and it is explained as the capacity of an individual to act in accordance with objective morality rather than under the influence of one's desires (1).
Women's autonomy is a complex and general term which has contextual meaning and is influenced by personal attributes of women as well as socio -cultural norms of the society. It can be defined as the capacity and freedom to act independently. It encompasses women's ability to formulate strategic choices, control resources, and participate in decision-making. Women's autonomy identified by researchers include access to and control over resources, participation in economic decisions, self-esteem, mobility, and freedom from domestic violence, which plays central role on maternal health service utilization (2).

Everyday about 800 women die due to pregnancy related complications worldwide and 99% of them occur in low and middle income countries. More than half of these occur in sub-Saharan Africa and one third in South Asia. Efforts were made to reduce (MMR), but it is still unacceptably high in many low- and middle-income countries including Ethiopia. Even though the government is expanding health institution and maximizing health personnel, to avoid this social injustice, the utilization issue left underquetion.Many studies showed that women's autonomy in deciding health care is likely to increase the utilization of maternal health care services. Forexample, study from Tajikistan (3).

Maternal mortality is a major public health problem in low and middle-income countries. Most of the maternal deaths could be prevented if there is adequate and timely utilization of maternal health care services by women. But, how well the cultures of the society give space for women to use maternal health service looked little. Higher autonomy of women is associated with higher utilization of maternal health care services. Increment in participation of women in decision making process regarding health care and household matters showed to be increased for the better use of maternal health care services (4).

Women's autonomy is one of the determinants of maternal health care services utilization in developing countries. So, exploring the role of women's autonomy as a mediating factor in the utilization of maternal health care services is other dimension, Therefore, it can be considered as essential component affecting maternal health service utilization but has got little or no attention (5).

1.2. Statement of the Problem

Despite various efforts, maternal mortality is still high in most low resource countries of Sub-Saharan Africa including Ethiopia. Ethiopia has made remarkable progress in maternal mortality reduction. However, most MHSU like completion of four antenatal care visits, skilled care at birth, institutional deliveries and postnatal care visits have not attained set targets. The high utilization of maternal health care services makes it possible to reduce maternal and neonatal morbidity and mortality (6).

Women's autonomy is one of the determinants of maternal health care services utilization in developing countries. Most studies have focused on assessing the association with the demographic and socioeconomic factors and the utilization of maternal health care services rather than exploring the role of women's autonomy as a mediating factor in the utilization of maternal health care services(7).

In developed countries where (MMR) is very low like US, evidence indicates that women believe that they have a direct effect on healthcare decision-making not only for themselves but also for their family. A substantial amount of women are responsible not only for their own health, but also for their family's health and believe this impression begins with a life event of giving birth. Thus, giving a central place for women's during decision making about own health have been found to have positive impact on improving maternal health care utilization, which in turn uses to decline maternal morbidity and mortality (8).

In contrast, in developing countries, the most important causes for the high mortality rate are the three delays: delays in (taking decision for seeking health care, accessing care and receiving health care in health institution).Accordingly, delay in seeking health care is due to cultural beliefs, financial problems, transportation problems and decision making power in household, which can be summarized by women autonomy (self decision making power of women) that plays a vital role for the utilization of health care services (9).

Maternal mortality is social injustice and although most of them are preventable, the most recent available data indicate that in Africa it is among the highest worldwide. According to the WHO (2015) report, 303,000 women worldwide died during pregnancy or after, and most of these deaths occurred in SSA. In Ethiopia currently, the MMR is considerably high, 412 per 100,000 live births. This is because of that in most SSA cultures, women leaving their homes to seek maternal healthcare are unacceptable and people put women as powerless family member that is given for the care of that family (10-13).

Evidences found varying levels of health care decision-making autonomy in different countries and among different regions of the same country. Among Nepalese women, a low level of women's autonomy was found to be a contributory factor to poor maternal health service utilization and high MMR (14).

For ex. a study in rural SSA showed that women who were expected not to visit healthcare facilities were less likely to use ANC and skilled delivery services. On the other hand, in the study of Colombia, women who had some degree of autonomy were found to complete four or more ANC visits (, 15 and16).

Gender role expectation put vary in use of maternal healthcare services in rural SSA, the evidence show that, different level of women's autonomy in different areas that could be seen as a cause for their variation in status of using maternal health (17).

There were higher proportions of women with high decision-making authority in Ghana (46%) and in Uganda (52%) mean while, their maternal health service utilization was observed to be good. The proportion of women with high decision-making authority is 36%

in Kenya and 37% in Tanzania, which resulted in poor utilization of maternal health care service (18).

One of the study from Ethiopia showing the similar findings, very low institutional delivery, even though higher governments effort by constructing health institution, producing educated health professionals, however, the utilization by women's is not actually going in line with the government's effort which figured out that very fewer deliveries were attended by skilled birth attendants, that result in un acceptably high (MMR) (19).

However, there is limited or no research conducted on the study area regarding the self decision making power of women on their maternal health care utilization, specially no study in sighted the impact of some traditions' (culture) on the autonomy of women. Therefore, this study aims to investigate the autonomy of women's on decision making on their maternal health care utilization and associated factors in Ambo town.

1.4. Significance of the Study

The findings of this study contribute to knowledge, which might give good reason for stakeholders' expectations of the role of women in decision making regarding their maternal health service utilization. The researcher believes that the starting point to improve the performance of women on deciding about their maternal health service utilization and identifying their practices and challenges.It can help to inform health planners and program managers in Ethiopia to promote attitudes and practices that favor gender equality, in order to attain wider use of healthcare services among women, specially to encourage or discourage harmful traditions(cultures) and useful traditions' having impact on women's autonomy, base line for future/further researchers, use as secondary data. For policy makers it helps to consider strategies to increase utilization of maternal healthcare services if had been minimized due to having less autonomy& identify the impact of gender inequality on maternal

CHAPTER TWO: LITERATURE REVIEW

Women's autonomy is a subjective term which has a relative meaning. It is influenced by individual characteristics of a woman and socio-cultural norms and values of the society. Prior literature focused on couple's education, occupation and other socio-demographic characteristics i.e. age at marriage, age difference at marriage, numbers of children and sex of children for measuring the women's autonomy(19).

Evidences suggest that, autonomy and reproductive healthcare-seeking behavior are cause and consequences. Women's autonomy is an important influence on their reproductive healthcare-seeking behavior. Women's participation in domestic decision-making is strongly associated with ever-use of family planning. Women's autonomy regarding maternal and child health are important factors in determining health seeking behavior(20).

2.1. Status of women's autonomy on decision making regarding their maternal health service utilization

According to study conducted in Ghana, on the decision making,number of women having power on their health servivice utilization, 22.01% decided by themselves on their own health care ,53.25% decided jointly with their partners and 24.78% had their decisions made by their partners, As a result, 75.26% of women had health care decision making autonomy either alone or jointly. Inthis study it was identified that, low women autonomy, power inequalities at the household level between married couples has the ability to restrict health decision making autonomy of women which affects their health care utilization and other health outcomes(21).

In synthesized evidences from four of rural SSA countries concerning women's position of decision making on her health service utilization, the following condition have been observed. In Ghana, Kenya, Uganda and Tanzania respectively, Out of these clusters cover 1814 women in Ghana, 2662 in Kenya, 4223 in Tanzania and 3529 in Uganda. Women decision-making

authority index over the four countries distributed as follows; No" decision-making authority= 237 (.016) 257 (.013) 201 (.012) 242 (.014) respectively. Low decision-making authority= 301 (.019) 380 (.012) 276 (.011) 386 (.013) respectively. High decision-making authority= 462 (.024) 362 (.013) 523 (.015) 372 (.014) respectively (22).

Another study conducted in Bale revealed that, less than half (41.4%) had higher autonomy regarding decision of their own health utilization. Among those who had autonomy, (65.2%) had regular access to source of money, of which 38.1% were able to use the money by their independent decision. Furthermore,, 49.6% of the women were autonomous to take their children to health facilities while 43.9% of them were free to go to health facility for their own health care services, 56.7% of women had lower freedom of movement, 52.7% of women had higher financial control(23).

2.2. Factors associated with women's autonomy regarding maternal health care utilization

The study conducted in Mediterranean region showed that a women's health care decision making autonomy is independently influenced by their educational level, control over earnings and partner's education (24).

According to study conducted in Bangladeshi, demographic variables such as age of respondent, age at marriage, age differences between spouses, number of living children, respondent's educational level, occupation, partner's educational level, partner's occupation, monthly income, religion, using media were found to be associated with women's autonomy.

Gender role expectations in Bangladesh are primarily male dominated and limit the autonomous decision making of women when it comes to prenatal and postpartum care, and daily activities. Tradition dictates that Bangladeshi women rely heavily upon their husband and mother-in-law for direction regarding healthcare, finances, and daily

activities.Autonomous motility for most womenwas restricted and this prevents them from seeking care outside the home (25).

Other evidence in Ethiopia found socio-demographic factors like age,income,parity,number of living children,women's status like education,occupation,exposure to media, spousal age differences&structure of family are the main to affect the autonomy of women's on decision making on maternal health care utilization (26).

Determinants of autonomy of maternal healthcare utilization in Zimbabwe, thesociodemographiccharacteristics of women were found to have influence. On average, each woman has 4 children whilst only 25.89 percent are formally employed, 10.62 percent of the respondents never attained any education whilst 46.75 percent and 40.54 percent attained only primary and secondary education respectively. 46.57 percent of these women live in poverty whilst 74.92 live in rural areas. 75.99 percent of the women are married whilst 4.24 percent are divorced and 12.83 percent are widowed, over all autonomy of women were low (27).

Evidences in different countries indicated that, issues of access and autonomy to use of maternal health services is vary , while also being affected by , economics, and cultural elements like Polygamous practices, which have been found to influence the rate of MHC utilization. It often rejected by Christians while acceptable in Islamic religions in different countries (28).

Polygamous household environments place women in a competitive position in the family, where wives are considered rivals. In this family structure, the natural way to gain precedence is to have as many children as possible, and as such ignore female family planning practices. Nonetheless, when women in polygamous families want to practice family planning, their husbands and in-laws often do not agree and often punish women with violence29).
The male- female disparity in health and wellbeing has been well documented in developing countries and particularly in the Asian context, high levels of morbidity and mortality in women can often be indicative of female disadvantage relative to males. This is particularly

thought to be the case where cultural norms and economic systems limit women's autonomy (30).

2.3. Summary

Evidence showed that wealth and access to media in general enhance autonomy of women, although not in terms of spousal discussion. Women's employment is important for freedom of movement and access to resources, but not for other dimensions of autonomy, and a husband's job is important in determining women's access to resources, but has no effect on other autonomy dimensions. More surprisingly, education has very little effect, except in association with knowing the age at marriage law (31)

According to the nationally representative household surveys South Esia,13.4% of ever-married women in the reproductive age group in Nepal, 17.6% in Bangladesh, and 28.1% in India had taken the decisions alone regarding care for their own health. However, the decisions were made without women's participation in the majority of Nepal (72.7%) and approximately half of Bangladesh (54.3%) and Indian (48.5%) households (32).

2.4. Objectives of the Study

2.5. General objective

1) To assess the prevalence of women's having autonomy of deciding on their maternal health service utilization and associated factors among reproductive age group of women in Ambo town, West Showa Zone, Oromia national regional state.

2.6. Specific objectives

1) To assess prevalence of women's having autonomy of decision making on maternal health service utilization among reproductive age group of women in Ambo town.
2) To identify factors associated with autonomy of women's decision making on maternal health service utilization among the reproductive age group of women of Ambo town.

2.7. Conceptual Frame Work

This study seeks to examine women's autonomy and the association between some traditions' (cultural factors) on autonomy of women to decision making for maternal health service utilization. It assumes that women's autonomy is affected by their socio-demographic characteristics. Reviewed from published as well as grey literature on women's autonomy and the utilization of maternal health care services.

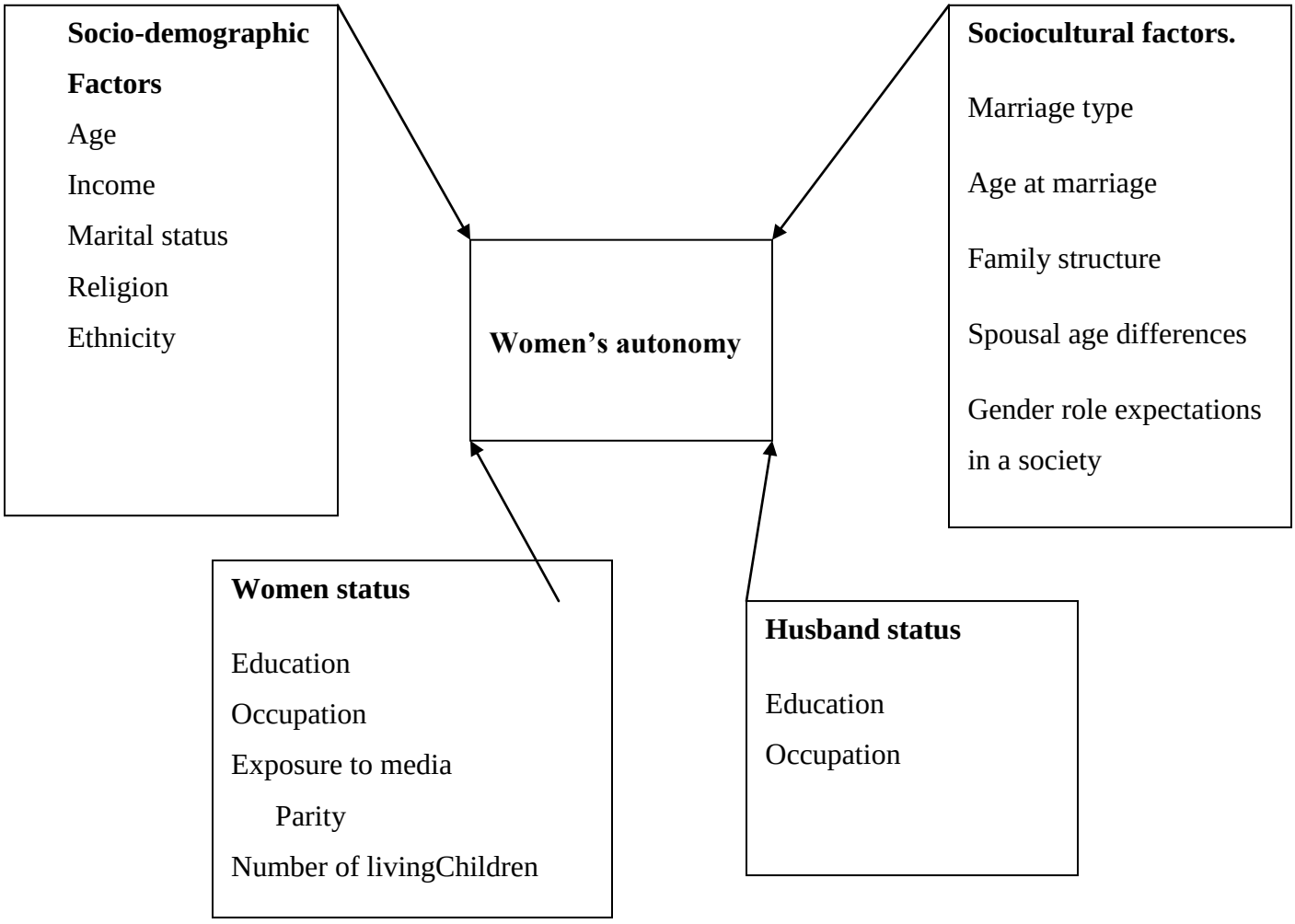

Figure 1 Conceptual frame work on women's autonomyadapted from (20*),(23).*

CHAPTER THREE: METHODS AND MATERIALS

3.1. StudyArea and Period

Ambo town is one of the zonal towns in Oromia regional state of Ethiopia which is found in W/Showa zone 148kms, far to west Showa from Addis Ababa. It has 6 kebeles, having 83053, residents of which 42693 are females and under one year child are 2666,under three years children 7749, women having under five years children are 13645,reproductive aged women(15-49) are18379,pregenant women are 2882,housebholds are 17303,according to report from Ambo town health office of 2010 annual plan. It has four governmental and 4 Private health institutions which provide maternal health service. The study was conducted from March 03 to April 03 2018.

3.2. Study Design

To minimize respondent reached at health facility bias of pure information provision and for addressing existing situation in the community regarding the mothers position on deciding about their maternal health service utilization, Community based, quantitative cross sectional study design was conducted.

3.3. Population and sample

Source population;all women of reproductive age groups in Ambo Town during the study.Study population: All women of reproductive age having under five children in Ambo town and met the inclusion criteria were included in the study.

3.4. Inclusion and Exclusion criteria

Inclusion criteria: All mothers at reproductive age and having under five child alive or not(experienced maternal health service utilization in the last five year).
Exclusion criteria: Women who are critically ill during data collection period.

3.5. Sample Size Determination

The sample size for the study was determined using a single population proportion formula as follows; $n = (Z\alpha/_2)^2 \times p(1-p)/ d^2$ Where n = Sample size $Z\alpha/2$ = Confidence level at 95% =1.96 **P =** proportion of women who have higher autonomy in decision making regarding their own health care from study conducted in similar region (41.4%)(23).

d = margin of error of 5%=which comes= 371.7 by substituting the values**.**

The calculated sample size, 372, and 10% of the calculated sample size, 37.2, was added for non-response. This makes the final sample size(409).

3.6. Sampling technique

All kebeles included for increasing the generalazablity of the finding, after getting the number of eligible women's from all kebeles(13645)house holds,Proportional allocation one by one for each kebeles after counting entire the population(sample frame from each Kebele) and systematic sampling technique was used.

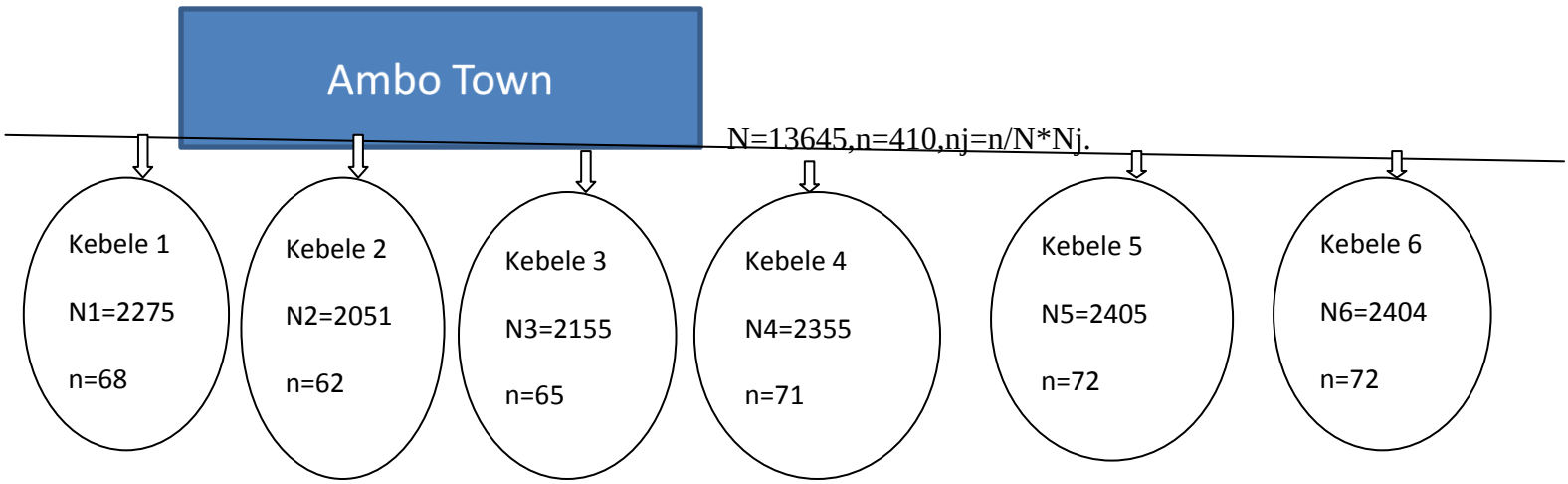

Figure 2; schematic representation of sampling procedure

After calculating each n for each kebelesnf=n1+n2+n3+n4+n5+n6. = 410.To reach each household, we have to find "k" for each kebeles. Therefore=Nj/n=5, which comes

approximately equal for nj.The first household was selected by lottery method and then every fifth house hold was interviewed.

3.7. Study variable

3.7.1. Dependant variable

Prevalence of women's having autonomy of decision making for their maternal health service utilization at home level.

3.7.2. Independent variables

Socio-demographic variables: Age, Marital status, monthly income, Ethnicity, religion.

Woman status; Educational status,Occupation, Exposure to media, Parity, Number of living Children

Husband status; Education, Occupation

Socio-culturalfactors; Marriage-type, age at marriage, family-structure, spousalage differences, gender role expectation in the society.

3.8. Data Collection Procedure and Instrument

Face to face interview was used to collect data using structured questionnaires adapted from different literatures. The validatedtool was used having Cronbach's Alpha 0.84 of total items. The data was collected using pre-tested, and interviewer guided questionnaire. Four BSc mid-wives who have lived in Ambo town for at least one year was recruited from Ambo general hospital after having two days training for data collection. The questionnaire was first be prepared in English and it was contextualized to suit to the research objective, local situations and language.

We conducted a pre-test of the drafted interview inGuder district. We interviewed 20(5%) married women from 15 to 49 year old, on March 03 to 05. After completing all 20

interviews, the principal investigator and enumerators held a meeting to analyze the data for building up consensus and modified the scale in view of the pretest feedback and finalized the tools. However, major changes were not required in the questionnaire; some questions needed further clarity on content and language, and we modified and made simple accordingly.

3.9. Data Quality Control

For quality, the data was collected by trained data collectors and pretesting of the instrument was made out of the study site before the actual data collection at Guder Town. During entry of data, double entry verification was checked using Epidata 3.1 and then exported to SPSS version 22 for analysis. The researcher with the supervisor had checked the data collection procedure and counter checkthe entries at random to ensure quality of data collection. Local language of the residents (Afan Oromo) was used for data collection as it contributes for the quality of data.

3.10. Data analysis

Data was analyzed by using SPSS 22 statistical software. Descriptive statistics was used for determining frequency, percentage, mean and standard deviation as well as autonomy status. A binary andmultiple logistic regression analysis was used to determine the independent variables could be candidate formultiple logistic regressions. Independent variables with p-value less than 0.25at 95% CI were screened as candidate under binary multiple logistic regressions. undermultiple logistic regression, the independent variables having value less than 0.05 was considered as significantly associated with dependent variable and being reported using both p-value and adjusted odds ratio.

How can we measure women's autonomy?

Women's autonomy was measured by using the composite index of the three constructs of women's autonomy: control over finance, decision-making power and extent of freedom of movement. A composite measure for each construct was created using the sum of equal weighted binary (1 for higher degree of autonomy versus 0 = otherwise) and three input variables (2 = stands for women who were able to decide independently, 1 = stands for joint decision and 0 = otherwise). Based on these values the overall score was 27. Therefore, those women who scored more than half of the total score i.e. 13.5 was considered as having higher autonomy while those who scored less than 13.5 was said to have lower autonomy (23).

Decision-making power on healthcare utilization

The index for decision-making power on healthcare utilization is composed of nine questions. The women was asked "who in her family usually has the final say on the following decisions": 1. Health care for yourself, 2. Health care for your child, 3. Visit family or relative, 4. Number of children, 5. Use of maternal and child health (MCH) services such as contraception, antenatal care (ANC), preference of delivery site, and child immunization. The possible responses for each item 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; thesum of the scores was made to represent an overall index of a woman's decision-making power as indicated by different studies. The total score on decision making power is 18. Hence, those women who scored more than nine was categorized as high decision making power whereas those who scored less than nine was categorized as low decision making power.Here,from the nine items assessing health decision making autonomy, two of the items concerns the childhealth, butit does not mean that child health is equivalent to mother health, we only used it for assessing the health decision making autonomy(one dimension of the three constructs) as maternal health is inseparable from child health (23).

Decision-making power over finance

The index for control over finance is composed of four items: whether the woman had regular access to a source of money (including both wages earned and gifts or support from family) and whether she state that she could spend this money without consulting anyone, who decides how the money she earned and her husband's earnings are used(23). A score to each of the factors is given as that of index of decision-making power responses, except that 1 and 0 for items with binary responses (i.e. yes or no response). The total score on control over finance is 6. Those women with a score of three and above was considered as having high control over finance, while those women who was score less than three was said to below control over finance (20).

Decision-making power on freedom of movement

The index of freedom of movement consisted of three items pertaining to the woman's ability to leave the house without the company of another adult: whether she could go out to take a child to health facility, to visit family or relative and go to health facility for her own health care (23). These items were seen with binary responses (yes or no). Hence, those with 'yes' response was score 1 while those with 'no' response was score 0. The total score on freedom of movement is 3. Those women who scored more than one & half was considered as havinghigh freedom of movement whereas those who scored less than one and half was categorized as having low freedom of movement(20). Another study Nepal, Women's autonomy refers to women's decision-making autonomy, which was measured based on responses to "Who makes the following decisions in (respondent's) household about: 1) obtaining health care for yourself; 2) large household purchases; and 3) visits to family or relatives?" Response options were: a) respondent alone; b) respondent and husband/partner; c) respondent and other person; d) husband/partner alone; e) someone else; f) other. The value of 1 is assigned if the response was (a), (b), or (c), that is, involvement of the respondent, or else 0, for no involvement of the respondent(6).

3.11. Ethical consideration

Ethical clearance was obtained from ethical committee (IRB) of Jimma University& institute of health science.Ethical (permission) letter was obtained from Ambo zonal health department. Ethical Consent form was obtained from the respondent before conducting any data collection to approve their voluntariness.

3.12. Data dissemination plan

Result of the study will be communicated to each of Ambo town health institution and Jimma University. Furthermore, all attempts will be made to publish thefinding on different reputable journal.

3.13. Operational definitions

Women's autonomy: According to this study it is measured in terms of control over financial resources (economic autonomy); freedom of movement (physical autonomy); opportunity to participate in decisions (decision-making autonomy) about maternal and child health care utilization. From the overall score, means from the three dimension (27score) those who score more than half which is >13.5(the mean score) out of the total score provided 27 for the three dimensions was categorized under having higher autonomy, while those who was score below the mean score was said lower autonomous.

The description of the three indexes one by one.

Decision making power: According to this study it is measured by nine questions related to women's own &child's health care having 18 total score, therefore who score >9 was said to have decision making power.

Freedom of movement: According to this study it is measured by three questions related to physical autonomy those who score >1.5 was said to have freedom of movement.

Control over financial resources: In this study it is measured by 6 questions related to economic autonomy and those who was score>3 was said to have autonomy over financial

resource. Therefore, the summation of the three dimensions gives us the total score (27) of which those who score more than the mean (13.5) was said having higher autonomy.

Antenatal care services: According to this study it refers the care given for the mother during her pregnancy that she asked whether she attended or not.

Reproductive age mothers: The mothers from age of 15 to 45**.**

Maternal health care utilization: It refers tothe health care that a woman receives during pregnancy, childbirth and immediately after the birth which is crucial for the well being of a mother and new bornbaby. It includes antenatal care, delivery care and postnatal care and in this study it can be one of it that the mother can utilized.

Child health: It is the health of child from born to age of five year, under this study; it is used to assess the health decision making autonomy of mother.

Child immunization: It is vaccination (immunization) given for child from birth to 9 month of age for prevention of many diseases, under this study it is used to assess one dimension of women's health decision making autonomy.

Higher autonomy: Under this study, itrepresent a woman who scored >13.5 from the given 27 score by three dimension**.**

Lower autonomy: Under this study, itrepresent a woman who scored <13.5 from the given 27 score by three dimension.

CHAPTER FOUR: RESULT

Of the total 410 eligible women, 381 completed the questionnaire making the response rate 92.9%.

4.1. Socio-demographic characteristics

The mean (±SD) age of women was 29.2(±6.0) years. Most of the women346 (91.1%) were married. Eighty-three percent 317(83.2%) of women were Oromo followed by46(12.1%) Amhara by ethnicity.Therty eight percent 147(38.3%) of women and forty-four 169 (44.4%) of the husbands have attended tertiary education.178(46.7%) and 137(36%) are of the women are orthodox and protestant religion follower respectively. Forty-seven 182 (47.8%) of the women and forty-eight184 (48.3%) of their husband are merchant and sixty-eight 260 (68.2%) of the women earn>=1001ETB per month and seventy-three 281(73.8%) were using media.

4.2. Socio cultural events (factors)

Regarding age of marriage, sixty- nine265(69.6%) of the women married at their age of >=18years and seventy-seven294(77.2%) of the women have monogamy marriage type. Seventy-two276(72.4%) of the women's family structure was nuclear and sixty-eight260 (68.2%) of the partners have moderate(5-10years) spousal age difference. Sixty-four244 (64%) of the women responded that the gender role expectation in the society were equality.

Table 1 Socio-demographic characteristics of sampled respondent Ambo town 2018.

Variables name	Frequency	Percentage
Age		
18-19	98	25.7
20-24	57	15.0
25-29	97	25.5
30-34	97	25.5
35-39	98	25.7
Monthly income		
<=500	102	26.8
501-1000	19	5.0
>=1000	260	68.2
Marital status		
married	346	91.1
unmarried	11	2.9
widowed/divorced	24	6.0
Religion		
orthodox	178	46.7
protestant	137	36.0
catholic	18	4.7
Muslim	16	4.2
other	32	8.4
Ethnicity		
Oromo	317	83.2
Amhara	46	12.1
Tigre	8	2.1
Gurage	10	2.6
Parity		
1-2	139	36.5
3-4	128	33.6
>=5	114	29.9
No of living children		
1-2	247	64.8
3-4	105	27.6
>=5	29	7.6

Table 2 status of women by education and occupationAmbo town 2018.

Variable name(women)	frequency	percentage
Educational status(Women's)		
illiterate	8	2.3
read/write	89	23.4
primary	35	9.2
Secondary.	102	26.8
Tertiary.	147	38.3
Occupation(women)		
Merchant	182	47.8
day laborer	67	17.6
agriculture	5	1.3
Government employ	113	29.7
other	14	3.7
Exposure to media		
Yes	281	73.8
No	100	26.2

Table 3 status of husband by education and occupation Ambo town 2018.

Variable name(husband)	Frequency	Percentage
Husband's Educational Status		
Illiterate	4	1.0
Read/write	88	23.1
Primary	28	7.3
Secondary.	92	24.1
Tertiary	169	44.4
Husband's Occupation		
Merchant	184	48.3
Day laborer	58	15.2
Agriculture	17	4.5
Government employ	118	31.0
Other	4	1.0

Table 4 Socio cultural events (factors) on women's autonomyAmbo town 2018.

Marriage type	frequency	percentage
monogamy	294	77.2
polygamy	87	22.8
Age at marriage		
<=18yrs	116	30.4
>=18yrs	265	69.6
Family structure		
nuclear	276	72.4
extended	105	27.6
Spousal age differences		
little(<5yrs)	121	31.8
moderate(6-10yrs)	260	68.2
Gender role expectations in a society		
Male dominance	137	36.0
equality	244	64.0

Out of 381women, sixty-nine percent 263 (69.0%) of the women decide about their own health care independently, of which 68% were able to take their child to health institution by their independent decision for immunization. In this study, 216 (56.7%) of women were autonomous to decide the number of children they want to have, 207(54.3%) of women were free to go to health facility for their own antenatal care service consumption during pregenancy.According to this study, 200 (52.5%) of the women independently decide about using contraceptive (modern family planning method) and 155(40.7%) could decide independently about where to be their place of delivery. The women's having higher autonomy on health care decision making was144 (37.7%)

Concerning women's freedom of movement, 225(59.1%) could leave home alone without asking another adult's (husband/partner) permission to go to health facility for own health care and226 (59.3%) could leave home alone without asking another adult's (husband's/ permission to take a child to health care facility while only111 (29.1%) leave home alone without asking another adult's (husband/partner) permission to visit family or relatives. The overall women's freedom of movement (autonomy of movement) is 229 (60.1%).

Regarding financial control, 238 (62.5%), have regular access to a source of money (both own wage and husband's wage) among this only 88(23.1%) can spend it without consulting anyone.102 (26.8%) of the women usually decides how the money she earns will be used independently and 279 (73.2%) of them decide it jointly with partner.Only22(5.8%) of the women usually decides independently how her husband's/partner's earnings will be used and 359(94.2%)decide it Jointly with their partner. The overall women financial autonomy is 223(58.5%).The overall women's autonomy mean (±SD) indicating that212 (55.6%) of the women had higher autonomy while the remaining169 (44.4 %) had lower autonomy. see figure below.

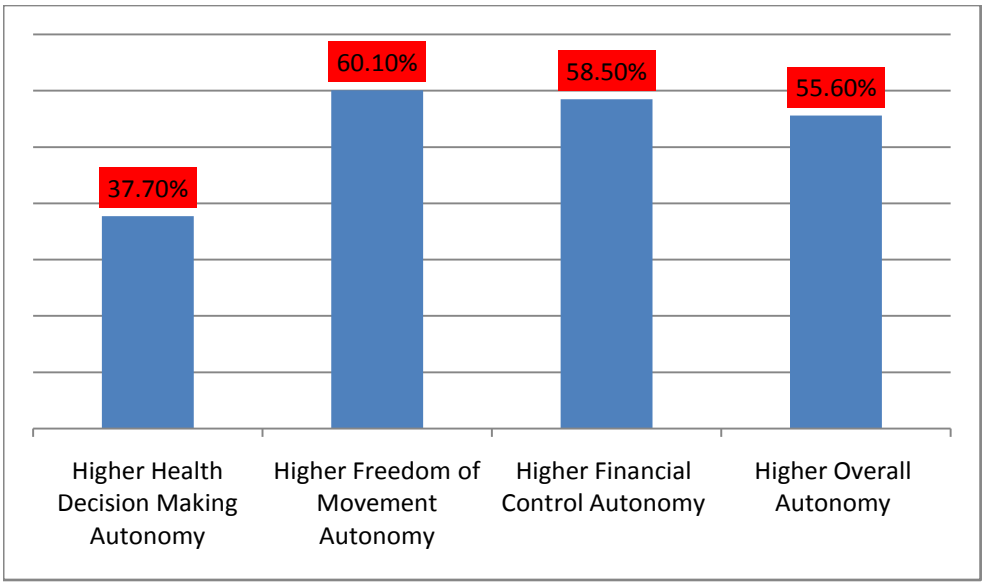

Figure 3Women's autonomy measured in three dimension.

4.3. Factors associated with women's autonomy

The binarylogistic regression model showed that, sixteen independent variables were found to be candidate for multiple logistic regressions to decide factors associated with women's autonomy of decision making on their maternal health service utilization.

Table 5 Binary logistic regression model for factors associated with women's autonomy (sociodemographic characters)Ambo town 2018.

		Women's autonomy status		P.value,COR		[95%CI]	
		Heigherautonomoy (%)	Lower autonomy (%)				
Age of mother (year)	18-19	53(54.1)	45(45.9)	.656	1		
	20-24	33(57.9)	24(42.1)	.645	.86	.604	2.257
	25-29	57(58.8)	40(41.2)	.510	.82	.686	2.133
	30-34	55(56.7)	42(43.3)	.713	.89	.632	1.956
	35-39	14(43.8)	18(56.2)	.311	1.51	.296	1.475
Monthly income	<=500	21(20.6)	81(79.4)	.000	2.91	.062	.185
	501-1000	7(36.8)	12(63.2)	.000	1.29	.091	.635
	>=1000	184(70.8)	76(29.2)	.004	1		
Marital status	Married	149(43.1)	197(56.9)	.132	1.0		
	Unmarried	5(45.5)	6(54.5)	.875	.908	.272	3.031
	Widowed/divorced	16(65.2)	8(34.8)	.044	.38	.167	.976
Religion	orthodox	67 (37.6)	111(62.4)	.00	1		
	protestant	79 (57.7)	58 (42.3)	.00	.443	.281	.698
	catholic	10(55.6)	8(44.4)	.15	.483	.182	1.28
	Muslim	7(43.8)	9(56.2)	.63	.776	.276	2.18
	other	6(18.8)	26(81.2)	.05	2.62	1.0	6.68
Ethnicity	Oromo	143 (45.1)	174(54.9)	.215	1.0		
	Amhara	16 (34.8)	30 (65.2)	.19	1.54	.81	2.94
	Tigre	6(75)	2(25)	.12	.274	.05	1.38
	gurage	4(40)	6(60)	.749	1.233	.341	4.453

Table 6 Binary logistic regression model for factors associated with women's autonomy (women status)Ambo town 2018.

Variable name	Women's autonomy status		P.value,COR		[95%CI]	
Parity	Heigherautonomoy (%)	Lower autonomy(%)			Lower	upper
1-2	50(36)	89(64)	.045	1		
3-4	63(49.2)	65(50.8)	.029	.580	.355	.946
>=5	56(49.1)	58(50.9)	.036	.582	.351	.964
Number of living children						
1-2	125(50.6)	122(49.4)	.001	1.0		
3-4	41(39)	64(61)	.048	1.599	1.005	2.545
>=5	3(10.3)	26(89.7)	.000	8.88	2.619	30.103
Educational status(Women's)						
illiterate	3(37.5)	5(62.5)	.000	1.02		
read/write	83(93.3)	6(6.7)	.992	.044	.232	4.381
primary	7(20)	28(80)	.000	2.46	.018	.107
Secondary.	21(20.6)	81(79.4)	.053	2.37	.989	5.907
Tertiary.	56(37.7)	91(62.3)	.005	1	1.299	4.185
Occupation						
Merchant	79 (43.4)	103 (56.6)	.000	1		
Day laborer	56(83.6)	11(16.4)	.000	.151	.074	.306
Agriculture	1 (20)	4(80)	.320	3.068	.336	27.990
Government employ	30(26.5)	83(73.5)	.004	2.122	1.274	3.534
Other	3(21.4)	11(78.6)	.122	2.812	.759	10.421
Exposure to media						
yes	78(27.8)	203(72.2)		1.0		
no	91(91)	9(9)	.000	.038	.018	.079

Table 7 Binary logistic regression model for factors associated with women's autonomy (husband status)Ambo town 2018.

Variable name	Women's autonomy status		P.value,COR		[95%CI]	
Husband's Educational Status	Higher autonomy (%)	Lower autonomy(%)			Lower	upper
illiterate	2(50)	2(50)	.000	.496		
read/write	81(92)	7(8)	.488	.043	.068	3.611
primary	9(32.1)	19(67.9)	.000	1.046	.019	.099
Secondary.	21(22.8)	71(77.2)	.918	1.676	.445	2.461
tertiary	56(33.1)	113(66.9)	.083	1	.936	3.001
Husband's Occupation						
merchant	89 (48.4)	95 (51.6)	.000	1.0		
Day laborer	46(79.3)	12(20.7)	.000	.244	.122	.491
Agriculture	2(11.8)	15 (88.2)	.011	7.026	1.562	31.599
Gov. employ	31(26.3)	87(73.7)	.000	2.629	1.592	4.342
Other	1(25)	3(75)	.375	2.811	.287	27.521

Table 8Binary logistic regression model for factors associated with women's autonomy (socio- cultural events)Ambo town 2018.

Variable name	Women's autonomy status					
Marriage type	Heigherautonomoy (%)	Lower autonomy(%)	P.value,COR		CI at 95%	
monogamy	83(28.2)	211(71.8)		1.0	lower	upper
polygamy	86(98.9)	1(1.1)	.000	.005	.001	.033
Age at marriage						
<=18yrs	87(75)	29(25)		1.0		
>=18yrs	82(30.9)	183(69.1)	.000	6.695	4.083	10.98
Family structure						
nuclear	81(29.3)	195(70.7)		1.0		
extended	88(83.8)	17(16.2)	.000	.080	.045	.143
Spousal age differences						
little(<5yrs)	91(75.2)	30(24.8)		1.0		
moderate(6-10yrs)	78(30)	182(70)	.000	7.078	4.334	11.56
Gender role expectations in a society						
Male dominance	87(63.5)	50(36.5)		1.0		
equality	82(33.6)	162(66.4)	.000	3.438	2.219	5.325

In the multiple logistic regression models, after adjusting for the potential confounders; parity,number of living children, educational status (women's),exposure to media, marriage type and age at marriage were the final predictors of women's autonomy(see table 9)

Table 9multiple logistic regression models for factors associated with women's autonomyAmbo town 2018.

Variables	Women's autonomy status		P.value.	AOR	[95%CI]	
Parity	L.autonomy	H.autonomy			Lower	Upper
1-2	50(36)	89(64)	.000	1		
3-4	63(49.2)	65(50.8)	.002	.173	.058	.513
>=5	56(49.1)	58(50.9)	.000	.024	.007	.079
Number of living children						
1-2	125(50.6)	122(49.4)	.000	1		
3-4	41(39)	64(61)	.000	.011	.002	.066
>=5	3(10.3)	26(89.7)	.009	.094	.016	.556
Educational status(Women's)						
illiterate	3(37.5)	5(62.5)	.052	1.0		
read/write	83(93.3)	6(6.7)	.018	.022	.001	.527
primary	7(20)	28(80)	.036	.021	.001	.782
Secondary.	21(20.6)	82(79.4)	.018	.012	.000	.463
Tertiary.	55(37.7)	91(62.3)	.008	.007	.000	.271
Exposure to media						
yes	78(27.8)	203(72.2)		1.0		
no	91(91)	9(9)	.000	.004	.000	.040
Marriage type						
monogamy	83(28.2)	211(71.8)		1.0		
polygamy	86(98.9)	1(1.1)	.000	.000	.000	.012
Age at marriage						
<=18yrs	87(75)	29(25)		1.0		
>=18yrs	82(30.9)	183(69.1)	.008	.038	.003	.418

4.4. Discussion

According to this study, the overall women's found to have higher autonomy of decision making regarding their maternal health service utilization was 55.6% in Ambo town West showa Ethiopia. This finding is somewhat higher compared to the study conducted in Ghana which is nearly half (49.2%) of the MHSU was independently decided by husbands and women have very little autonomy on deciding about their maternal health service utilization. This discrepancy may be due to the variation in study design, year of study, the way the study used to measure the autonomy of the woman, sociocultural difference between the two countries and the strong government effort on women empowerment in decision making position at home level in Ethiopia.

This finding is also higher than the study conducted in same region Bale zone which only 41.4% had higher autonomy on decision making on their MHSU.This difference may be due to the fact that the difference in study area (this study involved the town women only) and study period, in Ethiopia over the period of time (since the study conducted in Bale) there is strong commitment and effort has been made by Ethiopian government on maternal health. This can be evidenced by the Ethiopia's addressing the MDG prior to any other African country.

It can also seen that, regarding own health care decision making autonomy 37.7% of the women in the Ambo town have higher autonomy, this result is by far higher than the result found in study conducted at some countries of S.Esia which is only 13.4% of women in Nepal, 17.6% of women in Bangladesh and 28.1% of women in India had taken the decisions alone regarding care for their own health.This variation may be due to the fact that, different in sample size,socio cultural and socio economic variation, again the recent study area is only focused on the urban population which may believed to be in improved in educational and economic status.

Regarding financial control, 238 (62.5%), have regular access to a source of money (both own wage and husband's wage) among this only 86(22.6%) can spend it without consulting anyone.102 (26.8%) of the women usually decides how the money she earns will be used independently and 279 (73.2%) of them decide it jointly with partner. This finding is comparable with the study conducted at Bale zone the same region may be due to the socio cultural and socio economic similarity.

In this study, those women who were in>=5 parity were less likely by 97.6% to have higher autonomy as compared to those who were in 1 to 2 parity [AOR: .024 (95% C.I: .007-.079)]. Women who had 3-4 living children had by 98.9% higher odds of increased autonomy as compared to women who had 1-2 living children [AOR:.011 (95% C.I: .002-.066)],and the odds of having higher autonomy decreased by 90% as the women's children get larger in number (>=5) {AOR [95%CI].094(.016-.556)}

Regarding the education status of the women, as we go from no formal education to tertiary education level, the odds of having lower autonomy decreased. For read/write, primary, Secondary and tertiary the AOR&CI at 95%,.022[.001-.527], .021[.001-.782], .012[.000-.463], .007[.000-.271] respectively. This finding is in line with the study conducted at Nepal (4) also similar with the study conducted in Ethiopia. The reason may be due to the fact that well educated women can challenge their husband in order to have equal voice in decision making concerning their day to day life at their home and also are hoped to have knowledge about maternal health.

Women who had not exposure of media had by 99.2% times a lower odds of having higher autonomy as compared to women those who had exposure to media [AOR: .008 (95% C.I: .001-.079)].This finding is in agreement with the study conducted in Ethiopia.

The women those who married at age of >=18years are by 96.2% more likely to have higher autonomy as compared to their counterparts (those who married at the age of 18 years old, AOR&CI at 95%.038[.003-.418].This finding is by far different from study conducted at Bangladeshi, this may be due to the fact that there may be socio cultural difference among the two countries which the age of marriage at Bangladeshi was 13.5 that resulted in restriction of women's autonomy, and the sample size variation may also.

It was found that in the town, though the progress of women health (maternal health) decision making autonomously over the last two decade was fast, still there is a gap when compared with men counterpart. Men/ some other parents family highly involved in maternal health care

service utilization decision making than women, which lead the women to have tendency of dependency.

Even though involvement in maternal health care service utilization is encouraged; certain cultural back-grounds in a society give no/little position for the women to decide their health issue which can be seen as a reason for mothers to utilize maternal health care service below the countries demand. In addition, according to the results of the finding mostly women join low level own health decision making autonomy conditions which can be a reason for one of the three delays (major reason for maternal mortality).

4.5. Scope and Limitation of the Study

The study was community based, also to some extent explored the existing status of the women's autonomy. It may facilitate the policy makers and planners to prioritize their intervention programmes on maternal health care in future. Prior to this reaserch,eventhough many reaserchs conducted on factors associated with autonomy, but none of them tried to investigate the effects of certain socio cultural(societies traditions') having negative impact on women's autonomy. Therefore, these reaserchs tried to fulfill this gap. Finally, the reaserchs could address its objective properly.Despite the number of strengths, the study was based on the reported information which was obtained from women only and prone to recall bias. Hence, it needs further empirical assessment for precise measurement of the women's autonomy on the utilization of maternal health care services. This study covered only autonomy of deciding in one town but not maternal health care coverage paralely with the status of autonomy, due to the wideness of it and shortage of time and budget.The study was focused on only the quantitative dimensions of women's autonomy on the utilization of maternal health care services. Women's autonomy and health seeking behaviors are complex subjects. Therefore, it may also require more qualitative studies for further precise assessment.

CHAPTER FIVE: CONCLUSION AND RECMMANDATION

This study showed that more than half of women were found to have higher autonomy of decision making regarding their maternal health service utilization. Women status(parity, number of living children, educational status),Socio economic(exposure of media)Socio cultural factors(marriage type and age at marriage), being in a monogamous marriage, being in>=18 years old age of marriage, having exposure to media were positively associated with women's autonomy. Generallythe main point of this study is that women in the study area who have high autonomy utilize more maternal health care services than women with restricted or low autonomy. Specifically, women who have high physical, financial and decision making autonomy utilize more maternal health care services than women with restricted or low autonomy. Therefore, these factors should be taken into account while designing interventions.

RECMMANDATION

Government: Best to stand for women (special attention) for the woman community on progressive and sustainable economic development (improvement).

Oromia regional health bureau: Search mechanism by which it can discourage or encourage certain harmful/harmless traditional practices having positive/negative impact on the health seeking behavior of the women, like polygamy, earlymarriage, through teaching the target society.

Ambo town health institutions and offices: Strong effort on teaching the low socio economic status and low educational status community on giving prioritization for the utilization of maternal health through community service.

In general, targeted, community oriented and promotive strategies including women empowerment through involving women and men in income generating means such as small and microenterprises are recommended. Furthermore, strengthening the health extension

workers (HEWs) activities that are directed in increasing awareness and improving attitude towards maternal health care services are recommended to empower women to seek these services.

Therefore, there has to be mechanisms like women capacity building (awareness creation) through on the- job, organized in a society for those who have low educational level and for those who have not accessibility of media, continuous life skill training (health education) for women to enhance their independent decision making regarding their maternal health service utilization irrespective of their socio cultural or any personal back ground like number of parity, number of living children,welth (economic status) presence or absence of additional house-wife.

For this, different health institutions, different government office, education institutions, NGOs and policy developers could be the primarily responsible bodies. The major reason for underrepresentation of decision making position is relatively they have less freedom because of their family responsibility. Mainly, gender-based discrimination and socio cultural perception of gender role at many levels prevents women from getting senior positionstraditionally held by men that can hurt the autonomy of women on decision making about their maternal health service utilization.

Some women not have the level of education necessary for knowing their extent of right on decision making regarding their maternal health and other related issue at home level in relation to their counterparts (husbands) in a society. Thus, opportunities should be given for women to increase their education level to fit whatever decision making positions they are supposed to join at home level.

The concerned women are also responsible to update themselves and equally compete with their men counter parts (not to be passive recipient but being active participant in any issues concerning their home and independently decide their maternal health service utilization).

CHAPTER SIX: REFERENCES

1. Global journal of medicine and public health, women's autonomy: new paradigm in maternal health care utilization gjmedph 2014; vol. 3, issue 5.
2. (Basu 1992, Bloom et al. 2001, Kishor and Subaiya 2008), (Bloom et al. 2001, Jejeebhoy 1995, Kishor 2005).
3. Kamiya Y. Endogenous Women's Autonomy and the Use of Reproductive Health Services: Empirical Evidence from Tajikistan. 2010..
4. Situ k.c: women's autonomy and maternal health care utilization in nepal september 2013.
5. Women's autonomy in health care decision-making in developing countries: a synthesis of the literature 7 June 2016..
6. Tulsi ram bhandari,ph.d. thesis2015,women's autonomy and utilization of maternal health services in kapilvastu district,nepal.
7. (2012) United States Department of Labor. Latest Annual Data.
8. Weiner SJ, Schwartz A, Sharma G, Binns-Calvey A, Ashley N, et al. (2013) Patient-centered decision making and health care outcomes: an observational study. Ann Intern Med 158: 573-579.
9. Shrestha R. Maternal Mortality in Nepal Addressing the Issue - Student Pulse. Student pulse. 2012;4(10):1–4.
10. Tsegay Y, Gebrehiwot T, Goicolea I, Edin K, Lemma H and Sebastian MS. Determinants of antenatal and delivery care utilization in Tigray region, Ethiopia a cross-sectional study. International Journal for Equity in Health. 2013;12(30).
11. Zureick-Brown S, Newby H, Chou D,Mizoguchi N, Say L, Suzuki E, et al.Understanding global trends in maternal mortality. Int. Perspect. Sex Reprod. Health. 2013;39(1):32-41
12. Global Health Observatory (GHO) data 2015. http://www.who.int/gho/maternal health/mortality/maternal mortality text/en/. Accessed 15 Nov. 2017

13. WHO, UNICEF, UNFPA and The World Bank estimates. Trends in maternal mortality:1990to2013.http://www.who.int/reproductivehealth/publications/monitoring /maternal-mortality-2015/en/.Accessed 12 May 2016.
14. Shamaki MA,Buang A.Sociocultural practices in maternal health among women in a less developed economy: an overview of Sokoto state, Nigeria. GMJSS.2014;10 (6):1–114.
15. Thapa DK, Niehof A. Women's autonomy and husbands' involvement in maternal health care in Nepal. *Soc Sci Med*. 2013;93:1–10.
16. Kabakyenga,JK,ÖstergrenP-O,Turyakira E,PetterssonKO.Influence of birth preparedness, decision-making on location of birth and assistance by skilled birth attendants among women in south-western Uganda. PLoS. One.2012;7(4):35747.
17. OsorioA.Bolance C, Madise N.Community socioeconomic context and its influence on intermediary determinants of child health: evidence from Colombia. J Biosoc Sci. 2015;47(01):1-27.
18. Lawn JE, Tinker A, Munjanja S, Cousens S. Where is Maternal health and Child healthnow? Lancet 6, 7-9. 2010.
19. Say L, Raine R. A systematic review of inequalities in the use of maternal health care indeveloping countries: examining the scale of the problem and the importance of context.Bull World Health Organ 2007 Oct;85(10):812-9.
20 Factors associated with women's autonomy regarding maternal health care(Makinwa-Adebusoye and Jensen 1995),(Abadian 1996).
21 Determinants of health care decision making autonomy among mothers of children under five years in Ghana: analysis of 2014 Ghana demographic and health survey
22 Gender inequality and the use of maternal healthcare services in rural sub-Saharan Africa 2014.
23 Factors associated with women's autonomy regardingmaternal and child health care utilization in Bale Zone: a community based cross-sectional study 2014.
24 Health care decision making autonomy among mothers of child baring Cross-cutting gender issues in women's health in the Eastern Mediterranean Region Document WHO-EM/WHD/011/E/02.07/500.

25 World Health Organization (2010). Improving Maternal, Newborn and Child Health in the South-East Asia Region: Focus on Bangladesh
26 Women's Autonomy and Reproductive healthcare seeking Behavior in Ethiopia 201
27 Determinants of Maternal Healthcare Utilization in Zimbabwe 2012.
28 Women's Navigation of Maternal Health Services in Ghana's Upper West Region in the Context of the National Health Insurance Scheme Andrea Rishworth 2014,(Solo, et al., 2005)
29 (Dyson and Moore, 1983) (Das Gupta, 1987, Santow,1995)(Autonomy-related reproductive health behavior).
30 Effects of dimensions of autonomy on maternal care seeking in Mumbai 2011
31 How intra-familial decision-making affects women's access to, and use of maternal healthcare services in Ghana: a qualitative study, Pregnancy and Childbirth (2015) 15:173
32 Women's Autonomy in Decision Making for Health Care in South Asia 2014.

CHAPTER SEVEN: APPENDICES

Annex I: Informed consent and questionery

Informed consent (English version)

Dear participant! Good morning,(good afternoon …)

I am student of masters' degree in maternity nursing at Jimma University. I am inviting you in a study that was examine Autonomy of mothers on decision making regarding their maternal health care and associated factor at Ambo Town. The information was gathered during any time respondents found to be volunteer (allocated proportionally at each of the listed Keble, using quantitative methods and then this study was reported in my thesis and themathised based on the interest of my sponsorship which is Jimma university. Reproductive aged mothers living in Ambo town was recruited for the study. There is no potential risk intended monetary compensation involved for participating this study. It only costs your time of 30 to 40 minutes. The potential reward of knowing that the participant has contributed to a knowledge base that was help mothers of reproductive aged group's about autonomy of decision making on their maternal health care and associated factors. Confidentiality of the participants was protected. I was the only person to receive your consent form and gather your information included in the study for the findings part of my thesis. Although your input would be greatly appreciated, your participation in this study is absolutely voluntary. You may withdraw from this study at any time you believe to do so.

Sing below for your confirmation……

I understand that if I decide at any time that I do not want to participate in this study, I can tell the researchers and was withdrawn from it immidietely.This was not affect me in any way, Confidentiality and anonymity was maintained and it was not be possible to identify me from any publication.

Respondent

Name…….Sign……Date……

…Tadele Yadessa , Address: Mob 0913872857/0932002907,(tadeleyad@gmail.com)

Questionery of assessing maternal autonomy, adapted from different Literature.

Section 1.Sociodemographic questions.

I. Demographic Information					
1001.1Sex:	*ID*				
101.2Age					
1001.3 Monthly income					
1001.4Marital status	*1.un married*		*2.married*		*3.widowed/ divorced*
1001.5Religion	1.Orthodox	2.Protestant	3.Catholic	4.Muslim	5.Others
1001.6 Ethnicity	1. Oromo	2.Amhara	3.Tigre	4.Gurage	5.Others
1001.8Parity					
1001.9Number of living children					
Women/husband status.					
1002.0	1.Illiterate	2. read /		4.Secondary	5.College

Educational status		write	3.Primary education	education	graduate
1002.1 Husband's Educational Status	1.Illiterate	2. read / write	3.Primary education	4.Secondary education	5.College graduate
1002.2 Occupation:	1. *merchant*	2 Day labor	*3.Agriculture*	*4.gov.employee*	*5.0thers*
1002.3Husband's Occupation	1. *merchant*	2 Day labor	*3.Agriculture*	*4.gov.employee*	*5.0thers*
1002.4Exposure to media	1.Yes	2.No			
Sociocultural factors					
1002.5Marriage type	1.Monogamous		2.Polygamous		
1002.6Age at marriage	*1.Less than 18 years old*		*2.Greater than 18 years old*		
1002.7Family structure	*1.Nuclear*		*2.Extended*		

1002.8Spousal age differences	*1.Less than 5 years little* *2.Moderate6-10yrs*	
1002.9Gender role expectations in a society	*1.male dominance*	*2.Equality on every aspect of decision making.*

Section-2: Now I would like to ask you some questions related to your role in decision making (women's autonomy) regarding your own and your child health care.

Section-2A: Questions to assess women's decision making power at household level			
Probe questions from Q1002.2-1003.8:*"Who in your family usually has the final say on the following decisions":*			
Q1003.0	Health care for yourself?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb jointly…….4 Respondent alone……..5	Description
Q1003.1	Health care for your child?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb. jointly…….4 Respondent alone……..5	1,2,3=0 4=1 5=2
Q1003.2	Visit family or relatives?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb. jointly…….4 Respondent alone……..5	
Q1003.3	The number of children that you want to have?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb jointly…….4	

		Respondent alone……..5	
Q1003.4	Use family planning/ contraception?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb. jointly…….4 Respondent alone……..5	
Q1003.5	Antenatal care need during pregnancy?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb. jointly…….4 Respondent alone……..5	
Q1003.6	Where to be your place of delivery?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb jointly…….4 Respondent alone……..5	
Q1003.7	Your child vaccination?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb. jointly…….4 Respondent alone……..5	
Q1003.8	Seeking advice or treatment from health personnel for your ill/sick child?	Someone else……1 Husband/partner ……..2 Husband/partner and someone else-------3 Respondent and husband/sb. jointly…….4 Respondent alone……..5	
Section-2B: Questions to assess women's freedom of movement			
Q1003.9	Would you leave your home alone without asking another adult's (husband's/ partner's or someone's)	Yes ----------1 No ----------2	1=1 2=0
Q1004.0	Would you leave your home alone without asking another	Yes ----------	

	adult's (husband/partner or someone) permission to go to health facility for your own health care?	1 No ---------- 2	
Q1004.1	Would you leave your home alone without asking another adult's (husband/partner or someone) permission to visit family or relatives?	Yes ---------- 1 No ---------- 2	
Section-2C: Questions to assess women's control over financial resources			
Q1004.2	Would you have regular access to a source of money (both your wage and your husband's wage)?	Yes ----------1 No ----------2	
Q1004.3	If yes to Q1003.5would you spend it without consulting anyone?	Yes ----------1 No ----------2	
Q1004.4	Who usually decides how the mo Who usually decides how the money you earn was used?	Someone else…1 Husband/partne….2 Husband/partner and someone else----------3 Respondentandhusband/sb.jointly...4 Respondent alone…….5	
Q1004.5	Who usually decides how your husband's/partner's earnings was used?	Someone else……1 Husband/partner ……2 Husband/partner and someone else-3 Respondent and husband/sb. jointly4 Respondent alone……5	

Check the questionnaire to make sure that all the questions have been responded accordingly

Thank you!!!

Name of interviewer_____Signature _____Date_____

Checked by

Supervisors; Name _____signature_____Date_____

ANNEX II AFAN OROMO VERSION

Gaaffiilee murtee kennuuf danda'uu haadholee waa'ee tajaajila fayyaa haadholee argachuuf qoratan.

Kutaa 1.Odeeffannoo haala hawaasummaa

<table>
<tr><td colspan="7">I. Odeeffannoo haalduree fi haala qabeenyaa dhuunfaa hawaasaa.</td></tr>
<tr><td>1001.1Saala:</td><td colspan="2">1dhir.</td><td colspan="4">2 dhal.</td></tr>
<tr><td>101.2Umurii</td><td colspan="2"></td><td colspan="4"></td></tr>
<tr><td>1001.3 galiiji'aa</td><td colspan="2"></td><td colspan="4"></td></tr>
<tr><td>1001.4Haalagaa'ilaa</td><td colspan="2">1.kaheerumte</td><td colspan="2">2.ka hin heerumne</td><td colspan="2">3.kajalaadu'e/ hiikte</td></tr>
<tr><td>1001.5Haalamaatii</td><td colspan="2">1.Qof- buloota</td><td colspan="4">2.Hedduun buloota</td></tr>
<tr><td>1001.6 Amantaa</td><td>1.Orthodoxii</td><td>2.Protestantii</td><td>3.Catholicii</td><td>4.Muslimii</td><td colspan="2">5.kabiraa</td></tr>
<tr><td>1001.7 Gosa gaailaa</td><td colspan="2">1.H.Warraa1</td><td colspan="4">2.H.warraa2 fi isaa ol</td></tr>
<tr><td>1001.8 Lammummaa</td><td>1.Amhara</td><td>2.Oromo</td><td>3.Tigrai</td><td>4.Guragie</td><td colspan="2">5.kabiraa</td></tr>
<tr><td>1001.9 baayina deesse.</td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
</table>

1002.0Baayina ijoolee lubbuunjiranii					
1002.1S.barnootaa	1.kahinbarannee	2. dubbisu / barreesuu	3.S.1ffaa	4.S.2ffaa	5.Kolleejjii/unv
1002.2S.barnoota/ab.war.	1. kahinbaranne	2. . dubbisu / barreesuu	3. .S.1ffaa	4. S.2ffaa	5.Kolleejjii/unv
1002.3 Hojii:	1.Qonna	2Hojiiguyy	*3.Daldal*	*4.Hojetamot.*	*5.kabiraa*
1002.4Hojii ab.warr.	1.qonna	2.hoj guy.	*3.dald.*	*Hoj.motu.*	*5.kabiraa*
1002.5 fayyadama midiyaa	1.eeyyee	2.lakki			
Barteewwan hawaasaa murteesummaa haadhaarratti dhiibbaa fiduu danda'an					
1002.6 gosa fuudhaa	1.haadha war.1		*2.haadhawar.2 fi isaaol*		
1002.7umurii heerumaa	<18years		*>18years*		
1002.8gosa waliin jireenya maatii	1.aantee/hadhwar. Fi abbwar.		*2.maatii biraa waliin*		
1002.9 garaagarummaa umurii maatii 2n.	Up to 5yrs		*>5yrs*		
1003.0Ilaalcha hawaasaa saalarratti	1.olaantummaa abbaa manaa(hamma malee)		*2.Walqixa murtii kennuu*		

hundaa'e			

Kutaa-2: Amma gaaffii waa'ee fayyaakeessaniif ofii murteessuu danda'uu keessaniin sakatta'anin sin gaafadha.

Gaaffii Q1002.2-1003.8:*"Maatii kankee keessaa eenyutu waan armaan gadiirratti murtii dhumaa kennaa?":*			
Q1003.1	Fayyummaakee?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Q1003.2	Fayyaa mucaakeef?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Q1003.3	Maatii/Hiriyootakee dubbisuu?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Q1003.4	Baayina ijoollee ati godha chuu barbaaddu?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Q1003.5	Fayyadama mala qusannoo maatii ammayyaa?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Q1003.6	Hordofii ulfaa yeroo ulfummaa?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	

Q1003.7	Bakka itti da'umsaa murteessuu?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Q1003.8	Talaalli mucaa murteessuu?		
Q1003.9	Gorsa ykn tajaajila fayyaa mucaa dhukkubsateef ?	Nama biraa(abbuma ta.e ----------1 Abbaamanaa fi nama biraa----------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu ----------4 Deebistuu qofaashee----------5	
Kutaa-2B: Gaafilee walabummaan sosochii haadhaa			
Q1004.0	Gaaffii malee manaa ba'uu ykn mucaa talaalchisuu dandeessaa qofaakee ?	Eeyyee-------1 Lakki--------2	
Q1004.1	Eeyyama namtokkoo mallee tajaajila fayyaa kankeef manaa ba'uu dandeessaa?	Eeyyee-------1 Lakki--------2	
Q1004.2	Firoota/hiriyootakee dubbisuuf eeyyama malee manaa ba'uu dandeessaa?	Eeyyee-------1 Lakki--------2	
Kutaa-2C: Gaaffii murteessumaa haadhaa, madda galii fi galii jirurratti.			
Q1004.3	Si ykn abbaan manaakee madda galii dhaabbiin qabduu?	Eeyyee-------1 Lakki--------2	
Q1004.4	Yoo deebiin gaaffii1003.5 eeyyee ta'e,gaaffii namtokkoo malee itti fayya damuu dandeessaa?	Eeyyee-------1 Lakki--------2	
Q1004.5	Yeroo mara eenyutu itti faayyadaminsa galiirratti murtii kennaa?	Nama biraa(abbuma ta.e--------1 Abbaamanaa fi nama biraa------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu -------4 Deebistuu qofaashee----------5	
Q1004.6	Yeroo mara eenyutu itti fayyadaminsa galii abbaa manaa keetiirratti murteessaa?	Nama biraa(abbuma ta.e-------1 Abbaamanaa fi nama biraa------2 Abbaa manaa qofaa----------3 Abbaa manaa fi deebistuu -----4 Deebistuu qofaashee----------5	

Gaaffileen marti sirnaan deebi'uusaanii mirkaneessi.

Galatoomaa!!!

Maqaa gaafataa_____ mallattoo _____Guyy_____

Maqaa supervisaraa_____mallatto_____Guy_____