ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF ALLIED HEALTH SCIENCES

DEPARTMENT OF NURSING AND MIDWIFERY

POSTGRADUATE PROGRAM

PREGNANT MOTHERS PREFERENCE OF MIDWIFE GENDER FOR BIRTH ATTENDANT AND ASSOCIATED FACTORS AT HEALTH INSTITUTION IN AMBO TOWN, OROMIA REGION ,ETHIOPIA, 2018.

BY: -REBUMA MULETA

A THESIS SUBMITTED TO DEPARTMENT OF NURSING AND MIDWIFERY, SCHOOL OF ALLIED HEALTH,COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTERS OF SCIENCE IN MATERNITY AND REPRODUCTIVE HEALTH NURSING.

JUNE, 2018

ADDIS ABABA, ETHIOPIA

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BY REBUMA MULETA

ADVISORS; 1. MR. BAZIE MEKONNEN (BSC. MSC., PHD FELLOW.)

2. S/R ADDISHIWET FENTAHUN (BSC., MSC.,)

JUNE, 2018

ADDIS ABABA, ETHIOPIA

APPROVAL BY THE BOARD OF EXAMINATION

This thesis by Rebuma Muleta is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of masters in maternity and reproductive health nursing.

Internal examiner:

_____	_____	_____	_____
Name	Rank	Signature	Date

External examiner:

_____	_____	_____	_____
Name	Rank	Signature	Date

Research advisors**:**

_____	_____	_____	_____
Name	Rank	Signature	Date
_____	_____	_____	_____
Name	Rank	Signature	Date

Department head

_____	_____	_____	_____
Name	Rank	Signature	Date

ACKNOWLEDGEMENT

First and foremost I would like to thank God. Next to that, I would like to forward my deepest appreciation and thanks to my advisors Mr Bazie M.(BSc., MSc. PhD fellow) and Sr. Addishiwet F.(BSc., MSc.) for their unreserved guidance, support, valuable comments and suggestions during the process of this thesis development.

Special thanks also extended to my family & friends for all rounded support throughout the study period.

Additionally, I would like to thanks all Academic Staffs of Addis Ababa University school of Nursing and Midwifery department, Addis Ababa University for financial support and IT Library for providing me valuable reference materials.

Finally, I would like to acknowledge staffs in Ambo health institution who assisted me on data collection, data collectors, all the study participants and other body who helped me directly or indirectly during this thesis preparation.

LIST OF ACRONYMS AND ABBREVIATIONS

AAU	Addis Ababa University
ACNM	American College of Nurse-Midwives
ANC	Antenatal Care
AOR	Adjusted Odds Ratio
BSc	Bachelor of Science
CHWs	Community Health Workers
CI	Confidence Interval
CS	Caesarian section
EDHS	Ethiopian Demographic health Survey
HCW	Health Care Worker
HEW	Health Extension Worker
HF	Health Facility
ICM	International Confederation of Midwifes
MMR	Maternal Mortality Ratio
SDG	Sustainable Development Goal
SPSS	Statistical Package for Social Sciences
SVD	Spontaneous vaginal Delivery
TBA	Traditional Birth Attendant

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ABSTRACT

Background: Globally, every minute, at least one woman dies from complications related to pregnancy and childbirth. A significant number of women in developing countries do not utilize obstetrics care service delivery. Identifying women's expectations, wishes, needs and fears enable the health care provider(s) to work toward a common goal of safe and positive childbirth experience. Mother's gender preference for obstetrics care is an important issue to promote maternal health care service utilization

Objective: To assess pregnant mothers' preference of midwife gender for birth attendant and associated factors at health institution in Ambo town, Oromia region, Ethiopia, 2018.

Method: Institutional based cross sectional study systematic sampling method was used. Data was collected using pre tested and structured questionnaire from 401 pregnant mothers at selected health institution in Ambo town from March 1 to April 1, 2018. The collected data was analyzed using SPSS statistical software packages. To identify the existence of association between the selected dependent and independent variables, bivariate and multivariate logistic regression with 95% CI and p-value <=0.05 was used.

Result:-Out of 388 pregnant mothers included in this study, 161(41.5%),135(34.8 %),92(23.7%)pregnant mothers preferred female, both (if male or female don't mind) and male gender of midwife health profession for delivery service respectively. Multinomial logistic regression analysis revealed that Muslims were more likely prefer female gender (AOR=5.783, 95% CI: 1.298, 25.771), mothers who have no formal education were more likely prefer female gender than male (AOR=4.006, 95 %(CI: 1.478, 10.857).

Conclusion and recommendation: This study revealed that even though there is preference of male gender, most women preferred female midwives.Religion, women's occupation and educational status were influenced preference of gender. Promotion of maternal health information and education should take into account for preferences of women. Therefore, mitigation measure is in need to ensure right and informed choice.

Key words: Midwife, Gender preference, pregnant mothers.

1. INTRODUCTION

1.1 Background of the study

There is a debate whether a midwife will be male or female. Wife on its own is a feminine title assigning females to males. The definition of a midwife, which says, midwife is a profession in midwifery, specializing in pregnancy, childbirth, postpartum, women's sexual and reproductive health and newborn care does not identify the gender [1]. Although gender differences are not clearly set in the field of health, in most societies, women have limited opportunity to access and control resources to protect their own health and have limited role in decision mechanisms [2]. Particularly, in relation to sexual and reproductive life, women hold limited power and ineffective position in decision-making processes [3].

Even though midwife stands for 'being with woman' doesn't identify that being midwifeness is either female or male, the ancient occupation of midwifery was exclusively dominated by women [4].

During the Hippocrates period (460 to 410 BC), it was thought that midwives should be required by law to have had children [5].During the seventeenth and eighteenth centuries, the advent of surgical instruments and institutional medical training brought many changes to midwifery. Initially, barber-surgeons, who carried with them destructive surgical instruments, were called to difficult births by midwives in a desperate attempt to save the life of the birthing woman. This role evolved what was termed the "man-midwife [6]. Males joined midwifery in the 20th century due to modernization. Problems arise when pregnant mothers find themselves being asked to undress in front of a male midwife.

McAllister reported, "Patients are dissatisfied when their expectations are not realized" therefore, there is a need to explore the midwife gender preference of mothers in order to promote the utilization of midwifery care by clients [7]

Since Emperor H/SelassieEthiopia has been training both male and female midwives with different proportion. Information from the Ethiopian Midwifery data Base showed that Ethiopia has an estimated 4,725 midwives in 2012 with a 1:5 male to female ratio for a population of 85 million [8].

Consideration and better understanding of the patients' needs on the part of the health care system might help increase the number of people seeking necessary health care. Many researchers have investigated factors that are important to women when choosing their health care provider. One of those factors is sex preference, which is likely to have a stronger impact when choosing health professionals engaged in intimate and psychosocial care practices. Indeed, many studies have found that women prefer female care provider, especially when it comes to obstetrical/gynecological issues [9,10].

Notably, the most frequent reasons for the women's choice were religious beliefs and cultural traditions [11, 12]

Globally, each year, nearly 50 million women suffer illness and disability due to complications associated with pregnancy and child birth [13].About 15 % of pregnant women in Ethiopia are estimated to develop obstetric complications which are potentially life-threatening [14]. Direct obstetric complications account for 85% of the deaths as well as many acute and chronic illnesses [15].

Developed countries and many middle-income countries achieved reductions in their maternal mortality rates initially through the provision of professional midwifery care at birth [16].

Research has shown that most of the maternal deaths are avoidable [17]. This can be done by Antenatal care through detection and treatment of pregnancy related illnesses, or indirectly through detection of women at risk of complications from delivery and ensuring that they could deliver in a suitably equipped facility with skilled health profession [18]. Assessing pregnant mother's gender preference for obstetric care and associated factors is very essential to promote the utilization of maternal health care services.

1.2. Statement of the problem

Studies showed that in religious countries ,With the exception of first-degree relatives, males are generally not permitted to look at or touch women. Accordingly, women are not allowed to be examined by male caregiver. Only during life, a male can treat threatening emergencies when a female is not available a woman.

Consequently, large numbers of women in a religious country such as Israel, avoid seeking medical attention for gynecologic/obstetric condition conditions for fear of being exposed to male physicians [19-21].

In Ethiopia, there is also a time when women refuse to be examined, most of them prefer females, and others prefer male reasoning more empathetic than females. This indicates less attention was given to gender preference for obstetric care. For instance the study done in shashemene shows that, although 18.8 % of the respondents preferred male gender 36.9 % were attended by male care provider [49].

Women encompass almost half of a population. Obstetric complications are the most problem for maternal morbidity and mortality.

Globally the annual number of maternal deaths decreased from approximately 532 000 in 1990 to an estimated 303 000 in 2015 [22].Even though it is decreased by 43 % , still it is high.

The disproportionate rate of maternal death across the world reveals the largest disparity in public health figures when comparing developed countries to developing country [23]. Developing countries account for 99% (302, 000) of the maternal deaths that occur throughout the world [24]. 62 % of these deaths occur in Sub Saharan Africa(179,000), followed by Southern Asia (69,000) and the lower levels of maternal mortality in developing country is recorded in the Oceania region at 510 [25].

Ethiopian women also suffer high rates of maternal morbidity and there are estimated to be 9000 cases of women suffering from obstetric fistula each year [26].

Most of African countries including Ethiopia are introducing free health care service for obstetric care to obscure this problem and meet the sustainable development goal. However,

still many of the women are not using this opportunity, as there is low institutional delivery and skilled birth attendant. This reality leads to the following questions: Is women's preference is affecting place of delivery. Why institutional delivery is very low? Therefore, there is something blocking mothers from utilizing maternity care services. Therefore, issues of women's choice and reasons for preference have to be addressed as key central role. Low maternal health care services utilization has been considered one of the factors that resulted in the slow progression of maternal mortality reduction programs [13]. This may have a relation with women's preference for obstetric care [27]. If this preference for obstetric care does not meet, there will be a decrement in institutional delivery and increase home delivery, which in turn increase maternal morbidity and mortality.

Midwifery is supposed to be client centered, providing services according to the preferences of the women. Because woman come from different cultural backgrounds and have different expectations from the maternity staff it is better to identify the woman's preference [28]. As mothers' preferences for midwife, gender have not been gathered and documented for midwife deployment in Ethiopia in general and Oromia in particular, this study seeks to establish the pregnant mothers' preference of midwife gender as a basis for midwifery deployment for obstetric care.

1.3. Significance of the study

Though many studies have been carried out to identify why maternal health care service utilization is low in Ethiopia, still there is no remarkable change. For instance, Ethiopia do not achieved the Millennium development Goal 4 and 5 [29].

There is limited study on mother's gender preference for obstetric care among midwives in Ethiopia as well as in Oromia. This shows that there is a gap of information related to this topic. To achieve the Sustainable Development Goal (SDG) it is better to give attention to this information.

The result of this study will aware policy makers, Ministry of Education, Ministry of health and concerned bodies regarding pregnant women's gender preference to take appropriate action for insuring the right choice of the women. Therefore, this study is designed to find out preference of midwife gender and its associated factors among pregnant mothers in Ambo town, West shoe zone, Oromia region, which will in turn contribute to reduce maternal mortality ratio (MMR) in Ethiopia. This study seeks to improve the delivery of midwifery services by meeting their clients' needs, provide a basis for the deployment of midwives at both hospital and national levels and Schools of training institution to determine the recruitment ratio of midwife students by gender.

2. LITERATURE REVIEW

This part reviews literatures of studies done on similar or related topics and gain insights into gender preference for obstetric care and associated factors.

2.1 Introduction

When dealing with some cultures a male midwife may be unacceptable to the woman, her husband and her family. This problem has not been explored. Midwives have a professional duty to offer equitable care according to clients' needs. It follows that an understanding of the client's cultural background is a pre-requisite to satisfy the pregnant mother in any given situation [17,30] . Patient satisfaction is an important dimension of the quality of care and a useful outcome measure [31, 32].

2.2 Utilization of institutional delivery

Although several studies have been carried out about maternal health care service utilization in developing countries, they don't give attention to maternal gender preference for obstetric care [33-35].

According to study conducted in Ethiopia, Amara Regional State, of the total number of respondents, 223(61.8%) choose home delivery where as the rest number of respondents 138(38.2%) choose health institution delivery. Concerning to the reasons for maternal choice of home delivery is 103(46.2%) of them were due to no female provider at Health Facility and 77(34.5%) of them were due to culture/religion [36] .

As a community based cross sectional quantitative study done in Bench Maji indicate, Out of the 495 respondents, 305(61.9%) gave birth to their last child at home while the rest, 190(38.1%), gave birth at health facility [37].

2.3 Mothers' midwife gender preference

Mothers' midwife gender preference for obstetric care could be a culturally influenced determinant of maternal satisfaction as it would decrease the sense of embarrassment and fear which parturient women may feel in a facility [38].

The WHO (World Health Organization) has recommended that the parturient woman should be accompanied by people whom she trusts and feels safe [39].

A study in India found higher preference for female on account of good comfort felt by women in communicating with them, a sense of privacy and attitude that females are more patient, 'deliver properly' and are good for examinations [21]. Women in Saudi Arabia and Thailand also felt that female providers have good understanding of the physical and psychological needs of pregnant women [40].

As study conducted on Physicians on gender preference in Turkey indicate, 160 (47.2 %) mothers preferred same-gender for the follow-up of their pregnancy period and at delivery, 42 (12.4 %) stated the opposite opinion; and 137 (40.4 %) mothers reported that gender was not important for them and that they always preferred gentle, considerate, experienced and professional physicians regardless of the gender [41].

The study done in Israel on religious and secular population indicates that most (63.8%) of the secular respondents preferred female care provider, while 74.5% had no gender preference. 68.6% of the religious women preferred female care provider as compared to 51.76% of those women who do not care for a gender [42].

A study conducted in Gweru provincial hospital Antenatal clinic and labor ward in Zimbabwe also showed that 14% mothers prefer male while majority of mothers 86% prefer female midwifes [43].

A cross sectional study done in Nigeria Showed that 18 (13.1%) of the respondents prefers a male midwife to be their midwife during labor, 46(33.6%) prefer a female midwife, while 73(53.3%) respondents prefer both male and female midwife [44].

2.4 Factors Associated With mothers' midwife gender preference for obstetric care

2.4.1 Socio-demographic factors

A cross-sectional study conducted in Israel on 196 women showed that non-married women are more likely preferred female care provider (73.3 %) than Married women (62.3 %). Religious (Muslim) women (68.6 %) are more likely preferred female care providers than seculars (52 %) and gender preference among women completed primary education is fifty fifty, where as among those who completed university education 66 % preferred female while 40 % preferred male [42].

A study conducted in Turkey and Nigeria indicated, two hundred twenty (78.8 %) of the housewives and 22 (48.9 %) of the women who have a job with an income stated that they preferred female consultants and more women whom their husbands are government employee preferred same gender [41, 45].

A study conducted in Zimbabwe found that women in the older age were more likely preferred female while younger age preferred male midwifes and the majority of women (92 %) who reside in rural area preferred female midwife than male 8% as compared to urban [43].

As study done in Kenya showed that, gender preference also differed between ethnic groups and religious groups with Muslim religion and elderly mothers were more likely gender dependent than Protestant [47, 48].

2.4.2 Obstetric History

According to study done in Nigeria on 137 respondents, 55.5% of the respondents have experience with a male midwife, women with two and three deliveries are more likely prefer male than others. 30.7% said that their partner is not comfortable with a male midwife and the majority of the women occupation is civil servant (44 %) followed by trader (28 %) and farmer (19 %) [45].

2.4.3 Service related factors

A study conduct in South-Western Uganda showed that mother who get information during ante natal care about birth preparedness plan are more likely confident to choose the person who will attend them during labor and delivery [46].

According to study done in shashemene town on preference of place of delivery and birth attendant ,though majority of respondents were attended by male HCWs 101(36.9%), Most of 151(54.7%) respondents preferred female attendants,52(18.8%) preferred male attendants where as 73(26.4%) unspecified care providers provided that they save both mother and baby. Out of 151(54.7%) the main reasons the respondents complain as reasons for preferring female Attendant were predominately cultural issues 69(45.4%), shame of male attendants 51(33.6%) religion 26(9.4%) and empathy 6(2.2%) [49]

As a study conducted on Maternal satisfaction on delivery service in Debre Markos indicate mothers who are satisfied by care service provider more utilize maternal care service and prepare birth attendant (AOR = 3.30, 95% CI: 1.38–7.9) [17]

In summary, the review of the literature indicates that ,even though ,there are male gender preference (14 %),(12.4) (13.1), more mothers preferred female gender during child birth (86%), (47.3 %), (33.6%).The main reason for female preference is being comfortable with female or the same sex ((69.7%).

2.5 Conceptual Framework

This study helped to explore different factors that may influence women's gender preference for birth attendant. The selection of the explanatory variables (see Conceptual framework adapted from McCarthy J and Maine) was based on their empirical importance, as reported in the literature for gender preference. The demographic background characteristics such as the variables age of mother and religion, and the socioeconomic variables such as maternal marital status and maternal education reflect the individual's own influence on gender preference. The other factors that influence the dependent variable include factors that impede delivery service utilization, obstetric history and service related factors.

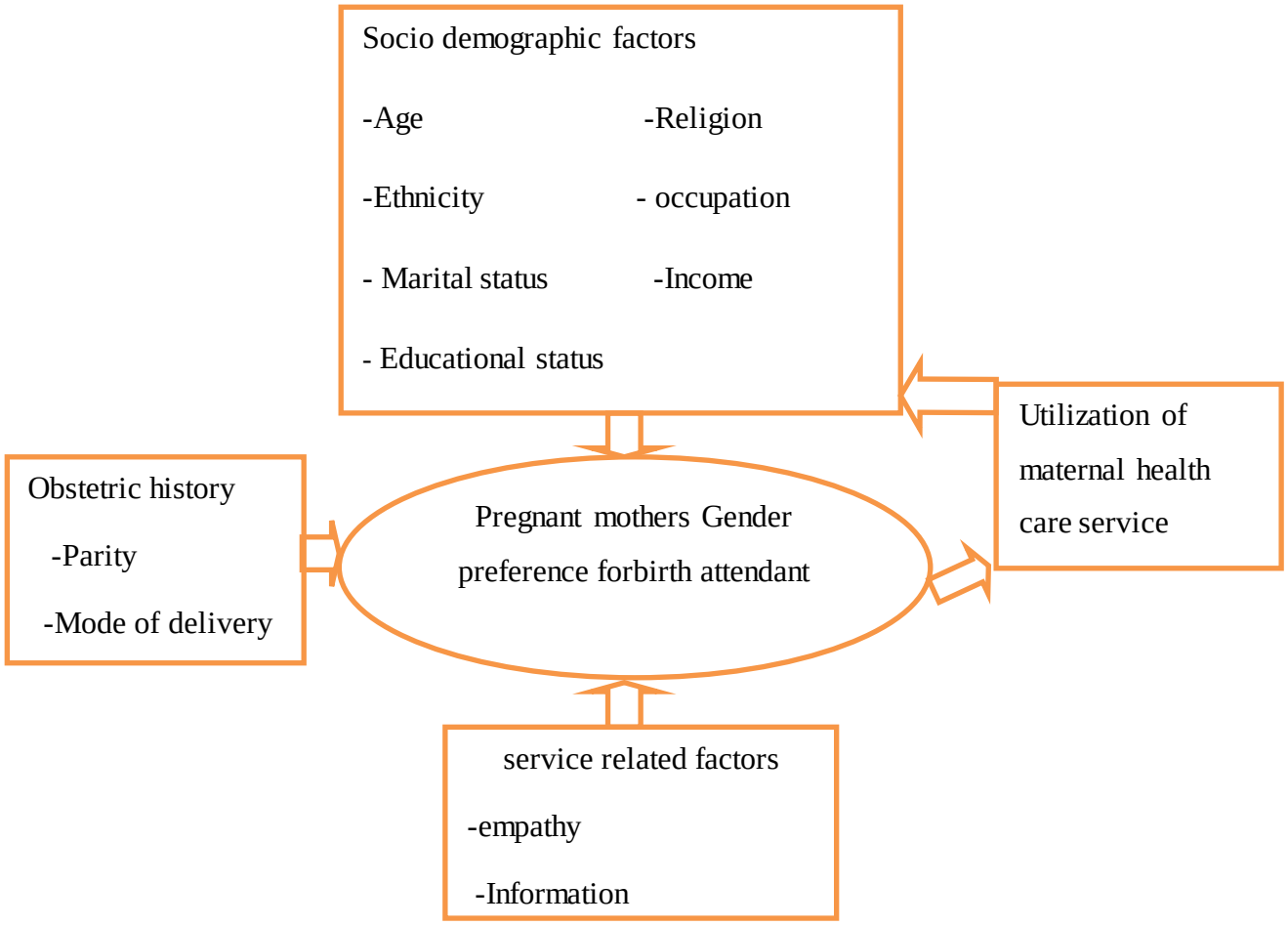

Figure 1: Conceptual framework for analyzing the determinants of maternal gender preference for birth attendant [Modified from McCarthy J and Maine 1992]

3. OBJECTIVE OF THE STUDY

3.1 General Objective

- ✓ To assess pregnant mothers preference of midwife gender for birth attendant and associated factors at health institution in Ambo town, Oromia region, Ethiopia, 2018.

3.2 Specific Objective

- ➢ To assess pregnant mothers preference of midwife gender for birth attendant.
- ➢ To determine factors that affect gender preference.

4. METHODS

4.1 study area

This study was conducted in Ambo town West shoe Zone, which is located at 115 kilometers to west of Addis Ababa, the capital city of Ethiopia. This town has a latitude and longitude of 8°59′N 37°51′E and an elevation of 2101 meters.

The total population of this town is estimated to be 80,712. Out of this total population, male accounts for 50.03 %(39,553) while female accounts for 49.97% (39,506). The majority of the inhabitants are followers of Orthodox Christian religion followed by protestant. The town has 6 kebeles, 2 governmental Hospital (1Referal Hospital and 1General Hospital) and 2 Health centers. Except Referral Hospital, which is established in 2016 as Ambo University teaching, and Referral Hospital, the rest institution provides ANC service for pregnant mothers. Ambo General Hospital is located at the center of the town and gives different health care services such as: Obstetric care, medical and surgical care, minor and major operation and laboratory service with a 24 hr. Previously it is known by Zonal hospital before changed to General Hospital in 2016.The two health centers located at both border of the town from each site. Both of these health centers provide MCH service, delivery service, inpatient and outpatient service and other health care services for a people coming from Ambo town and rural area of Ambo woreda [50].

4.2 Study Design and period

Institutional based cross sectional study was conducted from March 1 to April 1, 2018.

4.3 Source population

All pregnant women, in Ambo town.

4.4 Study population

The Study population in this study comprised of pregnant women who visit selected health Institution in Ambo town for ANC services.

4.5 Eligibility criteria

4.5.1 Inclusion criteria

- Pregnant women who visit selected health Institution in Ambo town for ANC services with two and above visits.

4.5.2 Exclusion criteria

- ✓ Those Participants who reside in the study area for less than six month.
- ✓ Participants with mental and other illnesses who are unable to communicate

4.6 Sample size determination

Sample size will be determined using the formula for single population proportion based on the following assumptions.

$$n = (Z\alpha/2)2\frac{P\,(1-P)}{d2}$$

Where:

n= is the size of the sample

Zα/2= is the standard normal value corresponding to the desired level of confidence

P=is the estimated proportion of an attribute that is present in the population (p=54.7% from previous study done in shashemene town [49]).

d =Degree of precession (the margin of sampling error to be used = 0.05

q = 1-p

$$n = (1.96)2\frac{0.54(0.46)}{(0.05)2} = 382$$

By adding 5% of non-response rate, the final sample size is n =401

4.7 Sampling procedure

The sampling method for this study was systematic sampling. In Ambo town, there are 1Referal Hospital, 1General Hospital, and 2 Health centers. All health institutions are selected except Referral Hospital, which has no ANC service. Data of the previous first quarter of pregnant mothers was obtained from ANC registration book and divided into three to get the average data of one month due to fluctuation from month to month. Then the calculated sample size was allocated proportionally to 1Hospital and 2 Health centers. (Fig.2). Then data was collected at every k^{th} interval from pregnant mothers on exit interview using a structured questionnaire on their return visit.

Proportional allocation: allocating sample proportionally to the total population of each hospital and health centers. Using the formula: $\text{ni} = \frac{n}{N} * Ni$

Where n=total sample size to be selected

N=total population

N i = total population of each strata

n i =sample size from each strata

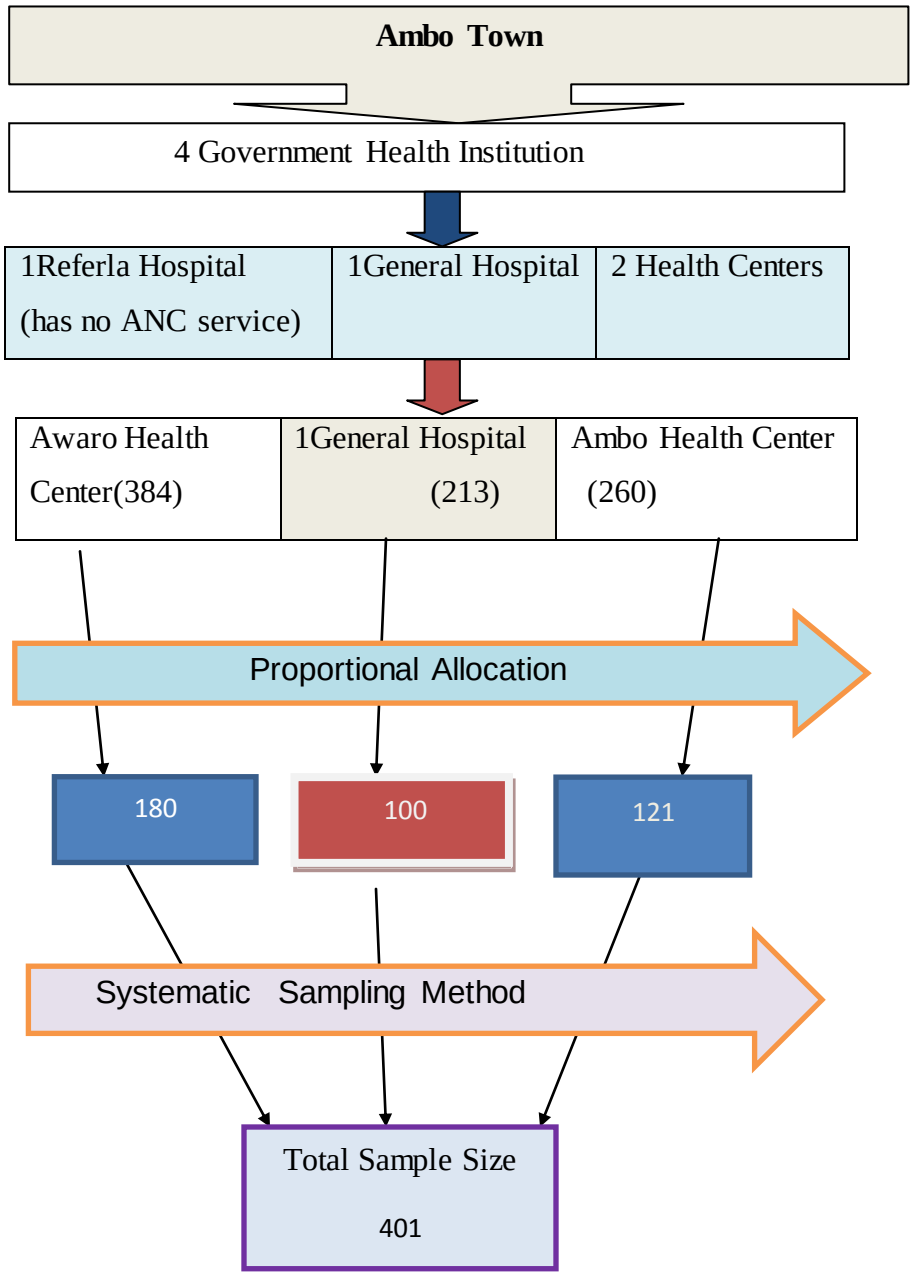

Figure 2:- Diagrammatic representation of sampling procedures for assessment of pregnant mothers gender preference for obstetric care among midwives and associated factors, 2018.

4.8 Data collection tool and procedure

A structured, questionnaire was used to collect data from the study participants. The questionnaire was adapted and modified from different sources and was reviewed by linguistic professionals to keep its reliability and validity [30,41,42].

The questionnaire was prepared in English translated into Afan Oromo and translated back to English by a third person to check for consistency .Matching was made on the exact fitness of the two versions.

Data collection with a face- to- face exit interview was done by 6 (3 male and 3 female) health professionals who have at least diploma and above educational level.

At the time of data collection, explanation was provided for the respondents on the

Purpose of the study and the importance of their involvement, then respondents who volunteered were interviewed.

4.9 Variables

4.9.1 Dependent variable

- Gender preference

4.9.2 Independent variables

- Socio-demographic variable:
  - Age
  - marital status
  - Ethnic group
  - Religion
  - Educational status
  - occupation
  - Income
  - Residence
- Obstetric History:

- parity

- service related factors
- Empathy
- Information

4.10 Data quality control

To assure the data quality high emphasis was given to data collection instrument. Proper check and pre-testing the questionnaire was done. A pretest was conducted among five percent (5 %) of similar respondents in Guder Hospital, which are not included in the study area. Any ambiguous and unsuitable questions were modified after the pretest.

After checking, the questionnaires completeness with pretest, the actual data collection will be conducted .Training for the interviewers and super visors about the data collection procedures, proper categorization and coding of the questionnaire was done.

Throughout the course of the data collection, interviewers were supervised at each site, regular meetings was held between the data collectors and the principal investigator .The collected data was reviewed and checked for completeness before data entry; the incomplete data was discarded.

4.11 Data analysis

After data collection, each questionnaire was checked visually for completeness and coding. The corresponding code number was written carefully at each margin. Data was entered using EPI INFO version 3.1 and subjected to cleaning using simple frequency and tabulation. Then data was exported to IBM SPSS version 20 packages for data analysis. Frequencies and summary statistics (mean, standard deviation, percentage, and range) were used to describe the study population in relation to relevant variables and outlines. To identify the existence of association between the selected dependent and independent variables, bivariate and multivariate logistic regression with 95% C.I and p-value <=0.05 was used.

The result was presented in the form of text, tables, figures and summary statistics.

4.12 Ethical considerations

Ethical clearance letter was obtained from Ethical Clearance Committee of department of Nursing and Midwifery of Addis Ababa University. Written Permission was sought from the

responsible body and informed consent was obtained from each participant after the data collectors explained the nature, purpose and procedures of the study. Participants complete the questionnaire only if they chose to do so. Anonymity and confidentiality of the data provided was strictly maintained. Participants were assured that their participation is voluntary, and they have a right to withdraw or refuse to give information at any time during data collection.

4.13 Dissemination of the result

The result of this study will be disseminated to department of Nursing and Midwifery College of Allied Health Science, postgraduate program and Addis Ababa University. The research result will also be disseminated and accessed to others to be used as source of information to do further research and even to critique the findings.

Presentations at professional, local, national and international meetings and publication in peer reviewed national or international journals will be attempted.

4.14 Operational definitions

Parity:-Total number of delivery that occur after 28 wks of gestational age.
Gender: Socially constructed attributes assigned to males and females result into differences in status and roles between males and females.
Gender preference: a pregnant women, who had attended maternity wards and choose of either sex of midwife health profession based on their preference.
Birth attendant: A person who is trained in midwifery course and able to conduct delivery care service.
Information: A woman has information if she answers at least one component of birth preparedness.

Empathy: a person who respect and understand one's person problem and assist with kind.

5. RESULT

Out of 401 pregnant women initially included in this study, 388 (96.7%) have responded to the interview at the selected health institution.

5.1. Socio-demographic characteristics of the respondents

The respondents' age ranges from 18 years to over 28 years of age. The majority of the Respondents125 (32.2%) were women aged less than or equal to 21 years; while the least 85 (21.7%) were above 28 years with a mean age of 23.4(±4.4).

The majority of the respondents 358 (92.3%) were married and the rest are single and divorced. Concerning the ethnicity 347(89.4 %) were Oromo while 33(8.5 %) and 8(2.1%) were Amhara and Gurage respectively. Regarding religion 247(63.7 %) were Protestant, 119(30.7 %) Orthodox and 22(5.7%) Muslim. Nearly, 82 % of the respondents attended formal education. Regarding the occupational status of the respondents, majority 136(35.1%) of them were house wife, 62(16.0%) Private employee. Concerning educational and occupational tatus, most 154 (39.7%) of the respondents husband educational status were Secondary education (9-12) while 52 (13.4%) of them are those with no formal education and majority113 (29.1%) of the respondents husband were merchant and the least 46(11.9 %) of them were daily laborer. Economically, of 388 respondents, 121(31.2%) of the respondents monthly income werefrom1001.00 - 2000.00 while only 81(20.9 %) had of >3001ETB.Concerning residence 343 (88.4%) were urban residents. [Characteristics of the respondents were summarized in Table 1].

Table 1: Socio- demographic characteristics of pregnant women at Ambo town, March-April, 2018(n=388)

Variables		Frequency	(%)
Respondents Age (years)	<= 21.00	125	32.2
	22.00 - 24.00	90	23.2
	25.00 - 27.00	88	22.7
	28.00+	85	21.9
Marital Status	Single	24	6.2
	Married	358	92.3
	Divorced	6	1.5
Ethnicity	Oromo	347	89.4
	Amhara	33	8.5
	Gurage	8	2.1
Religion	Orthodox	119	30.7
	Muslim	22	5.7
	Protestant	247	63.7
Womans Educational Status	No formal education	71	18.3
	Primary education (1-8)	101	26.0
	Secondary education(9-12)	138	35.6
	Diploma and above	78	20.1
Husbands educational status	No formal education	52	13.4
	Primary education (1-8)	78	20.1
	Secondary education(9-12)	154	39.7
	Diploma and above	104	26.8
Woman's occupation	House wife	136	35.1
	Governmental employee	101	26.0
	Merchant	89	22.9
	Private employee	62	16.0
Husband's occupation	Governmental employee	82	21.1
	Merchant	113	29.1
	Farmer	49	12.6
	Daily labor	46	11.9
	Private employee	98	25.3
Economic status	<= 1000.00	103	26.5
	1001.00 - 2000.00	121	31.2
	2001.00 - 3000.00	83	21.4
	3001.00+	81	20.9
Residence	Urban	343	88.4
	Rural	45	11.6

5.2 Women's obstetric history and care

From the total number of respondents, 151 (38.9%) were para zero (do not gave birth), while the rest 237 (61.1%) were Para one and above, 366 (94.3 %) replied that their current pregnancy is wanted. From those 237 women who have previous history of delivery, majority 222(93.6 %) of them gave birth by SVD, 9(3.7 %) by CS and 6(2.5 %) were assisted (instrumental), on previous delivery 99(47.8 %) birth was attended by female care provider, 75(36.2%) by male care provider and 33(16%) by both male and female care provider.
For 230 (97 %), their delivery outcome were normal and 7(2.9 %) were with complication (heamorrhage, fetal death etc.) (see table 2).

Table 2: Obstetric history of pregnant women at Ambo town, March-April, 2018(n=388)

Variables	Frequency	(%)
Status of pregnancy		
Wanted	366	94.3
Unwanted	22	5.7
Parity(n=237)		
1-2	201	84.8
≥3	36	13.1
Mode of delivery(n=237)		
1.Spontaneous vaginal Delivery	222	93.6
2. Assisted delivery(vacuum)	6	2.5
3. Caesarian section	9	3.7
Delivery outcome (n=237)		
Normal	230	97.04
With complication	7	2.6
ANC use(n=237)		
Yes	207	87.3
No	30	12.6
Previous delivery attendant(n=210)		
Male	75	35.7
Female	102	48.5
Both	33	15.7
Have you ever heard about Birth preparedness(n=388)		
Yes	224	57.7
No	164	42.3
Source of information		
Health professional	46	20.5
Health Extension worker	37	16.5
Media	10	4.4
Family	121	54.04
No one(self)	10	4.4
In your opinion, what are some things a pregnant woman can do to prepare for birth?		
Desired place of birth	97	25.0
Preferred birth attendant	49	12.6
Funds for birth-related and emergency expenses.	151	38.9
Birth companion.	65	16.8
Others**	26	6.7

**: porridge, cloth,etc.

On their previous delivery attendants, out of 210 who have gave their previous birth at health institution, 102 (48.5) delivered by female while 75 (35.7) by male and 33 (15.7) by both gender.

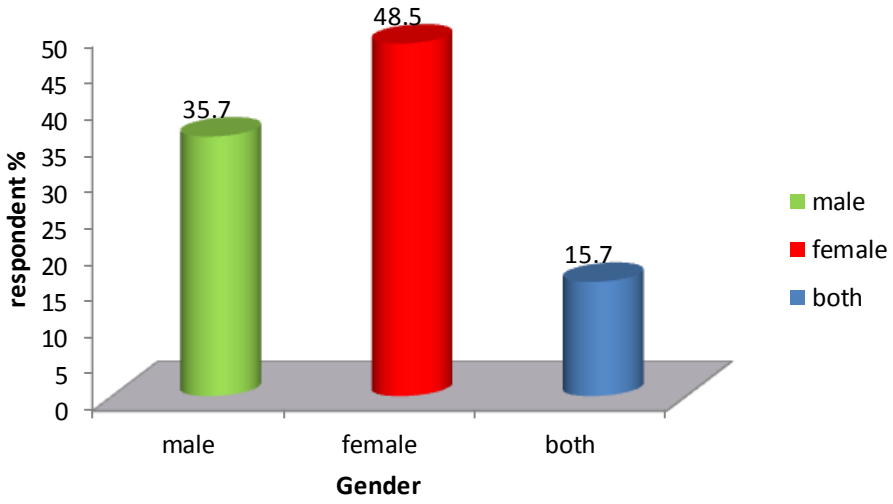

Fig 3:Gender of previous birth attendant of pregnant mothers (n=210) in Ambo town, West Shoa Zone, Ethiopia, March 2018.

Among 388 respondents 224 (57.7%) have information about birth preparedness plan while 164 (42.3 %) haven't heard about it. Most 121(54.04 %) of them heard this information from their family and health professional 46 (20.5 %).

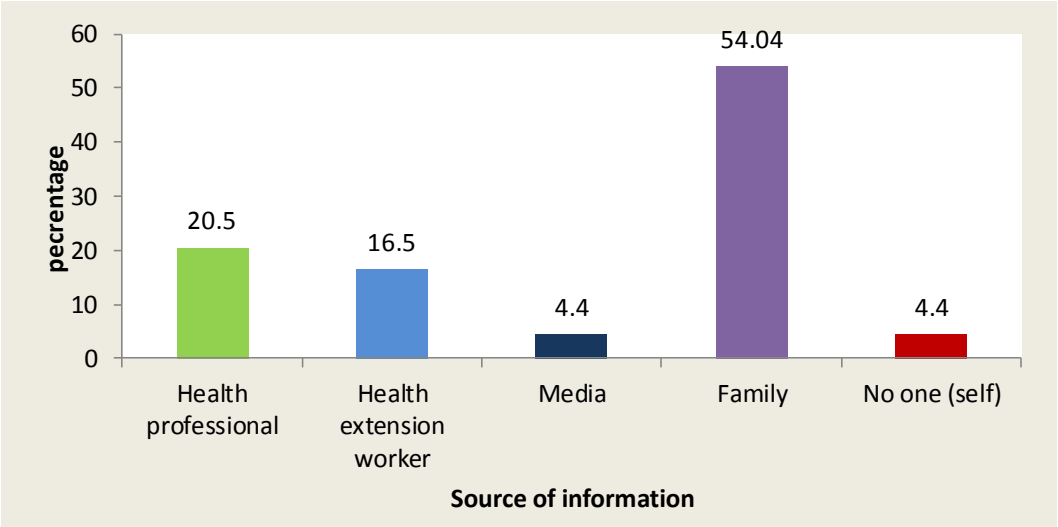

Fig 4: Reported sources of information about birth preparedness and complication readiness plan (n=224) in Ambo town, West Shoa Zone, Ethiopia, March 2018.

On place of delivery, majority of the respondents 379(97.7 %) preferred institutional delivery for their current pregnancy while 9(2.3 %) preferred home delivery by reasoning distance of health institution and lack of transportation.

5.3preference of the respondent

On gender preference for delivery care service among 388 respondents, 161(41.5 %) preferred female midwife, 135(34.8 %) both sexes (no sex preference) and 92(23.7 %) preferred male. On reason of preference, among respondents who preferred male,70(76.9%) said that males are empathetic than female, 10(10.8%) males communicate more than female and 11(12.09 %) said male midwife is more skill full than female, while from those who prefer female; 91(56.17 %)said females are empathetic, 31(19.13%) shame of male (fear),19(11.7%) said females are culturally accepted and 9(5.6 %) said female midwife is more skill full than Male and 7(4.3) said females communicate more than males.(table 3).

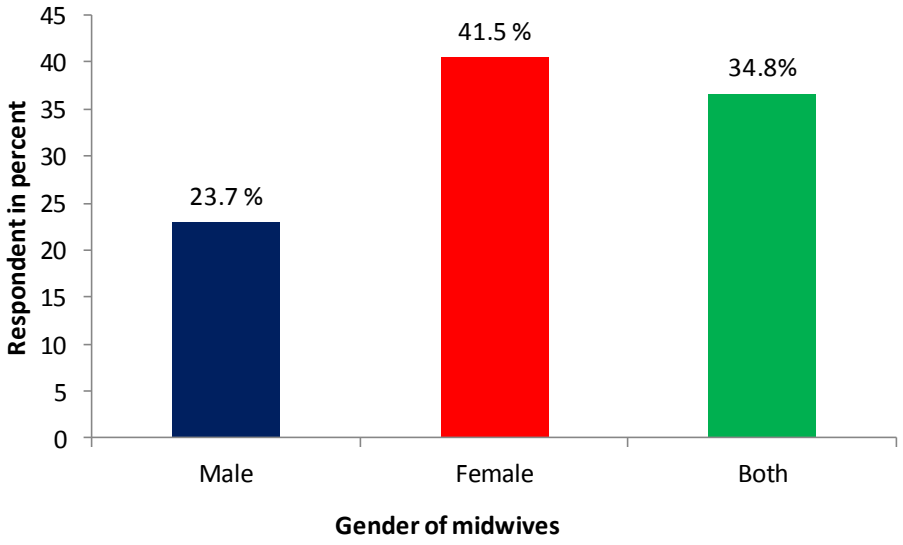

Fig 5: preferred gender of midwives for delivery care by Pregnant mothers in Ambo town, West shoa zone, March 2018

On encouragement to be a midwife 305(78.6 %), 62(16.0), 21(5.4 %) reported that they encourage both, female and male respectively to be a midwife. Out of 388 respondents 372(95.9 %) replied no for a question should male stopped from being a midwife.

Table 3: Gender preference for delivery service of pregnant women at Ambo town, March-April, 2018(n=388)

Variables	Frequency	(%)
preference of place of delivery for this pregnancy		
Health institution	379	97.7
Home	9	2.3
Preferred midwife gender for delivery attendant		
Male	92	23.7
Female	161	41.5
Both	135	34.8
Why do you prefer male midwife?		
Males are empathetic than female	70	76.9
Males communicate more than female	10	10.9
Male midwife is more skill full	11	12.09
Why do you prefer female midwife?		
female midwife is more skill full than Male	12	7.4
Females are empathetic	91	56.17
Females are culturally accepted as midwives	19	11.7
Shame of male	31	19.13
Religion	9	5.5
Whom will you encourage to be a midwife?		
Male	21	5.4
Female	62	16.0
Both	305	78.6
How do you see a male being a midwife		
Should be encouraged	368	94.8
Don't know	12	3.1
Don't like it	8	2.1
What was your experience with a male midwife on obstetric care?		
He was more caring	69	17.8
It was annoying	6	1.5
Just like any other midwife	136	35.1
Don't know how it was	177	45.6
Will you accept to be examined and attended by a male midwife?		
Yes	374	96.4
No	4	1.0
Don't know	10	2.6

5.4 Factors influencing pregnant mother's gender preference for delivery service among midwives at health Institution.

Since the dependent variable outcome was more than two, multinomial Logistic regression was used to assess the association between independent variable with the dependent variables. Religion, woman's occupation, woman's educational status and husband educational status are significantly associated with mother's gender preference among midwives for delivery service at health institution.

Muslim pregnant mothers compared to Protestants nearly six times more likely prefer female gender than male (AOR=5.783, 95% (CI: 1.298, 25.771).

On Educational status, mothers who have no formal education and primary education compared to those who have diploma and above were four times and two times more likely prefer female gender than male respectively (AOR=4.006, 95% (CI: 1.478,10.857), (AOR=2.48, 95% (CI: 1.000,6.181). Regarding to occupational status, house wives compared to privately employed were six times more likely prefer female gender for delivery service than male (AOR=6.39, 95% (CI: 2.730,14.993) and Governmental employed women compared to private employed were three times more likely prefer female gender than male gender (AOR=2.908, 95% (CI: 1.154, 7.325).

Merchant pregnant women compared to private employed were three times more likely prefer both gender than male gender. On the other hand pregnant mothers whom their husbands are farmers compared to those who are privately employed were nearly four times prefer female than male (AOR=3.609, 95% (CI:1.239,10.518).

Table 4: Logistic regression analysis of factors associated with gender preference for delivery service among pregnant women in Ambo town, Ethiopia, March , 2018 (n=388).

	Variables	No	COR(95% CI)	AOR (95% CI)
Female	**Religion**			
	Orthodox	50(12.9)	0.778(0.432,1.401)	0.895(0.518,1.548)
	Muslim	19(4.9)	**4.529(0.962,21.322)**	**5.783(1.298,25.771)***
	Protestant	92(23.7)	1	1
	Woman's educational status			
	No formal education	41(10.6)	**3.956(1.794,8.726)**	**4.006(1.478,10.857)***
	Primary education (1-8)	44(11.3)	**2.388(1.156,4.932)**	**2.486(1.000,6.181)***
	Secondary education(912)	57(14.7)	1.904(0.966,3.751)	2.288(1.021,5.128)
	Diploma and above	19(4.9)	1	1
	Woman's occupation			
	House wife	84(21.6)	**4.941(2.309,10.575)**	**6.398(2.730,14.993)***
	Governmental employee	35(9.0)	**2.708(1.154,7.325)**	**2.908(1.154,7.325)***
	Merchant	25(6.4)	0.735(0.337,1.606)	1.042(0.434,2.502)
	Private employee	17(4.4)	1	1
	Husband's occupation			
	Governmental employee	37(9.5)	1.129(0.542,2.353)	1.287(0.560,2.957)
	Merchant	35(9.0)	0.680(0.340,1.358)	0.701(0.334,1.469)
	Farmer	31(8.0)	**3.312(1.209,9.076)**	**3.609(1.239,10.518)***
	Daily labor	19(4.9)	1.740(0.639,4.737)	1.754(0.614,5.013)
	private employee	39(10.1)	1	1
Both	**Woman's occupation**			
	House wife	25(6.4)	0.741(0.332,1.650)	0.785(0.343,1.800)
	Governmental employee	35(9.0)	0.903(0.422,1.934)	0.956(0.408,2.240)
	Merchant	50(12.9)	**2.857(1.240,6.584)**	**2.922(1.226,6.966)***
	Private employee	25(6.4)	1	1

Male: is taken as the reference category in multinomial logistic regression.

*P value is significant at P<0.05 *percentage in bracket, odds and Adjusted for, religion, woman occupation, woman education and husbands educational status of the respondents.*

6. DISCUSSION

This institutional based-cross sectional study has attempted to identify gender preference for delivery attendants and their associated factors among pregnant women in Ambo town. The importance of obstetrics care services in reducing maternal morbidity and mortality has got a considerable recognition though implementing and assuring effective maternity care for women in developing country need an effort. According to data from EDHS 2016, birth attended by skilled provider in Ethiopia is 28 and institutional delivery is 26 percent. This low utilization of health care services may give some indication of service coverage in the country. As a consequence, each year a number of women die from problems related with pregnancy and delivery. The objective of providing safe obstetric care is to keep the life and health of the mother with due attention to reduce the health risk of complications through increasing the proportion of delivery attended by skilled birth attendants. Generally, in Ambo, as in other zone of the region, most of women do not equally access health care. Adequate care during pregnancy and delivery are essential based on their preference. In this study we found 41.5 %, 23.5 %, 35.1 % preferred female, male and both gender (indifferent/no sex preference) for birth attendant respectively.

This finding especially female gender preference is lower than study conducted in Syria by Hyam B. et al which says more than 85% of women preferred female attendants and Shashemene in which 54.7 % female gender is preferred [30,49].This may be due to religious factor.

Empathy (56.9 %) and shame (shyness) of male (19.3 %) as well as cultural acceptance (19.13 %) were the main reasons for female gender preferences as stated by women. Preferences for male were largely explained by their empathy (76.9 %) perceived competency and skill (12.09 %). This is in line with the studies done in Shashemene by Abdurahmen, J et al, and Addissie M., Zimbabwe by shavai, f. and e. chinamasaand in Syria by Hyam B. et al [30, 43, 49]. As a study done in shashemene on preference of place of delivery and birth attendant showed that sex preference was a strong predictor for place of delivery.

Religion, educational level, occupation of the respondents and educational level of the respondent's husband are factors significantly associated with gender preference. Muslim pregnant mothers compared to Protestants were nearly six times more likely prefer female

gender than male(AOR=5.783, 95% (CI:1.298, 25.771).This is similar with study done in Syria and Israel [30,42].

In this study, Occupation and educational status of women was found to be the most significant factor influencing gender preference. Women's who have no formal education more likely prefer female midwives. This is in line with the study done in Turkey and Israel [42, 44]. Female gender preference decrease as educational level increase. This means educated women do not fear or ashamed with male care giver. Those who are house wives when compared to private employed were six times more likely prefer female than male(AOR=6.39, 95%(CI: 2.730,14.993) and governmental employed as compared to private employee were three times more likely prefer female than male (AOR=2.908, 95% (CI:1.154,7.325). This finding agrees with the studies done in shashemene by Abdurahmen, J et al, and Turkey by kirimlioglu, n. and ö. saylıgil [41, 49].

7. Strength and Limitation of the Study

7.1 Strength

- The study used well-experienced data collectors, which results a high quality data.
- Use of multinomial logistic regression.

7.2 Limitation of the Study

- The cross-sectional study could not help the researcher establish cause- effect relationship between the possible determinants of gender preference and the outcome of interest.
- Since mothers who have given birth in the past period were included in the study, recall bias may occur.

8. CONCLUSION AND RECOMMENDATION

8.1 Conclusion

This study revealed that most women preferred female midwives to provide delivery care services. However, still substantial number of women preferred male professionals as well. Religion, education and occupation are identified factors affecting gender preference for delivery services.

Without a proper understanding of women's preferences, health policy makers and Practitioners might not be able to provide a satisfactory standard of health care.

8.2 Recommendation

As a recommendation, there should be a need to understand and expand services availability and accessibility at facility level. Provision of gender-sensitive health care is an important issue in the modern era. Attention should be given to the preference of women to ensure equal access to maternity health care services since they are not using maternity care services equally. Government and policy makers should work on strategies and Programs on training and recruitment of midwives based on the women's preference and toward the education and empowerment of women so that they can make better choices in issues related to their health. Health care professions should work to improve mother's knowledge and create awareness on gender preference through health education at ANC, providing information about birth preparedness and respect women's choice in order to increase maternal health care service utilization. For further research: this study has established the determinants of gender preference in promoting skilled birth attendant. The study recommends that further research should be undertaken to investigate about gender preference on delivery service in promoting skilled birth attendant and future maternal utilization of MCH service.

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ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF NURSING AND MIDWIFERY

10. ANNEXES

10.1 ANNEX I: English version Participant Information sheet and consent form

Good morning/ afternoon?

My name is _____. Currently I am a post graduate student in Maternity and Reproductive Health Nursing at Addis Ababa University, College of Health Sciences, School of Allied Health Sciences, Department of Nursing and Midwifery. And now I am conducting a research to assessment of pregnant mother's gender preference among midwifes health profession and associated factors at health institution in Ambo town, West Shoa Zone, Oromia region.

Duration: The duration of this study will be from February 01/02/2018 to March 01/02/2018,

Participants: The pregnant mothers who come to governmental health institution during this study period.

Risks: The risks of being participating in this study are very minimal, only taking few minutes.

Confidentiality: The information that you provide us will be confidential. The questioner will be coded to exclude showing your name on questionnaire and consent form.

Benefits: At this moment you may not get any direct benefit by being involved in this study but the information you provide is very important to solve problems of pregnancy and pregnancy related problems.

Rights: Participation in this study is fully voluntary. You have the right to declare not to participate in this study and you have the right to with draw from participating at any time.

So do you agree to participate in this study?

Yes □ No □

Thank you in advance for your cooperation

Data collectors Name_____ sign: _____

Name of the principal Investigator: Rebuma Muleta

Mobile: 09 04 19 29 29. E-mail: rebummul7@gmail.com

Verbal Consent Form

It has been read to me in the language I understand all conditions stated above. Therefore, I am willing to participate in this study.

Result of interview:

1. Completed 2. Respondent not available 3.Refused 4. Partially completed

Checked by:

Supervisor Name _____ signature_____

Date_____/_____/____E.C.

Time interview started: Hour: _____ Minute: _____

Questionnaire No: ____

Time interview ended: Hour: _____ Minute: _____

Name of interviewer _____

Date _____/_____/_____E.C**.** signature_____

If respondent does not agree to be interviewed thanks her and go to the next respondent

10.1.1 Annex II English version Questionnaires

Instruction: - Circle the responses for questions with alternatives and write for open ended questions on the space provided.

Identification Information

01. Code No._____

Part One: Socio – Demographic Characteristic

S.no		Response	Skip to
101	Age (in years)	1. _____	
102	Marital Status	1. Single 2. Married 3. Divorced 4. Widowed	
103	Ethnicity	1. Oromo 2. Amhara 3. Tigre 4. Gurage 5. Other (specify)_____	
104	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Other (specify)_____	
105	Woman's Educational Status	1. No formal education 2. Primary education 3. Secondary education 4. Diploma and above	
106	Husband's educational status	1. No formal education 2. Primary education	

		3. Secondary education 4. Diploma and above	
107	Woman's Occupation	1. House wife 2. Governmental employee 3. Merchant 4. private employee	
108	Husband's Occupation	1. Governmental employee 2. Merchant 3. Farmer 4. Daily laborer 5. private employee	
109	Economic status (monthly income)	1.____ birr.	
110	Residence	1. Urban 2. Rural	

Part two: obstetric history and care

S.no		Response	Skip to
201	Status of pregnancy	1. Wanted 2. Unwanted	
202	Parity(number)	_____. If 0 ----------➔	210
203	Mode of delivery	1.Spontaneous vaginal Delivery (SVD) 2. Assisted delivery 3. Caesarian section(CS)	
204	Delivery outcome	1. Normal 2. With complication	
205	Fetal condition	1. Alive 2. Dead	

206	Do you have ANC follow up?	1. Yes 2.No----------➔	208
207	What was the sex of the health care provider who gives you a care on your ANC follow up?	1. Male 2. Female 3.Both	
208	Do you have previous health Facility delivery experience?	1. Yes 2. No----------➔	210
209	What was the sex of the health care provider who attended you on your previous labor and delivery?	1. Male 2. Female 3.Both	
210	Have you ever heard about Birth preparedness?	1.Yes 2. No ……..➔	212
211	From whom did you get the information?	1.Health professional 2.Health Extension worker 3.Media 4.Family 5.Others (specify)	
212	In your opinion, what are some things a pregnant woman can do to prepare for birth?	1.Desired place of birth 2. Preferred birth attendant 3.Funds for birth-related and Emergency expenses. 4. Birth companion. 5. Others (specify).	
213	Do you get information about Birth preparedness plan to day?	1.Yes 2.No	

Part – three: Questions related to preference

S.no		Response	Skip to
301	Where is your preference regarding to your place of delivery for this pregnancy?	1. Health institution ……..….➔ 2. Home	303
302	(For those who prefer to home delivery) What is your main reason to prefer home delivery? (MORE THAN ONE ANSWER POSSIBLE)	1. Distance of health institution 2. No means of transportation 3. Lack of money 4. No female provider at HFs 5. Others (specify)_____	
303	From midwife health profession whom do you prefer to attend you on your labor for this pregnancy?	1. Male 2. Female……..➔ 3. Both…….……➔	 305 306
304	Why do you prefer male midwife?	1. males are empathetic than female 2. bad experiences in the hands of female midwives 3.Male midwife is more skill full 4. changing time 5.Other(specify)----------	
305	Why do you prefer female midwife?	1.female midwife is more skill full than Male 2.Females are empathetic 3. Females are culturally accepted as midwives. 4.Shame of male 5.Religion 6.Other (specify)----------	

306	Whom will you encourage to be a midwife?	1. Male 2. Female 3.Both	
307	How do you see a man being a midwife?	1.Don't like it 2.Should be encouraged 3.Don't know	
308	What was your experience with a male midwife on obstetric care?	1.He was more caring 2.It was annoying 3.Just like any other midwife 4.Don't know how it was	
309	Should males be stopped from being in labor room and examining women during labor?	1.Yes 2.No 3.Don't know	
310	How will you feel if your midwife during labor is a male?	1.Comfortable with that 2.Not be comfortable with him 3.Don't know	
311	Will you accept to be examined and attended by a male midwife?	1.Yes 2.No 3.Don't know	

Thank you for your cooperation!

UNIVERSIITII FINFINNETTI

KOLLEEJJII SAAYINSII FAYYAA FI MANA BARNOOTA

QINDAA'INA NARSII FI MIDIWAYIFERII

10.2 Annex III- Ragaa odeeffannoo fi unka eeyyamaa (Afan Oromo Version)

Akkam bultan/Ooltan?

Maqaan koo_____ Jedhama.Yeroo ammaa kanatti digirii lammaffaa isaa Universiitii Finfinnee Kollejjii Saayinsii Fayyaa Qindaa'ina Narsootaa fi Midwayiferootaatti barachaa kan jiru eebbifamuudhaaf qorannoo filannoo dubartoota ulfaa ogeessota midwiferootaa dhiiraa fi dhalaa keessaa Eenyuun tajajaajilamuu akka barbaadanii fi sababiiwwan isaanii irratti manneen yaala Godina keessanitti argamu keessatti gaggeessuuf odeeffannoo walitti qabaa jira.Qorannoon kun haawwoota mana yaala mootumma keessatti hordoffii ulfaatiif dhufani bahan hanga haawwoota 401 ta'utti gaggeeffama.

Qorannoon kun sa'aatii muraasa si jalaa fudhachuu irraa kan hafee miidhaa hin qabu. Qorannoon kun fayidaa battalaa qabaachuu baatus, dubartoota ulfaatiif yeroo hordoffii ulfaa fi dahumsaatti fedhii isaanii guutuuf fayidaa guddaa qaba.Odeeffannon ati nuuf kennitu hunduu icciitiin kan eegamuu fi maqaan kee kan hin barreffamne ta'uu isaa siif ibsa.

Itti aansee gaaffilee armaan gadii kanan si gaaffadha.Amanamummaan gaaffilee armaan gadii kana deebisuun milkaa'ina qorannoo kanaatiif gahee guddaa taphata.kanaafuu gaaffilee kana fedhaan akka naaf deebistun si gaaffadha.Yoo feete qorannoo kana yeroo feetetti dhiiste deemuf mirga qabda.Yoo gaaffii fi yaada qabatte teessoo armaan gadii kanaan na qunnamuu ni dandeessa.

Hirmaachuuf fedha ni qabda?Eeyyee □ Lakki □

Galatoomi hirmaanna keetiif

Maqaa Qorataa Rabbumaa Mul'ataa

Lakk.moobayilii: 0904 19 29 29. E-mail: rebummul7@gmail.com

Unka eeyyamaa odeffannoo Afaan Oromoo (Afan Oromo Version)

Waraqaa odeeffannoo qu'annoo kanaa ilaalchisee armaan olitti barraayee naa dubbifame hubadhee jira,wanta narraa barbaadamus naaf galee jira.

Walumaa galatti wayitiin barbaadetti sababii tokko malee osoo anaa fi maatii kiyyarratti rakkoo hin uumiin addaan kutuu akkan danda'ullee beekee jira.

Amma gaaffii itti fufuu danda'aa?

1.Eyyeen_____itti fufi

2.Lakki_____gaalateeffadhu gara itti aanutti darbi.

Bu'aa gaaffii qorannicha gaggeessuuf ta'ame

1. Guutuudha 2.Hirmaatan hin argamne 3. Ni diddee 4. Gar-tokkeen guutame

Kan Mirkanaa'een:

Maqaa Suparvaayizera_____Mallattoo_____

Guyyaa _____/_____/_____A.L.A

Yeroo gaaffiin itti jalqabame: sa'aatii_____Daqiiqa_____

Lakkoofsa gaaffilee_____

Lakk. ID Hirmaataa_____

Yeroo gaaffiin xumurame: sa'aatii_____Daqiiqaa_____

Maqaa gaafataa_____

Guyyaaa_____/_____/_____ A.L.A. Mallattoo_____

10.2.1 Annex VI: Afaan Oromo Version Questionnaire

Qajeelfama: Deebilee gaaffi fillannoon kennamef itti marsuun deebisi warra banaatiif iddoo duwwaa kennametti guuti.

Odeeffannoo Eenyummaa

01. koodii_____

Kutaa I:-Gaaffilee hawaasummaa ilaallatan

T. lakk.	Gaaffilee	Deebii	Irra darbi
101	Umriin kee waggaa meeqaa?	_____	
102	Haalli gaa'ila keetii maali?	1. Hin Heerumne 2. Heerume nan qaba 3. Wal-hiikne 4. Narraa du'e	
103	Sabni/qomoon kee maali?	1. Oromoo 2. Amaaraa 3. Tigree 4. Guraagee 5. Kan biro yoo ta'e ibsi_____	
104	Amantaan kee maali?	1. Ortodoksii 2. Musliima 3. Piroteestaantii 4.Kan biro yoo ta'e ibsi_____	
105	Sadarkaan barumsa keeti hangaami?	1. Hin barannee 2. Sadarkaa 1ffaa 3. Sadarkaa 2ffaa 4. Kollejjii fi isaaoli	

106	Sadarkaan barumsa Abbaa manaa keeti hangaami?	1. Hin barannee 2. Sadarkaa 1ffaa 3. Sadarkaa 2ffaa 4. Kollejjii fi isaaoli	
107	Hojiin/Dalagaan kee maali?	1. Haadha mana 2.Hojjattuu Mootummaa 3. Daldaltuu 4. Hojii dhuunfaa	
108	Hojiin/Dalagaan abbaa mana keetii maali?	1. Hojjattaa Mootummaa 2. Daldalaa 3. Qonnaan bulaa 4. Hojii humnaa 5. Hojii dhuunfaa	
109	Ji'aan galiin kee qarshiin hammam ta'a?	Qrsh_____	
110	Iddoon jireenya keetii eessa?	1. Magaala 2. Baadiyyaa	

kuta II: Gaaffilee waa'ee seenaa ulfaa fi da'uumsaa ilaallatan

T. lak.	Gaaffilee	Deebii	Irra darbi
201	Ulfa kee barbaaddee moo akka tasaa ulfoofte?	1. barbaadee 2.osoo hin barbaadiin	
202	Kanaan dura yeroo meeqa deessee beekta?	_____ Hin deenyee yoo ta'e.➔	203-209
203	Daa'ima kee haala kamiin deesse?	1. Karaa gadamessaatiin 2. Gargaarsa meeshaa da'uumsaatiin 3. Opereshiiniin/Karaa Baqaqsani hodhuutiin/	
204	Da'uumsa booda haalli fayyaa keeti	1. Nagaa	

	Akkam ture?	2. Rakkoohoradheeture	
205	Haalli daa'ima keeti akkami?	1. Lubbuun ni jira 2. Lubbuun hin jiru	
206	Hordoffii ulfaa ni qabdaa?	1. Eeyyee nin qaba 2. Lakki hin qabu	
207	Ogeessi fayyaa hordoffii ulfaa kee kanaan duraa irratti si gargaare dhiira moo dubara?	1.Dhiira 2.Dubara 3.lachuu	
208	Kanaan dura mana yaalatti deettee beekta?	1. Nan beeka 2. Hin beeku……..➔	
209	Ogeessi fayyaa da'umsa kanaan duraa irratti si gargaare dhiira moo dubara?	1.Dhiira 2.Dubara 3.lachuu	
210	Qophii da'umsaaf godhamu dhageessee beektaa?	1.Eeyyeen 2.Lakki……..➔	
211	Oduu kana Eenyurraa dhageesse?	1.Hogeessota Fayyaarraa 2.Hojjattoota Ekisteenshinii fayyaarraa. 3.Miidiyarraa 4.Maatiirraa 5. Kan biro yoo ta'e ibsi_____	
212	Akka yaada keetti, dubartiin ulfaa tokko qophiin da'umsaaf gootu maal fa'i?	1.Bakka itti deessu filachuu 2.Nama ishii deessisu filachuu 3.kanfaltii yeroo dahumsaa fi rakkoo uumamuu danda'uuf qopheeffachuu. 4.Yeroo dahumsaa nama	

		ishii wajjin deemu qopheeffachuu. 5. Kan biro yoo ta'e ibsi__	
213	Gorsi qophii yeroo dahumsaaf godhamu har'a siif kennameeraa?	1.Eeyyeen 2.Lakki	

kutaa III: Gaaffilee ulfaa fi dahumsaan wal qabatan

T.L akk.	Gaaffilee	Deebii	Irrad arbi
301	Ulfa kee kanaaf bakka dahumsaa eessa filatta?	1.Dhaabbata Fayyaa……➔ 2.Mana	302
302	(Warra manatti dahuu filataniif) Sababni manatti dahuu filattaniif maalii? Tokkoo ol deebisuun ni danda'ama.	1.Manni yaalaa mana koorraa fagoo waan ta'eef. 2.Tajaajilli geejjibaa waan hin jirreef 3.Qarshii geejjibaa waanin hin qabneef 4.Dubartootni tajaajila kennan waan Hin jirreef 5.Kan biro yoo ta'ei bsi_____	
303	Ogeessota deessiftootaa keessaa tajaajila da'umsaatiif dhiira moo dubartii filatta/barbaadda?	1.Dhiira 2.Dubarti……➔ 3.lamaanu yoo ta'e rakkoo hin qabu.	311
304	Yoo dhiira filatte maalif?	1.dhiirri garaa namaa laafa 2.dubartii irratti mudannoo badaa waanin qabuuf 3.Dhiirri beekumsa gahaa waan qabuuf 4.yeroon jijjiiramaa waan dhufeef 5.Kan biro yoo ta'e ibsi---------	
305	Yoo dubartii filatte maalif?	1.Dubartiin ogummaan waan caaltuuf 2. Dubartiin garaa namaa laafti 3.Aadaa	

		4.Dhiira nan saalfadha 5.amantii 6.Kan biro yoo ta'e ibsi_____	
306	Ogummaa deessiftuu irratti eenyuu jajjabeessita?	1.Dhiira 2.Dubartii 3.lachuu	
307	Dhiirri yoo deessistuu ta'ee akkamitti ilaalta?	1.natti hin tolu 2.jajjabeeffamuu qaba 3.hin beeku	
308	Ogessa deessistuu dhiira waliin muuxannoon ati qabdu akkami?	1.Caalatti nama gargaara. 2.kan namatti hin tolle 3.akkuma ogeessota biro 4.hin beeku	
309	Dhiirri kutaa da'umsaa seenuu hin qabu jettaa?	1.Eeyyee 2.Lakki 3.hin beeku	
310	Tajaajila da'umsa kee kan sii kennu dhiira yoo ta'ee maaltu sitti dhaga'ama?	1.natti tola 2.natti hin tolu 3.rakkoo hin qabu 4.hin beeku	
311	Ogeessa deessiftuu dhiiraan ilaalamu fi dahuuf eeyyamamtaa?	1.Eeyyee 2.Lakki	

Galatoomaa!

10.3 Annex V: Curriculum vita of principal investigator

Dear Sir /Madam

I would like to submit to Addis Ababa University, College of Allied health Science, Department of Nursing and Midwifery with the intention that you can ethically approving my proposal by considering my outstanding dedication and hard work in doing proposal development.

I was graduated from Gondar University as a Junior BSc. midwife in 2001 E.C.I have a three years experience in clinical area at Deder hospital Oromia Regional state, two years experience as an instructor at Shashemene Health science College and two years experience as an instructor at Ambo University .

Currently I am just attending post graduate program on Maternal and reproductive health Nursing at Addis Ababa University.

Enclosing here with my curriculum vita, my whole proposal writing/work will be sufficient to fulfill the criteria of Addis Ababa University proposal development. I am looking forward for your favorable positive response towards my proposal work and in accomplishment of my thesis work.

Your Sincerely

RebumaMuleta

Curriculum vitae (CV)

1.Personal Information

Name	Sex	Marital status	Nationality	Address	E-mail
Rebuma Muleta Gutema	Male	Single	Ethiopian	0910110364	rebummul7@gmail.com

2.Language proficiency

	Afan Oromo	English	Amharic
Speaking	Excellent	Excellent	Excellent
Listening	Excellent	Excellent	Excellent
Writing	Excellent	Excellent	Excellent
Reading	Excellent	Excellent	Excellent

3.Educational Back Ground

Institution	Level education	Qualification	Year
Gondar University	Degree	BSc	1999-2001 EC.
Ambo school	Preparatory	-	1997-1998 EC.
Guder School	High school	-	1995-1996 EC.
Bola school	Elementary school	-	1987-1994 EC.

4.Work experience

Institution	Place of work	Position/responsibility/	Year
Ambo Univesity	West Shoa zone Ambo town.	Lecturer	From October 5,2015-till now
Shashemene Health science college	Shashemene	Teaching	From October 5,2014-October 5,2015
Deder Hospital	Deder	MCH ,obs and Gyn care	From October 5, 2012- October 5,2014

5. Interest or Hobbies

4.1 Attending current affairs, involving research

4.2 Reading books and journals

4.3 Close relationship or good team sprit

6 Additional Training

S. N	Training curse	Organization name	duration	Date & year
1	TOT on comprehensive Integrated PMTCT/MNCH	FMoH and ICAP	14 days	From Feb 23-March 4,2015
2	BEmONC/	EMA with UNFPA	21 days	from June 3-22,2013
3	Clinical Nutrition care	USAID	3 days	June 7-9,2010
4	National Comprehensive HIV Care/ART	WHO	21 days	From June 29-July 18,2009.
5	Post abortion care	IPAS	9	From June 5-13,2011.
6	ETS	JHPIGO	7	From July 5-11,2015.

7. Work Experience

7.1 In Deder Hospital I have worked on:

- ANC
- PMTCT
- Delivery
- EPI/<5 OPD

7.2 With JSI L10K

- ✓ Mentoring and data collection at health centers
- ✓ On reporting system
- ✓ Recording system
- ✓ How to work with community
- ✓ BEmONC Fast tracking

8. Reference

1. Keneni Birhanu: Ambo university college of medicine and health sciences; department of midwifery

Mobile: 0911772466

1. Dr. Samson TekalignTucho Sergon at Metu Karl Referal Hospital.
   Mobile: 0911315629