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ASSESSMENT OF MALE PARTNERS' INVOLVEMENT IN PROMOTING SKILLED DELIVERY ATTENDANCE OF SPOUSES AND ASSOCIATED FACTORS IN LEMO WOREDA, HADIYA ZONE, SOUTHERN NATION NATIONALITY PEOPLE REGION, ETHIOPIA, 2014.

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This thesis by Nuradin Abusha is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of master's in Maternity nursing and Reproductive Health.

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TABLE OF CONTENTS

Table of Contents

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AMRF	African Medical and Research Foundation
ANC	Antenatal care
CI	Confidence Internal
DHS	Demographic and Health Survey
EDHS	Ethiopia Demographic health survey
HIV	Human immune deficiency virus
ICPD	International Conference on Population and Development
MDGs	Millennium Development Goals
MMR	Maternal mortality ratio
PNC	Post natal care
SBA	Skilled birth attendant
SNNPR	Southern nations, nationalities and peoples' region
SSA	Sub-Saharan Africa
SPSS	Statistical package of social science
UN	United Nation
UNFPA	United Nations Population Fund
WHO	World Health Organization

ABSTRACT

Introduction: - The involvement of men in the maternal health programs increase outreach as well as utilization of the various reproductive health services. However, the failure to incorporate men in maternal health promotion, prevention and implementation of maternal health services has had a serious impact on the health of women and children.

Objective: - To assess male partners' involvement in promoting skilled delivery of spouse and its associated factors among households who have children age 0-12 months in Lemo woreda, Southern Ethiopia.

Method: - A community based cross sectional study was conducted from March - April, 2014. The study was used multi-stage sampling scheme using simple random and systematic sampling techniques. Data was analyzed using SPSS version 16.0. A descriptive analysis was done using frequency, mean, quartile and standard deviation. Crude and adjust logistic regression were used to see relationship between independent variable with outcome variable in order control confounding factors. Significance level of $P<0.05$ and association of variables were tested by using 95% confidence interval (C.I) and odd ratio.

Results: Data were obtained from 335 male partners, yielding a response rate 94.1%. The prevalence of male partner's involvement in promoting skilled delivery attendant was 38.2%. After adjusting for the effect of confounding variables using logistic regression, variables like personal income, Cost of delivery service and knowledge of male partners have statistically significant association with male partner's involvement in promoting skilled delivery attendants.

Conclusion and recommendation: - In general, the study has revealed that male partner's involvement in promoting skilled delivery attendant was low. Finally the factors associated with high male partners' involvement in promoting skilled delivery attendants of spouses included; higher education status of the husband, male partners who can afford cost of health facility services, men who have high income, early adult hood and high status occupations with greater wealth. The government and other responsible bodies should make efforts to increase community based health education, awareness creation and improve male partner's involvement on skilled delivery attendants of a spouse that strategy may reduce MMR by improve reproductive health care.

Key words: Male involvement, skilled delivery attendant, Lemo Woreda

1. INTRODUCTION

1.1 Background

In 2010 there were an estimated 287,000 maternal deaths worldwide and 63.1% of births are assisted by skilled attendants. Sub-Saharan Africa accounted for 56 percent of these deaths (1). Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community at the United Nation (UN) Millennium Summit in 2000. Fifth Millennium Development Goals aims at reducing the maternal mortality ratio (MMR) by 75% between 1990 and 2015.Its' aim also seeks to achieve a 5.5% annual decline in MMR from 1990. Globally the annual percentage decline in maternal mortality ratio (MMR) between 1990 and 2008 was only 2.3% (2).

Child survival project has achieved significant improvements in a number of maternal and child health indicators, deliveries by skilled providers is still very low, and this is partially attributed to low male partner involvement in delivery issues and specifically failure by male partners in supporting male partners' spouses to access delivery services from skilled attendants (3).

Male contribution in maternal health care has been described as a process of social and behavioral change that is needed for men to take part in more responsible roles in maternal health care with the purpose of ensuring women's and children's health (4). The concept of male involvement in maternal health is now being promoting as an essential element of World Health Organization (WHO) initiative for making pregnancy safer. However, the failure to incorporate men in maternal health promotion, prevention and care programs by policy makers, program planners and implementers of maternal health services has had a serious impact on the health of women, and the success of programmers (5).

In developing country most community give lower position to women. In effect women are either under collective decision making with their partner or completely depend on the male partner's decision on issue that affect of maternal health (6).

In Ethiopia context, the proportion of births attended by skilled personnel is very much lower than sub –Saharan Africa. Even for women who have access to the services, the proportion of birth occurring in health facilities is very low. According to Ethiopia Demographic Health Survey (EDHS) in 2011 birth attended by skilled personnel was ten percent. In this country, women traditionally have suffered socio-cultural and economical discrimination and have had fewer opportunities than men for personal growth, education, and employment (7).

Therefore this study is design mainly to assess male partners' involvement in promoting skilled delivery of spouses' and its associated factors which is important for reduction of maternal mortality rate.

1.2 Statement of problem

Over 75% of maternal deaths are due to causes directly related to pregnancy and childbirth (8). The complications that root of the deaths and disabilities of mothers affect the unborn fetus. These deaths could be avoided if preventive measures were taken and adequate cares available particularly during pregnancy, childbirth and postpartum period through obstetric care services. More than 60% of maternal deaths occur immediately following delivery, with more than half occurring within a day of delivery (2). Most maternal deaths occur during labor, delivery and in the first couple of days after child birth. Sub-Saharan Africa (SSA) has 42%of child birth assisted by skilled attendants (9). Maternal mortality is only the tip of ice-berg and mains a public health challenge worldwide. In Ethiopia, skilled delivery and maternal mortality ratio are 10% and 676/100,000 respectively and antenatal care coverage was reported to be 34 % (7).

A male companion at antenatal care (ANC) is rare and in many communities, it is unthinkable to find male companions accompanying a woman to the labour room during delivery (10). However, men have social and economic power, especially in Africa, and have tremendous control over their partners. They decide the timing and conditions of sexual relations, family size, and whether their spouse will utilize available health care services (11).

Men play a key role in determining women's access to critical health services, including antenatal and intrapartum care through such mechanisms as determining the availability of transport for women to reach a clinic and decisions that affect whether a woman can be successfully referred to a higher-level facility if required. But in order to make informed decisions, men need to know why ANC and skilled birth attendance are important, the risks associated with pregnancy and childbirth, how to prepare for childbirth and how to recognize signs of complications (12).

The involvement of men in the maternal health programs increase outreach as well as utilization of the various reproductive health services. Interventions that include men during pregnancy and childbirth have shown to yield positive health benefits to women and their children. The role of men in maternity care is emphasized in the reproductive and child health programmes (13).

In 1994 International Conference on Population and Development (ICPD) held in Cairo recognized men as legitimate targets for sexual and reproductive health promotion. This recognition was born of the experience of many health-promoting agencies in the 1980s and 1990s who realized that without working with men, change would be very difficult or impossible. It was proposed that men should be involved because their active participation is crucial to the success of programs and to the empowerment of women (14).

In Ethiopia health facilities have been relatively spread fairly in the country (15). However, very few mothers' access skilled care during child birth. Expectant women continue to consult non-medical and traditional healers for care during pregnancy. Even though, men and women have equal responsibility, men participation in maternal health is still low in Ethiopia due to social and cultural taboos. Husband support for women during pregnancy and delivery which is a critical time for them have not yet been promote effectively. A community based cross-sectional study conducted in Northern part of Ethiopia in 2008 reported that among 326 (87.9%) who give birth at home 32(14.14%) were influenced by family delivery at home and male preference skilled delivery was low 69 (19.4%) (16). No similar study conducted in the study area. Therefore, the purpose of this study is to identify gaps and notify the findings to policy makers, health care workers, health bureau and also online access to other maternal health.

1.3 Significance of study

Male partners' involvement in promoting skilled delivery of spouses' and its associated factor in Ethiopia, especially in Hadiya zone, has not been well assessed. It is necessary and timely to study this important issue in the zone. This study is therefore aimed to evaluate male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors among households who have children age 0-12 months in Lemo woreda, Hadiya zone, SNNPR, Ethiopia. The study will provide basic data on the issue that may help local and national policy makers to implement and scale up safe motherhood program in an attempt to reduce the highest maternal mortality rate and neonatal mortality rate in similar district in Ethiopia.

The result also will be useful in enabling the planners and program managers to design appropriate strategies, which address the male partner involvement in promoting skilled delivery. Further, this study will support the health care providers to introduce measures that could promote male involvement in care and support of their partners.

2. LITRATURE REVIEW

2.1. Maternal mortality and morbidity

An African women's chance of dying from pregnancy or child birth is 1 in 16 over her life time, compared with 1 in 3,800 in developed countries (17).

Maternal deaths have very serious consequences within the family given the vital role of the mother for her children's health. The death of the mother enhances the hazard to the survival of her young children especially if the family is not able to provide a substitute for the maternal role. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality (18).

Majority of maternal deaths that occur are avoidable or preventable (15). An emerging consensus has it that, these deaths can be prevented if deliveries are overseen by skill attendants. However, it has been estimated that only 50% of women in the world have access to such skilled care. Maternal deaths are strongly associated with inadequate medical care at time of delivery. Several factors have been identified as barriers to access to skilled care by women especially in developing countries; these include unavailability of services, inadequate number of skilled personnel, cultural value, geographical inaccessibility and poor quality of care (19).

The presence of a skilled birth attendant is important for averting maternal morbidity and mortality. The WHO defines a skilled birth attendant (SBA) as "an accredited health professionals- such as a midwife, doctor or nurse- who has been educated and trained to proficiency in the skills needed to manage normal or uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns'' (20).

In September 2000 the members of the UN adopted the Millennium Declaration and set eight millennium development goals, one of which is reducing maternal mortality. Delivery by SBAs serves as an indicator of progress towards reducing maternal mortality worldwide and is the fifth MDG. Use of SBAs during pregnancy, labour and delivery during the postpartum period could prevent many instances of maternal morbidity and mortality (21).

In SSA in 2011, maternal mortality claimed the lives of an estimated 122,275 women, representing nearly half (44.7%) of worldwide burden that Year (22). In SSA little is known about the level of maternal mortality at the community level although some efforts have been made to use Demographic and Health Survey (DHS) data and indirect methods of estimation levels. Wherever studies have been conducted, the levels appear to be quite high by international standards (up to 200 times the levels in Western countries (23). In Ethiopia the estimated maternal mortality ratio is almost the same in the 2011 EDHS (676) as it was in the 2005 EDHS (673) (7).

2.2 Male involvement in maternal health care

There is no single definition for male involvement. The United Nations Population Fund (UNFPA) explains male involvement as an umbrella term which comprises of the several aspects of men and reproduction: reproductive health problems and programs, reproductive rights and reproductive behavior. Furthermore, the UNFPA gives male involvement two dimensions: (1), men as supportive partners in women´s reproductive health needs, choices and rights and (2), men´s own reproductive and sexual behavior. Accordingly, male involvement can mean different strategies from education and awareness rising to actual participation. Involving men in reproductive health programs is considered beneficial in many ways, and this perspective has been justified for example through men´s various roles as sexual partners, husbands, fathers, family and household members, community leaders and many times as gatekeepers to health information and services (24).

There is growing recognition that addressing maternal health at all levels in society is not possible without efforts to directly engage men as partners' in theses process. This need was clearly reflected in the 1994 ICPD program action. More recently work seeking to engage men increasingly been seen as essential not only empowering women and improving women and children's health; but no to improving men's own health outcomes. There is an increasing acknowledgement and evidence that men's lack of health seeking behaviors (often due to social and cultural norms) have direct health implication to the wellbeing of their partners and children. A growing body of international research and interventions are demonstrating significance potential in encouraging men positive roles in building maternal and children health (25).

A man is viewed as a ruler and protector of his household also viewed as the head of the family and therefore, expected to provide essential care to his wife and children. Both men and women

were interested in men's involvement during maternity care. Men have increasingly become aware of their critical role in reproductive health care. Involvement of men in the maternity care of their counterparts has become important because of the realization that men's behavior can significantly affect the health outcomes of the women and babies (26).

Studies in many settings showed that the support of their male partners influences women's uptake of maternal health services, their workload, nutrition and wellbeing during pregnancy, and the ways they care for and feed their babies. So there are many potential benefits to reaching expectant fathers with information and services. There have been few intervention studies that aim to engage men in maternal and child health, but available evidence demonstrates: increased use of family planning, reduced workload for women during pregnancy; improved preparation for birth; improved couple communication and emotional support for women during pregnancy and increased attendance at postnatal care (27).

Improving maternal health is one of the eight Millennium Development Goals. There is slow progress towards attaining the fifth MDG in developing countries. The slow progress of fifth MDG advice that empowering male partners with knowledge about antenatal care services this may enhance their antenatal care involvement and in turn increase skilled delivery. This strategy may reduce MMR by improve reproductive health care. Knowledge about skilled delivery services was the major independent variable associated with male attendance of maternal health care with their spouses. There is a need to develop strategies to empower men with knowledge about maternal care. Such strategies may contribute to increasing male attendance in antenatal care, improve skilled attendance at delivery and improve maternal health outcomes (28).

A number of studies have also shown that the male involvement in the labour room shortens the labour, reduces pain, panic and exhaustion of the women (29).

A cross sectional study done in Jinja district eastern Uganda on factors associated with male involvement in maternal health care services has shown that about 43% of the men accompanied their spouses' to the health facility during ANC,43% accompanied their partners during delivery and nearly 32% accompanied partners for postnatal care. Majority of the men reported joint couple decision-making with the wife on where to attend ANC, Delivery and postnatal care 62.7%, 32.5% and 66.6% respectively (30).

Despite of the increasing efforts to target men, the research over men´s influence on maternal health outcomes and maternal health care utilization in developing countries is still scarce. Regarding the determinants of male involvement in maternal health services, one review focusing the prevention of mother to child transmission of HIV was traced (31).

Another study conducted in Uganda showed that 65.4% male partners attended at least one skilled ANC visit. Mean age was 31.9 years. Perceived benefits of attending ANC were: HIV screening (74.5%), monitoring fetal growth (34%) and identifying complications during pregnancy (18.9%). Factors independently associated with higher ANC attendance were: knowledge of 3 or more ANC services, obtaining health information from facility health workers and if spouse had skilled attendance at last childbirth. However, factors for low attendance were: male partners intending their spouse to carry another pregnancy and living more than 5 Km from a health facility (32).

According to study done in India on male participation in maternal care only 22.2 % of husbands took advice from their wives in making family decisions. Only 18.33 % of husbands accompanied wives for antenatal checkups. Only 32.5 % of husbands provided help in household work during pregnancy. Majority of couples (71.39 %) did not take decision together about delivery (33).

A study conducted on men´s socio-demographic background and maternal health care utilization in

Ethiopia indicated that 57 % and 12% of husbands had participated in promoting at least one antenatal visit and institutional delivery respectively. Among men whose partners used antenatal care, 43 % participated in antenatal visits. Low number of children, higher educational level, better wealth and urban type of residence were associated with more frequent service utilization. In addition, occupation and ethnicity turned out to be independent predictors. Partly different factors seemed to contribute to partner´s institutional delivery in urban and rural areas (34).

A study conducted on male partner's involvement in promoting skilled delivery attendants of a spouse and associated factors in Ethiopia indicated that 69.9% of male partners involved in promoting skilled delivery attendants of spouses. Of those who had involved 44.4%, 64.2%, 58.3% and 73.9% discussed with doctors/health professionals', relatives, friends and family members respectively (35).

2.3 Knowledge and attitude of male partners on skilled delivery attendant of a spouse.

Male involvement will enable men to support their spouses to utilize emergency obstetric services early and the couple would adequately prepare for birth and ready themselves for complications. This would lead to a reduction in all three phases of delay and thereby positively impact birth outcomes (36).

Male participation in the implementation of Safe Motherhood initiatives is particularly vital role of male partners' as gatekeepers. However, it is widely recognized that men are often marginalized by maternal health services and are provided limited access to information and knowledge that they need to make informed choices to protect their and their family's health (37).

According to descriptive cross sectional study done on the couples' attitudes to the husband's presence in the delivery room during childbirth, mean ages of women and men were 26 and 30 years respectively. Most had high school diplomas or higher. Most women (58.1%) were employed and most men (77.6%) had non-educational jobs. Mean attitude scores were 100 for women and 97 for men. Attitude scores were significantly related to age, job and education. Most women (88.4%), men (82.1%) and couples (76.9%) had positive attitudes to the husband's presence in the delivery room. Providing facilities to accommodate husbands and training for their presence in the delivery room is recommended (38).

A study conducted in India showed that men´s knowledge about pregnancy related care increases its utilization and suggested that men´s presence during antenatal visits might increase the likelihood of institutional delivery (39).

Study conducted in Kenya showed that utilizing a skilled birth attendant were 2.8 times higher for

women who were go together with their male partners' to at least one ANC visit than for women who had ANC but not go together with their male partners'. As for the husbands perception, about half (49.5 percent) of the women whose husbands had a positive perception were attended by a skilled birth attendant. Further, women whose male partners' had a positive perception of the use of a skilled birth attendant had slightly higher utilizing a skilled birth attendant than women whose male partners' had a negative perception(40).

In Mali, husbands or household heads generally have good knowledge about pregnancy-related care including frequency and timing of antenatal and postnatal visits, and danger signs before, during and after delivery. However, lack of knowledge about needs and financial constraint continue to create discrepancy between knowledge and behavior (41).

Ethiopian comparative cross-sectional community based study found that husbands´ attitude was associated with antenatal and safe delivery service utilization, positive attitude contributing to more frequent utilization (42).

2.4 Factors associated with male partners' involvement in promoting skilled delivery attendance of a spouses'

A number of factors have been reported by several researchers as being responsible for influencing male involvement in skilled delivery attendance of spouses. Some of which are noted in the paragraphs that follow in this segment. Traditionally, health providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to family planning, prevention of unwanted pregnancies and of unsafe abortions, childbirth, and promotion of safe motherhood (29).

Previous study in developing countries has recommended several grounds for low utilization of reproductive health care which include: problems in access, low educational level and other factors describing socio-demographic background (mostly studied from the female perspective), lack of woman´s autonomy, low quality of services, cultural beliefs and other community members´ influence (43).

In Ethiopia, the women not delivering in an institution explain their action by stating that it is not necessary (61 %), it is not customary (30 %) and/or that the distance is too long or they had no transportation (14 %) (7).

According to study done in Bangladesh on Determinants of male participation in reproductive healthcare services mean age of the respondents was little over 34 years while their mean years of schooling was 3.7, and their mean monthly income was about US$ 48.5714 at the time of the study. Rickshaw-pulling and driving was the main occupation of the respondents from the urban while farming were main occupation in the rural area respectively. About two-thirds of the respondents discussed reproductive health issues with their wives and accompanied them to healthcare facilities.

The current contraceptive-use rate was 63% among the men who attended the evening clinics. Results of bivariate analysis showed a significant association with education, occupation, income, access to media, and number of living children. Results of logistic regression analysis showed that secondary to higher education level, number of living children, paid employment status, long marital duration, and access to media were important correlates of males' involvement in reproductive healthcare services (44).

A study from Nigeria concluded that husband´s educational and occupational levels are connected to the decision about delivery place, higher levels being contributing to institutional delivery (45).

Another study conducted in Uganda showed that men who had completed at least eight years of education were twice more likely to participate than those who had studied less than that (46).

According to study done in Rwanda on Voluntary counseling and testing for HIV men in low-personal income were less likely to accompany their spouses to the health services than their counterparts (47).

Study from the Kenya Demographic and Health Survey indicated that women whose husbands attended at least one ANC visit were two times. Likely to have skilled birth attendance than those whose husbands did not attend any ANC visits. Maternal characteristics that had a statistically significant association with delivery by an SBA included educational level, employment, number of ANC visits, and parity. The province where the couple resided also was statistically significant (48).

Another study done in Kenya showed that an important relationship between level of education and level of income of the male partner and his support for skilled delivery. Lack of knowledge by male partners of complications associated with delivery, cultural beliefs, high fees charged for deliveries at health facilities and "un-cooperative" health workers are major contributing factors to low male

partner involvement in child birth activities. Improving the levels of education and income of male partners, addressing the cultural beliefs and practices, improving health care provider-client relationship and sensitizing men on complications associated with pregnancy and child birth can contribute significantly in enhancing male partner involvement in promoting deliveries by skilled attendants (49).

The births attended by skilled personnel are usually those taking place in hospitals or other health institutions. Thus, the vast majority of Ethiopian women delivers at home with assistance of traditional birth attendants (28 %) or relatives (57 %), or alone (4 %). Long distances are reality for most of the rural-dwellers in Ethiopia; fewer than half of them living within a walking distance of a health care facility. Taking transport to a facility, lack of money and distance to a health facility were the three most important factors that Ethiopian women mentioned when asked about barriers to health care utilization (7).

How does male partner' involvement in promoting in skilled delivery of spouse in Ethiopia? To date, no more studies have apparently been conducted straight on this topic in Ethiopian context. More knowledge about male influence is needed to have a wider selection of method for promoting skilled delivery of spouse in Ethiopia.

2.5 Conceptual frame work

Concepts that are directly and indirectly related to the major variables of the study that Male partner's involvement in promoting in skilled delivery attendance of a spouse and its associated factors are developed from different literature reviews.

This conceptual framework considers person related factors as well as associated factors. The person related factors include the male partner's socio-demographic characteristics, male partner's knowledge and attitude, socio - cultural factors and the perceived benefit and need of involving male partners in promoting skilled delivery of spouses'. Economic accessibility (paid employment status), employment status, educational status and access to media mainly influence of male partners involvement in promoting skilled delivery of spouse.

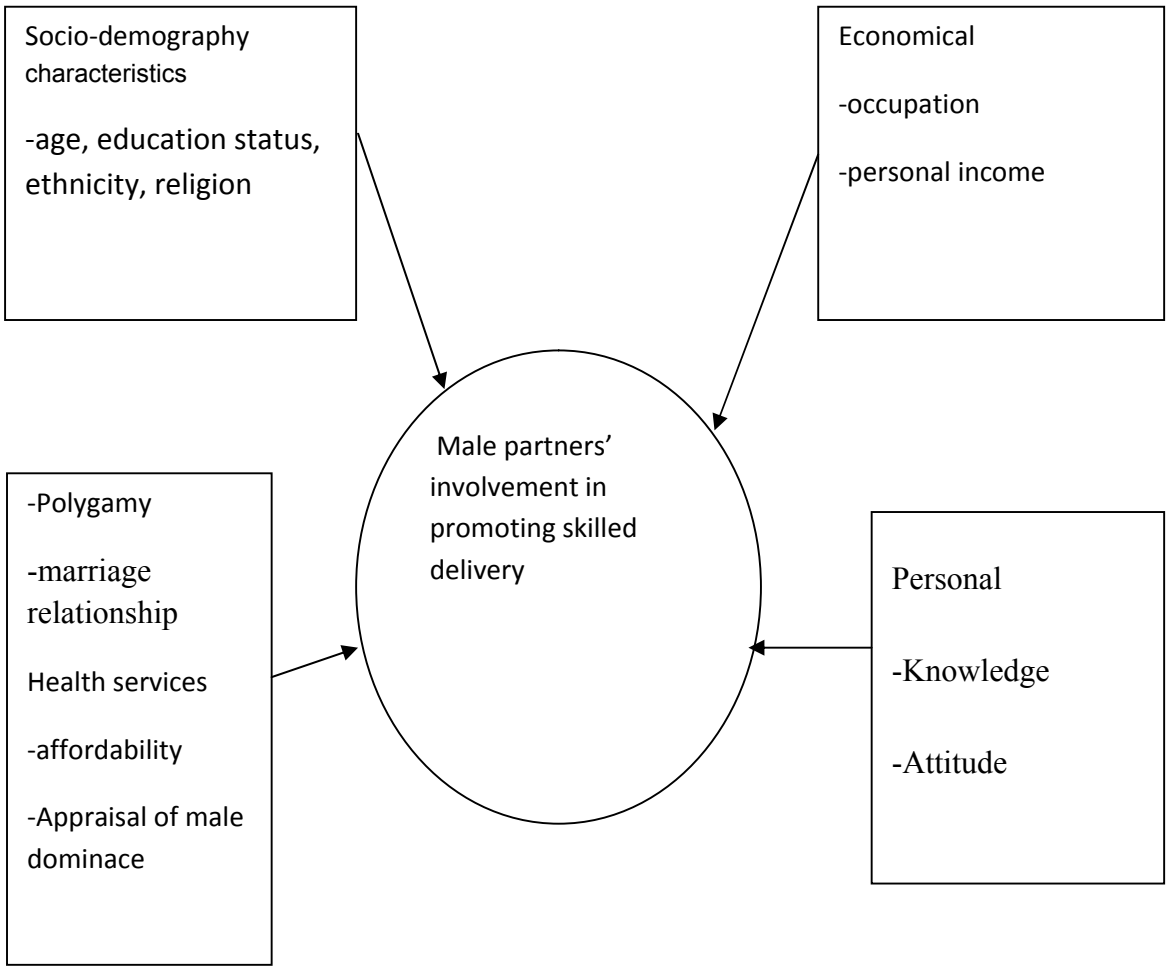

Figure 1. Conceptual framework on male partner's involvement in promoting skilled delivery of spouse's and its associated factors.

3. STUDY OBJECTIVES

3.1 General objective

To assess male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors among households who have children age 0-12 months in Lemo district, southern Ethiopia

3.2 Specific objective

To determine the prevalence of male partners' involvement in promoting spouse skilled delivery attendance in the study area.

To assess knowledge of male partner on skilled birth attendance of a spouse in the study area.

To assess attitude of male partner on skilled birth attendance of a spouse in the study area.

To assess factors associated with male partners' involvement in promoting skilled delivery attendance of spouses in study area.

4. METHODS AND MATERIALS

4.1 Study area

The study was conducted in Lemo woreda, Hadiya Zone of the Southern Nations, Nationalities and peoples' Region (SNNPR). Lemo woreda is one of the 11woredas including Hossana town in the zone. The total population of the Woreda was estimated to be 144244 at the end of 2013. Male 70,680 (49%) and female 73,564 (51%). Its capital town, Hossana, is located at a distance of 235 km South of Addis Ababa and majority of the population lives in rural areas. Lemo is bordered on the south by the Kembata Tembaro Zone, on the southwest by Duna and Soro, on the west by Gomibora, on the northwest by Misha, on the northeast by Ana Lemo, and on the southeast by Shashogo. The woreda is divided in to 35 kebeles with health infrastructures of no hospital, 7 health centers, 14 private clinics and 33 health posts (50).

4.2 Study design

A quantitative cross sectional community based study was conducted to assess male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors among households who have children age 0-12 months in Lemo woreda, Hadiya zone, (SNNPR), Ethiopia. This design was used because of the short time period of the study and aid for data collection and analysis on the spot in time.

4.3 Study period

The study was Conducted from March - April, 2014.

4.4 Source population

All male partners having children age 0-12 months in Lemo woreda, during study period.

4.5 Study population

All male partners' having children's age 0-12 months from selected kebeles in the study area during the study period.

4.6 Study unit

Father available in selected house hold of the woreda in selected kebeles.

4.7 Inclusion and Exclusion criteria

Inclusion criteria

Male of 18 years of age and above who consented to participate in the study and had fathered at least one child in the last one year.

Exclusion criteria

Study participant who were sick, no permanently reside in the study area.

Parents who were mentally ill, unconscious, parents who have hearing-impairment and parents who can't speak were excluded from the study.

Parents who have no a child

Parents who have a child more than one year old.

4.8 Sample size determination

Sample size was determined by using single population proportion based on the following assumptions: 95% confidence level, prevalence of 12% from previous study (41), and a 5% margin of error.

$n= \ ((Z\alpha/2)2 \ \times \ p(1-p) \ )/d^2$

Where: - n= sample size

z = critical value = 1.96 for 95% CI

p = prevalence of male involvement on promoting skilled delivery attendants= 12%

d = precision (marginal error) = 5%

$$n=(1.96 \times 1.96 \times .12 \times .88)/(0.05 \times 0.05)$$

n=162

Design effect assumed to be 2 owing to the use of multi stage sampling and supposing that adequate sample size was obtained.

Based on the above assumption, the required sample size was 162 x 2= 324

Expecting a 10% or 32 non-response rate was considered for eligible male partner who may refuse to participate, missed, change their residence, and the final sample size was calculated to be **356.**

4.9 Sampling procedure

The Woreda was selected purposively. The study was used multi-stage sampling scheme using simple random and systematic sampling techniques. From thirty five kebles seven Kebeles were randomly selected. Out of the seven selected kebeles, a total of 356 samples were selected. The participant households were distributed to Kebeles by population proportion to size (PPS) formula. Systematic sampling method was applied to select study households. The interval was determined by the division of total number of households in the study area estimated to be 1231 by the sample number 356 which result in an interval of 3th households. Interviews were conducted by face to face at male partners' house of those who were eligible for the study.

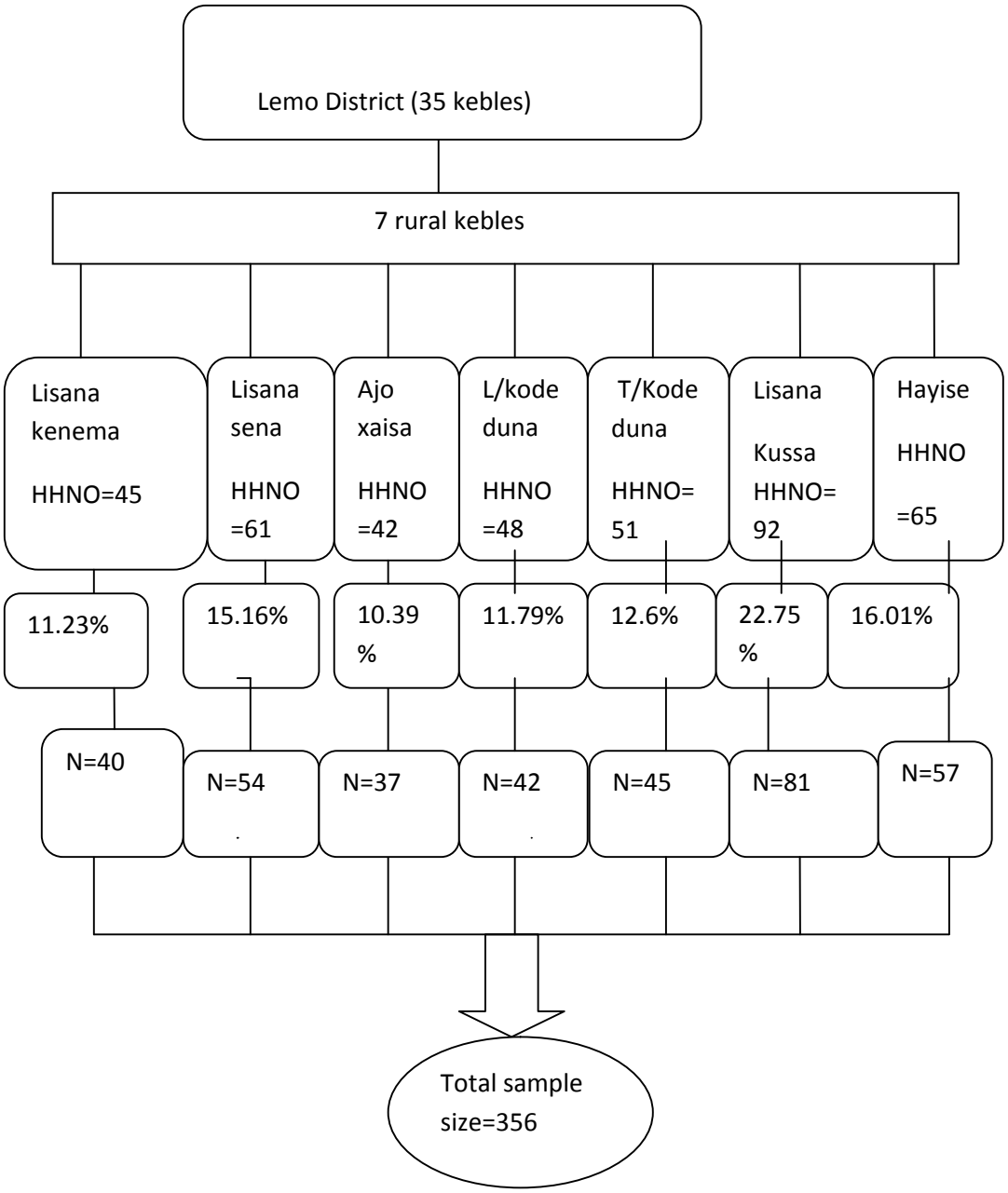

Figure 2 Schematic presentation of the Sampling procedure

4.10 Measuring Instrument

A structured, interview administered questionnaire having four parts which were adapted from the survey tools developed by African Medical and Research Foundation (AMRF), Child and Reproductive Health Programme (3). First part contain general information, the second parts contain assess male partner's involvement in promoting skilled delivery, the third parts contain assess knowledge and attitude of male partner's toward skilled delivery and fourth one contain assess of associated factors, the questionnaire developed in English in such a way that it includes all the relevant variables to meet the objectives, which were male involvement, attitude and knowledge. An individual who had very good knowledge of both English and Hadiya languages translated the English version to Hadiya for better understanding of the enumerators and respondents. Another individual of similar ability also translate the Hadiya version back to English to check for it original meaning.

4.11 Data Collection Procedure

A total of 6 diploma nurses were selected and recruited for data collection. Two degree nurses from the heath institutions in the woreda were selected and recruited to supervise the data collectors. The interviewers and supervisors were given one day training on how to administer the questionnaire, including elementary skills of communication and operational definitions used in the study. During data collection the respondents were assessed house to house visiting and appointing time if not available in the house during data collection.

4.12 Pre-Testing of Questionnaire

The pre-test of the questionnaire was carried out one week prior to the actual data collection period in one adjacent kebele of the woreda which was not be included in the study. A total of 32 respondents

(10%) were interviewed. On average, it was taken 50 minutes (range from 40' to 60') to complete the interview. Both the interviewers and supervisors were assessed clarity, understandability, uniformity and completeness of the questions, and then the results were edited and coded

4.13 Data Quality Assurance

The quality of data was assured through :-

• Careful designing, translating and re-translating, and pre-testing of the questionnaire

• Proper training of the interviewers and supervisors

•By close supervision of data collecting procedures

•By proper categorizing and coding of the data

The interviewers were supervised daily in the field. Supervisors were able to handle problems, and receive and check completed forms in order to clean up incorrect reporting. The field supervisors in turn met with the principal investigator each day to go through the completed forms and discuss problems.

4.14 Data Entry and Analysis

Data was coded and entered into EPI-Info version 3.5.4 statistical software program and finally analyzed using SPSS version 16.0 software by the principal investigator. After cleaning the data set, frequency distributions were made for each variable. Both descriptive and bi-variety/multivariate logistic regression analyses were performed. A descriptive analysis was done using frequency, quartiles, mean and standard deviation. Crude logistic regression was used to see relationship between one independent variable with outcome, and adjust logistic regression was used to assess relation between many independent variables with outcome variable in order control confounding

factors. Significance level of P<0.05 and association of variable was tested by using 95% confidence interval (C.I) and odd ratio.

4.15 Study Variables

Dependant variable: male partners' involvement.

Independent variables:

Socio demographic and economic variables: age, education, ethnicity, religion, personal income, occupation.

Health services related factors: Accessibility of services.

Other variable: knowledge, attitude, availability of means of transport, , number of children.

Socio-Cultural factors: - polygamy, marriage relationship, appraisal of male do mince

4.16 Operational Definitions

Male involvement: the actual involvement of married male partners in promoting Spouses' skilled delivery attendance like discussion with health professionals on the place of spouses delivery, deciding institutional delivery, accompanying spouse for ANC, birth preparedness, and discussion with relatives and friends. Those participations that had involvement less than three of these components were considered as no involvement while those who had involved equal to three or more than were considered as male involvement.

skilled birth attendant:- an accredited health professional, such as a midwife, doctor, or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period and in the identification, management, and referral of complications in women and newborns

Knowledge of male partners on skilled birth attendants:- Eleven knowledge related items were asked and the response was scored based on the mean value (measured as poor knowledge for those who scoreless than mean and good knowledge for those score more than mean)

Attitude: - Good attitude are those who had positive attitudes towards skilled attendants, negative attitudes are those who had bad attitude towards skilled attendants.

Personal income:-By using quartile the income was classified in to three areas. Those incomes below 490 birr, between 490-800 birr and above 800 birr.

Affordable: - A service is affordable if the community can pay for the services they got in the institution.

4.17 Ethical clearance

Ethical clearance letter was obtained from Addis Ababa University Department of Nursing and Midwifery research committee and College of Health Sciences Institutional Review Board. Written permission was requested from lemo woreda of the respected health bureau. Moreover, all the study participants were informed verbally about the purpose and benefit of the study along with their right to refuse and verbal consent was obtained. Furthermore, the study participants are reassured for an attainment of confidentiality and consent information was also taken.

4.18 Dissemination and Utilization of results

Result of the study will be disseminated to Addis Ababa University School of Nursing as partial fulfillment of master's degree in maternity and reproductive health nursing. The findings this study will be presented in hard and soft copy will be available in the library of Addis Ababa University for graduate students as well as for other concerned readers.

5. RESULTS

5.1 Socio-demographic characteristics of male partners

Out of the total 356 samples, 335 male partners were enrolled making a response rate of (94.1%). Of the total respondents, 178 (53.1%) were between the age group of 30-39 years. The mean age was (35.67±7.6). Two hundred eighty (83.6%) and 25 (7.5%) were Hadiya and Kambata by ethnicity, respectively. Two hundred fourteen (63.9%) were followers of Protestant and 57 (17%) Orthodox in religion. Majority of the respondents were unemployed 308 (92%). With regard to educational status, 116 (34.5%) of the respondents can't read and write, 90 (27%) can read and write, and 102 (30.4%) had completed primary school. Pertaining to the income distribution of respondents 151 (45.1%) had income less than 490 birr, 55 (16.4%) had income between 490-800 birr and 129 (38.5%) had income greater than 800 birr per month based on quartile classification.

Table 1 Socio-demographic characteristics of male partners' involvement in promoting skilled delivery in Lemo woreda, 2014

Variables	Frequency (n) =335	Percentage (%)
Age category		
20-29	67	20
30-39	178	53.1
40-49	74	22.1
>=50	16	4.8
Total	335	100
Religion		
Protestant	214	63.9
Orthodox	57	17
Muslim	36	10.7
Other (catholic)	28	8.4
Total	335	100
Ethnicity		
Hadiya	280	83.5
Kambata	25	7.5
Gurage	14	4.2
Others (Donga , Silite , Amahara , Oromo)	16	4.8
Total	335	100
Respondents occupation		
Unemployed	308	92
Private employee	19	5.6
Civil servant	8	2.4
Total	335	100
Respondent educational		

status		
No formal education	206	61.5
Primary school (1-8)	102	30.4
Secondary school and above	27	8
Total	335	
Personal income		100
< 490	93	27.7
490-800	160	47.8
>800	82	24.5
Total	335	100
Number of wife partner have		
One	313	93.4
Two	22	6.6
Total	335	100
Partners Ex- wives		
Yes	13	3.9
No	322	96.1
Total	335	100
Cost of healthy facility services		
Can afford	183	54.6
Can't afford	152	45.4

5.2 Male partners involvement in promoting skilled delivery attendants

The overall male partners' involvement in promoting skilled delivery attendants were 128 (38.2%). From the 335 respondents, 244 (72.8%) respondents were involved in birth preparedness of recent child. However, 52 (15.5%) of male partners' less involved in discussing with their relatives (below table 2).

Table 2 Distribution of male partner's involvement in skilled delivery in Lemo woreda, 2014

Variables		Frequency	Percentage
Accompanied their spouse for ANC follow-up	Yes	148	44.2
	No	187	55.8
Birth preparedness support by male partners for recent child	Yes	244	72.8
	No	91	27.2
Discussed with health provide	Yes	95	28.4
	No	240	71.6
Discussed with their friends	Yes	67	20
	No	268	80
Discussed with their relatives	Yes	52	15.5
	No	283	84.5
Decided to deliver in health institution for current child	Yes	137	40.9
	No	198	59.1
Prevalence of male partners' involvement	yes	128	38.2
	No	207	61.8

5.3 Knowledge of male partners toward skilled delivery attendants.

When the knowledge of male partners toward skilled delivery attendants were dichotomized using mean score, about250 (74.6%) of participants scored above the mean (mean score of 5.5) and the rest (25.4%) 85 who scored below the mean.

Out of study subjects, 270 (80.6%) reported that they had know about ANC follow up of their spouses. The main reasons for taking their spouse to health facility for delivery were to avoid delay in getting medical care in a case of emergency 198 (59.1%), access to skilled attendants 208 (62.1%), to get immediate treatment for mother and new born 216 (64.5%) and they did not know why institutional delivery is important 8 (2.4%) . From study participants, 57.3% mentioned vaginal bleeding as a sign of complication, 44.2%, 33.7%, 80%, 30.7% fever, abdominal pain, difficult in labor, convulsion respectively and 4.5% they did not know sign of pregnancy complication.

Table 3 Male partners' knowledge towards skilled delivery services in Lemo woreda, 2014.

Variables		Frequency n=335	Percentage (%)
Male partners had know about ANC follow up of their spouses	Yes	270	80.6
	No	65	19.4
Institutional delivery prevent delay in getting medical care in a case of emergency	Yes	198	59.1
	No	137	40.9
Institutional delivery has access to skilled attendants	Yes	208	62.1
	No	127	37.9

Institutional delivery has important to get immediate treatment for mother and new born	Yes	216	64.5
	No	119	35.5
Male partners did not know why institutional delivery is important	Yes	8	2.4
	No	327	97.6
Mentioned vaginal bleeding as a sign of complication during pregnancy	Yes	192	57.3
	No	143	42.7
Mentioned fever as a sign of complication during pregnancy		148	44.2
	Yes No	187	55.8
Mentioned abdominal pain as a sign of complication during pregnancy	Yes	113	33.7
	No	222	66.3
Mentioned difficult in labor as a sign of complication during pregnancy	Yes	268	80
	No	67	20
Mentioned convulsion as a sign of complication during pregnancy	Yes	103	30.7
	No	232	69.3
Did not know sign of pregnancy complication	Yes	15	4.5
	No	320	95.5

5.4 Attitude of male partners toward skilled delivery attendants

Among the study participants, 144 (43%) of respondents had positive attitude toward skilled delivery attendants and 191 (57%) had negative attitudes towards skilled attendants.

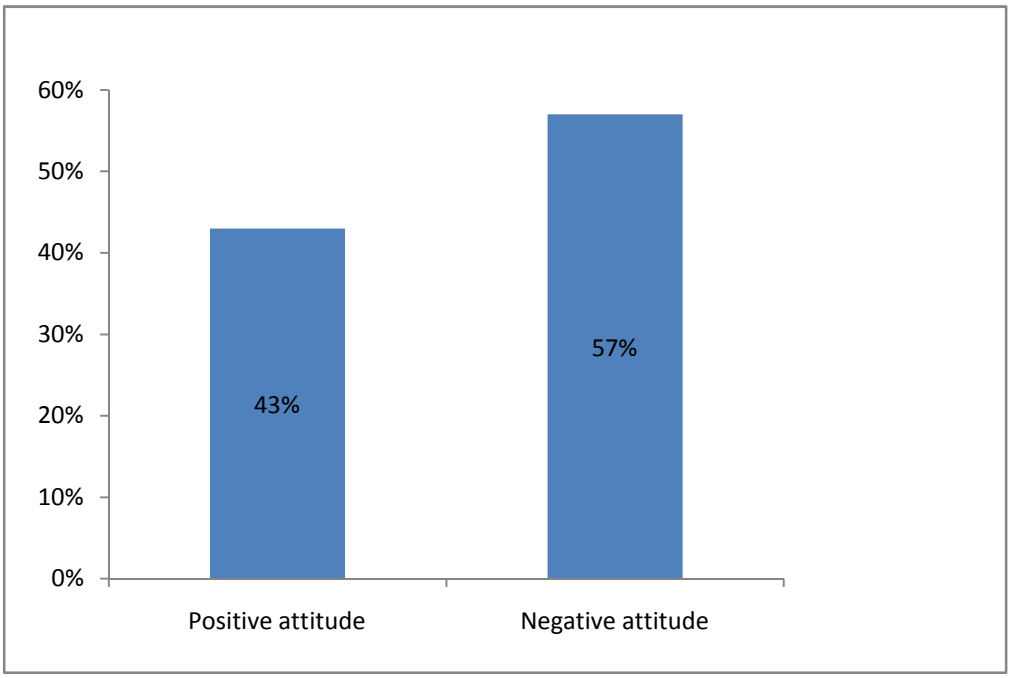

Figure 3 : Percentage distribution of male partners attitude towards skilled delivery services in Lemo woreda, 2014

The main reasons mentioned for having positive attitude were good quality of services, good approach of health workers, fair price and better outcomes of institutional delivery which accounted 89 (53.9%), 13 (7.9%), 6 (3.6%) and 57(34.5%) respectively. The main reasons for having negative attitudes were unwelcoming approach of health workers 29(15.2%), placenta should not place in the placenta pit 56 (29.3%), expensive price 65(34%) and better to delivery at home 41 (21.5%).

Table 4 Male partners reasons for having positive and negative attitudes towards skilled delivery services in Lemo woreda, June 2014

Variable	Frequency (n)	Percentage (%)
Reason for good attitude toward skilled delivery service (n=165)		
• **Good quality of services**	89	53.9
• **Good approach of health workers**	13	7.9
• **Faire price**	6	3.6
• **Better outcomes of institutional delivery**	57	34.5
Total	165	100
Reason for poor attitude toward skilled delivery (n=191)		
• **Unwelcoming approach of health workers**	29	15.2
• **Placenta should not place in the placenta pit**	56	29.3
• **Expensive price**	65	34
• it is better to delivery at home	41	21.5
Total	191	100

5.5 Factors influencing partner's involvement in promoting skilled delivery

In the bivariate analysis significant association was observed between the age, occupation, and educational status, personal income, knowledge and attitude with male partner's involvement on promoting skilled delivery attendants.

Male partners' who were in the age group of 20 to 29 were 3.96 times more likely to involved in promoting skilled delivery attendants than those who were the age group of 50 and above (95%CI=1.033, 15.188).

Male partners who were private employed and unemployed were respectively 0.008 and 0.089 times less involved in promoting skilled delivery attendants than those who were civil servants (COR=0.008(95%CI=0.000, 0.45), COR =.089 (95%CI=.011,.734).

Male partners who were no formal education and primary school respectively 0.23 and 0.33 times less involved in promoting skilled delivery attendants when compared to Secondary school and above (COR=0.232(95%CI=0.085, 0.0638), COR =0.332 (0.117,0.937)).

The odds ratio of male partners who had income between 490-800 birr were 0.24 times less in promoting skilled delivery attendants when compared to income 800 and above (COR=.244(95%CI=.107,.558)).

In this study male partners who can afford cost of healthy facility services were 1.68 times more likely to participate in promoting skilled delivery attendants as compared to those who were not. (COR=1.683 (95% CI=1.073, 2.639)).

Others Socio-demographic variables have no statistical association with male partner's involvement in promoting skilled delivery attendants.

In the bivariate analysis significant associations were observed that male partners who have good

knowledge had 2.69 times higher than those who had poor knowledge in promoting institutional delivery (COR =2.685(95%CI=1.521-4.740)).

Male partners who have positive attitude were 1.67 more likely to involve in promoting institutional delivery than those who had negative attitude (COR =1.672(95%CI=1.070, 2.611)).

After adjusting for the effect of confounding variables using logistic regression, variables like personal income, Cost of delivery service and knowledge of male partners have statistically significant association with male partner's involvement in promoting skilled delivery attendants, while the rest are not statistically significant $p<0.05$.

Male partners who had income between 490-800 birr were 0.29 times less in promoting on skilled delivery attendants when compared to income greater than eight hundred and above (95%CI=.116,.719))

Cost of health facility services was significantly associated with male partner's involvement in promoting skilled delivery attendants. Male partners who can afford cost of health facility services were 1.79 times more likely to participate in promoting skilled delivery attendants as compared to those who were not (95%CI=1.059,3.040))

Male partners who have good knowledge had 2.9 times higher in promoting institutional delivery than those who had poor knowledge (95%CI= **1.521, 5.510**)).

Table 5 Association of selected socio-demographic variables, knowledge and attitude with male partners involvements on promoting skilled delivery in Lemo woreda, 2014

Characteristics	Male involvement		COR (95%CI)	AOR (95% CI)	P-value
	Yes	No			
Age of respondents					
20-29	32 (47.8%)	35 (52.2%)	**3.962 (1.033-15.188)**	3.537 (.760, 16.451)	.107
30-39	70 (39.3%)	108 (60.7%)	2.809 (o.772-10.212)	3.657(.882,15.160)	.074
40-49	23 (31.1%)	51 (68.9%)	1.954 (.507-7.527)	2.482(.569,10.828)	.227
>=50	3 (18.8%)	13(61.8%)	1.00	1.00	
Respondents occupation					
Private employed	1 (5.3%)	18 (94.7%)	**.008 (000,45)**	8.209(.455,148.018)	.154
Unemployed	113 (38.4%)	181 (61.6%)	**.089 (.011,.734)**	.086(.007,1.040)	.054
Others	7 (50%)	7 (50%)	.143 (.014,1.487)	.0.97(.75,2.65)	.434
Civil servant	7 (87.5%)	1(12.5%)	1.00	1.00	
Male partners level of education					
No formal education	69 (33.5%)	137 (66.5%)	**.232 (.085-.638)**	.937 (.243,3.611)	.924
Elementary	46 (41.8%)	64 (58.2%)	**.332 (.117-.937)**	1.115 (.283,4.393)	..876
Secondary and above	6 (31.6%)	13 (68.4%)	1.00		1.00
Knowledge					
Good	109 (43.6%)	141 (56.4%)	**2.685(1.521-4.740)**	**2.9(1.521,5.510)**	**.001**
Poor	19 (22.4%)	66 (77.5%)	**1.00**	1.00	

Attitudes					
Positive	65 (45.1%)	79 (54.9%)	**1.672 (1.070,2.611)**	1.088(.433,2.737)	.858
Negative	63 (33%)	128 (67%)	1.00	**1.00**	
Cost facility services					
Affordable	80 (43.7%)	103 (56.3%)	**1.683 (1.073-2.639)**	**1.79(1.059,3.040)**	**.030**
Not affordable	48 (31.6%)	104 (68.4%)	1.00	1.00	
Personal income					
<490	67 (44.4%)	84 (55.6%)	1.144 (.711,1.840)	.914(.414,2.017)	.824
490-800	8 (14.5%)	47 (85.5%)	**.244 (.107,.558)**	**.288(.116,.719)**	**.008**
>800	53 (41.1%)	76 (58.9%)	1.00	1.00	

Statistically significant at $p<0.05$

6. DISCUSSION

The aim of this study was to assess male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors among households who have children age 0-12 months in Lemo woreda, Southern Ethiopia.

The study finding revealed that the prevalence of male partners' involvements' in promoting skilled delivery attendants was 38.2% which is lower than study done in Shashemane city adminstration, Ethiopia (69.9%) and Uganda (43%) (30, 35). The possible explanation for such low involvement might be due to socio-demographics variation. However, the finding was higher than the study done in India on male participation in maternal care that showed (32.5 %.) (33). The reason why this finding is slightly higher might be socio-demographic characters.

Using bivariate analysis those participants who attend secondary and higher level of school had more involvement in promoting institutional delivery. This finding was supported by the study done in Bangladesh, Nigeria, Uganda and Kenya (44, 45, 46 and 47). The possible explanation is that education enhances male knowledge on institutional delivery.

Respondents who were in the age group of 20 to 29 were 3.96 times more likely to involved in promoting skilled delivery attendants than those who were in the age group of 50 and above. The finding appeared to be inconsistent with other study done in Mediterranean Orientale (38). The difference might be due to different socio demographic and socio cultural characteristics of the study participants.

Husband's occupation was one of the significant factors in promoting institutional delivery. Male partners who were privately employed and unemployed were less involved in promoting skilled delivery attendants than those who were civil servants [(COR=0.008(95%CI=0.000, 0.45) and COR =.089 (95%CI=.011.734) respectively]. This was similar with other study done in Nigeria (44). This

implies that low status occupations are associated with minor wealth, making it difficult for the family to pay costs and better understanding about the institutional delivery that did not promoting skilled delivery attendant.

Male partners who have positive attitude were 1.67 more likely to involved in promoting institutional deliveries than those who had negative attitude. This was similar with other study done in Ethiopia (42).

By using multivariate analysis knowledge on skilled delivery was significant predictor for male partners' involvement in promoting skilled delivery. Male partners who had good knowledge on skilled delivery were 2.9 times more likely to involve in promoting institutional delivery than those who had poor knowledge. The finding was consistent with other study done in India and Mali (39, 41). Having good knowledge about skilled delivery could influence male partner's involvement in promoting skilled delivery attendants.

The finding revealed that male partners who had income between 490-800 birr were less involved in promoting on skilled delivery attendants when compared to income greater than 800 and above. This was similar with other study conducted in Rwanda and Kenya (47, 49) (AOR=0.29(95%CI=.116, .719)).

The present study showed that male partners who can afford cost of health facility services were 1.79 times more likely to participate in promoting skilled delivery attendants as compared to those who were not. Similar studies done in Ethiopia and Kenya which correspond with present study (7, 49).

7. STRENGTH AND LIMITATION OF THE STUDY

Strength of the study

- Being community based, it could reflect the actual experience of the male partners during the study period.
- The questioner was pretested on similar setting and a necessary modification was made to minimize the difficulty during the data collection

Limitation of the study

- Since the study is cross –sectional it may not demonstrate direct cause and effect between dependent and independent variables.
- Since the data collectors were Health professionals there may be some social desirable responses for some of the variables.
- Since study was limited to rural area it may not be generalizable to the urban population.
- The findings were not triangulated by qualitative studies due to time and budget constraint to employ qualitative approach.

8. CONCLUSION AND RECOMMENDATION

8.1 Conclusion

- In general, the study has revealed that male partner's involvement in promoting skilled delivery attendant was low. Above half of respondents had good knowledge toward skilled attendants while below half of them have had positive attitude toward skilled attendants. Final the factors associated with high male partners' involvement in promoting skilled delivery attendants of spouses in Lemo woreda included; higher education status of the husband, male partners who can afford cost of health facility services, men who have high income, early adult hood and high status occupations with greater wealth.

8.2 Recommendation

- In general, the study has revealed low male partners involvement in promoting skilled delivery attendants. Thus it needs to be stressed that deliberate and active participation of male members are the need of every household. So, this has to be achieved by woreda health office.
- The woreda health office should provide means of opportunities to support male involvement through media coverage, posters and campaign that can change knowledge, and attitudes of male partners.
- The woreda education office should improve higher educational level of male through increasing government and private colleges.
- The government and other responsible bodies should make efforts to increase community based health education, awareness creation and improve male partner's involvement on skilled delivery attendants of a spouse that strategy may reduce MMR by improve reproductive health care.
- Further studies should be undertaken to find further associations of knowledge, attitudes and

practices of male partners' involvement in promoting skilled delivery attendant of a spouse. Studies involving qualitative studies should also be under taken to investigate male partners involvement in promoting skilled delivery attendants of spouses

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ANNEXES

Addis Ababa University College of health sciences

Department of nursing and midwifery

Annex I: Information Sheet

Questionnaire on Assessment on male partners' involvement in promoting skilled delivery attendace of a spouse and its associated factors in lemo woreda, hadiya zone.

Code of the kebele_____

Hello! My name is (Name of the data collector-) _____. We are conducting health research on Assessment male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors among households who have children age 0-12 months.

This is beneficial to identify areas of improvement in the male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors and highlighting the need for corrective actions. By doing this we will provide sufficient information for policy makers, clinicians so that they could make informed decision. In order to attain this goal, you are kindly requested to provide your genuine response on the questions given below.

I would like to confirm you that you have the right to stop the interview at any time or skip any question that you do not wish to answer. Because taking part in this survey is voluntary and your responses will be held in strict confidence. Your privacy will also be protected and no one will know your answer. If you do not wish to participate, it will not affect the services you receive at the clinic now or in the future.

I also request you to answer it candidly because your answers are like one important piece of

brick in the whole research and determine the outcome of this study. Thank you very much for your willingness to listen to me. In case if you have any question you can ask:

NURADIN ABUSHA **Mobile phone: *+251910610523,*** ***Email nuradinabusha@yahoo.com***

Are you willing to participate?

If the answer is, YES, - Please continue

NO _____ Thanks

Signature: _____ Date: _____

Annex II: Hadiya version of the information sheet

Sommo'i II:Sawitte sidim'i ido'o

Ku xammichi soroobokkoki horoor woshshomi goon meenti qarimmi ammane lachchaam manni anganne qarro'isa isimminne yookki hara'mmaxxi bikkinate. Ku soroobom'I baxaammokkoki Hadiyyi zonane Lemi woradanet.

Kabale kod'i_____

Xummi Ki'nnena ihona! I summi_____(xammaancho). Ku soroobo'i soroobokkoki Fayya'oo'm bikina goon meenti qarimmi ammane lachchaam manni anganne qarro'isa isimminne yookki hara'mmaxxi bikkinate. Ku qananaat mo'ookkok annannannem 0-12 agan afeebe'e anno'o minii-min afeebe'e moo'oo sawwite.

Ku soroobo'i goon meenti qarimmi ammane lachchaam manni anganne qarro'isa isimminne yookki awwaxx'i bikkina kuroohane.

Ka soroobo baxximine wixxako'i sawwite gatii seera gudisanina,killinik baxxaninana mullikeninami horoor woshsha affakamisina awwado'o bikina worroni yoo'i xammichcha daaabale. Mat mati xa'mmichchuwwa xa'mmineena hansoommo,dabattakko'I beeta'nim galaxxinoommmo. Xa'mmichchuwwinam ayyi ballam dabachcha uwwimmi xanamoo haannooma tiissiinsoommo. Kasoroobo'onne hineookki xa'mmichchuwwanne hara'mmatoo issitakko'ibeeta'nnim fayyo'oom duuha'anne siidakkam awwadom ihukko mulli awwaadom siidimmii egedooyyo. Ki'nne uwwitakkam dabaachcham mulli manniise maaxamma, yimmim dabatakkam dabachchi ka soroobo'ina araqa harammohane ihukkuuyyi odim lobakata hara'mmo sawwite baximmina, dargaasimmina dasimminne qarimmi ammane ammo'onnem ihukko cilluwwane afoo qedda egedimminatte. Machchesakko'I bikina galaxinoomo.Xammichch heeulas ka siliki xigine sidde NURADIN ABUSHA +251910610523, Email nuradinabuha@yahoo,com

Xa'mmichcha dabarimmina eeyyit yoo?

Ooyya Ihooyyo

Ooyya yitakko'ilas xa'mmichcha xa'immommo.

Ihooyyo y yitakko'ilas galaxoommo,xummikkehe.

firma'a _____ balla _____

Annex III: English version of consent form &questionnaire

Consent Form

Greeting Hallo

My name is. ---------- (Interviewer)

I temporarily represent Addis Ababa University, college of health science, Department of Nursing and midwifery. This is a study to be conducted with the objective of assessing male partners' involvement in promoting skilled delivery attendance of a spouse and its associated factors among households who have children age 0-12 months. As the study is directly related to male partners' having children's age 0-12 months from selected kebeles in the study area in this study. Therefore, you are kindly requested to participate in this study and provide the information required from you. I would like to ask you a few questions if I may, but you can refuse to answer any question I ask. You may end the interview at any time. You can also refuse to participate in the study entirely. Your refusal will not restrict you from obtaining the required medical care when you need. The interview will last approximately 20 minutes. Your responses will be kept confidential and there will be no way of linking your individual responses to the final results of the study findings. We would like to inform you that the responses that you

provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful in the planning and implementation of intervention activities to prevent delays and improve maternal and neonatal survival. Are you voluntary to respond to the questions?

Yes----------

No----------

If yes continue the interview

If no thanks the men and proceed with next respondents

Name of the interviewer----------sign----------Date----------

Name of the supervisor----------sign----------Date----------

Annex IV: - Hadiya version of the consent form

Somo'i IV: - Hadiyyi Suu'mmi tiraxxi Iittancho'ane Xa'mmichchi Haala.

Addis Ababane Fayya'oo'm Bikkina Sorooboo Kolleejja Narsinganee Miidiwaafere'i Dipaartmeenta.

Ittanchi haala

Xummi Ki'nnena ihona,

I summi_____(xammaancho)

Ammanoomina ani Addis Ababi Universite'ene Fayya'oo'm bikina sorooboo Kolleejjanne Narsingaa Miidiwaafere'I Dipaartmeenta bikkoommo. Ka sorooboik horoor woshshi goon meenti qarimmi ammane lachchaam manni anganne qarro'isa isimminne yookki hara'mmaxxi bikkinate. Ku qananaat mo'ookkok annannannem 0-12 agan afeebe'e anno'o minii-min afeebe'e moo'oo sawwite.Ku soroobo'I mo'ookkok leemo'I worexxi gattenne doo'llamitemukki qabale'uwwannette. Eebbikki'nnem ka soroobo'onne harammato issitakonaa sawwitem uwwitakkoona mashaallom uunxinoommo. Mat mati xa'mmichchuwwa xa'mmineena hansoommo,dabattakko'I beeta'nim galaxxinoommmo. Xa'mmichchuwwinam ayyi ballam dabachcha uwwimmi xanamoo haannooma tiissiinsoommo. Kasoroobo'onne hineookki xa'mmichchuwwanne hara'mmatoo issitakko'ibeeta'nnim fayyo'oom duuha'anne siidakkam awwadom ihukko mulli awwaadom siidimmii egedooyyo. Ku xa;mmichii 20 daqiiqa masseena xanookko. Ki'nne uwwitakkam dabaachcham mulli manniise maaxamma, yimmim dabatakkam dabachchi ka soroobo'ina araqa harammohane ihukkuuyyi odim lobakata hara'mmo sawwite baximmina, dargaasimmina dasimminne qarimmi ammane ammo'onnem ihukko cilluwwane afoo qedda egedimminatte. Xa'mmichcha dabarimmina eeyyit yoo?

Ooyya

Ihooyyo

Ooyya yitakko'ilas xa'mmichcha xa'immommo.

Ihooyyo y yitakko'ilas galaxoommo,xummikkehe.

Xa'mmanchi summi_____ firma'a_____ balla_____

Xambaanchi summi_____ firma'a_____ balla_____

Annex –V: English version questionnaires for exit interview

Identification Information

001. Code No._____

002. Keble____″Gott''_____

Section 1: Socio-demographic and economical Information

No.	Question	Options	Skip to question
101	Age in year at present	……	
102	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Other specify	
103	Ethnicity	1. Hadiya 2. Silite 3. Gurage 4. Kambata 5. Others	
104	Respondent's occupation	1. Civil servant 2. Private employee 3. Farmer 4. Merchant 5. Other	
105	Respondent's educational status	1. Illiterate 2.Read and writes 3. Primary education (1-8) 4.Secondary education (9-12) 5. Diploma and above	
106	Monthly house hold	1.<633	

	income	2.633-1399 3.>1399	
107	Number of wife	1.One 2.Two 3.Three 4.four and above	
108	Do you have X wife?	1.Yes 2.No	

Section 2 Male partners' involvement in promoting skilled delivery of spouse

201	Have you ever visit health facility for ANC care with your spouse during the last pregnancy?	1.Yes 2.No	If no-pass Question number 203
202	How many times you visit with her?	1.One 2.Two 3.Three 4.Four 5.Above four	
203	When your spouse were pregnant for the current child, did you prepare for her delivery?	1.Yes 2.No	
204	What preparation did you make towards most current delivery?	1.Saved money for delivery 2.Arranged for transport 3.Planned ahead for a place of delivery 4.Identified a person who fellow her in the health facility for delivery 5..Prepare essential items for delivery 6.Diffirent food item preparation 7. Other (specify)……	
205	Have you had discussions with health provider during your spouse pregnancy	1.Yes 2.No	If no---pass question number 207

206	What makes you to discuss with health professionals?	1.My previous experiences 2.When she feels pain 3.you interest 4. Other (specify)……	
207	Have you had discussions with your friends about place of delivery during your spouse pregnancy?	1.Yes 2.No	If no---209
208	If yes, what was their suggestion while your spouse was pregnant for place of delivery?	1.They encouraged me to bring health institution 2.They discourage me to me bring health institution 3.They gave no suggestions 4.I don't remember	
209	Have you had discussions with your relatives about place of delivery during your spouse pregnancy?	1.Yes 2.No	If no---pass question number 2011
2010	If yes what was the suggestion of your relative's while your spouse was pregnant for place of delivery?	1.They encouraged me to bring health institution 2.They discourage me to me bring health institution 3.They gave no suggestions 4.I don't remember	
2011	Where did your spouse give birth for current?	1.Hospital 2.Health center 3.Private clinics	
2012	Who initiate idea of communication about place of delivery?	1.You 2.Your spouse 3.Family 4.Relatives 5.Both of us	
2013	Did you decided to delivery in health institution current child?	1.Yes 2.No	If no---2015
2014	If yes why did you decide to delivery in health institution?	1.It is here preferences 2.Based on our previous bad experience from home delivery 3.Health extension referral	

		4.It is both our interest 5.Other specify……	
2015	If no who decide institutional delivery	1.Spouse(wife) 2.Family 3.Relatives 4.Other specify	
2016	If answer is no to question no. 2013, Why you didn't decide to delivery in health institution? (more than one answer possible)	1.Health workers are uncooperative and harsh 2.I am not satisfied with quality of services in the health facility 3.I have faced poor outcome from institutional delivery 4.Forced to undertake a mandatory HIV test of spouse 5.Transportation problem 6.Fear of referral 7.Fear of caesural section 8.I was busy at that time 9.It is not our culture of male partners to decide where to give birth unless prolong labor 10. Others specify……..	
2017	What was your opinion about the cost of accessing health facility delivery?	1.Absolutely free 2.Partially free 3.Affordable 4.Expesive 5.Very expensive	
2018	If ans. to Q 2017 is No.4 and 5 In which health facility?	1.Governmental hospital 2.Health center 3.Private clinic	
2019	What are cultural reasons that make male partners no to involve decision place of delivery? (more than one answer is possible)	1.Child-birth is a woman's affairs that does not require men participation 2. Child-birth is natural phenomenon that should not be given much attention 3.It's not our culture to discuss with wife about place of delivery 4.Placent must be disposed secretly which is not possible with facility delivery 5.Accompanying wife to health facility for delivery is women's responsibility 6.Fear of being seen by others	
	What you dislike	1.Distance covered to access skilled	

2020	about your nearest health facility delivery. Tick the answer based the condition you faced when your spouse gave birth to your last child.(more than one answer is possible)	care 2.Attitude/behavior of health staff 3.Opening hours (day/night) 4.Service provider readiness(bed, water, medicine) 5.Cost 6. Other specify	
2021	Is there accessibility of delivery site.(yes, if less than 30 minutes walking, no if more than 30 minutes walking)	1.Yes 2.No 3.I don't know	If no---pass question number 2023
2022	If yes which site is more than accessibly for you if need arise?	1.Hospital 2.Health center 3.Private clinics	
2023	How do you rate the easiness for you to get institutional delivery services if the need arise?	1.very easy 2.Fair 3.very difficult 4.Imposible 5.I cannot assess	
2024	If very difficult and impossible in Q 2023 why?	1.Health facilities are not available 2. Health facilities are not nearby 3.I can't pay for the services 4.No transportation services 5. I can't pay for transportation 6.Other reason specify……	
Section 3 Question about male partner's involvement decision in place of delivery (KNOWLEDGE)			
2025	Do you know your spouse have received ANC follow up?	1.Yes 2.No	
2026	What is the recommended minimum number of times a pregnant woman is to attend	1.0nce 2.Twice 3.Three times	

	ANC?	4.Four times	
2027	Why do you think institutional delivery is important(MORE THAN ONE ANSWER POSSIBLE)	1.Access to skilled care 2.prevent delay in getting emergency care if needed 3.Immediate treatment to the mother and baby 4.I don't know	
2028	What are the sign of complication(MORE THAN ONE ANSWER POSSIBLE)	1.Vaginal bleeding 2.Fever 3.Abdomomenal pain 4.Diffcult in labor 5.convulion 6.I don't know	
2029	For whom do you think skilled delivery is important?	1.Mother alone 2.Baby alone 3.Mother and baby only 4.The family 5.For all 6.Other(specify)	
Section 4 Question about Attitude			
2030	Attitude towards skilled delivery services?	1.Good 2.Bad	If bad to---pass question number 2032
2031	Why good attitude to skilled delivery services?	1.Good quality of services 2.Good approach of health workers 3.Faire price 4.Better outcomes of institutional delivery 5.Other specify	
2032	Why bad attitude to the skilled delivery services?	1.Poor quality of services 2.Unwelcoming approach of health workers 3.Placenta should not place in the placenta pit 4.Expensive price 5.Poor outcomes of institutional	

		delivery 6.I believe it is better to delivery at home 7.Other specify	
2033	How do you evaluate the quality of institutional delivery services?	1.Good 2.Bad	
Section 5 Question about Finance			
2034	What is family's main source of income?	1.you 2.Your wife 3.You and your wife 4. Others	
2035	Do you earn monthly income by your own?	1.Yes 2.No	
2036	How do you perceive your families economic status?	1.Poor 2.Moderate 3.Rich 4.I don't know	
2037	Can you afford to pay for services by skilled delivery attendant?	1.Yes 2.No 3.I don't know	

AnnexVI:- Hadiya version of the questionnaires

Somo'i VI:-Hadiyyi suu'mmi tiraxxi iittanchanee xxammichchi haala qoosisaanchi sawwite

01. Xiqqi ogora_____

02. Kabale'e_____gooxa_____

Minaadabaa heechchi qaanqa

Xigo	Xa'mmicha	Dollicha	Higgimma
101	Umur mee'o	_____	
102	Amma'nnato	1. Ortodoksa 2. Kaatolika 3. Protestaanta 4. Islaama 5. Mullane ihulas_____	
103	Giiri-giichchi	1. Hadiyicho 2. Silxekkicho 3. Guraagekicho 4. Kambaaticho 5. Mullane ihulas_____	
104	Ki baxi maha	1. Adi'l baxaancho 2. Adi'llan ihubee'I baxaancho 3. Abuullaancho 4. Daddaraancho 5. Mullane ihulas_____	
105	Losa'n gabali hinkaa'nna	1. Losubee'ana 2. Kitaabimma qanaa'imma xanoohane 3. Luxxi gaba'lli losaancho (1-8) 4. La'mmi gaba'lli losaancho (9-12) 5. Diploomaa eehannii hanaan	
106	Aga'nni siixxo'I qaxoom hinkaana	1. < 633 2. 633-1399 3. > 1399	

107	Mee'I meenti yoo?	1. Mato 2. Lamo 3. Saso 4. Sooro eehanni lobane	
108	Mulli manni la'oo bee'I meenti yoohonni	1. Ooyya 2. Eedeyyo	

Baxxanchi lamo

Meenti fayya'oo'm egechchi minenne qarimmi ammane gooni isimmi hasisoo hara'mmato.

Xigo	Xa'mmicha	Dollicha	Higgimma
201	Hoongooma'n ammane kimin ama maqirem fayya'oo'm egechi mine matahaa laqqoo?	1. Ooyya 2. Ihooyyo	Ihooyyo yitlas xa'mmichchi---203
202	Mee'I kore maqirem mattaa?	1. Mat kore 2. Lam kore 3. Sas kore 4. Soor kore 5. > 4	
203	Ki mi'n ama kaba yoo ciilicho lamfoor hee'llo'I ammane qarimmi ammanina guddaa hee'llittonnihe?	1. Ooyya 2. Ihooyyo	
204	Ooyya yitlas mamaha guddaa hee'llitto?	1. Diinate (bira) gudisaa hee'llitto 2. Tiraanspoorta gudisaa hee'llitto 3. Qarimmi beyo gaassitta gudisaa hee'llitto 4. Qarimmi bikkinaawwonoo lachchi manna annannistaa laqqaa hee'llitto 5. Qarimminna hasisoo mu'uta gudissaa 6. Annanni hurbaata gudissaa 7. Mullek yoolas	

205	Ki min ami lamfooroo'm ammane lachchi manna atoorassitaa laqqoo?	1. Ooyya 2. Ihooyyo	Ihooyyo yitlas xa'mmichchi---207
206	Lachchi manchi beyyoo mattoo'isa isuluwwi yoohonni?	1. Illagee'n hayyo'om 2. Jabbitam hee'llo'I bikkina 3. Kihasan ihubikkina 4. Mullek yoolas	
207	Ki mi'n ami lamfooroo'mi ammane kibeshshuwwinne qarimmi beyyina atooratta laqqoo?	1. Ooyya 2. Ihooyyo	Ihooyyo yitlas xa'mmichchi---209
208	Ooyya yitlas kibeshshuwwi sawwite mah hee'ukko	1. Fayya'oo'm mine massitona faare'isansamukko 2. Fayya'oo'm mine massitoobee'isa bushisamukko 3. Sawwite uwwamukkoyyo 4. Yamu –luchcho tiiroommoyyo	
209	Ki mi'n ami lamfooroo'm ammane qarimmi beyyi bikkina ki qari manninni atoorattoo?	1. Ooyya 2. Ihooyyo	Ihooyyo yitlas xa'mmichchi---2012
2010	Ooyya yitlas ki qarmanni sawwit mah hee'ukko?	1. Fayya'oo'm mine massitona faare'isansamukko 2. Fayya'oo'm mine massitoobee'isa bushisamukko 3. Sawwite uwwamukkoyyo 4. Yamu –luchcho tiiroommoyyo	
2011	Kaba yoo ciilicho hinke'e qatto'o?	1. Hospitaalanne 2. Heggeeqqi fayya'oo'm egechchi mine (xeena xaaba'anne) 3. Adi'llan ihubee'I	

		kiliniikane	
2012	Qarimmi beyyi bikkina faare'isansookkok ayyette?	1. Ati 2. Ki mi'n ama 3. Abaroos hundim 4. Qarmanni 5. Lamemi	
2013	Kaba yoociila fayya'oo'm egechchi mine qarimmina murtechchi hee'ukkko?	1. Ooyya 2. Ihooyyo	Ihooyyo yitlas xa'mmichchi---2015
2014	Ooyya yitlas fayya'oo'm egechchi mine qattamisina mah murte'isukko?	1. Isi doo'lli ihubikkina 2. Mine qarimmanne eraare hee'ukki hawwojja sawwimminne 3. Fayya'oo'm ekisteenshiin baxaan mulli beyyo assechchinne 4. Lami lasanom ihubikkina	
2015	Ihooyyo yitlas qarimmi beyyo doo'llukkok ayyete?	1. Ki mi'n ama 2. Abaroos 3. Ki qarmanni 4. Mullek yoolas	
1016	Xa'mmichch 2013 ki dabachi ihooyyo yitlas mahina fayya'oo'm egechchi mine qarimmina hassitoyyo?	1. Fayya'oo'm baxaanone moo'amo jollaa mongaa 2. Uwwamoo awwadon liiramummi bee bikkina 3. Ka illagee'n qarimmi ammanne jori haala moo'ummi bikkina 4. Eeyyit bee'ekam HIV-yooiisa teim bee'isa la'immina hawwisakkam bikkina 5. Tiraanspoortashin qeddi 6. Mulli beyyo ijaajakkam bikkina 7. Diqimma bedimma 8. Matayyummi bikkina 9. Xuuchchi	

		kee'mmubeelas ni heechchi qaanqanne goon qarimmi beyyo xanoo bee'I bikkina 10. Mullek yoolas	
2017	Fayya'oo'm mine qarimmi ammane firoo diinaxxi bikkina ki saawit maha?	1. Maham xa'mmakkamoyyo 2. Koll miqimmine 3. Miqimma xanakkam qaxa 4. Xee'aalla 5. Horem Xee'aalla	
2018	Xa'mmichchi 2017 dabachchi sooro onto ihulas hinka fayya'oo'm egeeechchi minenne?	1. Adi'l hospitaalanne Hospitaalanne 2. Heggeeqqi fayya'oo'm egechchi mine (xeena xaaba'anne) 3. Adi'llan ihubee'I kiliniikane	
2019	Gooni meenti beyyo doo'lloo bee'isa issoo minaadaphi heechi qaaanqi xooxi maha?	1. Qarimmi meentane bagaan goona hasoo bebikkina 2. Ooso qarimmi qooccam ihubikkina goona hasooyyo 3. Qarimmi beyyi hasaaluwimma heechi qanqa bee'ane 4. Fayya'oo'm egechchi mine qarimmi ammane ama maaxakka'a waammakkam beebikkina 5. Meenti qarimmi beyyo gudishi meenti bax ihubikkina 6. Mulli keen moo'amchi baddisoo bikkina	
2020	Ati awwaaxxitoo fayya'oo'm egechchi mi'n bikkina sabboo luwwi	1. Qee'llooma 2. Fayya'oo'm egechchi mi'n baxaa'n haalato 3. Foqoo bax ammane (balla/hiimo)	

	yoohnni?(Matiinse loboka doo'llimma xanakkamo)	4. Awwaaxxi mu'uti gudimmi haala(Araa,wo'o,qaraare) 5. Miqo'o 6. Mullek yoolas	
2021	Qarimmi beyyi siidamoo duuha'I abisimmi yoohonni? Ooyya yitlas < 30 d aqiiqi hoffane, > 30 daqiiqi loboka massokko	1. Ooyya 2. Ihooyyo 3. La'oommoyyo	Ihooyyo yitlas xa'mmichchi---2023
2022	Ooyya yitlas hink fayya'oo'm min abbisoo?	1. Hospitaala 2. Hegeeqqi fayya'oo'm egeechchi mine 3. Adi'llan ihubee'I kiliniika	
2023	Fayya'oo'm egechchi minenne lachchi uwwoo qasisimmi awwaado hinkid moo'llootto?	1. Horem sholle'aalla 2. Erane 3. Horem kee'mmaalla 4. Xanamoobee'ane 5. Ka bikkina onsummoyyo	
2024	Xa'mmichchi 2023 dabachchi horem kee'mmallaa xanamooyyo yitlas mahina?	1. Fayya'oo'm egechchi min lophphaa siidamoo beebikkina 2. Fayya'oo'm egechchi min hinceen ihubeebikkina 3. Awwaaxxi miqo'I kee'mmaalli ihubikkina 4. Tiraanspoorti danoobee'ane 5. Tiraanspoorti miqimma xanoommooyyo 6. Mullek yoolas	

Baxxanchi- saso

Gooni meenti qarimmi beyyi doo'llimmanne lachchi keenoo soroobo'I xa'mmichchuwwa

2025	Ki min ama qarimmi illaqqi awwaado fayya'oo'm egechch minenne sidada'e	1. Ooyya 2. Ihooyyo	

	laqqaa		
2026	Qarimmi illage uwwamoo awwaado mee'I kore kimi'n ama siidimmi hasisoo?	1. Mat kore 2. Lam kore 3. Sasi kore 4. Soori kore	
2027	Fayya'oo'm egechchi awwaado uwwoo mine qarimmi mahina awwaadookko yitaa sawwitoo?(matii lophphaakkoo dabachi xanamookko)	1. Lachchi manni yoobikkina 2. Qarimmi ammanne dango afoo hawwinse egerimmina 3. Qaqqiso uwwakkam hara'mmato amanaa ciilina siidakkam bikkina 4. La'oommoyyo	
2028	Qarimmi ammane afeena xanoo hawwi mare'uwwi mah maha (matii lob-dabachchi xanamookko)	1. Qa'lli orachchi xiigee'imma 2. Kee'mmalli iibbi mare'e 3. Godabi xissimma 4. Xuuchi kee'immima 5. Gaga huushimma 6. La'oommoyyo	
2029	Lachchi mannine qarimma ayyena awwaadoo	1. Amanna xale'e 2. Ciilina 3. Amanaa ciilina xale'e 4. Hundinami 5. Mullek yoolas	

Baxxanchi sooro

Haalato keenaanchi xa'mmichcha

2030	Lqarimmi bikkina yookki sawwite mahaachchimanni uwwookki	1. Danaamo 2. Jora 3. La'oommoyyo	
2031	Mahina danaami sawwityookkok	1. Danaam awwaado uwwamoo bikkina	

		2. Lachchi mannine danaam hincaa'immi yoobikkina 3. Gudaanchi miqo'I yoobikkina 4. E'lloo mishaam awwaado siiximmi bikkina 5. Mullek yoolas	
2032	Mahina jori sawwit yookkok	1. Jor awwad uwwamoo bikkina 2. Lachchi mannine jori hincaa'immi yoobikkina 3. Ama waammakkam beebikkina 4. Miqo'I xee'aalla 5. E'lloo mishaam awwaado siidakkam beebikkina 6. Mine qarimma erane yaa ammanummi bikkina 7. Mullikeen yoolas	
2033	Fayya'oo'm egechchi min uwwoo qasiishshi awwaado hinkid moo'llotto	1. Danaamo 2. Jora 3. La'oommoyyo	
2034	Ki abaroos siixxo'onne luxxi beyyo bikkammoo ayyete	1. Ati 2. Ki mi'n ama 3. Lamim 4. Mullikeenim	
2035	Agana egettaa siidoo siixxo'I bu'I yoo	1. Ooyya 2. Ihooyyo	
2036	Ki abaroosika siixxo'I duuha'a hinkid moo'lloo	1. Buxicho 2. Lambe'aancho 3. Goddaancho 4. La'oommoyyo	
2037	Lachchi mannine uwwamoo qarimmi awwaaxxi miqo'o xantoo	1. Ooyya 2. Ihooyyo 3. La'oommoyyo	

Annex VII: - DECLARATION

I THE UNDER SIGNED DECLARE THAT THIS THESIS IN MY ORIGINAL WORK HAS NOT BEEN PRESENTED FOR A DEGREE IN ANY OTHER UNIVERSITYAND ALL THE SOURCE OF THE MATERIALS USED FOR THIS THESIS WORK AND ALL PEOPLE AND INSTITUTIONS WHO GIVE SUPPORT FOR THIS WORK ARE FULLY ACKNOWLEDGED

NAME OF THE STUDENT NURADIN ABUSHA

SIGNATURE ----------

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DATE OF SUBMISSION----------

THIS THESIS WORK HAS BEEN SUBMITTED FOR FINAL WITH MY APPROVAL AS UNIVERSITY ADVISOR

NAME OF THE ADVISOR YOSIEF TSIGE (RN, BSC, MSC, Lecturer)

SIGNATURE----------