

Addis Ababa University
College of Education and Behavioral Studies
School of Psychology

Maternal Attitudes towards Giving Birth in Some Selected
Health Facilities and its Associated factors in kirkos Sub-city

Addis Ababa

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This thesis report is submitted to the School of Psychology of Addis
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Acronyms

ANC-Anti Natal Care

BMOC- Basic Maternity and Obstetric Care

CBI-Caring Behavior Inventories

CSA-Central Statistical Agency

EDHS-Ethiopia Demographic and Health Survey

ESCR- Economic, Social and Cultural Rights

FDRE-Federal Democratic Republic Of Ethiopia

HIV-Human Immunodeficiency Virus

AIDS—Acquired Immunodeficiency Syndrome

HSTP-Health Sector Transformation Plan

IMC-International Medical Corps

ICF-Intermediate Care Facility

MOH-Ministry of Health

MDG-Millennium Development Goals

PMTCT-Prevention Mother to Child HIV/AIDS Transmission

PNC-Post Natal Care

UN-United Nations

WHO-World Health organization

Abstract

The major objective of the present study is to examine the attitudes of mothers towards giving birth in some selected health facilities, whether their attitudes varies across the selected health facilities, selected demographic variables and its relation with service provided in the health facilities. For these reason, a quantitative non experimental research design employed which allows descriptive method. Both random and non-random sampling methods were employed. The study was conducted in Kirkos sub city, since it have large population size with more exposure to modernity, urbanization and industrialization as well as well-known former health facilities available, compared to the other sub cities. Specifically, using simple random sampling among the woredas in the sub city, woreda 02 selected and using anon- random sampling which was purposive the health facilities were selected since the only available health facilities that gave maternity service were only the two selected health facilities which was Efoyita health center and Marie Stops International private clinic Ethiopia. A total of 500 participants each 250 from private and 250 from public were participated. In addition, data were generated from primary sources using quantitative methods (Likert scaled questionnaires). In order to report research questions data were analyzed using independent t-test, one way ANOVA and Pearson correlation coefficient techniques. Consequently, the current study generally revealed several important findings about maternal attitude in giving birth in the selected health facilities. First, That maternal attitude varies across the private and the public health facilities. Second maternal attitude in giving birth varies by the level of education and number of children that the mother have. Third, maternal attitude do not vary across the health facilities by age and residence. Fourth, that maternal attitude is strongly related with quality of service provided in the selected health facilities. Moreover, based on the results of the study, the following conclusions were drawn. Maternal attitude differs in the individual health facilities and that maternal attitude influences preference of place to give birth, mothers with higher level of education and low number of children have better attitude in giving birth in the selected health facilities and that quality of service provided by the health facilities influences maternal attitude.

Key words: *maternal attitude, private health facility, public health facility.*

Chapter 1: Introduction

1.1. Background of the Study

The most recent studies which were updated on 2017 estimated that 303,000 women lose their lives each year in the world of which 99% occurs in developing countries (WHO, 2017). There are nearly 2.6million stillbirths (Goldenberg, 2011). Four million newborns die in the first month of life despite there has been significant progress in reducing preventable deaths and disabilities. The millennium development goal five targeted to achieve reducing maternal deaths by three quarters by the end of 2017, in low and middle income countries (Goldenberg, 2011). In 2017, it was estimated that 830 women died from pregnancy related complications around the world every day (WHO, 2017).

Sub Saharan Africa has the highest maternal mortality rate 546 maternal deaths per 100,000 live births with poor progress in reduction (CSAE, 2016). Recent statistics show that Ethiopia has the highest maternal mortality statistics globally 353/100000 and is one of the 10 countries that accounted for 59 % of global maternal deaths in 2017 (CSAE, 2017). Improving the maternal health service and increasing the number of deliveries attended by skilled personnel to 80% by 2020 is one of the strategies in the health sector plan of Ethiopia (FDRE, 2017).

The most recent survey finally done on 2016 in Ethiopia, 62% pregnant mothers visited for antenatal care and 28% of births were attended by skilled provider nationally; regional variations were very wide there is a wide gap in skilled birth attendant use between urban and rural areas from 80 % to 21% (CSAE, 2017). The

current annual rate of improvement in skilled birth attendant use nationally is only 0.4% which is the lowest among the six countries with the highest annual number of maternal deaths (Crowes et al., 2015).

Attitudes and behavior of health care workers can affect patient care has long been recognized and also have been given to much attention according to Aubeil, et al., (1999) and also the attitudes and behavior of the mother may be affected by their previous experiences with maternal health care provider's, by social, cultural or ethnic differences, and by personal characteristics such as shyness, level of autonomy, and self-confidence. A good relationship between a patient and health care provider described as one in which there is mutual respect, openness and a balance in their respective roles in decision-making accordingly (Govender & Pena, 2017).

As Kolinsky, et al., (2003) stated significant improvements in maternal and newborn health and survival depend on women being able and willing to access other reproductive health services and giving birth or deliver in health facilities. Some other studies state that financial costs are not the only barrier to women's use of maternal health care, when services are available (Koblinsky & Campbell, 2003).

The health care delivery system characterized, in most developing countries by very poor initiatives and inconsistent policies. As a result the system is poorly developed, implemented and practiced, in which the staff is poorly motivated in public health facilities. Health care providers in public health facilities considered to be unfriendly to the mothers, do not respect them and sometimes exploit them. In addition, they wait for long time to be attended even in labour by providers (Betrand et

al., 2012). While the health care providers in the private health facilities are friendlier and attend to the mothers within shorter periods (Betrand et al., 2012).

In Ethiopia the government expands access to affordable and acceptable facility delivery for all women due to this the public health sector is the main provider of primary health care for mothers for free and serves two thirds of the population who cannot afford private health care. Efforts were made to improve maternal care and attitudes towards public health facilities but evidence is still inadequate on their perspective (Jacove, 2012 & Bohren et al., 2014 & Kumbani et al., 2012).

The main objective of the public health sector as stated in the National health policy is that “Giving comprehensive and integrated primary health care services in a decentralized and equitable fashion” (HSDP, IV, 2010-15).

Federal Ministry of Health Ethiopia(FMOH) has clearly outlined its strategic objective in its health sector development plan IV, creation of a health system that satisfies the community’s health care needs through the fulfillment of the required inputs, delivering safe and optimum quality of health services in an integrated and user-friendly manner (FMOH, 2010). According to the latest information gathered on 2010/11 the total health centers constructed in Ethiopia extended to 2,660 which around 83% of the 3,200 target is set to attain universal primary health coverage (FMOH, 2011). In Addis Ababa the capital city of Ethiopia have 14 government hospitals, 96 health centers, 31 private hospitals, 164 Non-governmental organizations(NGO) and 122 private higher clinics though the private health facilities (hospitals and higher clinics) outnumber the public health facilities only 22.2 % of deliveries take place in the private while 71.4% deliver in public health facilities 3.0%

in NGO's 3.0% still deliver at home 0.4% in other places totally 96.6% of deliveries take place at a facility (EDHS, 2016). Even though the difference in number shows that mother's prefer delivering in public health facilities it doesn't clearly explain improved maternal attitude in relation with the increased number of facility delivery.

According to social psychological scholars attitude is a positive, negative, or mixed evaluation of an object that is expressed at some level of intensity—nothing more, nothing less. *Like, love, dislike, hate, admire, and detest* are the kinds of words that people use to describe their attitudes (Bargh et al., 1996; Cunningham et al., 2003; Duckworth et al., 2002; Ferguson, 2007; Albarracín, Johnson & Zanna, 2005; Crano & Prislin, 2008; Fazio & Petty, 2008).

In the present study maternal attitude referred as expectant maternal affective feeling of like and dislike towards giving birth in the selected health facilities thus the women's personal experience towards giving birth in the selected private and public health facilities can be favorable and unfavorable.

Having favorable attitude towards giving birth in health facilities is the most valuable precondition for any healthy outcome of child and maternal health. Previous studies shows that women have more favourable attitude towards giving birth in private than in public health facilities (Lamina et al., 2006) and (Ekele et al., 2007).

In many ways changing attitudes are the most challenging task but are also the least costly. Proper campaigns and improved dissemination of information are the most beneficiary things to do regarding maternal health (Tigest et al., 2016). A qualitative research conducted by Tigest et al., (2016) explained maternal attitude in relation with their preference of facility. Mothers prefer public health facility because

despite hearing rumors about poor quality and abusive care they didn't experience it themselves, others because service in public health facility is free of payment, others because they experienced that private facility promote cesarean delivery for financial gain, changing attitudes among women on the higher quality of care available in the private facility thus similar service with higher cost, others prefer public health facility because of good ANC service experience and because they have heard government effort to improve the quality of care in public facilities (Tigest et al., 2016).

While mothers prefer to deliver in private health facility secondary to prior rumors of the public health facilities poor quality of care and poor attitudes of health professionals others because service in public health facility is free of payment in which they perceive that they will not get good care, because public health facility have no readily available cesarean delivery service they prefer to deliver in private health facility in order to have elective caesarean delivery (Tigest et al., 2016).

Studies states that availability of working health facility, accessibility of health facility within safe physical reach for all sectors of the population, acceptability of the health facilities by the society and quality of maternal health care service have been found to be the associated contributing factors for changing maternal attitudes (WHO,2010).

Most researches done on attitudes are more concerned on the attitudes of health care providers but published studies on the attitudes of mothers and its effect towards giving birth in health facilities have remained rare. Many of the studies have not linked the attitudes of mothers to their choice of health facilities with the increased maternal morbidity and mortality. None has given information to show if the current

attitudes of mothers towards health facilities are still the same or if there is actual better progressive modification.

As a study on Women's perceptions of antenatal, delivery, and postpartum services in rural Tanzania tells previous research on maternal health in Tanzania has favored the perspectives of service providers. Published studies exploring women's perspective is scarce (Mbekenga et al., 2011).

The study generally considers that it is important to study the maternal attitude towards giving birth in the selected health facilities also if this maternal attitude affect maternal preference of the facility meaning in choosing health facilities, also if it has any relation with the growing number of institutional delivery and also its effect on their preference of place to deliver. Therefore, the research aims to explore maternal attitudes towards giving birth in public as well as in private health facilities by identifying progress and gaps in service provision which may lead to lower quality of service by affecting the attitudes of mothers and its relation with the increased risks associated with maternal morbidity and mortality in Addis Ababa kirkos sub city in a selected health facilities.

1.2. Statement of the Problem

Ethiopia shows a progress in reduction of maternal mortality. Evidence shows that even though, government is putting its effort in improving the quality of care in its public facilities by training birth attendant on basic maternity and obstetric care (BMOC) maternal mortality and poor quality of service utilization is still high (WHO & FMOH, 2016). Quality of care affects choice of mothers to give birth which needs further explanation.

Other researches and studies were more concerned on increased number of deliveries (or birth) in health facilities and more focused to investigate why mothers do not deliver in health facilities as clearly stated in the introduction part, in Addis Ababa the capital city of Ethiopia the private health facilities (hospitals and higher clinics) outnumber the public health facilities but only 22.2% of deliveries take place in the private while 71.4% deliver in public health facilities while, 6.4% deliveries take place at home (EDHS, 2016). In Ethiopia, more than two in three women which are about 70% report having at least one of the specified problems in accessing facility based health care. Among these problems, getting money for advice or treatment was the leading issue 55%, followed by the distance to a health facility 50%, not wanting to go alone 42%, and getting permission to go for treatment 32% (EDHS, 2016). Almost all specified studies don't clearly explain attitude of mothers as the cause for the overseen increment of delivery in facility especially in public health facilities.

Other study aimed at determining the magnitude and factors that affect facility based delivery service utilization among women in rural Ethiopia(Abeba, et

al., 2017) doesn't classify facilities in to public and private health facilities and is more concerned on mothers who live in rural areas in which this present research is going to identify.

Researchers have found that attitudes serve important functions, such as enabling us to judge, quickly and without much thought, whether something we encounter is good or bad, helpful or hurtful, and to be sought or avoided (Maio & Olson, 2000). The disadvantage is that having preexisting attitudes toward persons, objects, and ideas can lead us to become closed-minded, bias the way we interpret new information, and make us more resistant to change (UN, 2015). For this reason even if there is free and well-established access of public facilities maternal preexisting attitudes might tend to suppress their participation and satisfaction. In addition, partners experience and advice might tend to make them feel to choose one other than the other.

The stated reports tell that the causes for maternal deaths were only complications but there are unanswered questions regarding other causes. The attitudes of health professionals were studied and found to be one of the causes for maternal death and delay (Florence et al., 2014). But the attitudes of mothers themselves regarding the health professionals providing the service and the institutions providing the service has not been studied well yet.

Other studies on maternal attitudes concentrates on private health facilities only in other countries of Africa (Betrand, 2012) doesn't compare maternal attitude in both private and public health facilities and more over no published literature was

found regarding maternal attitude in relation with preference of delivery in Addis Ababa kirkos sub city.

Antenatal services can create a chance for women to get information on the status of their pregnancy that in turn alerts them to decide where to deliver. In addition, use of Antenatal care (ANC) may signify the availability of a nearby health care service, which may also provide delivery care a report from developed countries revealed that majority, 97% of the pregnant women receive antenatal care (ANC) service and almost all births 99% use skilled obstetric service during delivery. On the contrary, in low income countries only 52% of pregnant women had four or more ANC visits during their pregnancy and skilled health personnel attended 68% of deliveries (Mpembeni et al., 2007). This might affect the choice of mothers to deliver because decreased performance of ANC intern tends to affect where to deliver. In addition, association of ANC with the changing maternal attitude on both the private and public health facilities not identified, in which this study aims on finding.

Moreover, mothers including those in labor were left to wait for long times before being attended which tend to happen in public facilities (Asuquo, et al., 2000). While the situation happening in mothers using private facilities were not explained well yet while some other public facilities have no much customers but still why most mothers prefer to wait in the corridors of the private facilities instead, were not clearly addressed in other studies.

Maternal attitude can affect mothers themselves by causing to increase or decrease their facility birth (WHO, 2010). If they have unfavorable attitude towards the facilities they may not come to the respective facilities and they also may be exposed to

unexpected health risk and expense. The feared consequence of maternal attitude towards giving birth is that if it is unfavorable. Because if mother who gathered at that respective facility have no favorable attitude towards giving birth in that facility then this may expose her to delay for any maternity service which further increase the risk of developing maternal new complication and further death.

Other mothers who have favorable attitude may develop a sense of mistrust towards the health facilities because others have no favorable attitude. Also the MDG goal of FMOH was that decreasing maternal mortality and this may also contribute to counter influence on the MDG goals.

Maternal Attitude is one of the consequences for nowadays increased maternal health risks (WHO, 2010). Secondary to unfavorable attitude towards giving birth in the health facilities, mothers can be exposed to unnecessary delays and which resulted to maternal complication or death. The present study aims to study if maternal attitude towards giving birth in health facilities have variation whether it is favorable or not and other related attributes that can affect maternal attitudes regarding the respective health facilities.

Generally, the facts and gaps indicated above clearly suggest variation maternal attitude in relation to their choice of health facilities need further studies and researcher fears that the attitude by the mothers side might not be answered what if the cause behind the increasing number of maternal death exist even though the number of facilities increased here something should be done regarding their attitude.

Therefore, the present study attempt to address this felt gap by employing quantitative approach to gather data with the objective of determining factors associated with maternal attitudes in giving birth towards selected health facilities.

1.3. Research Questions

- Do mothers prefer the private or the public health facility for giving birth?
- Do maternal attitude vary as a function of some selected demographic variables such as age of the mother, number of children, level of education and residence?
- Is maternal attitude significantly related to the quality of service provided in private and public health facility?

1.4. The Objective of the Study

1.4.1. General objective. The overall objective of the study is to learn about the attitudes of mothers towards giving birth in the health facilities by adding further knowledge. The main focus is on mothers who visit the health facilities. Identifying, whether their attitudes have any effect in their choice of facility and its variations based on some selected demographic variables and its relation with the service provided and health professionals in the individual selected health facilities.

1.4.2. Specific objective.

- To identify difference of maternal attitude in giving birth in private and public health facilities.

- To identify variation of maternal attitude in some selected demographic variables such as maternal age, number of children, level of education and residence.
- To identify, the relation of maternal attitude with quality of service provided in private and public health facility

1.5. Significance of the Study

The findings of this study can have both theoretical and practical values. Its theoretical significance can be regarding maternal attitudes identifying and clarifying its relation with the service provider's. Its practical value can be by knowing the status of maternal attitude improving maternal health care service further and decreasing maternal death occurring secondary to maternal attitude.

First, since the federal ministry of health (FMOH) targeted in decreasing the maternal death, maternal attitude in relation to the service provided by the public and private health facilities can be the main factor, it is the primary beneficiary from the results of the present study.

Second, the finding of the study benefit the health facilities providing the service by knowing the attitude of the mothers towards them they may undergo improving or sustaining activities regarding the service they must give.

Third, since acquiring information about maternal attitude by the health professionals working in both facilities can support the health professionals in turn to improve their attitudes, health professionals are also the major beneficiaries from the results of the present study.

Finally, the findings of the present study may also benefit other researcher's social psychologists health professionals and policy makers and others by giving primary information regarding any relation of maternal attitude with the increased number of maternal death further since much not studied regarding maternal attitudes towards private and public health facilities.

1.6. Delimitation of the Study

Though Addis Ababa comprised of ten sub cities the present study site is limited to kirkos sub city also there are many types of health facilities the study is limited to one public and one private health facility which provide maternity services.

Even though it tries to reach mothers who come to a private and public health facility, it doesn't include mothers that do not come to the health facilities by the time of data collection and includes mothers who have survived and with better outcome after any maternity care including giving birth.

Similarly, though maternal constrain towards health facilities might be so many but the study is limited to maternal attitudes.

Lastly, though there are a number of demographic, familial, and socio-economic variables, the study only concerned on maternal age, number of children, level of education and residence only considered due to issues of realism and resource limitations.

1.7. Definition of Terms

- **Attitude:** refers to a relatively stable and enduring predisposition of mothers to behave or react in a certain way towards giving birth in the selected health facilities also imply a tendency to classify or categorize with a favorable, negative or both attitude (perception, opinion, feeling, and behavior) learned regarding public and private health facilities.
- **Maternity service:** refers to providing comprehensive sexual and reproductive health service including any obstetric, gynecologic and neonatal service and providing child vaccination.
- **Giving birth (childbirth):** refers the whole process of getting antenatal, parental, labour and delivery and postnatal care in the health facility.
- **Public health facility:** refers to organizations owned and operated by the government.
- **Private health facility:** refers to organizations owned and not part of the government.

Chapter 2: Literature Review

2.1. General Overview of Maternal Health

The WHO (2010) conceptualizes maternal health as the health of women during pregnancy, childbirth or during the postpartum period. Furthermore, maternal health combines the health status of women with the health services adequate to provide the needs of women. Giving birth can bring many risks to a woman's health, including physical, mental and social impacts. If these risks not managed effectively in a timely manner these conditions can create serious health problems for both mother and child, can even result in death.

Maternal health has been becoming a global concern because the lives of millions of women in reproductive age can be saved through maternal health care services. Despite efforts that have been made to strengthen maternal health care services, maternal mortality is still high in most of the developing countries. Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth and 99% of all maternal deaths occur in developing countries (Gyimaha et al., 2006). Though the causes of maternal deaths are numerous and vary from place to place depending on various factors, the major ones are hemorrhage (mainly postpartum hemorrhage), hypertension and sepsis (Say et al., 2011; Ali et al., 2005; Oladapo et al., 2014; Babusha et al., 2014).

The large number of maternal mortality, especially in developing countries has been due to low level of maternal health care seeking behavior. The low

proportion of antenatal care compounded by the extremely low skilled person attended delivery might be some of the major reasons for the high maternal mortality persisting during the last decade (Berhan, 2014).

Some other evidence also shows that in some countries the issue of financial constraints in many households has been largely associated with poor access to maternal healthcare services (Shattuck et al., 2011). Contributing to low levels of improvement in maternal health particularly in developing countries where income of households is largely dependent on the husband (Shattuck et al., 2011) and where maternal health issues are consistently regarded as the responsibility of women rather than a concern for both partners (Mustafa et al., 2008).

Mothers living in developing world face 300 times more risk of death than their counter females living in industrial world Sub-Saharan Africa and south Asia accounts for 86% of these deaths (WHO, 2005; UN, 2008; WHO, 2004). Maternal deaths (mortality) occur predominantly during labour, delivery, or in the immediate postpartum period, often due to anemia, infections, or hypertensive disorders. Roughly half of maternal deaths take place within one day of childbirth (Hogan et al., 2010). Maternal health is a major challenge in most developing countries, including Ethiopia. With a maternal mortality ratio of 673/100,000 and 19,000 maternal deaths annually, Ethiopia is a major contributor to the world-wide death toll of mothers (Koblinsky et al., 2010).

In Ethiopia about 80% of maternal deaths related to direct causes namely Hemorrhage, Obstructed labour, eclampsia and unsafe abortion while 20% related to indirect causes such as anemia, malaria, HIV/AIDS and (cardio vascular disease)

CVD. Between 11 to 17% and 50 to 70% of deaths occur during delivery and postnatal period, respectively of which 45% occur immediately within 24 hours following delivery mainly due to postpartum hemorrhage (WHO, 2004). Most of maternal deaths in Ethiopia also occur among families who have no formal education or poor access to obstetric information. Women who have access to radio or information are more likely use skilled attendants (Nigussie et al., 2004, Islaam et al., 2005 & Samuel et al., 2008).

Most of these deaths are preventable (Jowett, 2000) but prevention hinges on women being able to access antenatal care skilled attendants at birth and immediately after labour. Prevention of maternal death is also related to delivery in a health facility ensuring women are close to emergency services and sufficient skilled care should the need arise (Campbell & Graham, 2006).

Over the years, to scale down the maternal mortality figures a lot of energy and initiatives applied which have minimal or no effects. Currently, the presence of Basic maternal and obstetric care (BMOC) and the skilled birth attendant (defined by the World Health Organization (WHO) as 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 post-partum period, and in the identification, management and referral of complications in women and newborns are the two most important evidence based interventions at reducing maternal mortality ratio within the developing countries including Ethiopia (WHO, 2005 & Koblinsky, 2003).

2.2. Associated Factors Affecting Maternal Attitude

Barriers for access to maternal care in Ethiopia even though the improvement made in terms of reducing (maternal mortality rate) MMR, serious challenges remain. There are substantial backlogs in the infrastructure; an over increasing demand for more health goods and services, including those of socially and geographically mobile communities; and acute concerns about quality, which in turn are the byproduct of the inadequacy or lack of implementation of laws and policies.

Availability of a working public health system and healthcare facilities, goods and services, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical staff and essential drugs (ESCR General Comment 14, 2000). However, Ethiopia is lacking in the provision of most of these elements. The WHO identifies Ethiopia as among the 57 countries in the world facing a critical shortage in its health workforce (WHO, 2015). In addition, there is low availability of medicines due to the fact that the medicine supply system is unreliable and having long procurement procedures. Essential medicines are only available to 52% of the hospitals in the public sector and 88% in the private sector (WHO, 2015). Despite large improvements in recent years, access to and use of primary health services remain limited in the country. According to the 2011 welfare monitoring survey (CSA & ICF, 2017), 64.7% of households are within less than five kilometers of the nearest health post, 40.1% are within five kilometers of a health center, and 14.2 % are within five kilometers of a hospital (Workie & Ramana, 2013). There is also a significant urban-rural disparity in the distribution of

health facilities. For instance, in urban areas, health service providers, that is health posts, health centers, and hospitals, are available within less than five kilometers for about 88.2%, 87.7%, and 49.4% of the households, respectively (Workie & Ramana, 2013). In addition, there is limited access to well-equipped health facilities and obstetric care in Ethiopia (IMC, 2016). Especially in the rural areas, the problem is severe, as much research conducted in these areas has revealed. In these areas, there is not enough ambulance (Thirdeyemom, 2014). An assessment of the quality of health care in the Jimma Zone, South West Ethiopia, shows that the human aspect of care is 'poor', and that the health institutions are facing shortages of human and material resources (Beyene et al., 2011).

Accessibility Human rights norms require that health facilities, goods and services must be within safe physical reach for all sections of the population, economically affordable for all, accessible without discrimination and especially to the most vulnerable or marginalized sections of the population (ESCR General Comment 14, 2000). Although the Ethiopian government provides public health services to the uninsured through the different public health institutions, many poor Ethiopians turn to private health services (Nair et al., 2010). As the cost of private health care is high, this impedes poor families' ability to pay for other necessary health goods or it means families are forced to go without health care altogether. Consequently, women are at greatest risk in the hours during and following childbirth. Limitations on access to maternal and child health care contribute to high maternal and infant death rates (Nair et al., 2010). Furthermore, the disease burden is still high and the service utilization rate remains low in the country, partly due to the burden of high out-of-pocket

spending that restricts an already poor society from health-care utilization (WHO, 2015). A recent survey indicates that inaccessibility of transport, long distances from functioning health-care facilities, and the lack of confidence in the services provided are some of the barriers impeding access to maternal health care (Berhan & Berhan, 2014).

Similarly, the 2011 EDHS study shows that the major barriers for pregnant women to access health-care services are lack of transport to a facility 71%, lack of money 68%, and distance to a health-care facility 66%, (CSA & ICF, 2017). Among the various reasons, the most important ones were the limited number of health facilities and medical personnel in the rural areas; and the fact that the few government and private hospitals available were constructed around the big towns while more than 85% of the population lives in the rural areas. The problem is worse in the rural parts and there is regional variation in terms of women's access to health care (CSA & ICF, 2017).

Acceptability An important dimension of access to health care is its acceptability in society. More specifically, acceptance of antenatal care (ANC) and postnatal care (PNC) services significantly affects trends of mortality in a given population (Regassa, 2011). The content of services received and the kinds of information given to women during their ANC visits are essential components of quality care. Some evidences tell that quality of antenatal care (ANC) is dependent on the qualifications of health professionals and the number and frequency of ANC visits. These services raise awareness of the danger signs during the pregnancy, delivery, and postnatal period, improve the health-seeking behavior of women, orient them to birth

preparedness issues, assist women where to deliver and provide basic preventive and therapeutic care (WHO, 2010).

The World Health Organization WHO (2010) recommends that a woman without complications should have at least four antenatal visits, the first of which should take place during the first trimester. In the world urban women are more likely than rural women to have made four or more visits (66 percent versus 27 percent). About one in every four (24 percent) women reported that they were informed of signs of pregnancy complications during their ANC visit. Women are more likely to be informed of signs of pregnancy complications while pregnant with their first birth compared with pregnancies of birth order six or higher. Urban women (42 percent) are more than twice as likely as rural women 20 percent to be informed of signs of pregnancy complications (WHO, 2010).

About four in every ten Ethiopian women 41 percent did not receive any antenatal care for their last birth in the five years. This represents a marked decline from fifteen years ago when almost three in four (73 percent) pregnant women did not receive any antenatal care. Urban women are more than twice as likely as rural women to receive ANC from a skilled provider. Eighty percent of women located in urban areas received ANC services from a skilled provider for their last birth compared with 35 percent of women in rural areas. 25 percent, urban women are eight times more likely, than rural women, at three percent, to receive antenatal care from a doctor. Conversely, 20 percent of rural women received antenatal care compared with two percent of urban woman. Antenatal care from a skilled provider ranges from a low of 19 percent in the Somali region to a high of 94 percent in Addis Ababa (WHO, 2010).

A large proportion of maternal and neonatal deaths occur during the 48 hours after delivery, and these first two days following delivery are critical for monitoring complications arising from the delivery which is also referred to as Postnatal care (PND). The level of postnatal care (PND) coverage is extremely low in Ethiopia. Only 13 percent of women received postnatal care within two days, as recommended. The great majority of women (82 percent) with a live birth in the preceding five years did not receive a postnatal checkup at all (mini DHS, 2014).

For this reason, an important component of efforts to reduce health risks of mothers is increasing the proportion of babies that are delivered in health facilities. Nevertheless, under-utilization of modern health-care services for various reasons is one of the major challenges for poor health in developing countries. A recent study indicates that in Ethiopia close to 90% of birth deliveries occur outside of a health service facility: 45% because mothers did not think it was necessary and 33% because mothers stated that it was not customary (CSA, 2014).

The acceptance of the delivery of health services has a correlation with the socio- cultural situation of a country. Since Ethiopia is a populous nation constituting several ethnic groups, giving attention to the many cultural preferences of its people is a key to delivering the highest quality of care (The Borgen Project, 2014). It has been observed that the birthing position used at the health centers (which made the women feel uneasy) was one of the reasons for Ethiopian women choosing to deliver at home rather than at a local health center (The Borgen Project, 2014). The incidence is indicative of the fact that, when government attempts to expand the health facilities, it will be equally crucial to train health professionals to understand and respect the

culture of the local community to avoid maternal and child mortality as a result of birth complications.

Quality the final element required, according to the world health organization, “quality health care is defined as that care which consists of the proper performance according to standards” (Roemer, et al., 1988). Therefore, maternal health care service quality is the application of those necessary multi-sectorial services required to ensure a state of physical, mental, social and perhaps spiritual well-being of mothers in the community and their offspring’s (Lane & kelman, 1975). This includes services required to minimize the noxious consequences of preexisting or concurrent health hazards or conditions and upgrading the health and social functioning of those women who require (Lane & kelman, 1975). Also it includes that ‘health facilities, goods and services must also be scientifically and medically appropriate and of good quality’ (ESCR General Comment 14, 2000) Quality of care is an important determinant of health outcome (Cohen JR, 2005).

As postulated by Donabedian (1988), quality of care has been assessed in three general domains: Structure, process and outcome. Outcome assessment concerns the results of care on the health status of clients, including challenges in client knowledge, perception and behavior, attitude, client satisfaction with health care, biologic changes in disease, complications of treatments, morbidity and mortality. Despite this, the country’s quality of health goods and services, for instance related to maternity and new-born care services is low. Various factors contribute to the low quality of services, especially to the lower segment of the population in the country. Delay in providing treatment is usually the major reason for the poor quality of service

(Berhan & Berhan, 2014). In any country, a health service are conducted by a team involving staff with different backgrounds, such as administrative and support, clinical, laboratory, imaging and pharmacy. The reasons for the delay in giving treatment as early as possible may therefore be multi-factorial.

In the context of Ethiopia the following are identified as the main causes for delay in treatment. First, the number of well-trained health professionals is insufficient and this accounts for the biggest delay in providing medical care for those who have access to a health facility (Berhan & Berhan, 2014). It is common to see only one or two midwives, one to three general practitioners, and rarely one gynecologist in hospitals in public health facilities Understaffing in these hospitals often leaves health professionals under work pressure which is likely to result in burnout. Second, the few available health professionals often exhibit poor knowledge and skill. This is associated with poor evaluation and a lack of diagnostic skill or a lack of qualified health professionals which results in incorrect diagnosis, leading to delays in getting timely treatment in public health facilities (ESCR General Comment 14, 2000). In some instances it can lead to the death of mothers. In connection with the skill of health professionals, an assessment made of ten public health facilities and nine private health facilities in Ethiopia reveals that only about 40% of the health service providers knew how to prevent, identify, and manage common maternal and peri-natal complications like obstructed labour, preeclampsia/eclampsia, postpartum haemorrhage, maternal sepsis, neonatal sepsis, and new-born resuscitation (Berhan & Berhan, 2014). Third, non-functioning health facilities due to a lack of essential medical goods in laboratories pharmacies, imaging facilities, delivery suites, and

operating theatres further lowers the quality of treatment. Fourth, poor leadership in public hospital settings, uncooperative behavior of patients or relatives who refuse medication, procedures, blood donation or blood transfusion, and the inability of patients or relatives to afford health service costs are further factors that lead to delays in the timely provision of treatment for pregnant women (Berhan & Berhan, 2014). Finally, expansion in infrastructure networks has not matched the necessary quality requirements.

The government celebrates progress on the reduction of maternal and child mortality rates mainly because of its political commitment to train and deploy the (health extension workers) HEWs. In fact, these community health workers have widely been engaged to provide care for a broad range of maternal and child health issues. Nevertheless, the HEWs have not received sufficient practical training and lack skills in assisted delivery. HEWs are found to be weak in health facility deliveries, skilled birth attendance, and on time referral through early identification of danger signs. In a recent study, more than half 54% of HEWs had poor knowledge about the contents of prenatal care counseling, and the majority 88% had poor knowledge about danger symptoms, danger signs, and complications in pregnancy (Medhanyie et al., 2012).

Research showed that women's satisfaction with childbirth, partly related to the health of the mother and the baby. Fulfillment and discrepancy theories are the major theories of satisfaction described in literature. Fulfillment theories states that person's experience determines satisfaction whereas discrepancy theories argue that

satisfaction is determined by the difference between the person's expectation and what have actually happened (Sawyer et al., 2013).

The intervention motivated from caring is the influence of judgment, decision making, and action. Brody (1988) has stated it is not just the competent performance of technical skills that evokes the image of caring, but the compassionate attitudes and feeling of the nurses toward the patient as they perform their tasks that is the essence of caring.

As mentioned earlier in the introduction part social psychological books define attitude as a positive, negative, or mixed evaluation of an object that is expressed at some level of intensity—nothing more, nothing less. *Like, love, dislike, hate, admire, and detest* are the kinds of words that people use to describe their attitudes. Everyone routinely forms positive and/or negative evaluations of the people, places, objects, and ideas they encounter. This process is often immediate and automatic much like reflex action (Bargh et al., 1996; Cunningham et al., 2003; Duckworth et al., 2002; Ferguson, 2007) self-esteem is an attitude we hold about ourselves, that attraction is a positive attitude toward another person, and that prejudice is a negative attitude often directed against certain groups. Indeed, the study of attitudes—what they are, where they come from, how they can be measured, what causes them to change, and how they interact with behavior—is central to the whole field of social psychology (Albarracín, Johnson & Zanna, 2005; Crano & Prislin, 2008; Fazio & Petty, 2008).

A study in Ogbomoso, South-West, Nigeria on Perception of pregnant women towards midwives: attitude and practice during child delivery in health

institutions showed that there is significant influence of attitude and practice of midwives towards the perception of pregnant women during delivery. This signified that the attitude and practice of midwives gave a positive attitudinal change on the pregnant women's perception, which correlates with the concept of fulfillment and discrepancy theory (Florence et al., 2014).

Other social psychological books state that, attitudes can be formed because of, experiences that have been simply learned, or alternatively as a result of information/thought process (Carl, 2006).

Evidence suggests that the impact on care seeking behavior for reproductive and maternal health services reveal a range of context-specific influences including cost, distance, mother's education, cultural beliefs, and lack of autonomy of women. And that it is striking that most studies also mention poor attitudes and behavior of maternal health care providers (MHCPs) and observations of this as significant barriers. The study also states that in a qualitative study of maternal and newborn health care seeking practices in Bangladesh, Nepal and Pakistan only mention 'staff attitudes' as a barrier to seeking ANC (Anti natal care) in Pakistan. In their systematic review of evidence in relation to access to and use of health services for the poor in Uganda, Kiwanuka, also identified health worker attitudes as a significant barrier to use of health care services."100A" mixed methods study of maternal health care seeking behavior in a rural community in Edo State, Nigeria in 2004, also found that irregular availability of health care providers and their poor interpersonal relationships were a factor influencing pregnant women in choosing where they would deliver (Osubor et al., 2006).

The Human Rights Watch study in South Africa was another that reported that women's experiences influence them to avoid delivery care, illustrated by one woman who had given birth in a large hospital in 2009: *"The nurses were shouting and pinching us on the thighs telling us to open up. After delivery, I was feeling very weak but the nurse told me to leave the bed [and to] carry the child to another ward. She was very rude and said I was lazy. After this experience I told myself I will never again go to government hospitals. If I have no money to go to a private hospital, I will deliver at home"* (HRW, 2011).

Sometimes women's will seek health care, but concerns about poor attitudes and behavior by health staff result in them by-passing their nearest health facility to attend a government or mission hospital. Such bypassing is costly, time consuming and inefficient both for the women and their families, and for the health system (Kruk et al., 2009).

In a quantitative, questionnaire survey in rural Tanzania more than 40% of poor women who chose to deliver in a health facility preferred to travel to a government hospital or mission facility to deliver rather than deliver at their nearest primary care facility, and one of the reasons given was greater trust in the Maternal health care providers (MHCP) at the distant facility.

In the Ghana study of mothers' perceptions, women expressed their wish to be treated with patience, encouragement and tolerance (David et al., 2005). They also said that they would seek alternative care if they experienced poor treatment, and recommend facilities when they receive good treatment:

“I wanted to deliver in (health facility C) but while attending antenatal clinic, a nurse was rude to me, so I changed my mind and delivered in another facility.” and “Compared with my previous delivery attendant this one was very good, polite, patient and reassuring. Therefore, I will recommend her” (David et al., 2005).

Positive experiences and formed positive attitudes can have a greater impact on a woman’s decision to return to a facility than negative ones: *“I will go there again because even though one of the nurses was unfriendly and impatient, the other was very accommodating and I pray I will meet someone like her anytime I have to go there”*[Mother, Ghana] (David et al., 2005).

Another study on Women’s perceptions of antenatal, delivery, and postpartum services in rural Tanzania tells that previous research on maternal health in Tanzania has favored the perspectives of service providers (Mbekenga et al., 2011). Published studies exploring women’s perspectives on maternal health care services remain scarce.

In Ethiopia, qualitative gender assessment that included respectful maternity care as a component were conducted by Maryce Ramsey, Intra Health International in six urban and peri-urban health centers of Oromiya and Amhara region in 2012. Study revealed that most health care providers insulted the women in labor. Some women also reported that health care providers were not friendly and mistreat mothers who went to health facilities to deliver. Women who delivered at health center disclosed that health workers uses rough words, insults and shows no respect to them and for those who accompanies them. In addition, the women revealed that they were told to wait, for long hours, and referred without receiving any support from the health

workers. The findings also revealed that all staffs of the facility abuses the pregnant women in addition to health care providers. In general, the report has revealed that there are problems of disrespect and abuse in health facilities that discourage mothers to deliver at public health facilities (Ramsey, 2012).

Another study by Mekonin (2013) at a university teaching hospital and selected three catchment public health centers in Addis Ababa in August 2013 interviewed 173 mothers who delivered in facilities and 57 health providers using a 24 item questionnaire grouped in seven dimensions of disrespect and abuse. The study uncovered that disrespect and abuse was identified to be practiced in 96.5% of the deliveries surveyed (92.9% in health centers and 100% in SPHMMC). From the seven categories of disrespect and abuse, “failure to maintain women’s right to information, informed consent, and choice/preferences”; all forming a single indicator was the common problem reported by 95.4% of clients followed by leaving mothers without attention 39.3% (Mekonin, 2013).

The study also, showed that there was normalization of disrespect & abuse that showed only 12.7% of mothers reported disrespected and abused during childbirth. Mothers who delivered at public hospitals were more likely left without attention and their confidentiality and privacy not maintained, 72 percent of providers also reported practice of disrespecting mothers based on any specific attribute (such as by HIV status or ethnic group) in the three months preceding the survey. Furthermore, 79.6 % of providers believe that lack of respectful care is a factor, which discourages pregnant women from coming to health facilities for delivery (Mekonin, 2013).

Another study conducted in northern Ethiopia on Distance from health facility and mothers' perception of quality related to skilled delivery service utilization in The impact on mothers' factors on skilled delivery utilization has been studied by many scholars, (CSA, 2005) but has not been comprehensively assessed in Ethiopia (Bayu et al., 2015, Tefera et al., 2012, Worku et al,2013) many of the studies have not linked the attitudes of mothers to quality delivery service and skilled delivery use.

2.3. Factors Affecting Mothers to Choose the Health Facilities

Several studies have indicated that institutional delivery has potential to prevent or cope with complications that arise during childbirth. However, most of mothers prefer to deliver at home and institutional deliveries remain below the potential use. Availability and access of the service, maternal or partner education, income status, maternal age are among the major factors affecting general health facility delivery utilization (Anuja, et al., 2008; Nigussie, et al 2004; Amardeep & Kabir 2004). Mothers who live in rural or poor access areas to health facility, most likely give birth at home (Leda F. & Nazim N.H. 2009).

Study conducted in Indonesia shows mothers who have primary or further educational level tend to use institutional delivery more. Also this shows 59% lower odds of facility delivery utilization among women residing in rural area than urban (Amardeep & Kabir, 2004). Similar study conducted in Bangladesh has shown mothers with secondary and higher education four to nine times more likely to use professional assisted delivery when compared without completing education (Ahmed et al., 2010). Further another study from the same area has indicated the likely hood of

lower utilization of institutional delivery among non-educated OR=0.24 and 0.40 among elementary mothers when compared with at least secondary education level. Furthermore this study has shown, as upper age mother's more likely to receive modern health care delivery than lower age groups (Mustefazun & Rahman, 2009).

Another cross sectional study conducted in Rural Bangladesh to assess knowledge, attitude and practice regarding hospital delivery revealed 97% consider pregnancy as period of risk and 80.6% mentioned home delivery as risk however only 7.1% knew delivery danger signs. Though 85.5% showed positive attitude to facility delivery but only 33.2% gave birth at health facilities (Nawazia et al., 2009).

In Indonesia, religion is another factor that affects institutional delivery service utilization. Non-Muslims had 92% lesser utilization of skilled attended delivery (Amardeep & Kabir, 2004). Study in Ghana shows 5.439 more likely utilization of facility delivery among Muslims (Samuel et al., 2008). Nevertheless, in Nigeria Christian uses more than Muslims and local traditional belief followers (Asres A, 2008). In Ethiopia Orthodox/Catholic, Muslim, and Protestant women exhibit greater use of maternal health care services than women who follow traditional beliefs (Mekonin.Y & Mekonin.A, 2002).

A study conducted in Ethiopia in 2016GC shows that women status affects freedom to make choice of place of delivery and positive health outcomes. Empowered women by education during antenatal care (ANC) and postnatal care (PNC) service more likely choose where to give birth. The study has shown only 15% of mothers make their own choice of facility while one third reported such decisions made by their husband alone (EDHS, 2016).

Maternal attitude and knowledge is another factor that affects choice of place of delivery. Women may not access delivery care or delay in reaching the care due to their prior experience of quality in delivery care, or their perceptions of the experience that stems from cultural inappropriateness of care, disrespectful and inhumane services, lack of emotional support, as well as high costs (Ronsmans, 2001).

In a study conducted in Nigeria even, when women booked for, and received antenatal care (ANC) in public hospitals, a substantial number of still deliver in private hospitals (Lamina et al., 2006) and (Ekele et al., 2007). In another study to evaluate the provision of essential obstetric services in Anambra State in Nigeria it was found that deliveries in the private facility accounted for 79% of all deliveries and a similar study in Lagos involving 3296 mothers, reported 1659 (50.3%) deliveries in private facilities, while 1637 (49.7%) were in public facilities. The study clearly recommends that it is necessary to critically review the reasons why the women preferred the private hospitals for antenatal care and delivery and public-private partnership, intimately involving the private facilities, is necessary in the reduction of maternal mortality ratio in this part of the country. As revealed in the same study, topmost among these reasons was the unfriendly attitude of the health workers at the public hospitals and concluded that women in Nnewi Nigeria prefer private hospital to public health facility for any maternal care including delivery.

In Ethiopia, delivery care utilization is 52 % among Educated and 2% in uneducated mothers, which is 4.5 to eight time more utilization among primary and secondary level educated mothers (CSA, 2005; Mekonin Y & Mekonin A, 2002). According to study based on analysis of EDHS 2000, delivery care utilization ranges

71% in Addis Ababa, to 31% in other urban areas. Mothers living in Addis Ababa, likely to use institutional delivery 40 times more than those living in rural and four times than other urban areas(CSA, 2005; Mekonin.Y & Mekonin A, 2002). Another study conducted in Bench woreda shows 48.8% of urban and 18.5% of rural mothers gave birth at health institutions (Gemed, 2008). Another Study conducted in Becho woreda showed 2.7 times likelihood of facility delivery utilization among mothers that have secondary education level (Gemed, 2008).

In Ethiopia, more than two in three women 70% report having problems in accessing facility based health care among these problems accessing facility-based health care and getting money for advice or treatment account 55%, followed by the distance to a health facility 50%, not wanting to go alone 42%, and getting permission to go for treatment 32% (EDHS, 2016).

2.4. Mothers Attitude in Giving Birth in Private and in Public Health Facility

In these case the application of the theories of habitus will support the premises, the French sociologist Pierre Bourdieu (Bourdieu, 1977) presents habitus as a conceptual frame work in which there are varying degree of explicitness of and competition among norms, he stated that under this frame work there are three ways that people experience the norms of their social existence they do so through a set of materially predisposed practices that expose a belief about the way the world works and that reproduce that world view, contrasting ,heterodoxy situation of more or less equally competing possibilities. Habitus can be shared by people with similar background, education, profession etc. As Borden suggested habitus is the end product

of structures which practices tend to reproduce in such a way that the individual involved are bound to reproduce them either by consciously reinventing or by subconsciously imitating already proven strategy as the accepted. Which allow individuals to find new solutions to new situations without calculated deliberation based on their gut feelings and intuitions? Thus in which attitudes, habits and moral intuition's have influence on the individual's choices and chances and the following study will try to examine the relation and effect of attitude on individual mother's choice of place of delivery (Bourdien, 1977).

Hence the choice of place of delivery for pregnant woman is an important aspect of maternal health care. The public health sector is the main provider of primary health care and serves two-thirds of the world population who cannot afford private healthcare (Jacob et al., 2012). The place of delivery is an important factor often related to the quality of care received by the mother and infant for influencing maternal and child healthcare outcomes (Murthy et al., 2012).

A cross sectional study conducted in Rural Bangladesh in 2009GC to assess knowledge, attitude and practice regarding hospital delivery though 85.5% showed positive attitude to facility delivery but only 33.2% give birth at health facilities of which 8.3% give birth in private shows less attitude progress while and 24.9% give birth in public health facility shows high attitude progress and concluded that maternal attitude differs by the place of delivery (Nawazia, 2009).

A case study conducted in Sudan indicate that financially poor women rely more on public or governmental health services than on private health care facilities (Ahmed, 2007). Private facilities are not affordable to the poor although the quality of

services is still questionable (Richard, 2010). In Addis Ababa Women in the low wealth quintile households were less likely to deliver at private healthcare facilities compared to those in the rich wealth quintile households compared to women of better living conditions (Yibeltal et al., 2015).

In Ethiopia fifteen percent of mothers deliver in a public facility and one percent in a private facility. Even though the percentage of public health facility births are high the total health facility births continues to be low in Ethiopia, there has been remarkable progress in the last fifteen years (WHO, 2010).

As Yibelta et al., (2015) stated that women's attitude varies in giving birth in private and public facility, the reasons behind women's preference for their places of delivery in Ethiopia Addis Ababa for public health facility is attributed to short distance, perceived low cost service, and experienced low cost service. On the other hand, preference for private health care facilities associated positively with short waiting time, perceived good quality of service, experienced good quality of service, of service provider. There was no statistically significant influence of families, friends, or husbands on women's preference for places to give birth (Yibeltal et al., 2015).

The reasons behind women's preference further elaborated by Yibeltal et al., (2015), attributed to short distance (72.7% versus 36.4%; $P = 0.000$), perceived low cost service (6.1% versus 2.4%; $P = 0.037$), and experienced low cost service (16.7% versus 4.3%; $P = 0.000$).

On the other hand, preference for private health care facilities associated positively with short waiting time(19.1%versus8.7%; $P = 0.000$),perceived good quality of service (15.2% versus 7.6%; $P = 0.001$), experienced good quality of

service(43.1% versus 20.6%; $P = 0.000$), perceived good approach of service provider (10.0% versus 5.7%; $P = 0.034$), and experienced good approach of service provider (22.9% versus 10.5%; $P = 0.000$). There was no statistically significant influence of families, friends, or husbands on women's preference for places to give birth ($P > 0.05$) and finally Yibeltal concluded that maternal attitudes varies in giving birth in private and public health facilities as a result of the above associated factors.

Another qualitative research conducted in Addis Ababa, Ethiopia explained maternal attitude in relation with their preference of facility. Mothers prefer public health facility because despite hearing rumors about poor quality and abusive care they didn't experience it themselves, others because service in public health facility is free of payment, others because they experienced that private facility promote cesarean delivery for financial gain, changing attitudes among women on the higher quality of care available in the private facility thus similar service with higher cost, others prefer public health facility because of good ANC service experience and because they have heard government effort to improve the quality of care in public facilities (Tigest et al., 2016).

According to the above research mothers prefer to deliver in private health facility secondary to prior rumors of the public health facilities poor quality of care and poor attitudes of health professionals others because service in public health facility is free of payment in which they perceive that they will not get good care, because public health facility have no readily available cesarean delivery service they prefer to deliver in private health facility in order to have elective caesarean delivery (Tigest et al., 2016).

A study from Entebbe, Uganda, which showed that mother with two or less living children were more likely to attend Public facilities than private. A study conducted in India shows mothers with birth order less than two 1.6 times more likely use public facility for delivery which claimed that maternal attitude varies as a result of number in children (Cjtann et al., 2007).

In Ethiopia Addis Ababa women attitude also can be affected by number of children thus a women with two or less living children are more likely to deliver at public healthcare facilities than at private compared to those with three or more living children. It is possible that women with three or more living children claim to be experienced and seen reason to deliver at health facilities. Alternatively, negative previous experiences may deter women from delivering at health facilities there by exposing themselves to the complications of child birth (Yibeltal et al., 2015).

A study conducted in Bangladesh indicated that maternal attitude can also be affected as a result of age and states that as upper age mother's more likely to receive modern health care delivery than lower age groups and upper age groups have highly motivated attitude to give birth in private than lower age groups (Mustefazun & Rahman, 2009). A study from Entebbe, Uganda, which showed that mother likewise mothers of age greater than 30 years and 20 to 30 years, 61% and 63 % more likely use public facility respectively for delivery compared with age less than 20 years who likely use private facility (Amardeep et al., 2017).

Empowered women by education during ANC and PNC service more likely choose where to give birth. The study has shown only 15% of mothers make their own

choice of facility while one third reported such decisions made by their husband alone (EDHS, 2016).

Related studies show that maternal attitude significantly varies by the level of education well-educated mothers are more likely to go to private hospitals seeking for maternal health care (Cjtann et al., 2007). In Addis Ababa, if they use health facilities, those with no formal education and those with primary level of education were 82% and 67% less likely to use private healthcare facilities, respectively. The findings point to the power of education in empowering women to seek maternal care and high socioeconomic opportunities both of which reduce the risks of child births in areas lacking professional care.

Another related Studies have shown strong correlation of maternal or partners' education status with the choice of place of delivery 80% of mothers who are educated prefer to give birth in private health facility while 95% mothers who are not educated prefer to give birth in public health facilities the same applies to mothers who have educated husband (Anuja et al., 2008; Nigussie et al., 2004; Amardeep & Kabir, 2004).

Residence is another factor affecting maternal attitude studies explains that since there is a significant urban-rural disparity in the distribution of health facilities. For instance, in urban areas, health service providers, that is health posts, health centers, and hospitals, are available within less than five kilometers for about 88.2%, 87.7%, and 49.4% of the households, respectively (Workie & Ramana, 2013). In addition, there is limited access to well-equipped health facilities and obstetric care in rural Ethiopia which affects the attitude of mothers (IMC, 2016).

Mothers living in Addis Ababa, likely to use institutional delivery 40 times more than those living in rural and four times than other urban areas (CSA, 2005; Mekonin.Y & Mekonin A, 2002). Another study conducted in Bench woreda shows 48.8% of urban and 18.5% of rural mothers gave birth at health institutions and according to the study residence can also be a cause in variation of maternal attitude (Gemed, 2008).

Study conducted in Indonesia shows 59% lower odds of facility delivery utilization among women residing in rural area than urban (Amardeep & Kabir, 2004) and the study further explains mothers who live in rural or poor access areas to health facility, most likely give birth at home which tells maternal attitude varies in relation to residence (Leda F. & Nazim N.H. 2009).

Finally quality of service is associated with maternal attitude according to a research conducted in Nigeria on 280 women maternal attitude is found to be significantly associated with quality of service and level of satisfaction at ($p < 0.05$) (Nnebue, et al 2006).

Unfortunately, during the literature review, sufficient study could not be obtained that has been conducted in Addis Ababa, which aims to study one of the contributing factor which is maternal attitudes in choosing public and private health facilities. Some study general utilization of facilities some other of the literatures studies perception and attitude interchangeably and others study other maternal factors in which the following research will try to provide basic information on the effect of maternal attitudes towards giving birth in private or public health care facilities and tries to examine the possible constraints.

Because of the above reasons, researcher believes that this study will be the first and unique analyzing maternal attitudes towards giving birth in private and public health facilities in Kirkos sub-city, Addis Ababa, Ethiopia in selected one private and one public health facilities.

Chapter 3: Methodology

3.1. Research Design

In the current study, quantitative non experimental research design was used in the present study. Non-experimental designs are ones in which the researcher gathers data without making any active intervention. This design primarily selected for it allows broad heading of descriptive research. The major purpose of descriptive research is description of the state of affairs as it exists at present using a data collected by questionnaire (Kothari, 2004). This type of research method supports the current study in identifying describing and expressing the characteristics of an observed phenomenon in terms of quantity.

3.2. Participants

3.2.1. Study Site Description. According to the 2016 Population and Housing Survey Report (CSA, 2016), Addis Ababa- the capital city of Ethiopia, with land area of 527 km² populated with 3,384,569 of whom 1,433,730 (52.4%) are females. The city has 14 public hospitals, 96 health centers, 31 private hospitals 164 non-profit organizations and 122 private higher clinics. The area in which the study was conducted, in Kirkos sub city is one of the ten sub-cities found in Addis Ababa have eight woreda's and located in land area of 14.62km².

According to the sub-city health service office it is populated with 283,733 people there are 136,192 male and 147,541.7 female, out of the total population using a convolution factor there are 98,285 women in reproductive age (15-49) years.

In kirkos sub city there are 2 public hospitals and 8 public health centers, 3 private higher hospitals, 19 private clinics, 40 private specialty clinics 15 medium private clinics and 29 non-governmental organizations (NGO's) are available according to the data obtained from health regulatory office of the sub-city in 2018GC.

The selected health facilities were Efoyita Health Center kirkos sub city woreda 02 and Marie Stops International Ethiopia private clinic kirkos sub city woreda 02 wollo sefer purposively because they have large population size with more exposure to maternal service compared to the other health facilities and the mothers who use this facilities varies economically and with level of education.

3.2.2. Target population. The target population of the study was women of child bearing age group thus (15-49) that were having any maternity services and visiting the selected health facilities. The study was conducted in kirkos sub city. The research is focused on Addis Ababa kirkos sub city because since Addis Ababa is the capital of Ethiopia a variety of people can easily participate and kirkos sub city were chosen because it have large population size with more exposure to modernity, urbanization and industrialization compared to other sub cities many and formerly well-known health facilities are also available and it is the center of the capital and amongst the eight woredas in that sub city woreda two were selected by using simple random sampling addressing all of the woredas in a single research seem to be impractical due to scarcity of resources. In the woreda there are nine health facilities and only this two health facilities give maternity service in that woreda. The health facilities were selected purposively to exemplify private and public health facilities

because women with a variety of back ground age group residence level of education number of children comes to the health facilities for any maternity service.

3.3. Sample and Sample Size Determination

According to the sub-city health service office the sub city is populated with 283,733 people there are 136,192 male and 147,541.7 female, out of the total population using a convolution factor there are 98,285 women in reproductive age (15-49) years.

As stated by Neuman (2011), if the study population is 1000 or under, the sample ratio needs to be 300 (about 30%) individuals, for a population of 10,000 the sample size would be 1000 (about 10%); and for populations over 150,000, smaller sampling ratios (1%) are acceptable. According to Krejcie and Morgan (2013) ‘as the population increases the sample size increases at a weaker rate and remains constant at slightly more than 380 cases and based on the assumption that large samples tend to just add costs to the study with little return for the effort, the sample size was determined by using the assumption of Krejcie and Morgan (2013) table which tend to be 0.5%. Accordingly, out of 98,285 populations of the sampling frame, 0.5% (approximately 500) of the childbearing mothers was selected as representative participants of the study.

The number of participants in the current study was found to be 500 in which, 250 were from Efoyita health center and 250 were from Marie Stops International Ethiopia private clinic. In the current study both probability sampling which is simple random sampling and non-probability sampling which is a purposive technique was

used. Even though, Neuman (2011) pointed out that random sampling method is the common for the quantitative research. Purposively the two health facilities selected and using simple random sampling one woreda was selected and mothers of child bearing age group who came for any maternity care who were available by the time of data collection were used for the study.

3.3.1. Inclusion criteria. Participants of the study was selected using the criteria those women who are in childbearing age group thus 15-49 and who came for any maternity services in the selected health facility during the data collection who are volunteer to fill the questionnaire.

3.3.2. Exclusion criteria. Women who are mentally and/or physically incapable to correctly fill the questionnaire and not volunteer to participate were excluded.

3.4. Measures

3.4.1. Questionnaire scales. Data for the study was collected through structured Likert scale questionnaire. The questionnaire is reformed from standardized instrument caring behavior inventory (CBI).

Content of the questionnaire divided in to three parts, and adapted according to the local context and objectives of the study .The demographics consisted of 13 items over all maternal attitude towards the selected facility measuring scale consisting of 30 items and over all opinion measuring scale consisting of 3 items in which the reliability in terms of cronbachs alpha coefficient was calculated to be .98. Women responded to each item on a scale ranging from 1 (strongly disagree) to 5 (strongly agree). At the same

time, a high score for each item indicated that women has highly favorable attitude to that particular health facility.

3.5. Procedures

3.5.1. Instrument Validation Procedure. The content validity ratio (CVR) that involves estimating the statistical validity ratio as introduced by Lawshe (1975) was employed previously for the Caring behavior inventory (CBI) and the items content validity ratio with a panelist of five minimum acceptable contain validity ratio (CVR) proved to be closer to 0.99 at statistical significance level of 0.05. As a result 3 items from maternal attitude measuring scales were deleted with content validity ratio (CVR) values lesser than 0.99 while those having CVR values greater than 0.99 were placed in the instrument. Moreover, content validity index (CVI) was computed for items retained in the scale to be 89%, suggesting that the instruments can be viewed as valid and acceptable, and therefore can be used as assessment tools.

3.5.2. Instrument Translation Procedure.. Data was collected, from the childbearing mothers having maternity care by the time of the survey directly by letting them fill the questionnaire, in order to make the participants feel at ease in understanding each item of the questionnaire and give their responses appropriately, The English version of the structured questionnaire was translated in to local language of the participants Amharic. Since the participants of the current study who complete the self-report questionnaire items range from those who were unable to read and write to those who were able to read and write, for participants who do not read and write the researcher reads questionnaire items for them and record their responses properly.

3.5.3. Scoring procedure. The questionnaire consisted of 46 items divided in three parts namely, the demographics and additional information part with 13 items and Maternal attitude towards the type of the health facility measuring part which has 30 items each measuring over all attitude towards the health facility yielding a total raw score ranging from 30-150, lastly over all opinion measuring part with 3 items yielding a total raw score ranging from 3-15 which all produces positively worded items, strongly agree (SA) was scored 5 points, agree (A) was scored 4, do not know (DK) was scored 3, Disagree (D) was scored 2 and Strongly Disagree (SD) was scored 1. There was no negatively worded item, Composite scores computed, where high scores items for each scale indicate that mothers have progressive attitude while low scored items for each scale indicate that mothers have non progressive attitudes towards the health facility in which they were using by the time of data collection (see appendix C and D for details of the questionnaire scales).

3.5.4. Pre Testing Procedure. A *pretest* is used to improve the precision, reliability, and validity of data. It was conducted to test the practicality of the data collection instruments, detecting and improving the defects of the instruments prior to administration of the main data collection. As Du Plessis and Hoole (2006) suggested that a pretest allows the researcher to compute the scales' reliability; check whether the questionnaire's length, wordings and instructions were adequate enough to complete the questionnaire and determine the initial response rate. In regard to the adequacy of samples for a pretest, though there is some variation of opinion in the size of the group to be selected, Neuman (2011) suggests a small set of samples ($n \geq 20$) are normal in a pretest. After incorporating feedback and random ordering and

formatting of the 52 item scale , pre testing was conducted with a sample of 50 women in two health facilities 25 in one private and 25 in one public health facility in Addis Ababa kirkos sub-city other than the facilities selected for data collection. Initially, the participants were informed of the intention of the research and what is expected of them during the entire study, where administration of the instruments was facilitated and directed by the researcher herself. Prior to the administration of data collection, participants were asked to give their free consents, and accordingly their participation in the pretest was based on their agreements.

Using the finding of the pretest study, one item were moved to its descending question, another three items that were not clear to respondents were modified. After the pretest a tool with 46 items and 4 parts were retained for final data collection.

3.5.4.1. Characteristics of the Pre Test Participants. The pretest was conducted on a total of 50 participants who were thought to have similar characteristics as of the main study samples. As a result, out of the 50 participants, With respect to age, the respondent's age was between 25-29 years. In terms of residential areas, seven were from rural while 43 were from urban centers. In terms of educational levels, five respondents reported they cannot read and write, 15 had completed primary education, 18 had completed secondary education, 12 had tertiary and above. With regard to number of children 23 have no children 11 have one child 15 have two up to four children and one have five or more children.

3.5.4.2. The Procedures and Results of Reliability Indices. In the current study, the reliability of the questionnaire scales was established using Cronbach Alpha. Cronbach alpha (α) was primarily computed for it is an indicator of the internal

consistency of items with Likert-type scales (Shevlina et al., 1998; Streiner, 2003). For the interpretation of Cronbach alpha coefficient, as Gliem and Gliem (2003) suggested the following rule of thumb: $\alpha \geq .9$ is excellent, $.8 \leq \alpha \leq .89$ is good, $.7 \leq \alpha \leq .79$ is acceptable, $.6 \leq \alpha \leq .69$ is questionable, $.5 \leq \alpha \leq .59$ is poor, and $\alpha \leq .5$ is unacceptable. Similarly, Du Plessis and Hoole (2006) recommended Cronbach alpha level of .70 as accepted and indicative of a reliable scale.

In order to compute Cronbach alpha reliability index, primarily the data collected from the participants of the pretest were entered into SPSS 20.0 package. Then, Cronbach's Alpha coefficient was computed for each item. As a result, the reliability in terms of Cronbach's alpha of 33 likert scale items was calculated to be .981, (see Table 1) below item-analysis output for the likert scaled items.

Table 1: Simple Statistics of Cronbach Alpha's out put

<i>N of items</i>	<i>Mean</i>	<i>SD</i>	<i>Cronach's Alpha</i>
33	<i>3.37</i>	<i>1.783</i>	<i>.981</i>

Based on reliability data the researcher deleted those items whose item-total correlations (discrimination powers) were small ($\alpha < .3$) and whose deletion substantially increased Cronbach's Alpha coefficient. This decision was taken by the researcher partly because the existing literature assumes that in a reliable scale all items should correlate with the total score from the scale and that items within such a scale should be positively correlated. Accordingly, from the likert scale items three items was deleted from the

questionnaire because of its item-total correlations were very small and negative ranging from (-.984 ,-.393,-398) which was ($\alpha < .3$) and that their deletion increased Cronbach's Alpha on the one hand and is thought to improve the reliability of the remaining items of the scale.

In conclusion, after defective items were deleted from the scales based on Cronbach's Alpha values, 46 items as a result, 13 demographic items and 33 likert scaled items of the English version (see appendix C) and the Amharic version (see appendix D) were finalized.

3.5.4.3. Implications of the Pretest Results for the Main Study. From the processes of instrument administration and results of the pretest data, important lessons were obtained and drawn to the main study. One of the key insights drawn from the results of instrument validation to the main study was that the questionnaire were viewed as valid and acceptable and can be used as assessment tools.

3.5.5. Data Collection Procedure. The data collection was conducted from 1st Aug, 2018-7th Aug, 2018 and 8th Aug, 2018-15th Aug, 2018 in randomly selected mothers who came for any maternity service in randomly selected woreda in the selected health facilities which were, Efoyita Health Center and Marie Stops International Private Clinic Ethiopia kirkos sub city woreda 02.

Using support letter from Addis Ababa university school of psychology and behavioral studies the researcher went to kirkos sub city health office and communicated with the respective health office director and additional support letter was provided and went to the respective health facility directors and explained about the planned study, its benefit to the health system and requested their collaboration for

the study. After getting permission and fulfilling the necessary materials, for data collection the data collection was initiated. The researcher had overseen and participated in the data collection process to avoid bias in data collection.

3.5.6. Data Analysis Procedures. Quantitative data was collected through questionnaire scales and analyzed using the statistical analysis software ‘Statistical Package for the Social Sciences’ (SPSS) Version 20.0. Generally, a variety of statistical methods such as correlation, t-test and one way ANOVA were employed for they were considered to be appropriate with interval/ratio level data (Ferguson & Takane, 1989).

Since, preferred place of delivery and residence has only two levels, an independent t-test was employed to test the research question that maternal attitude differ as a function of some selected demographic variables thus last place of delivery and residence of mothers.

Since, level of education and age have more than two levels, ANOVA was employed to test the research question that maternal attitude in giving birth vary as a function of some selected demographic variables thus, level of education and age.

Lastly, Pearson correlation analysis was used to test relation of the dependent and independent variable it was used to test the research question that maternal attitude significantly related with quality of service provided in public and private health facilities.

3.6. Ethical Consideration

The proposal for this study was reviewed and approved and letter of data collection request was given from Addis Ababa University College of Education and

Behavioral sciences. All women interviewed was asked for their verbal consent using a consent form that includes basic principles of research ethics adopted by Ethiopia for its adherence to ethical principles including beneficence (autonomy, informed consent and confidentiality), respect for individuals and justice.

Chapter 4: Results

The objective of the study is to discuss whether the attitudes of mothers affect preference of giving birth in the selected health facilities and if maternal attitude vary across some demographic variables and lastly whether maternal attitude is related with the service provided in the selected health facilities.

Research question one do mothers prefer the private or the public health facility for giving birth.

Research question two does maternal attitude in giving birth vary as a function of some selected demographic variables such as number of children, level of education residence and age of mother.

Research question three is maternal attitude significantly related to the quality of service provided in the private and public health facilities.

A total of 500 women who were attendants at the time of survey were able to fill the questionnaire in the two different health facilities of which 250 was in private health facility Mary Stops Ethiopia and 250 was from public health facility Efoyita health center in kirkos sub city Addis Ababa.

All of the questionnaires were completed hence data collection was done by the presence of the researcher 500 samples were used for subsequent data analysis.

4.1. Basics of Data Analysis

4.1.1. Data screening and testing Model Assumptions. Before conducting analysis of data from questionnaire scales, data screening was conducted:

1. If data have been entered correctly or not,
2. For missing values and outliers,
3. For normality, and deciding how to deal with non-normality.

The accuracy of data entry was checked using frequencies. Similarly, outliers or extreme values in the data were examined and some of the cases with extreme values were eliminated so as to minimize their influences and make data normal and appropriate for the analysis. Lastly, prior to making a decision of whether to use parametric test since Parametric tests are more powerful than nonparametric tests because they not only derive from standardized scores but enable the researcher to compare sub-populations with a whole population (Louse, et al, 2000)

Missing data and patterns of missing data were reviewed before data entry and amended accordingly. Majority of missing data were on items that request about experience of admission in the facility neutral responses (I do not know) were imputed for these cases.

Item scores for the maternal attitude scale were transformed to standardized Z-score, to identify potential univariate outliers. Standardized scores were assessed using a statistical criteria suggested by Tabachnick and Fidall (2010) that states cases on standard score in excess of 3.29 ($p < 0.001$, two tailed) are potential outliers with large sample size a few outliers are expected (Tabachnick & Fidell, 2001). Out of 33 Likert scaled items, three were potential outliers but due to large sample size these items were not excluded.

In order to perform ANOVA and Correlational tests evaluating the assumption of linearity was done, analysis of the scatter plot, significant F value of the ANOVA table and correlation coefficients ($> .30$) between the dependent variable and

independent variable showed that there is good model fit. Similarly, the collinearity diagnostics (the greater tolerance of more than 0.10 which and a variance inflation factor-VIF of less than 2) confirmed that multicollinearity does not exist in the data.

4.1.2. Demographic characteristics of participants.

Table 2: Socio demographic distribution women respondents at Efoyita health center and Marie Stops International Ethiopia 2018GC

S.N.	Variable	Label	Participants	Percent
1	Age in years	1.15-24	155	31
		2.25-29	216	43.2
		3.30-49	129	25.8
		Total	500	100
2	Number of children	1.None	189	37.2
		2.One	169	33.8
		3.Two-four	136	27.2
		4.Five or more	6	1.2
3	Residence	1.Urban	457	91.4
		2.Rural	43	8.6
4	Level of Education	1.Noteducated	32	6.4
		2.Primary	67	13.4

		3.Secondary	216	43.2
		4.Tertiary education and above	185	37
5	Occupation	1. Housewife	87	17.4
		2. Student	105	21
		3. Public Servant	142	28.4
		4. Private Servant	140	28
		5.Other	26	5.2
6	Marital status	1.Married	293	58.6
		2.Single	188	37.6
		3.Divorced	13	2.6
		4.Widowed	6	1.2

The demographic variables summarized in Table 2 above clearly showed that the participants of the current study can qualify as primary sources of data to fill in the questionnaire scales. This demographic data designates there is a reasonable and balanced representation of samples or participants also confirmed the possibility of drawing implications for or generalizations from the sample characteristics to the target population since the samples seem to be representative of the target population.

The finding shows age group was between 20-29years while the number of children of the respondents have been 189(37.2%) have no children, 169(33.8%) have one child, 136(27.2%) have two up to four child, six of the participant women have five and more children. Most of the women participated in the research were from urban residence, regarding their level of education 32(6.4%) were not educated 67(13.4%) were primary educated 216(43.2%) have completed secondary education, 185(37%) have tertiary education and above. Similarly, as far as occupational status is concerned, 87(17.4) reported as being housewives, 105(21%) reported as being students,142(28.4%) reported as being public servants,140(28%) reported as being private servants, 26(5.2%) reported in others.

Table 3: Additional information obtained from women respondents at Efoyita health center and Marie Stops International Ethiopia 2018GC

S.N.	Variable	Label	Participants	Percent
1	Type of the Health Facility you are in know	1.In Efoyita health center	250	50
		2.In Marie stops International Ethiopia private clinic	250	50
		Total	500	100%
2	Services of arrival	1.For Family planning service	84	16.8
		2.For pregnancy screening	83	16.6
		3.For abortion service	82	16.4

		4.For ANC service	76	15.2
		5.For labour and delivery service	94	18.8
		6.For child vaccination	23	4.6
		7.For other	58	11.6
	Total		500	100%
3	Place of delivery of your last pregnancy if delivered	1.In private health facility	128	25.6
		2.In public health facility	183	36.6
		Total	311	62.2%
4	Was your last pregnancy intended	1.Yes	141	28.2
		2.No	183	36.6
		Total	324	64.8%
5	Antenatal care follow up status	1. None	164	32.8
		2. One	31	6.2
		2. Two	65	13
		3.Three	81	16.2
		4. Four	159	31.8
6	Preference of place to give birth	1. In private health facility	272	54.4

2. In Public health facility 228 45.6

Out of the women's who had participated in the research 84(16.8%) women's came for family planning service, 83(16.6%) came for pregnancy screening service, 82 (16.4%) came for abortion and another 76 (15.2%) came for antenatal follow up, 94(18.8%) came for labour and delivery , 23 (4.6%) came for child vaccination and 58 (11.6%) came for other services. Among mothers who have children 128(25.6%) gave birth in other health facility and 183 (36.6%) gave birth in public health facility. When asked if their last pregnancy intended/planned or not 141(28.2%) said that they have planned pregnancy and 178 (35.6%) have non planned pregnancy. When asked about their anti natal follow up status 164(32.8%) have no antenatal follow up, 31(6.2%) said one antenatal follow up, 65(13%) said two antenatal follow up, 80(16%) said three antenatal follow up and 160(32%) said four and above antenatal follow up. When asked where they would like to give birth 272(54.4%) would like to give birth in private health facility and 228(45.6%) would like to give birth in public health facility.

4.1.3 Difference of maternal attitude in giving birth in the selected health facilities.

Table 4: Independent t-test of Maternal Attitude in giving birth in private and public facilities

Independent t-test						
Variable	Giving birth	N	M	SD	t	P.
Maternal attitude	Private health facility	272	88.12	15.83	1.296	0.031
	Public health facility	228	82.05	12.53		

Independent t-test was performed. The Levene test indicated that the assumption for equality of variance was satisfied. The results of the t-test provides support the research question the results obtained are statically significant which revealed there is a significant differences in maternal attitude in giving birth in private and public health facilities [$t(498) = 1.296, P < .031$]. Which tells that maternal attitude vary in giving birth in private and public health facilities.

Demographic distribution is further elaborated on Table .5. below based on giving birth in public and private health facilities.

Table 5: The preference of place to deliver versus the actual facility respondents found

Variables	N	Type of facility they were in			
Place of delivery preferred		Private	Percentage	Public	Percentage
Private health facility	272	183	36.6	89	17.8
Public health facility	228	67	13.4%	161	32.2%

Since, maternal attitude significantly differ in giving birth in private and public health facilities the above tables clearly tells that mothers both from public as well as from private prefer to give birth in private and have favorable attitude towards giving birth at private health facility than at public health facility.

4.1.4. Maternal attitude as a function of demographic variables. Research question two does maternal attitude in giving birth vary as a function of some selected

demographic variables such as number of children, level of education residence and age of mother.

4.1.4.1. Difference in maternal attitude by age.

Table 6: One Way Analysis of Variance of Maternal Attitude as a Function of Age

A one-way analysis of variance						
Variables	Age in years	N	M	SD	F	P
Mothers attitude	15-24	155	79.48	5.898	0.478	0.06
	25-29	169	86.66	5.886		
	30-49	136	69.74	4.811		

To test the research question that maternal attitude differ as a function of maternal age, one-way analysis of variance was conducted. The results generally provided doesn't support for the research question $F(3,496) = 3.478$, $p = 0.06$ indicated that maternal attitude did not differ significantly by the age group of the mother. These, showed that mothers with different age category have similar attitudes towards the facilities.

4.1.4.2. Difference in maternal attitude by number of children.

Table 7: One Way Analysis of Variance of Maternal Attitude as a Function of Number of Children

A one-way analysis of variance						
Variables	Number of children	N	M	SD	F	P
Mothers attitude	None	189	60.77	19.54	4.481	0.006
	One	169	54.34	17.47		
	Two-four	136	43.72	14.06		
	Five and more	6	11.4	1.620		

To test the research question that maternal attitude differ as a function of maternal number of children, one-way analysis of variance was conducted. The results support the research question by [$F(4,496) = 4.481, p = 0.006, \eta p^2 = .09$]. Post hoc test using LSD showed the existence of significant mean differences between mothers who have no child and mothers who have two up to four children, mothers who have no child and mothers who have five and more children, mothers who have one child and mothers who have five and more children, mothers who have two up to four children and mothers who have five and more children (see Table 7 for the mean differences and standard deviations). These generally indicates that maternal attitude differ significantly by the number of children's they have. And further shows that, mothers with higher number of children have fewer attitudes towards the health facilities compared to those mothers who have small number of children and have no children at all.

4.1.4.3. Difference in maternal attitude by level of education.

Table 8: One Way Analysis of Variance of Maternal Attitude as a Function of Level of Education

A one-way analysis of variance						
Variables	Level of education	N	M	SD	F	P
Mothers attitude	Not educated	32	20	2.808	4.380	0.003
	Primary	67	20	2.924		
	Secondary	216	21	2.720		
	Tertiary and above	185	23	3.276		

To test the research question that maternal attitude differ as a function of maternal level of education, one-way analysis of variance was conducted. The results generally provided good support for the research question [$F(4,496) = 4.380, p = 0.003$ $\eta p^2 = .05$]. Post hoc test using LSD showed the existence of significant mean differences between mothers who have not educated and secondary level of educated, mothers who have not educated and tertiary and above level educated, mothers primary

level educated and secondary level educated, mothers primary level educated and tertiary and above level educated and mothers secondary level educated and tertiary and above level educated These findings Indicated that maternal attitude differ significantly by the educational level of women's. These showed that mothers with higher educational level and those with low educational level tend to have different attitudes towards the facilities. And generally indicates that mothers with higher level of education tend to have better attitudes towards the health facilities than those mothers with low educational level.

4.1.4.4. Difference in maternal attitude by residence.

Table 9: Independent t-test of Maternal Attitude as a Function of Residence

Independent t-test						
Variable	Residence	N	M	SD	T	P.
Maternal attitude	Urban	457	120.26	16.84	-2.38	0.06
	Rural	43	13.39	13.14		

Independent t-test was performed. The Levene test indicated that the assumption for equality of variance was not satisfied. The results of the t-test provides did not support the research question the results obtained are statically non-significant which revealed there is no a significant differences in maternal attitude as a function of residence [$t(448) = -2.38, P = .06$]. Which tells that maternal attitude do not vary across residence.

4.1.5 Relation of maternal attitude and quality of service in the facilities.

Table 10: Pearson product moment correlation (r) analysis on the relation of maternal attitude and quality of service provided in the public and private health facilities.

Pearson product of moment correlation (r)						
Variable	Quality of service provided	N	M	SD	Pearson (r)	P
Maternal attitude	In Private health facility	250	178.56	4.38	0.558	0.003
	In Public health facility	250	129.79	5.22		

Research question three maternal attitudes significantly related to with the quality of service provided in private and public health facility. This shows Pearson product moment correlation was used to analyze this research question at 0.05 level of significance, since r indicate the direction of the relationship and while the the magnitude of correlation indicates the strength of the relationship .1</math>/,3 small weak correlation .3</math>/,5 medium moderate correlation .5</math>/<1 large or strong correlation (Numan, 2011). The table shows Pearson Correlation Coefficient (r) value is ($r=0.558$, $N=500$, $p=.003$) which is strong positive relation. It follows then that there exists a positive relationship between the two variables. The level of significance (.003) which is less than 0.05 indicates that the relationship is significant. Therefore there is significant

relationship between attitude of mothers and quality of service in private and public health facilities. This indicates, if the quality of service is improved then maternal attitude will also be improved.

Chapter 5: Discussion

This study was conducted in Addis Ababa the capital city of Ethiopia at Kirkos sub city in randomly selected woreda in a selected public and private health centers.

5.1. Maternal Attitude Differs in Giving Birth in Public and Private Health Facilities

Independent t-test was performed to analyze this research question. The results of the t-test provides support the research question the results obtained are statically significant which revealed there is a significant differences in maternal attitude in giving birth in private and public health facilities [$t(498) = 1.296, P < .031$]. Which tells that maternal attitude vary in giving birth in private and public health facilities also tells that mothers from both facilities have more better attitude towards the private health facilities than the public. Before even trying to choose one should be aware of the use and this study tells that urban mothers are aware of the use of facility based delivery rather than giving birth at home. And which intern helps alleviate the increasing number of child and maternal death. In order for a mother to prefer the health facilities in which she gives birth she should have predisposed attitude meaning the theory of habituation which (Bourdien, 1977). As Borden suggested which allow individuals to find new solutions to new situations without calculated deliberation based on their gut feelings and intuitions? So the attitudes may be beliefs or previous intuitions. Habitus can be shared by people with similar background, education, profession etc. based on this theory the attitude can

be shared from others with similar back grounds. It is likely that maternal attitude varies as in the different place.

The findings of the current study are consistent with previous research who stated that place of delivery is an important factor often related to maternal attitude (Murthy, et al, 2012). Positive experiences and formed positive attitudes can have a greater impact on a woman's decision to return to a facility than negative ones (Dambruoso, 2005). A cross sectional study conducted in Rural Bangladesh in 2009GC to assess knowledge, attitude and practice regarding hospital delivery though 85.5% showed positive attitude to facility delivery but only 33.2% give birth at health facilities of which 8.3% give birth in private shows less attitude progress while and 24.9% give birth in public health facility shows high attitude progress and concluded that maternal attitude differs by the place of delivery (Nawazia Y, 2009). According to Yibeltal, et al (2015), maternal attitude varies by place of delivery in association of different factors such as short waiting time, perceived good quality of service, experienced good quality of service, perceived good approach of service provider and experienced good approach of service provider and finally Yibeltal concluded that maternal attitude differs in giving birth in private and public health facility which further support the current study (Yibeltal, et al, 2015).

Another qualitative research conducted in Addis Ababa, Ethiopia further support the finding of the current study explaining maternal attitude differs with their preference of facility. Mothers prefer public health facility because despite hearing rumors about poor quality and abusive care they didn't experience it themselves, others because service in public health facility is free of payment, others because they

experienced that private facility promote cesarean delivery for financial gain, changing attitudes among women on the higher quality of care available in the private facility thus similar service with higher cost, others prefer public health facility because of good ANC service experience and because they have heard government effort to improve the quality of care in public facilities (Tigest.S. etal., 2016).

Mothers, according to the above research prefer to deliver in private health facility secondary to prior rumors of the public health facilities poor quality of care and poor attitudes of health professionals others because service in public health facility is free of payment in which they perceive that they will not get good care, because public health facility have no readily available cesarean delivery service they prefer to deliver in private health facility in order to have elective caesarean delivery (Tigest.S. etal., 2016).

Generally, what the above literatures make clear is that maternal attitude strongly differs in giving birth in public and private health facilities.

5.1.2. Additional information obtained from the analysis is that. Much numbers of women prefer to give birth in private health facilities and from out of the mothers who have gave birth in the private set up prefer to give birth mostly in the private facility and vice-versa for the public health facilities thus mothers who had gave birth in public prefer to give birth in public.

Previous study consistent with the current study was conducted in Ethiopia fifteen percent of mothers deliver in a public facility and one percent in a private facility and the study prevailed that out of the fifteen percent who delivered in public health facilities 90% preferred to give birth in private health facilities than in private

but unable to have that due to financial problems which supports the current study. Even though the percentage of public health facility births are high the total health facility births continues to be low in Ethiopia, there has been remarkable progress in the last fifteen years (WHO, 2010). Based on ANC follow up most of the mothers during the survey who have previous history of child born have attended ANC four times and above none was found to have no ANC having previous history of delivery. In a study conducted in Nigeria even, when women booked for, and received antenatal care (ANC) in public hospitals, a substantial number of still deliver in private hospitals (Lamina.MA et al., 2006) and (Ekele BA, et al., 2007).

A study supporting this finding describes that Eighty percent of women located in urban areas of Ethiopia received ANC services from a skilled provider for their last birth compared with 35 percent of women in rural areas. 25 percent, urban women are eight times more likely, than rural women, at 3 percent, to receive antenatal care from a doctor. The content of services received and the kinds of information given to women during their ANC visits are essential components of quality care.

Some evidences tell that quality of antenatal care (ANC) is dependent on the qualifications of health professionals and the number and frequency of ANC visits. These services raise awareness of the danger signs during the pregnancy, delivery, and postnatal period, improve the health-seeking behavior of women, orient them to birth preparedness issues, assist women where to deliver and provide basic preventive and therapeutic care (WHO, 2010).

And substantially relative number of mothers came to the health facility for abortion and delivery which is also higher in private health facilities.

5.2. Maternal Attitude Varies as a Function of Some Demographic Variables

5.2.1. Difference in maternal attitude by age. In the current study, inconsistent results were obtained which doesn't prevail that maternal attitude differ as a function of maternal age. $F(3,496) = 3.478$, $p = 0.06$ indicated that maternal attitude did not differ significantly by the age group of the mother. These showed that mothers with higher age category and those with low age have a tendency to have similar attitudes towards the facilities. This means that a mother of higher age and a mother of lower age have no visible difference on their attitude.

Nevertheless, that the research question that maternal attitude as function of age was not supported by the results of the current study previous studies show contradicting finding a study conducted in Bangladesh has shown that maternal attitude vary as the age of the mother increase and decrease and clearly states that as upper age mothers have different attitudes than lower aged mothers among the women's aged 30 and above have negative attitude while mothers of lower age group have negative attitudes.(Mustefazun & Rahman K.M, 2009). In Indonesia, 92% of higher aged mother have varying attitude than mothers of lesser age group in the use of facility delivery (Amardeep & Kabir, 2004). Study in Ghana shows on 5.439 mothers contradicts the finding from Indonesia that it tells that there is no significant difference in attitude in different age group of mothers thus $F(2,5437) = 4.508$, $p =$

0.07 which supports the finding of current study a (Samuel et al., 2008). A study conducted in India also shows mothers attitude vary both negatively and positively in age greater than 30 years and 20 to 30 years, 61% and 63 % (Amardeep T.etal., 2017).

5.2.2. Difference in maternal attitude by number of children. The current study prevails that maternal attitude differ as a function of maternal number of children, one-way analysis of variance was conducted. The results generally indicated [$F(4,496) = 4.481, p = 0.006 \eta p^2 = .09$] that maternal attitude differ significantly by the number of children's they have. These showed that mothers with higher number of children and those with low number of children have a tendency to have different attitudes towards the facilities. And it further showed that, mothers with less number of children have better attitudes in giving birth in health facilities than mothers with higher number of children.

The finding of the current study is consistent with other studies. Across sectional study in mothers in Uganda 2008 shows that mothers who give birth previously and have one or more children have significant attitude difference with a mother that have no children at all and haven't experienced the delivery in facility as the study explained that mothers that have higher number of children have different attitude and less access and experience in giving birth in the health facilities due to economic problem and this further influences their attitude (Cjtann, et al., 2007). A qualitative study conducted in India shows mothers with birth order less than two 1.6 times more likely have better attitude towards health facilities (Amardeep T.etal., 2017).

Furthermore, another study which supports the current study was that In Ethiopia Addis Ababa which clearly explained that maternal attitude differs as a result

of number of children in which women with two or less living children are more likely to deliver in healthcare facilities than at home compared to those with three or more living children. It is possible that women with three or more living children claim to be experienced and seen reason to deliver at health facilities and attitude of giving birth in those facilities decreases. Alternatively, negative previous experiences may deter women from delivering at health facilities there by exposing themselves to the complications of child birth (Yibeltal, et al,2015).

5.2.3. Difference in maternal attitude by level of education. The study prevailed by using one-way analysis of variance was conducted. The results generally provided good support for the research question [$F(4,496) = 4.380, p = 0.003$] Indicated that maternal attitude differ significantly by the educational level category of women's. These showed that mothers with higher educational level and those with low Educational level tend to have different attitudes towards the facilities. Thus highly educated women have better understanding and awareness regarding the situation of delivering in health facilities so this helps the women to make decision on going to the health facilities and understands the benefits of delivering in health facilities.

Previous studies have also showed that education make significant difference and that it has also shown strong correlation of maternal or partners' education status with maternal attitude which help 80% of mothers who are educated prefer to give birth in private health facility while 95% mothers who are not educated prefer to give birth in health facilities the same applies to mothers who have educated husband (Anuja et al, 2008; Nigussie et al., 2004; Amardeep & Kabir, 2004).

Related studies also share the idea that well educated mothers have different attitude than less educated (Cjann et al., 2007). In Addis Ababa, if they use health facilities, those with no formal education and those with primary level of education have significant variation respectively. The findings point to the power of education in empowering women to seek maternal care and high socioeconomic opportunities both of which reduce the risks of child births in areas lacking professional care and improved maternal attitude (Nigussie et al., 2004).

5.2.4. Difference in maternal attitude by residence. The current study used t-test and the results showed no significant differences in maternal attitude as a function of residence [$t(448) = -2.18, P < .06$] which means that maternal attitudes do not vary as a function of residence in which even if mother is from urban or rural have no difference on attitudes toward the attitude.

Previous study conducted in Indonesia have inconsistent finding with the current study it relates maternal residence with maternal attitude also shows 59% lower odds of facility delivery utilization among women residing in rural area than urban (Amardeep & Kabir, 2004).

Another study by on Ethiopian EDHS revealed that the maternal attitude across urban and rural set up have only partial difference and further elaborates that maternal attitude was not proofed by cross sectional studies and the variation on attitudes were previously predicted by the outcome of the mothers who come to health facilities (EDHS,2016).

5.3. Maternal Attitude in Relation with Quality of Service Provided in Private and Public Health Facilities

The study shows Pearson product moment correlation (r) was used to analyze this research question at 0.05 level of significance result presented r -value (0.558) which is strong positive relation. It follows then that there exists a positive relationship between the two variables. The level of significance (.003) which is less than 0.05 indicates that the relationship is significant. Therefore there is significant relationship between attitude of mothers and quality of service in private and public health facilities. This indicates, if the quality of service is improved then maternal attitude will also be improved. Further quality can be influenced based on cost effectiveness, timely service and cleanliness of the health facility, the health service providers' way of activity and respect which are related to maternal attitude.

Another study supports the current study in that maternal attitude is highly related to Quality, the final element required, includes that 'health facilities, goods and services must also be scientifically and medically appropriate and of good quality' (ESCR General Comment 14, 2000).

Similar study conducted in Nigeria also supports the current study in that quality of service is associated with maternal attitude according to a research conducted in Nigeria on 280 women, maternal attitude is found to be significantly associated with quality of service and level of satisfaction at ($p < 0.05$) (Nnebue, et al 2006).

Quality of care is an important determinant of health outcome (Cohen JR, 2005). As postulated by Donabedian (1988), quality of care has been assessed in three

general domains: Structure, process and outcome. Outcome assessment concerns the results of care on the health status of clients, including challenges in client knowledge, perception and behavior, attitude, client satisfaction with health care, biologic changes in disease, complications of treatments, morbidity and mortality (Donabedian, 1988).

Further a study conducted in Ethiopia on quality of health goods and services related maternal attitude with quality. Even though, various factors contribute to the low quality of services, especially to the lower segment of the population in the country. Delay in providing treatment is usually the major reason for the poor quality of service and further tells quality of service have a significant relation at ($p < 0.05$) with the maternal attitude and concluded that maternal attitude is significantly related with quality of service (Berhan & Berhan, 2014).

Chapter 6: Summary, Conclusion and Recommendation

6.1. Summary

The overall objective of the study was to learn the attitudes of mothers towards giving birth in some selected health facilities. Its main focus was on mothers who visit the respective health facilities. Identifying, whether their attitudes have any effect in their choice of facility and its variation based on some selected demographic variables and its relation with the service provided and health professionals in the individual health facilities.

Quantitative non experimental research design was employed for the study since it allows broad heading of descriptive research. The study participants was all child bearing women thus aged (15-49) attending the selected health facilities during the time of the study. Data was collected through structured Likert scaled questionnaire which was reformed from standardized instrument caring behavior inventory (CBI) and a pretest was conducted to test the practicality of the data collection instrument prior to administration of the main data collection. In order to report research questions data was analyzed using independent t-test, one way ANOVA and Pearson correlation coefficient techniques.

The study identified that maternal attitude in giving birth across the selected public and private health facilities varies and that mothers have better attitude towards giving birth in private than in public this might be as a result of the quality of service nearness of the facility to residence and prior information obtained.

The study also provides that mothers with prior experience of giving birth in private health facility highly prefer to give birth in private and mothers with prior experience of giving birth in public highly prefer to give birth in public this shows that experience and exposure influences maternal choice.

The current study also identified that maternal attitude do not vary as a function of age and residence this means that maternal attitude in mothers with different age group and in urban and rural residents is relatively similar.

Also the study identified that maternal attitude varies by the number of children they have. Also it identified that mothers with less number of children have better attitude than mothers with higher number of children.

Also the current study identified that mothers attitude varies as a function of level of education and states that highly educated mothers have better attitudes towards the health facilities than less educated mothers.

The fact that maternal attitude varies as a function of some demographic variables and that maternal attitude substantially related to quality of service provided in private and public health facilities was confirmed, from this perspective the present study is said to have good theoretical implication and practical importance.

6.2. Conclusion

The present study had three major objectives Identifying variation of maternal attitudes in giving birth in private and public health facilities, identify variation of maternal attitude in some selected demographic variables, identify the

relation of maternal attitude with quality of service provided in private and public health facilities.

First, the results revealed that maternal attitude varies in giving birth in private and public health facilities and that mothers attitude in giving birth in the selected health facilities were better towards the private health facilities than to public health facilities, this implies that mothers attitude in giving birth in private health facility is different from mothers attitude in giving birth in public health facility and this supports the fulfillment theory by Sawyer in that the mothers experience determines their choice and satisfaction, also supports the theory of habitus by Bourdieu (1977) which states that attitudes have influence on the individual choices in which the finding from the study confirmed, that maternal attitude highly influence preference of health facility to give birth.

Second, the results revealed that maternal attitude varies across by number of children and level of education of the individual mother , which implies that mothers with higher number of children and with lower number of children have different attitude towards the health facilities and that mothers with less number of children have better attitudes this can be expressed as if mothers are empowered and have lesser number of children they will have better tendency to participate in maternal health care activities routinely and further gives them direction to choose where to deliver also mothers with high level of education and low level of education have different attitude towards the health facilities this shows that mothers with better education can have a better understanding and empowered enough by education to have better attitude towards the health facilities and this provides the women to prefer one facility other

than the other this further supports the theory of habitus stated by Bourdieu (1977) which states that opposing situation of more or less equally competing possibilities can be shared by people with similar background, education etc.

Third, the result further revealed that age and residence didn't influence and make difference on maternal attitude towards the health facilities meaning mother with higher or lower age group and mothers from urban residence as well as from rural residence have relatively similar attitude towards giving birth in the health facilities and these findings were consistent with other studies. Literature states that urban mothers have a better attitude towards the health facilities and those rural mothers have lesser attitude but since the current study confirmed that maternal residence doesn't influence maternal attitude need further studies to clarify this finding. Likewise in the study maternal age doesn't influence maternal attitude but literature states that maternal attitude varies by age and that upper aged mothers have better attitude in giving birth in health facilities than their counter lower age group mothers and also these finding also needs further studies supporting it.

Fourth, the results also stated that maternal attitude is related to quality of service provided in the public and private health facilities, this implies that the quality of service provided can influence maternal attitude towards the facilities which in turn influence maternal preference. This further supports the discrepancy theory by Sawyer (2013) which states that satisfaction is determined by the difference between the person's expectation and what has actually happened in this case the quality of service expected from the individual facilities by the mothers has determined their attitude.

Finally much number of women living in urban residence prefer to give birth in private health facilities than their counter rural mothers who prefer to give birth in public health facilities this shows that government have put its effort in improving and providing the health care service in its public health facilities for free but still urban women still doesn't prefer to give birth in them needs further supportive studies. And also the finding proved that antenatal care (ANC) coverage in urban residence with previous history of delivery had at least four and more (ANC) this implies experience and (ANC) itself played a significant role in empowering women to have facility based delivery.

Though the present study have several strengths such as identifying maternal attitude variation across private and public health facilities, selected socio demographic conditions, data collection instruments (likert-scaled self-report questionnaire) data analysis (descriptive inferential statistics) it have some limitations.

The number of facilities participated is selected non-randomly and study conducted in different set ups but including a variety of facilities in the sub-city which are randomly selected can further improve the reliability and generalizability of the finding.

Even though the study tries to include child bearing aged mothers it only included mother that were in the facilities by the time of data collection doesn't include those mothers who have not been in the facility and who have received service from the facilities but doesn't came by the time of study.

Maternal constraints can include attitude, perception, believe, thrust, ideas, behavior, values, etc. but the current study was limited only on maternal attitude and

variation across the different set ups, socio-demographic situations and its relation on the quality of service. Though a number of socio demographics, familial socio economic variables the current study were limited on maternal age, number of children, residence and level of education.

The study is conducted in urban setting so this tells that from the finding rural resident mothers who participated in the study were low and generalizing the finding about rural mother can be influenced.

The questioner scales were susceptible to response set because mothers choose their answers by actually telling the truth not what actually they feel, biased because they might give the answers rather by predicting what is acceptable and preferred and this somewhat can influence the generalizability of the results.

The tendency of telling the real age is not accustomed and since the study needed the age group of mothers 15-49 some deviations can occur as result of not telling the accurate age by the mothers this also can have influence on the generalizability of the finding.

6.3. Recommendation

On the basis of the discussions of the major findings made above and the conclusions drawn, the researcher forwards the following suggestions.

- Federal ministry of health and other policy makers should implement public private health facility partnership and identify and examine further the variation of maternal attitude across the facilities.

- The kirkos sub city health office should work on identifying the cause behind the difference in maternal attitude across different health facilities by conducting other studies.
- The private and public health facilities in the sub city should work in collaboration and share better practices across each other to have similar quality of service since maternal attitude is dependent on the quality of service provided in the facilities.
- The mothers or women in the sub city are advised to receive services like maternity care reproductive health antenatal care and any other service regarding their health in a health facilities which help them improve their level of awareness about the activities similarities or difference in service and which facility is better and preferred for them to give birth.
- Psychologists, social workers, specialists and health professionals working on mothers are recommended to familiarize themselves with the appropriate insides and inferences of relevant psychological theories, and in turn design effective intervention programs on maternal attitudes by designing and providing regular training educations and medias so that mothers will get knowledge about facility delivery which help integrate these activity in to their daily activity, and which in turn decrease the maternal morbidity and mortality.
- Psychologists, Experts and health Professionals working on mothers should create orientations and awareness programs like for example for the health professionals using antenatal care (ANC) effectively and by strengthening the

health education activities encouraging facility delivery and further influence maternal attitude in giving birth in the private and public health facilities.

- The present study has also some implications for future research. First, future research should expand the scope of the present study by incorporating other maternal constraints and also other contextual factors influencing maternal attitude that can provide a comprehensive picture about mothers. Second, in addition to self-report questionnaire other studies can use other qualitative methods observations focused group discussions and also participating mothers outside of the health facilities.

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Appendix A: Letter of Request

Addis Ababa University

School of Psychology

To the medical director

Request to conduct a study within the health facilities

I am a student of social Psychology I would appreciate it if I could be permitted to conduct a study entitled: maternal attitudes towards giving birth in government and private health facilities in Addis Ababa kirkos sub city from 1st of August, 2018gc-15th of August, 2018gc. Women, who choose to participate and acquire the inclusion criteria, will be asked to fill the questioner. The questioner will take 10 to 15 minutes and participants are assured of confidentiality. Your positive response in this request will be highly appreciated.

Yours faithfully

Million Assefa

Appendix B: Informed Consent Form

Dear women,

I am a Masters student at the School of Psychology of Addis Ababa University. My master's paper is on: Maternal attitudes towards giving birth in government or public and private health facilities. The purpose of this research project is to explore the maternal attitudes towards the health facilities. This informed consent form will give you the basic idea of what the research is about and what your participation will involve. Please take the time to read this form carefully and to understand any accompanying information.

As part of my study I am asking you to participate in this study by completing a questionnaire survey. My goal is to analyze the materials in the questionnaire in order to understand the participants' views towards private and public/government health facilities

This research is neither affiliated with nor funded by any political party, interest group. Your responses will be recorded anomalously; please do not write your name on any portions of the questionnaire. Ask the data collector if there is any unclear matter related with the questionnaire. When you have completed the questionnaire please submit to the data collector.

You may withdraw your consents if you feel you are inconvenient at any time. In signing this form you are agreeing to participate in this study. I would like to ask you your kind cooperation to participate. Your participation will help health facilities identify maternal attitude. I would be most happy to answer any questions you might have. Please write or call.

Here is my:

- telephone number : +25192192777
- e-mail address: millsassefa@gmail.com
- Thank you in advance,

Million Assefa

Investigator

I have read the above statement and agree to participate in this study.

Signature of participant _____ Date _____

Appendix C. Questionnaire PART-I: Demographic Information

I am a Masters student at the School of Psychology in Addis Ababa University. This questionnaire is prepared for master's degree thesis and its purpose is to study maternal attitudes towards the health facilities. This study can provide information regarding maternal attitude. Any information that you provide will be kept confidential. No one can force you to participate in this study. You have the right not to answer any question that you don't want to answer. Filling the questionnaire may take 15-20 minutes. You may withdraw your consents if you feel you are inconvenient at any time. I would like to ask you your kind cooperation to participate. Your participation will help health facilities identify maternal attitudes. In signing this form you are agreeing to participate in this study.

Agree_____

Disagree_____

I	<p>The following questions are used for the general information regarding yourself please choose one of the choices and put right sign or (✓) on the box provided</p>	
1	Age in years	1. 15-24 <input type="checkbox"/> 2. 25-29 <input type="checkbox"/> 3. 30-49 <input type="checkbox"/>
2	Residence	1. Urban <input type="checkbox"/> 2. Rural <input type="checkbox"/>
3	The service you come for	1.For Family planning service <input type="checkbox"/> 2.For pregnancy screening <input type="checkbox"/> 3.For abortion service <input type="checkbox"/> 4.For ANC service <input type="checkbox"/> 5.For labour and delivery service <input type="checkbox"/> 6.For child vaccination <input type="checkbox"/> 7.For other <input type="checkbox"/>
4	Date of filling questionnaire	Date month08 2018
5	Type of the Health Facility you are in know	1.Private health facility <input type="checkbox"/> 2.Public health facility <input type="checkbox"/>
6	Level of education	1.Not educated <input type="checkbox"/> 2.Primary education <input type="checkbox"/> 3.Secondary education <input type="checkbox"/> 4.Tertiary education and above <input type="checkbox"/>

7	Your occupation	1. Housewife <input type="checkbox"/> 2. Student <input type="checkbox"/> 3. Public Servant 4. Private Servant <input type="checkbox"/> 5. Other <input type="checkbox"/>
8	Marital Status	1. Married <input type="checkbox"/> 2. Single <input type="checkbox"/> 3. Divorced <input type="checkbox"/> 4. Widowed <input type="checkbox"/>
9	Number of your children	1. None <input type="checkbox"/> 2. One <input type="checkbox"/> 3. 2-4 <input type="checkbox"/> 4. 5 or more <input type="checkbox"/>
10	Where do you gave birth to your last pregnancy?	1. In private health facility <input type="checkbox"/> 2. In public health facility <input type="checkbox"/>
11	Was your last pregnancy intended(planned)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
12	Ante natal care (ANC) status (during pregnancy until delivery)	1. One <input type="checkbox"/> two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/>
13	Where do You prefer to give birth	1. In Private health facility <input type="checkbox"/> 2. In Public health facility

Questionnaire PART-2: Mothers Attitude towards Health facility

II	<p><i>The following questions are used to assess your attitude towards the type of the health facility you are found in; towards health professional's relation experience and care Please provide your agreement or disagreement to each question in a scale of 5. If you agree strongly to the statement use code (5),if you only agree to a statement use code (4), if you are not sure or don't know use code (3), if you don't agree to a statement use code (2) and if you don't agree strongly use code(1).</i></p>	<p>5. Strongly agree.</p> <p>4. Agree</p> <p>3- Don't know</p> <p>2 .don't agree</p> <p>1-Strongly don't agree</p>
14	I like the staffs and the service I get	
15	I trust the service I get	
16	The facility is near to my residence	
17	I have prior experience of treatment in the facility	
18	I get an advice from a friend to come	
19	I heard the advertisement and information about the facility	
20	I know that I can get a referral when necessary	
21	I get Specialist services when needed	
22	The facility avail the staff needed	
23	In the health facility I received cost effective and timely service	
24	The health facility and Examination room is neat.	
25	The health facility requested my consent for all procedures performed	

26	In the health facility respect my modesty (privacy) (for example, using screen and keeping me covered).	
27	The staff in the health facility is More friendly and cheerful staff	
28	The staff in the health facility keeps my secret confidential.	
29	The staff in the health facility treat me with respect	
30	The staff in the health facility treat patients equally	
31	The staffs in the health facility answer my questions clearly.	
32	The health professionals in the health facility teach me about my condition	
33	The health professionals in the facility appoint me just for follow up.	
34	The health professionals in the health facility Don't become upset & give up on me when I ' m difficult to get along with	
III	<i>The following questions 35 up to 43 needed to be answered if you get admitted anywhere in the facility if not leave it and go to the last instruction number IV</i>	
35	The health professionals in the facility Answer quickly when I call for them	
36	The health professionals in the facility check with me before leaving the room to be sure I have everything I need within reach.	
37	The health professionals in the health facility are gentle cheerful I with me.	

38	The health professionals in the facility Help me with my care until I'm able to do it for myself.	
39	The health professionals in the facility Know how to handle equipment (for example, monitors).	
40	The health professionals in the health facility give my treatments and medications on time.	
41	The health facility admission room is neat.	
42	The health professionals in the health facility keep my family informed of my progress	
43	The health professionals in the health facility Check my condition very closely	
IV	<i>The following answers needed to be answered to find out your overall opinion about the health facility</i>	
44	I am satisfied with the overall care and services provided by the staffs in the health facility	
45	I recommend this facility for others to give birth	
46	Because of the excellent service I get in this facility I will come back again	

Thank you

Appendix D. መጠይቅ ቁጥር 1 አጠቃላይ መረጃ

እኔ በአዲስ አበባ ዩንቨርሲቲ በሶሻል ሳይኮሎጂ ማስተርስ ተማሪ ነኝ። ለማስተርስ ዲግሪ የመመረቂያ የተዘጋጀ ሲሆን አላማውም እናቶች ስለግል ጤና ተቋም እና የመንግስት የጤና ተቋም ያላቸውን አመለካከት ለመዳሰስ የተዘጋጀ ነው። ይህ ጥናት ከእናቶች አመለካከት ጋር የተያያዙ ችግሮችን ለመፍታት አስተዋጽኦ ያደርጋል። ማንኛውም እርሶ የሚሰጡት ምላሽ በፍፁም ለሌላ ሰው አይነገርም። በራስ ተነሳሽነት ካልሆነ በስተቀር በዚህ ጥናት የመሳተፍ ግዴታ የለብዎትም። መጠይቅን የመሙላት ሂደት ከ15-20 ደቂቃዎች ሊፈጅብዎ ይችላል። በወይይቱ ወቅት በማንኛውም ሰአት ጥያቄውን ለማቆም ወይንም መመለስ ያልፈለጉትን ጥያቄ ያለመመለስ ሙሉ መብት አሎት። በጥናቱ መሳተፍዎ ለጤና ተቋሙት የእናቶችን አመለካከት ምን እንደሚመስል የሚገልጹ ስለሚሆን ተሳትፎዎን በአክብሮት እንጠይቃለን።

በወይይቱ ለመሳተፍ ፍቃደኛ ነዎት?

1. አዎን
2. አልስማማም

<p>መመሪያ 1</p>	<p>የሚከተሉት ጥያቄዎች አጠቃላይ ስለእርስዎ ለማወቅ የተዘጋጁ ጥያቄዎች ናቸው እባክዎ ከፊቱ ካሉት አማራጫዎች አንዱን በመመምረጥ በመርጫዎች አጠገብ ባሉት ሳፕሮች ውስጥ የትክክል ወይም (✓) ምልክት ያስቀምጡ</p>
<p>1</p>	<p>እድሜዎ</p> <p>1. ከ15-24 <input type="checkbox"/> 2. ከ25-29 <input type="checkbox"/> 3. ከ30-49 <input type="checkbox"/></p>
<p>2</p>	<p>የመኖሪያ ስፍራዎ</p> <p>1. ከተማ <input type="checkbox"/> 2. ገጠር <input type="checkbox"/></p>
<p>3</p>	<p>የመጡት ምን ዓይነት አገልግሎት ፈልገው ነው</p> <p>1. ለቤተሰብ ምግብ አገልግሎት <input type="checkbox"/> 5. ለወሊድ <input type="checkbox"/></p> <p>2. ለእርግዝና ምርመራ <input type="checkbox"/> 6. ልጅ ምንጊያ ስከት <input type="checkbox"/></p> <p>3. ለፅንሰ ማቋረጥ <input type="checkbox"/> 7. ለሌላ አገልግሎት <input type="checkbox"/></p> <p>4. ለእርግዝና ክት <input type="checkbox"/></p>
<p>4</p>	<p>መጠይቁን የሞሉበት ቀን</p> <p>ቀን ወር 12 አመተምህረት 2010</p>
<p>5</p>	<p>አሁን ያሉበት የጤና ተቋም ዓይነት</p> <p>1. የግል ጤና ተቋም <input type="checkbox"/></p> <p>2. የመንግስት ጤና ተቋም <input type="checkbox"/></p>
<p>6</p>	<p>የትምህርት ደረጃዎ</p> <p>1. ያልተማሩ <input type="checkbox"/> 3. ሁለተኛ ደረጃ <input type="checkbox"/></p> <p>2. አንደኛ ደረጃ <input type="checkbox"/> 4. ሶስተኛ ደረጃ እና ከዚያ በላይ <input type="checkbox"/></p>
<p>7</p>	<p>ስራዎ</p> <p>1. የቤት እመቤት <input type="checkbox"/> 3. የመንግስት ሰራተኛ <input type="checkbox"/></p> <p>2. ተማሪ <input type="checkbox"/> 4. የግል መስሪያ ቤት ሰራተኛ <input type="checkbox"/></p> <p>5. ሌላ ስራ ካለዎት <input type="checkbox"/></p>
<p>8</p>	<p>የጋብቻ ሁኔታ</p> <p>1. ያገቡ <input type="checkbox"/> 2. ያላገቡ <input type="checkbox"/> 3. የፈቱ <input type="checkbox"/></p> <p>4. ባለቤት ያለፈብዎት <input type="checkbox"/></p>
<p>9</p>	<p>የልጆችዎ ቁጥር</p> <p>1. ምንም ልጅ የለዎትም <input type="checkbox"/> 2. አንድ ልጅ <input type="checkbox"/></p> <p>3. ከ2-4 <input type="checkbox"/> 4. 5 እና ከዚያ በላይ <input type="checkbox"/></p>

10	በየትኛው የጤና ተቋም አይነት ወለዱ	1.በግል ጤና ተቋም <input type="checkbox"/> 2.በመንግስት ጤና ተቋም <input type="checkbox"/>
11	የመጨረሻ እርግዝናዎ በእቅድ የያዙት ነው	1.አዎ <input type="checkbox"/> 2.አይደለም <input type="checkbox"/>
12	የእርግዝና ክትትል ሁኔታ (ከእርግዝና እስከ ወሊድ)	1. ምንም ክትትል አድርገው አያውቁም <input type="checkbox"/> 2. አንድ <input type="checkbox"/> 3.ሶስት <input type="checkbox"/> 3. ሁለት <input type="checkbox"/> 4. አራት <input type="checkbox"/>
13	በየትኛው የጤና ተቋም ቢወልዱ ምረጫዎ ነው	1.በግል ጤና ተቋም <input type="checkbox"/> 2.በመንግስት ጤና ተቋም <input type="checkbox"/>

መመሪያ 2	<p>የሚከተሉት ጥያቄዎች ስለ አሉበት የጤና ተቋም ከጤና ባለሙያዎች ጋር ስለነበርዎት ግንኙነት ልምድና ስላገኙት እንክብካቤ የእርሶን አመለካከት ለመለካት የተዘጋጁ ጥያቄዎች ናቸው። በመቀጠል ለሚቀርብሎት እያንዳንዱ ጥያቄዎች የሚሰማሙ ከሆነ በጣም እስማማለሁ (5)፣ ወይም እስማማለሁ (4)፣ እንዲሁም ስለ ጉዳዩ የሚያወቁ ከሆነ አላወቅም (3)፣ በማለት የማይሰማሙ ከሆነ አልሰማማም (2)፣ ወይም በጣም አልሰማማም (1)፣ በማለት የመረጡትን ምርጫ ቁጥር ብቻ አንዲጸፉ በአክብሮት እንጠይቃለን።</p>	<p>5. በጣም እስማማለሁ 4. እስማማለሁ 3- አላወቅም 2 .አልሰማማም 1- በጣም አልሰማማም</p>
14	የማገኘውን አገልግሎት እና ስራተኞቹን እወዳቸዋለሁ	
15	በማገኘው አገልግሎት እምነት አለኝ	
16	ለምኖርበት አካባቢ ቅርብ ነው	
17	ከዚህ በፊት በጤና ተቋሙ አገልግሎት አግኝቼ አውቃለሁ	
18	የቅርብ ጓደኛዬ እዚህ እንድመጣ መክሮኛል/መክራኛለች	

19	ስለ ጤና ተቋሙ በማስታወቂያ እና በመረጃዎች ሰምቻለሁ	
20	አስፈላጊ ሆኖ ከተገኘ ወደ ሌላ ተቋም እንደምላክ አውቃለሁ	
21	አስፈላጊ ከሆነ በልዩ ሐኪም የህክምና አገልግሎት አገኛለሁ	
22	ጤና ተቋሙ ለአገልግሎቱ አስፈላጊ የሆኑ ሰራተኞች አሉት	
23	በጤና ተቋሙ ያገኘሁት አገልግሎት ሰዓትን እና ገንዘብን ያገናዘበ ነው	
24	የጤና ተቋሙም ሁነ የምርመራ ክፍሉ ንጽህናው የተጠበቀ ነው	
25	በጤና ተቋሙ ለተሰጡኝ አገልግሎቶች በሙሉ ቅድሚያ ፍቃደኛ መሆኔ ተጠይቋል	
26	በጤና ተቋሙ በወሊድ ሆነ በምርመራ ወቅት ለሌሎች ሰዎች እይታ አልተጋለጥኩም በመጋረጃ ተከልዬ እና ሰውነቴም ተሸፍኖ ነበር	
27	የጤና ባለሙያዎቹ ሲያናግሩኝ በፈጣሪ እና ጓደኝነት በተሞላ ስሜት ነበር	
28	በስራ አጋጣሚ ያወቁትን ሚስጢራን የጤና ተቋሙ ሰራተኞች ደብቀውልኛል	
29	የጤና ተቋሙ ሰራተኞች በአክብሮት አስተናግደውኛል	
30	የጤና ተቋሙ ሰራተኞች ታካሚዎችን እኩል ያስተናግዳሉ	
31	የጤና ተቋሙ ሰራተኞች ለምጣይቀው ጥያቄ በግልጽ ይመልሱልኛል	
32	የጤና ተቋሙ የጤና ባለሙያዎች ስለሁኔታዬ በደንብ ያስረዱኛል	
33	የጤና ተቋሙ የጤና ባለሙያዎች እኔን ለመከታተል ሲሉ ቀጠሮ ይሰጡኛል	
34	የጤና ተቋሙ የጤና ባለሙያዎች ባስቸግር እንኳን ተስፋ አይቆርጡብኝም	
መመሪያ 3	<i>የሚከተሉት ጥያቄዎች በጤና ተቋሙ ተኝተው የመታከም እርዳታ ካገኙ ብቻ ይመልሱዎቻቸው ተኝተው ካልታከሙ ሙሉ በሙሉ ከጥያቄ ቁጥር 35 እስከ 43 ያለውን ጥያቄ ትተው ወደ ቀጣዩ መመሪያ ቁጥር 4 ይሄዱ</i>	
35	የጤና ተቋሙ የጤና ባለሙያዎች ስጠራቸው ወዲያውኑ ይመጡልኛል	
36	የጤና ተቋሙ የጤና ባለሙያዎች በክፍል ውስጥ ትተውኝ ከመሄዳቸው በፊት	

	አጠገቤ የምፈልጋቸው ነገሮች እንዳሉ ያረጋግጣሉ	
37	የጤና ተቋሙ የጤና ባለሙያዎች በጥንቃቄ እና በደስታ ያገለግሉኛል	
38	የጤና ተቋሙ የጤና ባለሙያዎች እራሴን መደገፍ እስክችል ድረስ ይረዱኛል	
39	የጤና ተቋሙ የጤና ባለሙያዎች የህክምና መሳሪያዎችን እንዴት እንደሚጠቀሙ ያውቃሉ	
40	የጤና ተቋሙ የጤና ባለሙያዎች መድሀኒቶቹን እና ህክምናዬን በሰዓቱ ይሰጡኛል	
41	የአስተኝቶ ማከሚያ ክፍል ንጽህና የተጠበቀ ነው	
42	የጤና ተቋሙ የጤና ባለሙያዎች ስለ እኔ ሁኔታ ለቤተሰቤ ያሳውቃሉ	
43	የጤና ተቋሙ የጤና ባለሙያዎች ስለሁኔታዬ በቅርብ ይከታተላሉ	
መመሪያ	የሚከተሉት ጥያቄዎች ስለጤና ተቋሙ አጠቃላይ አስተያየትዎን ለማወቅ የተዘጋጁ ጥያቄዎች ናቸው፡፡	
44	ባጠቃላይ በጤና ተቋሙ ባገኘሁት አገልግሎት እንዲሁም በሁሉም ባለሙያዎች በተደረገልኝ አቀባበልና መስተንግዶ ረክቻለዉ	
45	ሌሎች እናቶች በዚህ ጤና ተቋም እንዲወልዱ እመክራለሁ	
46	በተሰጠኝ አስደሳች አገልግሎት ምክንያት ተመልሼ ወደዚህ ጤና ተቋም እመጣለሁ	