COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

POSTGRADUATE PROGRAM

ATTITUDE AND INVOLVEMENT OF MALE PARTNERS IN MATERNAL HEALTH CARE, IN NIFAS SILK LAFTO SUB-CITY, ADDIS ABABA, ETHIOPIA, 2020.

By: Zeytuna Mohammed

A Thesis Submitted to school of graduate studies of Addis Ababa University College of Health Science, School of Nursing and Midwifery in Partial Fulfillment of the Requirements for the degree of Masters in Maternity and Reproductive Health Nursing.

October, 2020

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I, the undersigned MSc student, declare that I have submitted my original work on a title "Attitude and involvement of male partner in maternal health care, in Nifas silk lafto sub city, Addis Ababa, Ethiopia, 2020".

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This thesis work has been submitted with my approval as an advisor and reviewer.

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APPROVAL BY THE BOARD OF EXAMINATION

This thesis by Zeytuna Mohammed is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of masters in **Maternity and Reproductive health Nursing**.

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LIST OF ABBREVIATIONS

ANC	Ante – Natal Care
PNC	Post – Natal Care
FP	Family Planning
MHC	Maternal Health Care
MCH	Maternal and Child Health
RH	Reproductive Health
EDHS	Ethiopian Demographic Health Survey
MI	Male Involvement
USAID	United States Agency for International Development
WHO	World Health Organization
AOR	Adjusted Odds Ratio
COR	Crudes Odds Ratio
HHs	Households
CI	Confidence Interval

ABSTRACT

Background: Males tend to be decision-makers within the family. But Most of the efforts to increase the uptake of maternal health services have mainly addressed women. Little has been done to involve the male partner in maternal health.

Objectives: To assess the attitude and involvement of the male partner in maternal health care in Nifas silk lafto sub city, Addis Ababa, Ethiopia.

Method: A community-based cross-sectional design was employed. A systematic random sampling technique was used to select the study participants. The data were collected using a structured self – administered questionnaire. A total of 411 married men included in the study. Data were entered in Epidata version 4.6 then exported and analyzed through SPSS version 25. The association between the dependent variable and independent variables was checked using Multivariable logistic regression. The adjusted odds ratio with 95% CI computed and variables with p-value ≤ 0.05 were considered as statistically significant.

Results: A total of 411 respondents participated in the study which makes the response rate of 100 %. About 142 (34.5%), 274 (66.7%), and 258 (62.8%) had good involvement in antenatal, labour and delivery, and postnatal care respectively. Males whose partner had unplanned pregnancy (AOR = 0.46, 95% CI: 0.222 - 0.956), those who did not live together with their partner (AOR = 0.09, 95% CI: 0.011- 0.804) and who do not get Information in antenatal and postnatal clinics (AOR = 0.101, 95% CI: 0.056-0.181) were less likely to have good involvement in maternal health care.

Putting the level of involvement in all the three aspects of maternity care together, 103 (25.1%) had good involvement in maternal health care. Among respondents, 200 (48.7%) had a positive attitude towards maternal health care.

Conclusion: participants who had good involvement in maternal health care were low and participants who had good attitude towards maternal health care were average. Moreover, access to information on men's involvement in maternal health, living arrangement, and whether the pregnancy was planned or not were factors associated with men's involvement in maternal health care. Encouraging pregnant mothers to communicate effectively on maternal health issues with their partner and effective counseling in family planning services should be applied.

Key Words: Male Involvement, Male Attitude, Maternal Health care.

1. INTRODUCTION

1.1. Background

Maternal health care is the health service provided to women during pregnancy, childbirth, and the postpartum period (1). These health services include preconception care, antenatal care (ANC), prevention of mother-to-child transmission (PMTCT), intrapartum care, postnatal care (PNC), and emergency obstetric care/management of obstetric complications (1). But for the purpose of this study maternal health care refers to ANC, Intrapartum care, and PNC. Proper care during pregnancy and delivery is important for maternal health (2).

Healthy mothers lead to healthy families and societies, strong health systems, and healthy economies (3).The care of mothers needs major consideration and be part of every program because Mothers and children make up over 2/3 of the whole population. Women in reproductive age (15 – 49) constitute 21% and pregnant women, 4.5% (4). Throughout the world, especially in developing countries, there is an increasing concern and interest in maternal health care(4).Interventions for maternal health encompass various approaches, including promotional, preventive, and therapeutic (5).Two indicators commonly used to assess care during pregnancy and delivery is antenatal care (ANC) and skilled birth attendance during delivery (6), and skilled birth attendance during delivery is considered as a key strategy in the reduction of maternal mortality (7).

Men's involvement in the health of their partners can play an important role in improving health outcomes (8).In most families, the men are empowered financially and are the main decision-makers in all issues including reproductive health. They may use this opportunity to ensure that their pregnant wives seek maternity services or arrange for skilled care during delivery (6).

All over the world, there is an increasing interest in mainstreaming male participation in reproductive health, since men usually are the key decision-makers in the home and often control household finances (6). So, women become equal partners in public and private lives and to encourage and enable men to take responsibility for their sexual and reproductive behavior (9). In many parts of the world, men play a central role in decision-making regarding the health of women and children; therefore, male involvement is critical in improving maternal health outcomes (10). Additionally, Most of the efforts to address these determinants, and to increase uptake of maternal health services have mainly addressed women. Little has been done to

involve the male partner in maternal health (4). Different programs have directed efforts to harness the support and active involvement of men for improved Maternal Health outcomes (9). Interventions to promote the involvement of men during pregnancy, childbirth, and after birth are recommended to facilitate and support improved self-care of women, improved home care practices, improved use of skilled care during pregnancy, childbirth, and the postnatal period, increase the timely use of facility care for obstetric complications, address the influence of gender inequality on Maternal Health and promote men's positive involvement as partners and fathers (9).

1.2. Statement of the problem

In most parts of the world, men are responsible for making important decisions regarding the allocation of financial resources and health care behaviors that could directly affect the health of the mothers and the infants (11). Likewise, men's behaviors would affect the reproductive health of their wives and children. However, most of the maternal and child health programs were focused on women's education and participation while men were neglected (12).

Men's behavior can considerably concern the outcome of the mother's health and their babies. Studies found that the effect of men's involvement on women's health outcomes is directly linked to men's knowledge, their attitudes, and their behaviors (13). Men's knowledge about pregnancy-related care and a positive gender attitude enhances maternal health care utilization and women's decision-making about their health care, while their presence during antenatal care visits markedly increases the chances of women's delivery in health institutions (14). Interventions to promote the involvement of men during pregnancy, childbirth, and after birth are recommended by the World Health Organization (WHO) to facilitate and support improved self-care of the woman, improved home care practices for the woman and newborn, and improved use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns (9).

Men's participation in maternal and child health presents an opportunity for the advancement of maternal and child nutrition as men often play a key role in decision-making particularly regarding women's reproductive health. While most research on men's involvement in maternal and child health has focused on men's participation in antenatal care, the present study focuses mainly on men's attitude and involvement towards maternal Health Care as a package in Nifas silk lafto Sub city, Addis Ababa, Ethiopia.

1.3. Significance of the study

Men's involvement in maternal and child health has been on the development agenda for over two decades. However, in policy practice, it has for the most part been overlooked and excluded from policy design (13). Men's supportive stance is an essential component for making women's world better. There are growing debates among policymakers and researchers on the role of males in maternal health programs (14), which is a big challenge in Ethiopia where society is male-dominated. The level of men's participation related to maternal and fetal health care is low and few studies were conducted concerning the causes for low participation of men and barriers to their participation in Africa including Ethiopia. Thus, carrying out more studies in this field is required for designing culture-sensitive and effective interventions on men's participation during pregnancy, delivery, and the postpartum period. This could help to improve the health of the mother and the infant.

The findings of this study will inform the health managers to recognize the role of fathers in the health of mothers in the health system and helps to develop policies. In addition, the paper may be useful to other researchers as a reference while conducting further studies. Knowing the attitudes and involvement of men towards maternal health care will also help to improve the future participation of male partners in Ethiopia.

2. LITERATURE REVIEW

2.1. Attitude of male in maternal health care

A study in Nigeria found that 56.5 % of men had a good attitude towards maternal health care (15). A cross-sectional study in Uganda stated that Men believed that issues related to pregnancy and childbirth were the domain of women. In this study, the women, on the other hand, women interested in receiving more support from their husbands. This study, therefore, proposed recommendations and the need for community health education directed at men that engages them in this area (16). In a study done in rural Tanzania, respondents reported to have negative attitude regarding their participation in antenatal care, but they were generally positive about their partner attending antenatal care (17). A study in Kenya revealed that Majority of men did not feel that there are benefits associated with attending ANC as partners though majority of them agree that women should always attend ANC regardless of their status (18). Additionally, male partners had the view that they should accompany their partner only when forced by the heath care provider or when an emergency arises (18).

A study done in Nigeria reported that almost all 98.7% the respondents said men have important roles in pregnancy and after delivery, whilst only 25.1% of respondents agreed that men should attend antenatal clinics with their wives (19). In a study done in Kenya, More than half of the respondents agreed that traditionally ANC is a place for women only and that men have specific roles to play during pregnancy (18). Another study in Kenya revealed men's attitude as a barrier to their involvement in maternal health care (20).

2.2. Involvement of male in maternal health care

In a study in Nigeria, Concerning the involvement of the men in maternal health care of their wives, 29.1% ever followed their wives to family planning clinic, 24.0% to the ante-natal clinic, and 27.1% to the delivery room respectively (15). A cross-sectional survey in Tanzania found that only 1 in 5 men were involved in maternity care of their partners (21). Another study done in Myanmar reported that the involvement level of 64 % (22). A community-based survey in Tanzania among married men found 94.4 % of the respondents reported having ever attended the RH service with their female partners at least once and 63% attended antenatal services (ANC) (23). A study in Kenya showed that the involvement of men in MCH clinics is far below the average expectations (≥30%) by the ministry of health (24).

A community-based cross-sectional study done in Wolaita Sodo town, Ethiopia found the participation of Husbands in BPCR was poor in the study area (25).

In another cross-sectional study in Nepal, male involvement in maternal and infant health care is low (26). A study in Ghana showed male involvement in various MCH services as 35% of respondents accompanied their partners to antenatal care during pregnancy, while 44% accompanied their partners to deliver and One-fifth of the respondents accompanied their partners for postnatal care services (27). A qualitative study in Nepal shows limited male involvement in reproductive health (28) whereas a study in Tanzania reported more than half of respondents had high involvement in antenatal care services. This study informs on Health promotion is needed to empower men with essential information for meaningful involvement in antenatal care services (29).In a study in Uganda the participation of men in maternal and child health care was found to be low (30). A descriptive cross-sectional survey conducted in North Gondar Zone, Ethiopia found males involvement in BP/CR to be very poor (31). A qualitative study carried out in Ghana suggests Initiatives to promote male involvement should focus on young men and use chiefs and opinion leaders as advocates to re-orient men towards more proactive involvement in ensuring the health of their partners (32). A qualitative study of policymaker and practitioner perspectives in four regional organizations in the Pacific suggests that increasing men's involvement in maternal and child health services will require initiatives to engage men in the community and clinic settings, engage boys and men of all ages and improve health infrastructure and service delivery to include men (12). A study done in east region of Ghana revealed that level of male involvement in antenatal care was above average 67.2%. About 71.9% accompanied their partners to antenatal clinics at one point during the pregnancy period (33). A study done in Nigeria reported that more than half of the respondents had good involvement in pregnancy related care (19).

2.3. Factors Associated with Male Involvement in MHC

Researches revealed that the involvement of males in MHC is associated with respondent's age (23,26), Level of education (26,27) and occupation (26,29). Findings of a study in Ghana show Male involvement in antenatal care and delivery was significantly associated with the type of marriage, living arrangement, and a number of children (27). In a study In western Tanzania, female partner invitation to HR services and having less than 2 children were associated with higher RH service attendance (23). In another study in Nepal, the involvement of the male is associated with Ethnicity, Illiteracy, and income, Therefore these factors should be considered during maternal and infant health policy development (26). A qualitative study in Malawi identified recognition by men of the impact of their involvement, pride, advocacy, incentives, and disincentives and male champions as facilitators of men's involvement. And as Barriers, the study identified socio-cultural beliefs, stigmatization, and opportunity costs (13).

A study In Tanzania found long waiting time to receive the service and limited access to information regarding men's involvement is associated with low men's involvement in maternity care so that, The study suggests Male friendly maternity care to be recognized and empowering mothers with relevant information to improve Spousal communication (21). A study in Nigeria also showed that long waiting time at the health facilities were the reason reported by participants for lack of involvement in pregnancy related care (19). In a study done in east region of Ghana, Factors such as staff attitude, time spent at the clinics, age, educational level, monthly income, living together, distance to the clinic and community acceptability were factors associated with male involvement in maternal health care (33). Another study in Kenya shows, Male participants who were more likely to accompany their spouses to MCH clinics were knowledgeable of the MOH effort to enhance men's attendance to MCH clinic (24). A study in Nepal founds Men's education and attitude, awareness, socio-cultural factors, psychological factors, health system factors, and policies play important roles in male involvement in reproductive health (28). A study in Bangladesh showed that Knowledge of women was significantly associated with the knowledge of their husbands with respect to the awareness of MCH services (34). A cross-sectional study in Tanzania founds religion, ethnicity, waiting time and men's perception about the attitude of care providers were significant factors influencing men's involvement in antenatal care services (29).

A study applying the three delays model to male involvement in Tanzania indicates that Men can leverage their influence over household resources and decision making to facilitate care-seeking and navigate challenges accessing care for women and newborns (35). A study in Uganda reported that Men's participation in MCH is affected by multiple factors emanating from the community and health institutions. The study suggests the Sensitization of communities is fundamental for increasing awareness of the significance of male involvement in MCH (30).

2.4. Conceptual Framework

Based on a review of related literature done in Ghana; Male partner involvement in maternal health care may be affected by socio-demographic characteristics, Whether the couples live together or not may be an important factor in determining the level of involvement. Cultural norms that cull out gender roles may not encourage men to take part in activities that are tagged as feminine. Other family members like mothers and mother's in-law may be seen as the ones responsible for issues related to pregnancy and delivery so men may be unwilling to get involved. Some taboos may prohibit male involvement in some aspects of maternal health care. And also health facility Factors may or may not encourage male involvement in maternal health care. Health facilities male-friendly care of the services and restrictions on the areas in the facility that can be accessed by men may influence male involvement. The study states that, Male involvement leads to improved maternal health outcomes by increasing women's utilization of health services (36).

Conceptual frame work

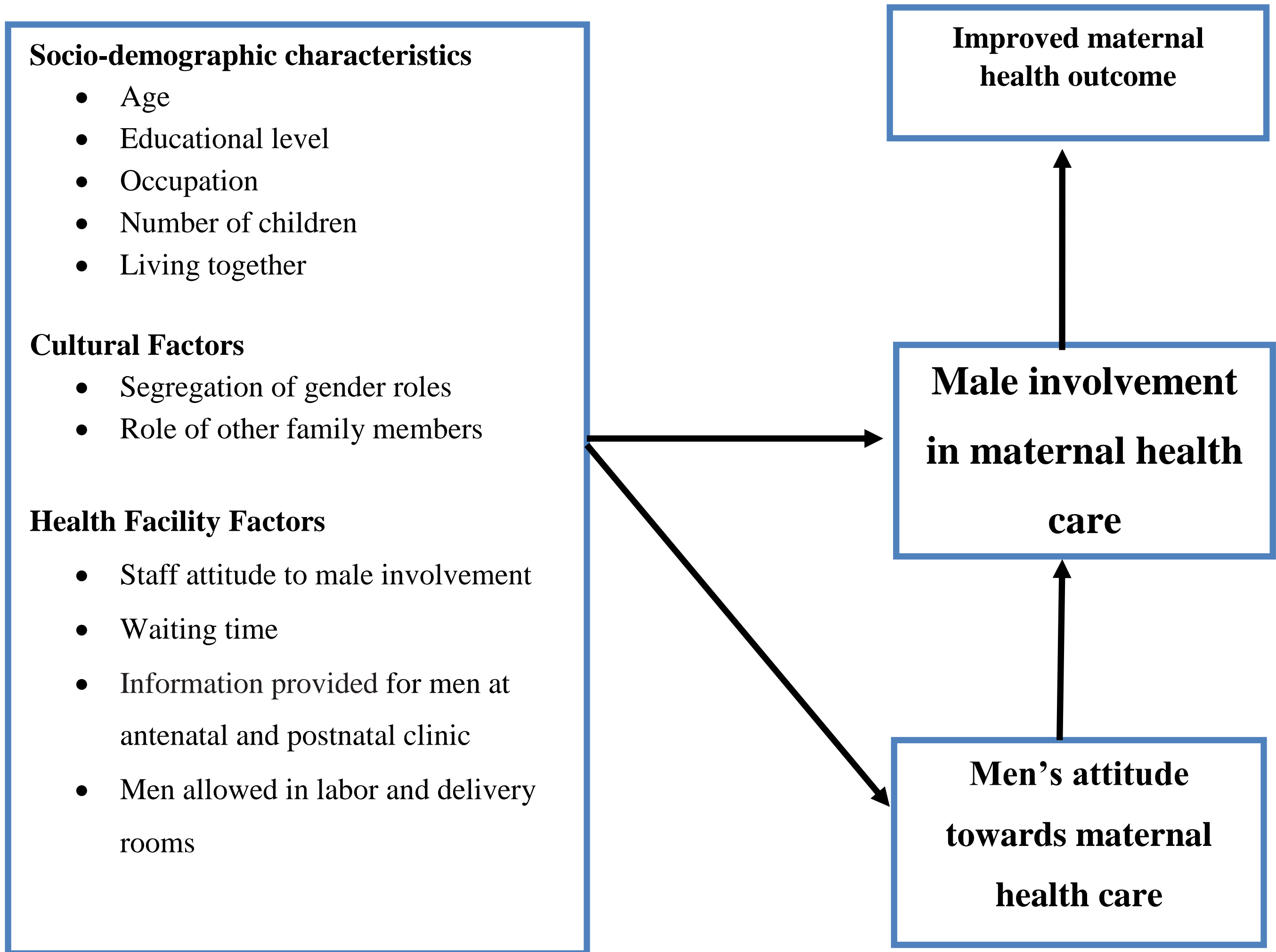

Figure 1: Conceptual framework of male partner involvement in Maternal Health Care among married men in Nifas silk lafto sub-city, Addis Ababa, Ethiopia 2020 (36).

3. OBJECTIVES

3.1. General objective

To assess the attitude and involvement of the male partner in maternal health care in Nifas silk lafto Sub-city, Addis Ababa, Ethiopia, 2020

3.2. Specific objectives

- To assess the attitude of the male partner in maternal health care in Nifas silk lafto sub-city, Addis Ababa, Ethiopia, 2020
- To evaluate the involvement of the male partner in maternal health care in Nifas silk lafto Sub-city, Addis Ababa, Ethiopia, 2020
- To determine factors associated with male partner involvement in maternal health care in Nifas silk lafto sub – city, Addis Ababa, Ethiopia, 2020
- To determine factors associated with attitude of male partners towards maternal health care in Nifas silk lafto sub – city, Addis Ababa, Ethiopia, 2020

4. METHODS

4.1. Study area and period

The study was conducted in Nifas Silk Lafto Sub-city, Addis Ababa. Addis Ababa is a capital city of Ethiopia and the diplomatic capital of the African Union. It is located about 2500 m above sea level and covers about 540 km2. It has ten sub-cities and 116 woredas in it. The city has an estimated population of 3.2 million of which 52.6% are females and 47.3% are males (37). Nifas Silk Lafto sub-city is one of the largest sub-cities among the ten sub-cities of Addis Ababa city administration. This district is situated in the southwestern part of Addis Ababa; it covers an area of 68.3 sq km and divided into 12 woredas. It has an estimated population of 335, 74 of which 158,126 are males and 177,614 are females. The study was conducted from April to June 2020.

4.2. Study Design

A community-based cross-sectional study was employed.

4.3. Source population

All married males residing Nifas silk lafto sub-city, Addis Ababa, Ethiopia.

4.4. Study population

All married adult males who at least have one child and give verbal consent to participate were included in the study.

4.5. Eligibility criteria

4.5.1. Inclusion criteria

All men above 18 years of age who are married and had at least one child at the time of data collection and consented to participate in the study.

4.5.2. Exclusion criteria

The man whose wife had a history of abortion in the 12 months prior to the study was excluded from the study to avoid any potential psychological trauma to the respondents through evoking the events associated with it.

4.6. Study Variables

4.6.1. Dependent variables

- Male involvement in maternal Health Care
- Men's attitude towards maternal Health Care

4.6.2. Independent variables

- Socio-demographic characteristics

  Age, Educational level, Occupation, Number of children and Living together
- Cultural factors

  Role of another family member
- Health facility factors

  Staff attitude to male involvement, waiting time, the information provided for men, and men allowed in labour and delivery rooms.

4.7. Sample size determination

The sample size was determined using single population proportion formula with the following assumptions: Proportion of male involvement was 41.9% based on the study conducted in Ambo town, Ethiopia (38) and by using 95% confidence interval with 5% margin of error,

$$n = \frac{(Z\alpha/_2)^2\, p\,(1-p)}{d^2}$$

Where, n- Required Sample size

z- Standard normal value at 95% CI which is 1.96

p- Estimated population proportion which is 0.419

d- Possible margin of error tolerated which is 0.05

$$n = \frac{(1.96)^2 0.419(1-0.419)}{(0.05)^2} = \mathbf{374}$$

Therefore, the final sample size was calculated by adding a10% non-response rate, **374 + 37= 411** of study participants will be included in the study.

4.8. Sampling technique/ procedure

A systematic random sampling technique was employed to select the study participants. First, all the 12 woredas of Nifas silk lafto sub-cities was listed. A simple random sampling technique using a lottery method was employed to randomly draw the number of woredas from which the study participants selected. From the 12 woredas, 30% of the woredas which are 4 woredas were selected; these are woreda 2, woreda 6, woreda 10, and woreda 11. The number of Households was obtained from woreda's administration bureau.

Following, the calculated sample size of 411 was allocated for each woreda based on probability proportional to size. The table shows the allocation of the sample size to the selected woredas by probability proportional to size.

Sample size allocation by number of households

Woredas	**Number of HHs**	**Proportionate**
2	11,000	411⁄36956×11000= 122
6	8,926	411⁄36956×8926= 99
10	8,500	411⁄36956×8500= 95
11	8,530	411 / 36956×8530 = 95
Total	N= 36,956	n = 411

Key: N= total number of households

Households from a selected woredas were chosen by systematic sampling technique. The total number of households in a selected woreda was divided by the required sample size to give the sampling interval (k=90). Finally, the selections were made based on every 90th of married men until the required sample size fulfilled.

4.9. Operational definitions

Maternal health care: Refers to the care given to a woman during her pregnancy, labour and delivery, and the postpartum period by the health professional.

Male partner: Refers to a woman's partner in marriage and/or who identify themselves as married and biologically responsible for her pregnancy.

Male partner involvement: Male involvement was measured as a composite measure using 5 points, which was equally weighted: Accompanying partner to the health facility, Discussing maternal health issues with a partner, Discussing maternal health issues with her health care providers, Providing financial and physical support to his partner and Involved in planning for emergency, delivery and postpartum care. Each of these five points was allotted a score of (1) when the participant performed the activity and (0) when the activity was not performed. A total score was computed for each participant and the level of involvement was categorized as good involvement for a score of 3 – 5 and a score of 0 – 2 was considered poor involvement (36).

Overall involvement: Respondents who participate in all the three aspects of maternal health care are said to have good involvement in maternal health care and those who did not participate in one of the three aspects of maternal health care are said to have poor involvement in maternal health care.

Men's Attitude: The attitude of respondents was assessed by putting 11 questions on a Likert scale; it had questions that ranged from Strongly Agree, Agree, Indifferent, Disagree, and Strongly Disagree. Respondents who scored below the mean score were said to have a negative attitude towards maternal health services while those with scores up to or above the mean score were labeled as having a positive attitude towards maternal health care (36).

4.10. Pre Test

Before the commencement of data collection, the questionnaire was pretested in 21 (5%) randomly selected respondents for validity and reliability in the Akaki kality sub – city which is out of the study area.

4.11. Data collection method

Data were collected by using a pre-tested structured face to face administered questionnaire adapted from a review of related literature (15,36). The questionnaire consists of three parts:

Section A of the questionnaire covers the socio-demographic status of respondents that is: (age, educational level, occupation, monthly family income, and a number of children and Age of the last child).

Section B covers the involvement of respondents in maternal health care services (previous involvement in various maternal health services such as ANC, Labor and Delivery, and PNCs).

Section C includes attitude to maternal health care services (Strongly agreeing, Agreeing, Indifferent, Disagreeing, and strongly disagreeing on issues related to men supporting their wife on maternal health care services).

The data were collected by 4 trained health extension workers. The data collection process was supervised by 2 BSc Midwives who had previous experience in data collection. In addition, data collectors were continuously supervised by the principal investigator throughout the data collection period.

4.12. Quality assurance

The questionnaires were first prepared in English and back-translated to local language (Amharic) by language experts and re-translated to English to ensure its consistency of meaning. The Amharic version was used for the data collection. The data collectors were trained in data collection procedures and were supervised. The principal investigator supervises the data collectors and provided feedback throughout the data collection period. Each questionnaire had the interviewer's initial and code to facilitate cross-checking of the completed questionnaire. The collected data was checked for its consistency and completeness before any attempt to enter code and analyze it.

4.13. Ethical clearance

Ethical clearance and approval letters were obtained from the Addis Ababa University research ethics committee or institutional review board (IRB). A permission and support letter to conduct the study was written by the Addis Ababa health bureau. A support letter for the selected woredas was obtained from the Nifas silk lafto sub-city health office. Permission letter to collect the data were obtained from each woredas health office. Participants were provided with informed verbal consent before data collection and Confidentiality were assured by using codes rather than names. Participation was voluntary and participants were informed that they could withdraw from the study at any time if they want.

4.14. Data analysis

The data was cleaned, coded, and entered into Epi-data version 4.6. Software and then exported to Statistical package for social sciences (SPSS) version 25 for further analysis. The bivariate analysis was done to identify the association between the independent and the dependent variables. Those variables with a $p\text{-value}<0.25$ in bivariate analysis were a candidate for multivariable logistic regression, and then those variables with a $p\text{-value}<0.05$ at 95% confidence interval (CI) in multivariable analysis considered as having statistically significant association with male involvement. Finally, results were presented in texts, graphs, and tables.

5. RESULTS

5.1. Socio-demographic characteristics

A total of 411 respondents participated in the study which makes the response rate of 100 %. About 183 (44.5%) respondents were within the age group of 30 – 39 years with a mean age of 37.20 (SD: ± 7.637). The average number of children per participant was 2.24 (SD: ± 1.161). The proportion of men with no formal education, primary, secondary, and tertiary level education and participant's occupation was shown in table 1.

Table 1: Socio-demographic characteristics of participants live in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia 2020

Variable	Category	Frequency(n= 411)	Percentage (%)
Age (years)	20 – 29	71	17.3
	30 – 39	183	44.5
	40 – 49	138	33.6
	≥ 50	19	4.6
Educational level	No formal education	17	4.1
	Primary	65	15.8
	Junior secondary	66	16.1
	Senior secondary	114	27.7
	Tertiary	149	36.3
occupation	Unemployed	10	2.4
	Private employee	174	42.3
	Public servant	105	25.5
	Private job	87	21.2
	Daily laborer	35	8.5
Number of children	1	141	34.3
	2 – 4	263	64.0
	≥ 5	7	1.7

5.2. Male involvement in Antenatal care

Among 411 participants, about 178(43.3%) of respondents make a Joint plan for emergency situations during pregnancy. 157 (38.2%) of the participants accompanied their partners at least once to the antenatal clinic. Using the five-point male involvement index, respondents who had good involvement in ANC was 142 (34.5%). Table 2 shows the proportion of males in different tasks of male involvement in Antenatal care.

Table 2: Male involvement in Antenatal care in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia, 2020

Variables		Frequency	Percent %
Living together at the time of pregnancy (n=411)	Yes	372	90.5
	No	39	9.5
Other family living with you (n=372)	Yes	112	30.1
	No	260	69.9
Which family member was living with you (n=112)	Her mother	30	26.8
	My mother	27	24.1
	Siblings	51	45.5
	Others	4	3.6
Planned pregnancy (n=411)	Yes	257	62.5
	No	154	37.5
Partner had antenatal follow up (n=411)	Yes	390	94.9
	No	18	4.4
	Don't know	3	0.7
Place where your partner attend antenatal care (n=390)	public hospital	72	18.5
	health center	256	65.6
	Private health sector	47	12.1
	Don't know	15	3.8
Involved in the decision on where she had antenatal care (n=411)	Yes	208	50.6
	No	203	49.4
Joint plan for emergency situation (n=411)	Yes	178	43.3
	No	233	56.7

Table 2 continued…

Variables		Frequency	Percent %
Put money aside for emergency (n=178)	Yes	153	86.0
	No	25	14.0
Made transport arrangement (n=178)	Yes	32	18.0
	No	146	82.0
Decided on where to go in case of emergency (n=178)	Yes	70	39.3
	No	108	60.7
Ever followed partner to antenatal clinic (n=411)	Yes	157	38.2
	No	254	61.8
How many times did you accompany your partner (n=157)	1	67	42.7
	2 – 3	57	36.3
	≥ 4	33	21.0
Attitude of the staff (n=157)	Friendly	82	52.2
	Unfriendly	36	22.9
	Indifferent	39	24.9
Time spent at the health facility (n=157)	Reasonable	73	46.5
	Too long	84	53.5
Financial and physical Support at the time of pregnancy (n=411)	Provide funds	243	59.1
	Remind her of ANC visits	103	25.1
	Helped with household chores	175	42.6

Most of the reasons given by participants who were not accompanying their partners to the antenatal clinic were inconvenient with work 186(73.2%). Figure 2 shows reasons given by married males for not accompany their partners to the antenatal clinics.

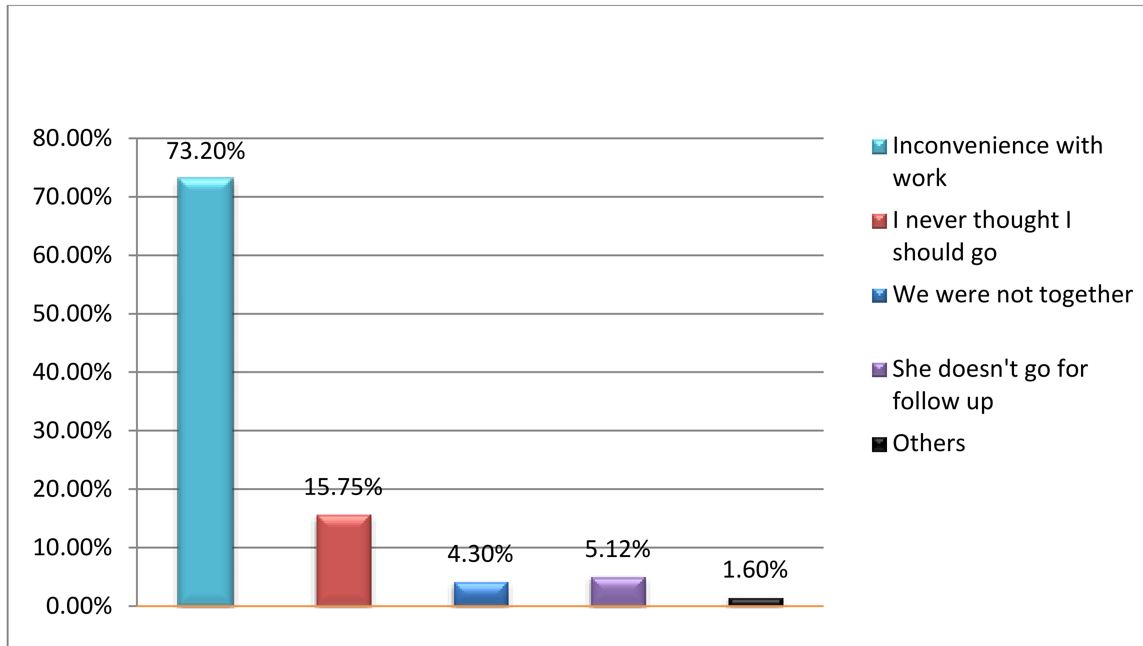

Figure 2: Reasons given by married males for not accompany their partners to Antenatal clinic in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia 2020

5.3. Level of male involvement during labour and delivery

About 333 (81.0 %) of the participants accompanied their partners to the labour and delivery. Among those who did not accompany their partner about 44 (60.3%) of participants delegated someone to take her to the health facility. Using the five-point male involvement index, participants who had good involvement in labour and delivery was 274 (66.7%). Table 3 shows the proportion of male in different tasks of male involvement in labour and delivery.

Table 3: Male involvement in Labour and delivery in Nifas Silk Lafto Sub-city, Addis Ababa, Ethiopia, 2020

Variables		Frequency	Percent (%)
Living together at the time of her labour and delivery(n=411)	Yes	357	86.9
	No	54	13.1
Accompany your partner to the facility at the time of labour and delivery(n=411)	Yes	333	81.0
	No	73	17.8
	Did not deliver in the health facility	5	1.2
If no, how did she get to the health facility that day(n=73)	Delegate somebody to take her	44	60.3
	She went alone	4	5.5
	Don't know	4	5.5
	Others	21	28.7
Make joint prior plans for labour and delivery during pregnancy(n=411)	Yes	219	53.3
	No	192	46.7
Support provided your during her labour and delivery? (n=411)	Provided funds	312	75.9
	Helped with household chores	228	55.5
Male partners allowed being present during labour and delivery in the facility she attended? (n=411)	Yes	0	0
	No	304	74.0
	Don't know	107	26.0
Do you wish you were present at the delivery room? (n=411)	Yes	105	25.5
	No	306	74.5
If one person should be allowed in the labour room with the laboring woman, who should it be? (n=411)	Husband	135	32.8
	Mother	142	34.5
	Mother in law	16	3.9
	No one	109	26.5
	Others	9	2.2

5.4. Level of male involvement in post-natal care

About 225 (54.7%) of the participants accompanied their partners to postnatal care. Using the five-point male involvement index, 258 (62.8%) had good involvement and 153 (37.2 %) had poor involvement.

Table 4: Level of male involvement in postnatal care in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia, 2020

Variables		Frequency	Percent (%)
Living together after delivery? (n=411)	Yes	386	93.9
	No	25	6.1
If no, who did she live with? (n=25)	Her mother	18	72.0
	My mother	4	16.0
	Others	3	12.0
Ever accompany partner for postnatal visits to the health facility (n=411)	Yes	225	54.7
	No	186	45.3
Involved in making prior plans for her postnatal care (n=411)	Yes	150	36.5
	No	261	63.5
What support did you provide your partner during the postnatal period? (n=411)	Provide funds	304	74.0
	Helped with household chores	228	55.5

Most of the reasons given by participants who were not accompanying their partners to the postnatal clinic were inconvenient with work 149(80.0%). Not living with their partner at that time 12(6.5%), they never thought they should go 7(3.8%), that the women don't go for postnatal care 10(5.4%) and others 8(4.3%) as she can go with her family and by herself were other reasons given by the participants.

Table 5: The proportion of participants who performed each of the five key activities used in the measurement of male involvement in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia, 2020

Activity	Period of maternity care n (%)		
	Antenatal	Labour and Delivery	Postnatal
The man make joint plan	178(43.3)	219 (53.3)	150 (36.5)
The man accompanies partner to health facility	157 (38.2)	333 (81.0)	225 (54.7)
The man provides financial and physical support	127 (30.9)	390 (94.9)	398 (96.8)
The man discusses maternal health issues with partner	344 (83.7)	245 (59.6)	347 (84.4)
The man discusses maternal health issues with her health care providers	79 (19.2)	75 (18.2)	104 (25.3)

Table 6: Level of male involvement in antenatal care, labour and delivery and postnatal care in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia 2020

Period of care	Level of male involvement (N = 411), n(%)	
	Good involvement	Poor involvement
Antenatal	142 (34.5)	269 (65.5)
Labour and delivery	274 (66.7)	137 (33.3)
Postnatal	258 (62.8)	153 (37.2)

5.5. Overall involvement of the male partner in maternal health care

Putting the level of involvement in all the three aspects of maternity care together, a total score was obtained and the overall level of involvement in maternity care was 103(25.1%) had good involvement and 308 (74.9%) had poor involvement. Figure 3 shows the overall level of male involvement in maternal health care.

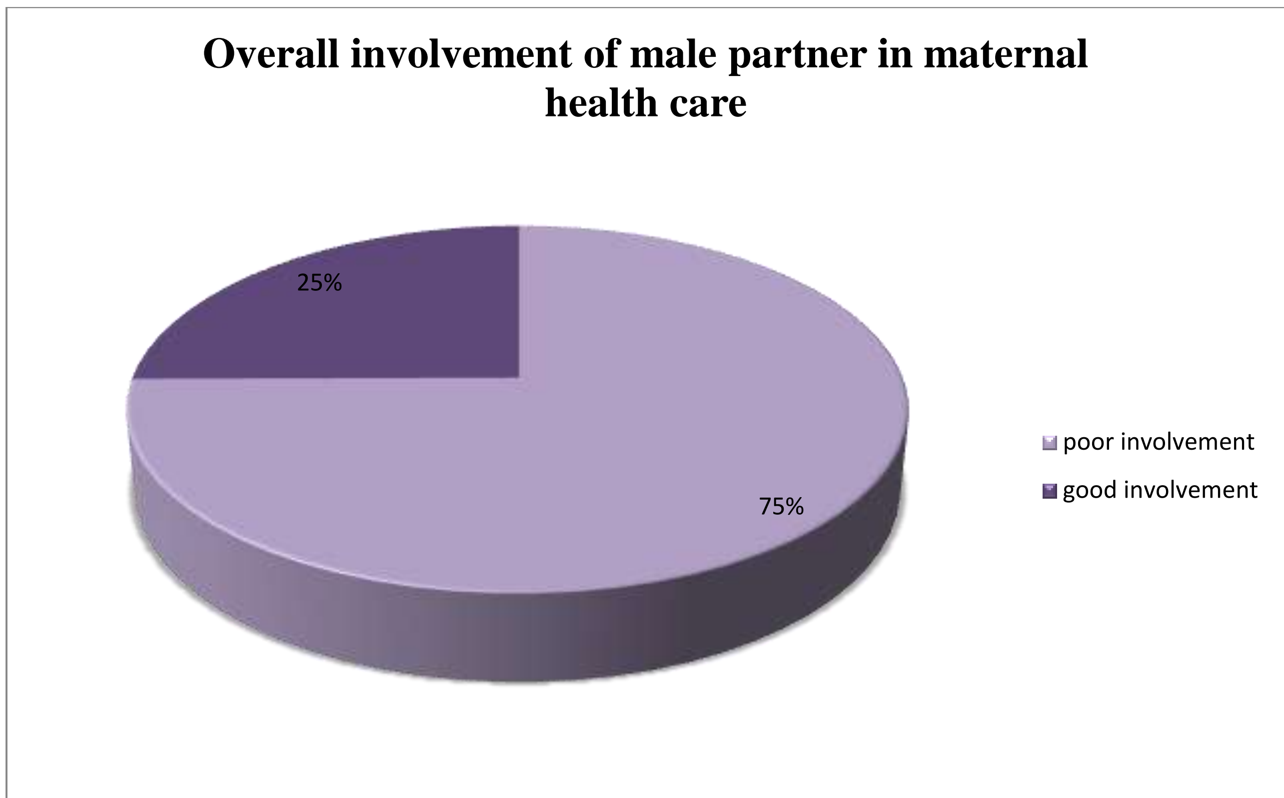

Figure 3 : The overall level of male partner involvement in maternal health care in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia, 2020

5.6. Attitude of man in maternal health care

The mean attitude of male partners towards maternal health care was 40.16 (SD ±5.063). 200 (48.7%) of the participants scored greater and equal to the mean which is categorized as a positive attitude and 211 (51.3%) scored less than the mean which is categorized as a negative attitude.

Table 7: The proportion of participants for attitude questions in measurement of the attitude of the male partner in maternal health care live in Nifas Silk Lafto Sub-city, Addis Ababa, Ethiopia 2020

Activity	Level of Attitude n (%)				
	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
Men should encourage Antenatal care	123(29.9)	260(63.3)	16(3.9)	11(2.7)	1(0.2)
Men should encourage FP	86(20.9)	222(54.0)	61(14.8)	34(8.3)	8(1.9)
FP encourages promiscuity	1(0.2)	8(1.9)	34(8.3)	255(62.0)	113(27.5)
FP could lead to infertility	24(5.8)	83(20.2)	156(38.0)	99(24.1)	49(11.9)
Men should follow their wives for ANC	63(15.3)	170(41.4)	99(24.1)	73(17.8)	6(1.5)
ANC encourages gossip	4(1.0)	17(4.1)	59(14.4)	247(60.1)	84(20.4)
ANC encourages promiscuité	1(0.2)	3(0.7)	17(4.1)	231(56.2)	159(38.7)
Men should provide finances for ANC	75(18.2)	226(55.0)	96(23.4)	11(2.7)	3(0.7)
Men should decide place of delivery	19(4.6)	109(26.5)	136(33.1)	121(29.4)	26(6.3)
Men should be present in labour room	46(11.2)	67(16.3)	46(11.2)	161(39.2)	91(22.1)
Men should assist with house chores	64(15.6)	201(48.9)	104(25.3)	28(6.8)	14(3.4)
Positive attitude (greater than mean score)		200 (48.7%)			
Negative attitude (less than mean score)		211(51.3%)			
Mean score= 40.16(SD ± 5.063)					

5.7. Factors associated with the level of male involvement in maternal health care

As of table 8, educational status, occupation, male attitude towards maternal health care, whether the pregnancy was planned or not, living together with a partner, and information given in antenatal and postnatal clinics were important features. Males whose partner had unplanned pregnancy were (AOR = 0.46, 95% CI: 0.222 - 0.956) less likely to have good involvement compared to those with planned pregnancy. Males who did not live together with their partner were (AOR = 0.09, 95% CI: 0.011- 0.804) less likely to have good involvement compared to those who lived with their partner.

Males who do not get Information in antenatal and postnatal clinics were (AOR = 0.101, 95% CI: 0.056-0.181) less likely to have good involvement in maternal health care compared to those who get information. Table 8 shows factors associated with male partner involvement in maternal health care.

Table 8: Factors associated with male involvement in maternal health care among men live in Nifas Silk Lafto Sub-city, Addis Ababa, Ethiopia 2020

variables	Involvement in maternal health care n (%)			COR(95% CI)	AOR (95% CI)	P – value
	Good involvement	Poor involvement	Total			
Educational status						
No formal education	6(35.3)	11(64.7)	17(4.1)	0.10(0.013-0.804)*	0.12(0.01-1.448)	0.095
Primary	27(41.5)	38(58.5)	65(15.8)	0.23(0.104-0.524)*	0.47(0.150-1.468)	0.194
Junior secondary	30(45.5)	36(54.5)	66(16.1)	0.197(0.084-0.46)*	**0.28(0.099-0.787)***	**0.016***
Senior secondary	65(57)	49(43)	114(27.7)	0.62(0.365-1.05)	1.096(0.539-2.23)	0.799
Tertiary and above	103(69)	46(31)	149(36.3)	1.0	1.0	
Occupation						
Unemployed	2(20)	8(80)	10(2.4)	0.86(0.085-8.71)	0.858(0.05-14.8)	0.916
Private employee	96(55.2)	78(44.8)	174(42.4)	2.09(0.695-6.3)	0.31(0.07-1.37)	0.122
Public servant	68(64.8)	37(35.2)	105(25.5)	3.71(1.21-11.359)*	0.34(0.072-1.63)	0.178
Private job	51(58.6)	36(41.4)	87(21.2)	3.49(1.12-10.861)*	0.44(0.097-2.04)	0.297
Daily laborer	14(40)	21(60)	35(8.5)	1.0	1.0	
Male Attitude						
Negative attitude	88(41.7)	123(58.3)	211(51.3)	0.25(0.156-0.42)*	0.55(0.285-1.052)	0.071
positive attitude	143(71.5)	57(28.5)	200(48.7)	1.0	1.0	
Planned pregnancy						
Yes	171(66.5)	86(33.5)	257(62.5)	1.0	1.0	
No	60(39)	94(61)	154(37.5)	0.207(0.12-0.38)*	**0.46(0.22-0.956)***	**0.038***
Living together						
Yes	225(60)	150(40)	375(91.2)	1.0	1.0	
No	6(16.7)	30(83.3)	36(8.8)	0.076(0.01-0.56)*	**0.093(0.011-0.80)***	**0.03***
Information given						
Yes	127(88.8)	16(11.2)	143(34.8)	1.0	1.0	
No	104(38.8)	164(61.2)	268(65.2)	0.08(0.047-0.136)*	**0.101(0.056-0.18)***	**0.00***

*Significant at $p < 0.05$

5.8. Factors associated with attitude of male partner in maternal health care

Educational status, occupation, whether the pregnancy was planned or not, information given in antenatal and postnatal clinics, staff attitude and the time spent in the health facility were important features in male partner's attitude in maternal health care. Males who complete primary education (AOR = 0.08, 95% CI: 0.032 - 0.205), those with junior secondary education (AOR = 0.292, 95% CI: 0.146 - 0.58) and those with senior secondary education (AOR = 0.506, 95% CI: 0.287 - 0.89) were less likely to have positive attitude compared to those with tertiary and above educational status. Males who do not get Information in antenatal and postnatal clinics were (AOR = 0.52, 95% CI: 0.306 - 0.879) less likely to have positive attitude towards maternal health care compared to those who get information. Table 9 shows factors associated with male partner involvement in maternal health care.

Table 9: Factors associated with male partner's attitude in maternal health care among men live in Nifas Silk Lafto Sub-city, Addis Ababa, Ethiopia 2020

variables	Attitude of males towards maternal health care n (%)			COR(95% CI)	AOR (95% CI)	P – value
	Positive attitude	Negative attitude	Total			
Educational status						
Primary	8(12.3)	57(87.7)	65(15.8)	0.05(0.023-0.117)*	**0.08(0.032-0.205)***	**0.00***
Junior secondary	23(34.8)	43(65.2)	66(16.1)	0.196(0.105-0.36)*	**0.292(0.146-0.58)***	**0.00***
Senior secondary	60(52.6)	54(47.4)	114(27.7)	0.408(0.243-0.68)*	**0.506(0.287-0.89)***	**0.019***
Tertiary and above	109(73.2)	40(26.8)	149(36.3)	1.0	1.0	
Occupation						
Unemployed	2(20)	8(80)	10(2.4)	1.185(0.11-12.8)	0.404(0.035-4.717)	0.469
Private employee	82(47.1)	92(52.9)	174(42.3)	9.5(2.81-32.2)*	1.577(0.398-6.254)	0.517
Public servant	68(64.8)	37(35.2)	105(25.5)	19.6(5.62-68.4)*	1.677(0.396-7.105)	0.483
Private job	46(52.9)	41(47.1)	87(21.2)	11.96(3.4-42.02)*	1.807(0.436-7.489)	0.415
Daily laborer	3(8.6)	32(91.4)	35(8.5)	1.0	1.0	
Planned pregnancy						
Yes	152(59.1)	105(40.9)	257(62.5)	1.0	1.0	
No	48(31.2)	106(68.8)	154(37.5)	0.31(0.205-0.477)*	0.69(0.418-1.153)	0.158
Information given						
Yes	97(67.8)	46(32.2)	143(34.8)	1.0	1.0	
No	103(38.4)	165(61.6)	268(65.2)	0.296(0.19-0.454)*	**0.52(0.306-0.879)***	**0.015***
Staff attitude						
Friendly	61(74.4)	21(25.6)	82(20.0)	1.0	1.0	
Unfriendly	139(42.2)	190(57.8)	329(80.0)	0.252(0.146-0.43)*	0.568(0.267-1.208)	0.141
Time spent in the health facility						
Reasonable	55(75.3)	18(24.7)	73(17.8)	1.0	1.0	
Too long	145(42.9)	193(57.1)	338(82.2)	0.246(0.193-0.45)*	0.66(0.310-1.409)	0.284

*Significant at $p < 0.05$

6. DISCUSSION

The present study assessed the attitude and involvement of male partners in maternal health care. This study showed that the man who accompanies his partner to the health facility for ANC service is low. This finding is consistent with the findings of studies done in Ghana (35%) (27,39) but this finding is higher than a study conducted in Nigeria (24%) (15) and lower than studies done in Eastern Ethiopia (45.2%), Tanzania (63.4%), Myanmar (82%) and Pakistan (85.5%) (21,22,40,41). This may be due to socio-cultural variation and health care settings.

In this study majority of the participants accompanies their partners to labour and delivery and more than half to the PNC. This finding is higher than the studies conducted in Ghana (44% and 20%) and (39.5% and 19%) (27,36).This might be due to differences in living arrangements and health care settings.

Although most of the participants accompany their partners to the health facilities at the time of labour and delivery, no one was present to the delivery room due to none of the health facilities in Ethiopia allows into delivery rooms. About a quarter of the respondents wished to be present in the delivery room and the majority of the respondents felt that women's mothers should be present in the delivery room when asked about their opinion if one person should be allowed to the delivery room. This is different from a study conducted in Ghana which is 48.8% of the respondents felt that the husband should be present in the delivery room if one person should be allowed (36).

In this study, the man involved in joint planning for Emergency situations in antenatal, labour, and delivery and Postnatal is low. This result was lower than the study done in Tanzania (89%, 88%, and 90.2%) and Ghana (63.1%, 76.9%, and 71.4%) This might be due to educational level and socio-cultural variations of respondents.

In this study, the majority of the respondents provide some sort of financial or physical support at the time of labour and delivery and the postnatal period. This finding is comparable with the study done in Central Tanzania (82.2% and 82.2%) (21).

This study showed that the majority of the respondents discuss maternal health issues with a partner at the time of pregnancy, labour and delivery, and the postnatal period but such discussions with their partners' health care providers were very low. This finding is in line with a

study done in central Tanzania (23.5%, 19.7% and 21.7%), Ghana (22.4%, 36.7% and 11.2%) and Myanmar (27%) (21,22,36).

By computing five different tasks this study showed that respondents who had good involvement in ANC are low. This finding is comparable with the findings of studies done in Ghana (35%)(27). More than half of the respondents had good involvement in labour and delivery and the PNC. This finding is higher than the findings of a study done in Tanzania (14.9%) and (59.3%) (21).

This study showed that more than half of the respondents had poor involvement in all three aspects of maternal health care. This finding is comparable with a study done In Tanzania (20.3%) (21).This study is lower than a studies done in Nigeria (53.6%), Nepal (41.1%) and Myanmar (15,22,26). This might be due to socio-cultural variation.

This study showed that (48.7%) of the participants had a positive attitude towards maternal health care. The finding is lower than a study conducted in Nigeria (56.6%) (15). This might be due to socio-cultural variation and educational status variation.

In this study involvement of male partners was found to be significantly associated with educational status, living arrangements, and gating information in antenatal and postnatal clinics about maternal health.

This study stated that male partners who did not live together with their partner involved less in maternal health care. This finding is in line with the findings of studies done in Ghana (29,36).
In this study, males who did not get information at antenatal and postnatal clinics had low involvement in maternal health care. This finding is in line with the finding of a study in Central Tanzania (21).

7. STRENGTH AND LIMITATION

- This community-based study was the first to assess the attitude and involvement of the male partners in maternal health care in Addis Ababa, Ethiopia. However, the findings of this study could only be generalized to married men in the study setting.
- As in all cross-sectional studies, we can infer association but not causation.
- The information obtained from study subjects could be subject to recall bias.

8. CONCLUSION AND RECOMMENDATION

8.1. Conclusion

Participants who had a good attitude towards maternal health care were average however; participants who had good involvement in maternal health care were low. Moreover, access to information on men's involvement in maternity care, living arrangement and weather the pregnancy was planned or not were factors associated with men's involvement in maternal health care. Limited access to information in maternal health care had a negative impact which is reflected in men's limited involvement. Additionally, unplanned pregnancy and not living together affects male involvement in maternal health care. These findings provide a helpful reference for targeting men's involvement interventions in the future.

8.2. Recommendation

8.2.1. For government and stakeholders

- The Health Management Team in collaboration with the community leaders should organize educational campaigns within the communities to educate community members especially the men, on the importance and benefits of male involvement in maternal health care. Satisfied peer educators can also be used to encourage their colleagues to get involved in maternal issues.
- Interpersonal communication and group counseling approaches should be introduced.
- Encouraging men to go with their wives when they see care for ANC, L&D, and PNC.
- Encouraging pregnant mothers to communicate effectively on maternal health issues to their partner.
- Effective counseling in family planning services should be applied.
- Sending invitation for male partners through pregnant mothers in antenatal clinics.

8.2.2. For researchers

- Since this research is cross-sectional and pocket, further large scale studies with the different designs will be recommended to address issues that were not addressed by this study.

9. REFERENCES

1. Yafeh MA, Suiye LC, Eunice OO, Janet ZH. Male Involvement in Maternal Health Care in Jimeta Metropolis , Adamawa State , Nigeria By Male Involvement in Maternal Health Care in Jimeta. Greener J Epidemiol Public Heal [Internet]. 2016;4(October):027–39. Available from: www.gjournals.org
2. CSA and ICF. Federal democratic republic of Ethiopia Demographic and Health Survey [Internet]. Addis Ababa, Ethiopia and Maryland, USA, CSA and ICF: Central Statistical Agency; 2016. Available from: csa@ethionet.et.%0AInformation
3. Africa progress panel. Maternal Health : Investing in the lifeline of Healthy societies & Economies [Internet]. Geneva, Switherland: Africa Progress Panel; 2010. Available from: info@africaprogresspanel.org
4. Addisse M. Maternal and Child Health Care. Ethiopia: Ethiopian Public Health Training Initiative; 2003.
5. Laverack G, Howard-grabman L, Researcher I, Nair N, Azad K. Alma-Ata : Rebirth and Revision 5 Community participation : lessons for maternal , newborn , and child health. 2008;6736(October).
6. Mangeni JN, Mwangi A, Mbugua S, Mukthar Vk. Male involvement in maternal healthcare as a Determinant of Utilisation of Skilled Birth Attendants in Kenya. East Afr Med J. 2012;89(11):372–83.
7. WHO. Proportion of births attended by a skilled health worker 2008 updates. In: Department of Reproductive Health and Research [Internet]. Geneva, Switzerland; 2008. Available from: reproductivehealth@who.int
8. Nigussie S. Obstetrics and Gynecology for Health Science Students. Hawassa, Ethiopia; 2006.
9. WHO. WHO recommendation on interventions to promote the involvement of men during pregnancy, childbirth and after birth. WHO Reprod Heal Libr [Internet]. 2015;(May):1–9. Available from: https://extranet.who.int/rhl
10. Assaf S, Moonzwe LD. Does men ' s involvement improve the Health outcomes of their Partners and children? DHS Analytical Studies. 2018;64(July).
11. Firouzan V, Noroozi M, Farajzadegan Z, Mirghafourvand M. Barriers to men ' s

participation in perinatal care : a qualitative study in Iran. BMC Pregnancy Childbirth. 2019;2:1–9.

12. Davis J, Vyankandondera J, Luchters S, Simon D, Holmes W. Male involvement in reproductive , maternal and child health : a qualitative study of policymaker and practitioner perspectives in the Pacific. BioMed Cent [Internet]. 2016;1–11. Available from: http://dx.doi.org/10.1186/s12978-016-0184-2
13. Mkandawire E, Hendriks SL. A qualitative analysis of men ' s involvement in maternal and child health as a policy intervention in rural Central Malawi. BMC Pregnancy Childbirth. 2018;1–12.
14. Chattopadhyay A. Men in Maternal care: Evidence from India. 2012;44:129–53. Available from: https://www.cambridge.org/core
15. Olugbenga-Bello Adenike I., Esther A-O, Adefisoye A, Adeleye A, Sunday O. Perception , attitude and involvement of men in maternal health care in a Nigerian community. J Public Heal Epidemiol [Internet]. 2013;5(June):262–70. Available from: http://www.academicjournals.org/JPHE
16. Singh D, Lample M, Earnest J. The involvement of men in maternal health care : cross-sectional , pilot case studies from Maligita and Kibibi. Reprod Health [Internet]. 2014;1–8. Available from: http://www.reproductive-health-journal.com
17. Vermeulen E, Miltenburg AS, Barras J, Maselle N, Elteren M Van, Roosmalen J Van. Opportunities for male involvement during pregnancy in Magu district , rural Tanzania. BMC Pregnancy Childbirth [Internet]. 2016;1–9. Available from: http://dx.doi.org/10.1186/s12884-016-0853-8
18. Ongeso A, Basil O. Factors influencing male involvement in antenatal care among clients attending antenatal clinic: a case of Kenyatta National Hospital, Kenya. Int J Adv Res. 2018;6(5):72–82.
19. Falade-fatila O, Adebayo AM. Male partners ' involvement in pregnancy related care among married men in Ibadan , Nigeria. Reprod Health. 2020;2:1–12.
20. Ongweny-kidero EA. Exploring male attitudes on involvement in antenatal care: the case of prevention of mother-to-child Transmission of HIV in Athi river sub-location of Mavoco Constituency, Machakos county. 2014;
21. Gibore NS, Ezekiel MJ, Meremo A, Munyogwa MJ, Kibusi SM. Determinants of Men ' s

Involvement in Maternity Care in Dodoma Region , Central Tanzania. Hindawi [Internet]. 2019;2019:10. Available from: https://doi.org/10.1155/2019/7637124

22. Ampt F, Mon MM, Than KK, Khin MM, Agius PA, Morgan C, et al. Correlates of male involvement in maternal and newborn health : a cross-sectional study of men in a peri-urban region of Myanmar. BMC Pregnancy Childbirth. 2015;1–11.
23. Chibwae A, Kapesa A, Jahanpour OLA, Seni J, Namanya B. Attendance of male partners to different reproductive health services in Shinyanga District , North western Tanzania. Tanzan J Health Res. 2018;20(2):1–11.
24. Odhiambo NO, Atieli H, Ndunyu L. Factors associated with low male partners ' involvement in maternal and child health services in Suba sub county , Western Kenya. J Heal Med Nurs. 2019;60:148–58.
25. Minyahil T, Andualem T. B, Benedict O. A. Husbands ' participation in birth preparedness and complication readiness and associated factors in. African J Prim Heal Care Fam Med. 2018;1–8.
26. Ghimire A, Khagi MP. Male Involvement in Maternal and Infant Health Care , Banke , Nepal. Int J Nurs Res Pract [Internet]. 2017;4(1):27–32. Available from: http://www.uphtr.com/IJNRP/home%0AInternational
27. Craymah JP, Oppong RK, Tuoyire DA. Male Involvement in Maternal Health Care at Anomabo , Central Region , Ghana. Hindawi Int J Reprod Med. 2017;2017.
28. Sharma S, Khatri A. Factors influencing male participation in reproductive health : a qualitative study. Dovepress J Multidiscip Healthc. 2018;601–8.
29. Gibore NS, Bali TAL, Kibusi SM. Factors influencing men ' s involvement in antenatal care services : a cross-sectional study in a low resource setting , Central Tanzania. Reprod Health. 2019;1–10.
30. Muheirwe F, Nuhu S. Men ' s participation in maternal and child health care in Western Uganda : perspectives from the community. BMC Public Health. 2019;1–10.
31. Mersha AG. Male involvement in the maternal health care system : implication towards decreasing the high burden of maternal mortality. BMC Pregnancy Childbirth. 2018;1–8.
32. Aborigo RA, Reidpath DD, Oduro AR, Allotey P. Male involvement in maternal health : perspectives of opinion leaders. BMC Pregnancy Childbirth. 2018;1–10.
33. Kumbeni MT. Factors Influencing Male Involvement in Antenatal Care in the Kassena

Nankana Municipal in the Upper East Region , Ghana. 2019;15(21):1–17. Available from: http://dx.doi.org/10.19044/esj.2019.v15n21p1

34. Rahman AE, Perkins J, Islam S, Siddique AB, Anwar MR, Mazumder T, et al. Knowledge and involvement of husbands in maternal and newborn health in rural Bangladesh. BMC Pregnancy Childbirth. 2018;1–12.
35. Greenspan JA, Chebet JJ, Mpembeni R, Mosha I, Mpunga M, Winch PJ, et al. Men ' s roles in care seeking for maternal and newborn health : a qualitative study applying the three delays model to male involvement in Morogoro Region , Tanzania. BMC Pregnancy Childbirth. 2019;8:1–12.
36. Doe RD. Male partner involvement in Maternity care in Ablekuma south district, Accra , Ghana. 2013;(July). Available from: http://ugspace.ug.edu.gh
37. Central Statistical Authority. 2007 Population and Housing Census of Ethiopia, Administrative report. 2012;(April).
38. Fekene DB, Gizachew Abdissa Bulto, Moti BE, Gemeda GM. Male Partner's Involvement and it's Associated Factors in Promoting Skilled Birth Attendance among Fathers who have Children Less than One Year of Age in Ambo Town, Ethiopia. EC Gynaecol Res Artic. 2019;6:465–74.
39. Umar S-U. Factors influencing male participation in antenatal care in the Kumasi Metropolis, Ghana. 2015;
40. Asefa F, Geleto A, Dessie Y. Male Par tners Involvement in Maternal ANC Care : The View of W omen Male partners involvement in maternal ANC care : The view of women attending ANC in Hararipublic health institutions , eastern Ethiopia. ResearchGate. 2014;2(September).
41. Younas M, Parpio Y, Ali TS, Awan S. Male partners ' knowledge and practices of antenatal care in district Swat , Khyber Pakhtunkhwa , Pakistan : A cross- sectional study. J Midwifery Reprod Heal. 2020;8(1).

ANNEXES

Annex I: Information and consent form (English Version)

Dear Respondent:

My name is **Zeytuna Mohammed** and I am currently studying my Master's degree at Addis Ababa University, School of Nursing and Midwifery.

I kindly request you to participate in a study that is aimed to assess the **attitude and involvement of men in maternal health care in Nifas Silk Lafto sub-city, Addis Ababa, Ethiopia, 2020G.C**

The thesis proposal has been approved by the Ethical and Review Committee of the Addis Ababa University, School of Nursing, and Midwifery. I would appreciate it very much if you could consider participating in this thesis. Your participation is important because it will provide valuable information and a deep understanding of the experience of the ***involvement of men in maternal health care***. Your involvement in the study includes participation in a face-to-face interview, which will take approximately 30 minutes.

Participation in this study is voluntary; you can also withdraw at any time from the study if you feel uncomfortable. Refusal to participate will not affect your work or care you shall seek at any of the health facilities in any way. Confidentiality will be ensured by not using your name or address on the questionnaire and final thesis report. There are no foreseeable physical, psychological or social risks or discomforts involved in participating in this study.

The study has no immediate benefits to the respondents but will have benefits later in improving the ***involvement of men in maternal health care***.

If you have any questions about the research or any related matters, please contact the researcher at **+251 911065773, Email- zeytunmoh1437@gmail.com**

Consent form

I, the undersigned, understand the nature of the study, benefits, my right to voluntary participation, confidentiality, and withdrawal from the study without any victimization. I have had the opportunity to ask questions and answered to my satisfaction.

I hereby freely consent to take part in this study.

Agreed _______________

Not agreed ____________

Date____________________________

Your participation will be greatly appreciated.

Respectfully,

Annex II: Questionnaire: English Version

Addis Ababa university college of health science school of Nursing and Midwifery; Questionnaire for assessment of male partner attitude and involvement in maternal health care in Nifas silk lafto sub-city, Addis Ababa, Ethiopia, 2020G.C

Questionnaire code: …………………………

Interviewer: ………………….. Date: ………………

Section A: socio-demographic characteristics

S.N	Questions	Response category	Skip
101.	Age	Years	
102.	Educational level	1. No education 2. Primary 3. Junior Secondary 4. Senior Secondary 5. Tertiary and above	
103	Occupation	1. Unemployed 2. Private sector 3. Government sector 4. private job 5. daily labourer	
104	Monthly family income in Ethiopian birr	________ Birr/month	
105.	Number of children:	________	
106.	Age of last child (years):	________ years	

Section B: involvement in maternal health care services

ANTENATAL CARE			
S.N	**Questions**	**Response category**	**Skip**
107.	Were you living together with your partner at the time of her pregnancy?	1. Yes 2. No	(If no, skip to question 110)
108.	Were there other family members living with you?	1. Yes 2. No	
109.	If yes, which family member was living with you?	1. Her mother 2. My mother 3. Siblings 4. Others (specify)……………	
110.	Was the pregnancy planned?	1. Yes 2. No	
111.	Did she attend antenatal clinic?	1. Yes 2. No 3. Don't know	
112.	Where did she attend antenatal clinic?	1.Public Hospital 2. Health center 3. Don't know 4. Private health sector	
113.	Were you involved in the decision on where she had antenatal care?	1. Yes 2. No	
114.	Did you make any joint plans for emergency situations during the pregnancy?	1. Yes 2. No	(if no, skip to question 116)

115.	If yes, please specify the preparation made	1. Put money aside for emergency 2. Made transport arrangement 3. Decided on where to go in case of emergency 4. Others (specify)…………………..	
116.	Did you ever accompany your partner to the antenatal clinic?	1. Yes 2. No	(if no, skip to question 120)
117.	If yes, how many times did you accompany her?	________	
118.	How would you describe the attitude of the staff?	1. Friendly 2. Unfriendly 3. Indifferent	
119.	How would you assess the time you had to spend at the health facility?	1. Reasonable 2. Too long	
120.	If no, why were you never present?	…………………………………….	
121.	What support did you provide your partner during her pregnancy?	1. Provided funds for ANC visits 2. Reminded her of her ANC visits 3. Helped with household chores 4. Others (specify)…………………	
122.	Did you discuss health issues relating to the pregnancy with your partner?	1. Yes 2. No	
123.	Did you discuss health issues relating to the pregnancy with her health care providers?	1. Yes 2. No	
LABOUR AND DELIVERY			
124.	Were you living together with your partner at the time of her labour and delivery?	1. Yes 2. No	

125.	Did you accompany your wife to the health facility at the time of labour and delivery?	1. Yes 2. No 3. Did not deliver in a health facility	
126.	If you did not accompany her, how did she get to the health facility that day?	1. I delegated somebody to take her 2. She went alone 3. Don't know. 4. Others (specify)………………….	
127.	Did you make any joint prior plans for labour and delivery during the pregnancy?	1. Yes 2. No	
128.	What support did you provide your partner during her labour and delivery?	1. Provided funds for her labour and delivery 2. Helped with household chores while she was away 3. Others (specify)…………………	
129.	Did you discuss health issues relating to the labour and delivery with your partner?	1. Yes 2. No	
130.	Did you discuss health issues relating to the labour and delivery with her health care providers?	1. Yes 2. No	
131.	Are male partners allowed to be present during labour and delivery in the facility she attended?	1. Yes 2. No 3. Don't know	
132.	Were you present at the labour and delivery?	1. Yes 2. No	(If yes, skip to question 134)
133.	Do you wish you were present?	1. Yes 2. No	

134.	In your opinion if one person should be allowed in the labour room with the laboring woman, who should it be?	1. Husband 2. Mother 3. Mother in law 4. Others (specify)……………….	
POSTNATAL CARE			
135.	Did your partner live with you after delivery?	1. Yes 2. No	
136.	If no, who did she live with?	1. Her Mother 2. My Mother 3. Others (specify)…………………	
137.	Did you ever accompany your partner for her postnatal visits to the health facility?	1. Yes 2. No	
138	If no, why were you never present?	…………………………………..	
139.	Were you involved in making prior plans for her postnatal care?	1. Yes 2. No	
140.	What support did you provide your partner during the postnatal period?	1. Provided funds for her 2. Helped with household chores 3. Others (specify)……………….	
141.	Did you discuss health issues relating to the postnatal period like family planning with your partner?	1. Yes 2. No	
142.	Did you discuss health issues relating to the postnatal period like family planning with her health care providers?	1. Yes 2. No	

Section C: - The attitude of respondents to maternal health care

To what extent do you agree or disagree with the following statements? Please, put a tick (✓) in a box where it applies.

S.N	Items	Options				
		Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
143	Men should encourage antenatal care					
144	Men should encourage FP					
145	FP encourages promiscuity					
146	FP could lead to infertility					
147	Men should follow their wives for ANC					
148	ANC encourages gossip					
149	ANC encourages promiscuity					
150	Men should provide finances for ANC					
151	Men should decide place of delivery					
152	Men should be present in labour room					
153	Men should assist with house chores					

THANK YOU VERY MUCH

Annex III: Information and consent form (Amharic Version)

ጤና ይስጥልኝ እንዴት አደሩ / እንዴት ዋሉ

ስ ሜ ***<u>ዘይቱና መሀመድ</u>*** ይባላል ፣ በአዲስ አበባ ዩኒቨርስቲ የድህረ ምረቃ ተማሪ ስሆን በእናቶች ጤና ላይ ባሎች (ወንዶች) ያላቸውን አመለካከት እና ተሳትፎ በተመለከተ በ ንፋስ ስልክ ላፊቶ ክፍለ ከተማ ውስጥ ጥናት እያካሄድኩ እገኛለሁ፡፡እርስዎ የጥናቱ ተሳታፊ እንዲሆኑ ተመርጠዋል፡፡የእርስዎ ተሳትፎ በጣም ጠቃሚ ነው፤ ምክንያቱም ብዙ ጠቃሚ የሆኑ መረጃዎችን በመስጠት ረገድ ፣እንዲሁም ስለ ወንዶች ተሳትፎ ጥልቅ የሆነ እውቀት እንድናገኝ ይረዳናል፡፡ የጥናቱ አስፈላጊነት በሚመለከታቸው አካላት ተረጋግጧል፡፡ ለጥያቄዎች መልስ ይሰጡን ዘንድ 30 ደቂቃ ያህል ሰዓትዎን ልንሻማብዎት ነው፡፡ የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ከመሆኑም ባሻገር በማንኛውም ሰዓት ማቋረጥ ይችላሉ፡፡ በጥያቄዎቹ ላይ ለመሳተፍ ፍቃደኛ አለመሆን በማንኛውም ሁኔታ ተጠያቂው ላይ ችግር ሊፈጥር አይችልም፡፡ የሰጡት መረጃ ከእርስዎ ስምምነት ውጪ ለሌላ ሰው ወይም አካል ተላልፎ የማይሰጥ መሆኑን ማለትም ሚስጢሩ የተጠበቀ መሆኑን እገልፃለሁ፡፡ በጥናቱ ላይ መሳተፍ ምንም አይነት አካላዊ፣ ስነ አእምሮአዊ ወይም ማህበራዊ ጉዳት ወይም ጭንቀት አያደርስም፡፡ ጥናቱ ለተሳታፊው በቀጥታ ጥቅም ባይኖረውም ለወደፊት የወንዶችን ተሳትፎ በማሳደግ ረገድ ጥቅም ያስገኛል፡፡ በመጨረሻም በጥናቱ ላይ ምንም አይነት ጥያቄ ወይም አስተያት ካላችሁ በ **<u>0911065773</u>** በመደወል ወይንም በ ኢሜይል አድራሻ <u>zeytunmoh1437@gmail.com</u> ማድረስ ይችላሉ፡፡

የስምምነት ቅጽ

እኔ ፤ የጥናቱን ባህሪና ጠቀሜታ፣ ተሳትፎዬ በ ፍቃደኝነት ላይ የተመሰረተ መሆኑን ፣ ሚስጥሬ የሚጠበቅ መሆኑን እና ባለመሳተፌ ምንም አይነት ችግር እንደማይገጥመኝ ተረድቻለሁ፡፡ ከ ጥናቱ ጋር በተያያዘ ጥያቄዎችን መጠየቅ እንደምችል እና እንደሚመለስልኝም አውቄያለሁ፡፡ ስለሆነም በዚህ ጥናት ላይ ለመሳተፍ ተስማምቻለሁ፡፡

ለመሳተፍ ተስማምቻለሁ…………..

አልተስማማሁም……………..

ቀን --------------------------

ተሳትፎዎ ይበረታታል

ስለተሳተፉ አመሰግናለሁ

Annex IV: Questionnaire: Amharic Version

ክፍል አንድ - ማህበራዊ - ስነ - ሕዝብ ባህሪያት ጥያቄዎች

ተ.ቁ	ጥያቄዎች	መልስ እና መለያ	ወደ….ይለፉ
101	እድሜ	________	
102	የትምህርት ደረጃ?	1.አልተማርኩም 2. ከ 1ኛ-6ኛክፍል 3. ከ 7ኛ- 9ኛክፍል 4. ከ 10ኛ-12ኛክፍል 5.ዲፕሎማ እና ከዛ በላይ	
105	የስራዎ ሁኔታ ምንድን ነው?	1. ስራ የለኝም 2. የግል ተቀጣሪ 3. የመንግስት ተቀጣሪ 4. የግል ስራ 5. የቀን ሰራተኛ	
106	ወርሃዊ አማካይ የቤተሰብ ገቢ ምን ያህል ነዉ?	የ ኢትዮጵያ ብር	
107	ስንት ልጅ አለዎት ?	________	
108	የመጨረሻ ልጅዎት እድሜ ስንት ነው?	________	

ክፍል ሁለት - በ እናቶች ጤና ላይ ያለ ተሳትፎ

ቅድመ ወሊድ ክትትል			
ተ.ቁ	**ጥያቄዎች**	**መልስ እና መለያ**	**ወደ….ይለፉ**
107	ባለቤትህ ነብሰጡር እያለች አብራችሁ ነበር የምትኖሩት?	1. አዎ 2. አይ	(መልሱ አይ ከሆነ ወደ ጥያቄ 110 ይለፉ)
108	ሌላ የቤተሰብ አካል አብሯችሁ ይኖር ነበር?	1. አዎ 2. አይ	
109	የ ጥያቄ ቁጥር 108 መልስ አዎ ከሆነ አብሯችሁ የነበረው የቤተሰብ አባል ማን ነበር?	1. የባለቤትህ እናት 2. ያንተ እናት 3. እህት/ወንድም 4. ሌላ (ይግለፁ)…………	
110	እርግዝናው በእቅድ ላይ የተመሰረተ ነበር?	1. አዎ 2. አይ	
111	ቅድመ ወሊድ ክትትል ነበራት?	1. አዎ 2. አይ 3. አላውቅም	
112	የ ጥያቄ ቁጥር 111 መልስ አዎ ከሆነ የት ነበር ክትትል የምታደርገው?	1. ሆስፒታል 2. ጤና ጣቢያ 3. አላውቅም 4. የግል ጤና ተቋም	
113	ቅድመ ወሊድ ክትትል የምታደርግበትን ቦታ መወሰን ላይ ያንተ አስተዋፅኦ አለበት?	1. አዎ 2. አይ	
114	በእርግዝና ወቅት ድንገተኛ ችግር ቢፈጠር ምን ማድረግ እንዳለባችሁ በጋራ አቅድ አውጥታችሁ ነበር?	1. አዎ 2. አይ	(መልሱ አይ ከሆነ ወደ ጥያቄ 116 ይለፉ)
115	የ ጥያቄ ቁጥር 114 መልስ አዎ ከሆነ ምን አድርገሃል?	1. ለ ድንገተኛ ጊዜ የሚሆን ገንዘብ ማስቀመጥ(ማጠራቀም) 2. ትራንስፖርት ማመቻቸት	

		3. ድንገተኛ ችግር ቢፈጠር የት መሄድ እንዳለባችሁ መወሰን 4. ሌላ (ይግለፁ)…………	
116	ለቅድመ ወሊድ ክትትል ከባለቤትህ ጋር አብረህ ሄደህ ታውቃለህ?	1. አዎ 2. አይ	(መልሱ አይ ከሆነ ወደ ጥያቄ 120 ይለፉ)
117	የ ጥያቄ ቁጥር 116 መልስ አዎ ከሆነ ምን ያህል ጊዜ ሄደሃል?	________	
118	ጤና ተቋም ውስጥ ያሉትን ሰራተኞች እንዴት ትገልፃቸዋለህ?	1. ተግባቢ እና (ጥሩ) ናቸው 2. ተግባቢ አይደሉም 3. እርግጠኛ አይደለሁም	
119	ጤና ተቋም ውስጥ የምትቆይበትን ሰዐት እንዴት ትገልፀዋለህ?	1. ተገቢ (ተቀባይነት ያለው) ነው 2. ረጅም ነው	
120	የ ጥያቄ ቁጥር 118 መልስ አይ ከሆነ ምክንያትህ ምንድን ነው?	…………………………………………	
121	ለባለቤትህ በእርግዝናዋ ወቅት ምን አይነት እገዛ አድርገሃል?	1. ለቅድመ ወሊድ ክትትል በ ገንዘብ አስተዋፅዖ በማድረግ 2. የቅድመ ወሊድ ክትትል ቀን ሲደርስ በ ማስታወስ 3. በቤት ውስጥ ስራዎች በማገዝ 4. ሌላ (የጥቀሱ)…………………	
122	እርግዝናን የተመለከቱ ጤና ነክ ነገሮችን ከባለቤትህ ጋር ውይይት ታደርጋለህ?	1. አዎ 2. አይ	
123	ከ እርግዝና ጋር የተያያዙ ጤና ነክ ጉዳዮችን በተመለከተ ክትትል ከሚያደርጉላት ጤና ባለሙያዎች ጋር ትወያያለህ?	1. አዎ 2. አይ	
ምጥ እና ወሊድ			
124	በ ምጥ እና ወሊድ ጊዜ ከባለቤትህ ጋር አብራችሁ ነበር የምትኖሩት?	1. አዎ 2. አይ	

125	ምጥ የመጣ ጊዜ ወደ ጤና ተቐም አብረሃት ሄደህ ነበር?	1. አዎ 2. አይ 3. በ ጤና ተቐም አልወለደችም	
126	አብረሃት ሄደህ ካልነበር እንዴት ነበር ወደ ጤና ተቐም የሄደችው?	1. ሌላ ሰው እንዲወስዳት አመቻቸሁ 2. ብቻዋን ነበር የሄደችው 3. ሌላ (ይጥቀሱ)…………… 4. አላውቅም	
127	ምጥ በመጣ ጊዜ ምን ማድረግ እንዳለባችሁብ እርግዝና ወቅት በጋራ እቅድ አውጥታችሁ ነበር?	1. አዎ 2. አይ	
128	በ ምጥና በ ወሊድ ጊዜ ምን አይነት እገዛ አድርገሃል?	1. በገንዘብ 2. በ ቤት ውስጥ ስራ በማገዝ 3. ሌላ (ይግለፁ)……………	
129	ምጥ እና ወሊድን የተመለከቱ ጤና ነክ ጉዳዮችን ከባለቤትዎ ጋር ውይይት ታደርጉ ነበር?	1. አዎ 2. አይ	
130	ምጥ እና ወሊድን የተመለከቱ ጤና ነክ ጉዳዮችን በተመለከተ ክትትል ከሚያደርጉላት ጤና ባለሙያዎች ጋር ትወያይ ነበር?	1. አዎ 2. አይ	
131	በ ጤና ተቐም ውስጥ በማዋልጃ ክፍል ወንዶች አብረው እንዲገቡ ይፈቀዳል?	1. አዎ 2. አይ 3. አላውቅም	
132	እርስዎ ማዋልጃ ክፍል ውስጥ ተገኝተው ነበር?	1. አዎ 2. አይ	(መልሱ አዎ ከሆነ ወደ ጥያቄ 134 ይለፉ)
133	ቦታው ላይ ብገኝ ኖሮብለህ ብለህ ተመኝተሃል?	1. አዎ 2. አይ	
134	በ ማዋለጃ ክፍል ውስጥ አንድ ሰው እንዲገባ ቢፈቀድ ማን መሆን አለበት ትላለህ?	1. ባለቤት 2. እናት 3. አማች 4. ሌላ……………………	

ድህረ ወሊድ ክትትል			
135	ከ ወሊድ በኋላ ከ ባለቤትህ ጋር አብራችሁ እየኖራችሁ ነው?	1. አዎ 2. አይ	
136	መልስዎ አይ ከሆነ ከማን ጋር ነው እየኖረች ያለችው?	1. ከእናቷ ጋር 2. ከ እናቴ ጋር 3. ሌላ……………………….	
137	ለ ድህረ ወሊድ ክትትል አብረሃት ሄደህ ታወቃለህ?	1. አዎ 2. አይ	
138	የ ጥያቄ ቁጥር 137 መልስአይ ከሆነ ምክንያትህ ምን ነበር?	……………………………… …	
139	ለ ድህረ ወሊድ ክትትል እቅድ ማውጣት ላይ ተሳትፈህ ነበር?	1. አዎ 2. አይ	
140	በድህረ ወሊድ ክትትል ጊዜ ምን አይነት እገዛ አድርገሃል?	1. በ ገንዘብ 2. በ ቤት ውስጥ ስራ በማገዝ 3. ሌላ ……………………	
141	ድህረ ወሊድን የተመለከቱ ጤና ነክ ጉዳዮችን ለምሳሌ የቤተሰብ ምጣኔ የመሳሰሉ ነገሮችን ከ ባለቤትህ ጋር ውይይት ታድረጋልህ?	1. አዎ 2. አይ	
142	ድህረ ወሊድ የተመለከቱ ጤና ነክ ጉዳዮችን ለምሳሌ የቤተሰብ ምጣኔ የመሳሰሉ ነገሮችን ከ ጤና ባለሙያ ጋር ውይይት ታድረጋልህ?	1. አዎ 2. አይ	

ክፍል ሶስት - በ እናቶች ጤና አገልግሎት አሰጣጥ ላይ ያለ አመለካከት

እባክዎ ምላሽዎት ላይ የ (✓) ምልክት ያስቀምጡ

	መግለጫዎች	ምላሾች				
		በጣም እስማማለሁ	እስማማለሁ	አስተያየት የለኝም	አልስማማም	በጣም አልስማማም
143	ወንዶች ቅድመ ወሊድ ክትትልን ማበረታታት አለባቸው					
144	ወንዶች የ ቤተሰብ እቅድ አገልግሎትን ማበረታታት አለባቸው					
145	የ ቤተሰብ ምጣኔ በ አንድ አለመወሰንን ያበረታታል					
146	የ ቤተሰብ ምጣኔ ለ መካንነት ይዳርጋል					
147	ወንዶች ከ ሚስቶቻቸው ጋር ወደ ቅድመ ወሊድ ክትትል አገልግሎት አብረው መሄድ አለባቸው					
148	ቅድመ ወሊድ ክትትል አገልግሎት ሀሜትን ያስፋፋል					
149	ቅድመ ወሊድ ክትትል በ አንድ አለመወሰንን ያበረታታል					
150	ወንዶች ለ ቅድመ ወሊድ ክትትል አገልግሎት በ ገንዘብ አስተዋፅኦ ማድረግ አለባቸው					
151	ወንዶች የ ወሊድ ቦታን መወሰን አለባቸው					
152	ወንዶች በ ማዋለጃ ክፍል ውስጥ መገኘት አለባቸው					
153	ወንዶች የ ቤት ውስጥ ስራዎች ላይ ማገዝ አለባቸው					