SCHOOL OF CONTINUING EDUCATION

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ANALYSIS OF SOCIAL AND CULTURAL FACTORS ON UPTAKE OF CHILD DELIVERY SYSTEM: THE CASE OF GEDEO ZONE, DILA ZURIYA WEREDA, SNNPR, ETHIOPIA

BY

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DECLARATION

I, the undersigned, declare that this thesis is my original work, has not been presented for a Degree in this or another university and that all sources of materials used for this thesis have been fully acknowledged.

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CERTIFICATE

This is to certify that Mr./Miss/Mrs._____ student of MRDA from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his /her project Thesis for the course .MRDP-001. His /Her project work entitled ANALYSYS OF SOCIAL AND CULTERAL FACTORS ON UPTAKE OF CHILD DELIVERY SYSTEM .THE CASE OF DILLA ZURYA WEREDA, SNNP, ETHIOPIA which he /she is submitting, is his/her genuine and original work.

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LIST OF ABBREVATIONS

TBA: Traditional birth Attendant

HEW: Health extension worker

NGO: Non-Governmental organization

MDG: Millennium Development Goal

BeMONC: Basic Emergency and Obstetric care

WHO: World Health organization

SNNP: Sothern nation and nationalities people

CSSM: Child Survival and Safe Motherhood

MCH: Maternal& Child Health

FGD: Focal Group Discussion

HSDP: Health sector Development plan

MoFED: Ministry of finance & Economic Development

(CEOC) Comprehensive Essential Obstetric Care

ABSTRACT

Social and cultural factors on uptake of delivery system at health institution is major public health concern in the world .In global health research institutional child delivery has emerged as an area of key concern ,especially in developing and sub-Saharan countries . Thus, this study was conducted to identify and analyze the social and cultural factors on child delivery system affecting institutional delivery practice among pregnant women in Gedeo zone, Dilla zuriya wereda.

The methodology used for this study was cross-sectional qualitative and quantitative method which includes interview and focus group discussion.

The result of the study showed that out of the selected women 72. % had delivered their children with traditional birth assistant while rest 28% delivered at health center with assistant of midwifes It was found that women who delivered their child with traditional home delivery without any professional assistant indicated that they think that they lack privacy at the health institutions during delivery. On the other hand it was found that the place where to deliver child is influenced by the husband .In addition to this home delivery is preferred due to different cultural practices given to the women after delivery for their welbeingness at home .Lastly the study draws a conclusion that mothers & husband's level of education, lack of pertinent information & lack of quality of care provided by health professionals were found a major factors for choice of delivery place ,these responsible bodies should make efforts to increase community based education, awareness creation and information regarding importance of institutional delivery .

Key words: Institutional Delivery, Home Delivery, Anti -natal checkup, Traditional birth Attendant.

CHAPTER ONE: INTRODUCTION

The Ethiopian health care system is amplified by the rapid expansion of private practitioners, NGOs engaged for non-profit and other partners who were involved in the sector. They had played significant role in boosting the health service coverage, thus, enhancing the public and NGOs partnership in the delivery of health care services in the country .Different bodies under the umbrella of the ministry of health take part in decision making process. The Federal Ministry of Health stretches its engagement to regional and wereda level in sharing roles and responsibilities by providing vital technical support and in managing and coordinating pending public health issues. Particularly, due attention were given for maternal health care service by embarking on essential service package.

The ministry formulates different health care reforms. .Under this package, institutional child delivery had been provided significant focus area in the MDG, to minimize maternal mortality rate which results from risks during prolonged labor and related incidences .Based upon this fact, the government had taken different measures and had formulated different interventional strategies in addition to policy reforms. .Currently the Ethiopian government has put considerable investment outlays in terms of technical and financial support to achieve the target set and to scale up the sector. Procurement of equipment for clean delivery and basic emergency and obstetric services had also been undertaken. With collaborating partners, staff was trained in Basic emergency and obstetric care training at master level. Pre- service training were provided to HEWs in MCH ,has been introduced and become functional in all regions .In addition, primary health care services were built everywhere ,as much as possible, to curb distance problems particularly to pregnant women and to those families or communities accompanying the labored women. Furthermore, under health care financing schemes in order to avoid out of pocket expenses, delivery services were exempted from payments. Gedeo zone is one of the populous zones in SNNP regional state, endowed with cultural and social customs and comprises prudent number of reproductive age group with homogenous kinship relations who shares similar social and cultural practices. This zone relatively produces cash crops and is also rich in livestock products. Currently, rural infrastructure and social amenities are accessible in most of the rural areas. In this zone alone 32 HC and 160

HPS are available with trained midwives and nurses at HC and health extension workers at health post level, who were trained in clean and safe delivery .In 2012, 36,567 pregnant women were recorded among 236,667 women who are in reproductive age group (GZHD 2012). There is not clear evidence supported by empirical study for the reason of low institutional child delivery across this zone .This study therefore primarily focuses on the specific cultural and social factor which impedes seeking professional assistance for giving birth at health institutions at this zone. It is well known that harmful traditional practices have been very slow to change over time, particularly given past national and international reluctance to confront problems that are ‘‘cultural’’ in nature (UNDP, 2008).In addition, longstanding customary and societal practices have continued in the zone. Women often do not have access to adequate transportation to health facilities or the cash to pay for it. They have to negotiate for transportation with men, other family members, or elders in the (Argaw 2007)Community. As different studies shows lack of transportation can cause delays in emergency situations. Absolute and relative poverty can pose a serious barrier to women's demand for and access to health care.

Thaddeus and Maine (1994) has described three principal causes of delay in scenarios that resulted in maternal death: (1) delay in deciding to seek care; (2) delay in arriving at a suitable health-care facility; and (3) delay in receiving appropriate care at that facility.

In many poor countries, childbirth is regarded as natural phenomenon that should take place outside of the hospital/clinic setting. Most births in sub-Saharan Africa takes place at home, generally in the presence of family members or a traditional birth attendant. Specific duties and responsibilities will vary greatly among different cultures. When an obstetric complication such as prolonged labor arises, the immediate questions that need to be asked are: Is this a problem? What is causing it? What should be done about it? The assumptions from which one starts in trying to answer these questions have a direct impact on what happens subsequently. For example, in many parts of Africa trouble in childbirth is often attributed to some kind of moral failure on the part of the laboring woman. Difficult labor is frequently seen as retribution from God or the ancestors for adultery or some other moral lapse, rather than being the product of faulty obstetrical mechanics. In such cases the efforts of the

birth attendants may well be directed toward getting the woman to confess ‘‘what she has done ‘rather than to seek medical attention. The decision to seek care for an obstetric problem involves economic costs, both the costs of transportation and the ‘‘opportunity costs’’ (lost wages, lost time working in the fields, etc.) that may be incurred. Often, particularly in cases of prolonged labor, the easiest decision is just to ‘‘wait and see what happens ‘in the hope that the woman will eventually deliver the baby by herself and that everything will come out all right in the end. Once labor has lasted over 24 hours, it is particularly dangerous. In many parts of Africa (particularly in northern Nigeria), women are normally expected to stays excluded within the family compound and are not normally allowed to travel without male accompany mentor permission. If the appropriate male authority figure is not present during obstructed labor, delays may be encountered before permission can be secured to take the woman to a health-care facility. Once the decision has been made that some kind of intervention is appropriate, the intervention that is chosen may still not lead to appropriate treatment. In many parts of southern Nigeria, for example, charismatic ‘‘spiritual churches’’ run maternity homes where the primary services provided are prayer and religious rituals rather than advanced obstetric care. Whatever the moral or spiritual value that such services may have, they are not effective in relieving the mechanical obstacle to delivery in obstructed labor. This only leads to further delay. In some cases the therapy chosen may actually be directly harmful to the laboring woman. For example, some recipes used by traditional healers in treating women in prolonged labor in parts of Africa do appear to have oxytocic properties that enhance uterine contractility and result in more forceful contractions. (Thaddeus and Maine, 1994)

1.2 STATEMENT OF PROBLEM

Ethiopia has vast ethnic diversity endowed with different cultural and social norms which affects decent life style positively and negatively. Among the needs to follow in normal situations, health is the prominent service in certain social group in order to achieve productive and sustainable all round development through maintaining prudent and quality way of life. Currently the government plans to make health care system more accessible by collaborating with different partners. Under MCH service package ,due attention must be given in providing basic maternal care service in

rural and urban setting on demand .Even in hard to reach kebeles and geographically inconvenient areas health posts are available ,staffed with at least 2 trained health extension workers and health promoters who serve the communities on voluntary terms .

Despite of all these provisions of facilitation, institutional delivery coverage is at insignificant level. DHS (2011) studies had revealed that 10 percent of births in Ethiopia are delivered at health facilities (9 percent in public facilities and 1 percent in private facility). Thus, most pregnant women didn't get professional medical support when pregnant and obstetric complication occurs and which results to maternal morbidity and mortality, accounting to 676 of 100,000 live births. From DHS result, in nine women out of ten had delivered at home .The figure is lowest at SNNP which was only 6.2% ,institutional coverage was 10 % and 93.2% were not given post - natal check-up. In SNNP social and cultural practices has been common affecting directly or indirectly their daily livelihood situations in all aspects. Even if pregnant women's are well informed of the free service and are aware of the importance of being delivered at facility in avoiding risks they tend to attend at home level delivery than go to public health facilities. Social restrictions on women's movement may also reduce their autonomy to seek care. For example, in Northern Nigeria, the purdah system may mean that a husband has to accompany his wife to use services and she may not be able to access services in his absence (Oxaal, Z; Baden, S 1996). Gendered attitudes toward maternity-related problems in some communities may also limit access to care. In addition, in some African societies, prolonged labor may be ascribed to marital infidelity and assistance may be withheld until the woman confesses to this (Oxaal and Baden, 1996).

Previous studies primarily focuses for factors affecting low institutional delivery, mainly supply side and demand side aspects, like proximity of primary health care, availability of trained professionals and affordability to pay for some services etc. are mentioned. .However, even with those facilities accessible and with mother friendly services, institutional delivery coverage is insignificant .Pregnant women must have antenatal follow -up at least once out of four expected visit .Therefore, only accessibility as such had not been crucial problem, instead the problem is may be manifested immensely from the demand side or acceptability of the service given to

the client who needs the service. According to DHS (2011) report, 64.8% had responded “not necessary “and 26.4 exclaimed “not customary “ regarding the need for attending health facility .This figures just indicates the coverage but not an indication of the very real contextual cause .Therefore, it is important to investigate what specific factors are responsible at the side of clients who seek care.

Fulfilling of material and man power needs of the facilities by itself not the solution to curb the problems .The focus of strategies should rather include identifying Priori major contextual factors and identifying the root cause of the problem. The extent of the problem varies from region to region, and even across zones and regional setting because of unique cultural and social values attributed. Particularly in the southern region, cultural practices and social settings has a strong bond among different tribal societies which strongly influences the community, particularly the rural women who are the domains of the community most likely be dominated by societal belief and customs bestowed from early generations. .In this regard, one needs to identify and graft -out specific social and cultural practices and beliefs to the extent of its seriousness which significantly exacerbate the problem of seeking home delivery. .Eventually one needs to act on the findings in the local context in order to take remedial action to increase institutional delivery.

1.3 SIGNIFICANCE OF THE STUDY

Most of the studies conducted in to address factors affecting child delivery in Ethiopia focuses on the urban setting relayed on the intermediate cause however this study have been mainly focused on rural areas particularly at grass root level pertaining the cultural, social and community practices which affects maternal delivery place therefore it is important to explore & describe factors affecting child delivery place in rural area at the primary health care unit level .It is ascribed that a number of initiatives has been implemented to increase uptake of child delivery service at health institution however the problem is still there therefore this study will provide valuable information and help the program managers and implementers to address the gaps & to understand factors influencing the use of institutional delivery service in many aspect **.**

1.4 OBJECTIVE OF THE STUDY

1.4.1 GENERAL OBJECTIVE

The study mainly focuses on identifying major cultural and social factors which affects institutional delivery in view of local setting and community context to the extent of dissemination among the community in the selected were

1.4.2 SPECIFIC OBJECTIVES

The followings are specific objective of the study which primarily focuses on:

1. To gain a better understanding about the socio-cultural background of Gedeo women on issues pertaining to home delivery and traditional child birth practices:
2. To explain the reasons for giving birth at home and carrying out traditional child birth practices among Gedeo rural women;
3. To explore the gender perspectives influencing home delivery and traditional child birth practices;
4. To envisage possible contextual strategies and community behavioral education based on major findings:

1.5 SCOPE & LIMITATION OF THE STUDY

In summary this study was carried out by combining both quantitative and qualitative methods ,it is facilitated to get reliable data strengthen the findings Despite the strength this study had also limitations the first place two study catchment area were excluded from the study because it was rain season and hard to reach area .in the excluded catchment area likely institutional child delivery was poorer than the other catchment area because of the topography impossible to access with any mode of transportation hence the results from these catchments might be worse than others .

secondly place those data collectors who are from the health centers were in pending assignments this might have impact the mothers response waiting at the spot however as such no variation were observed in final findings .Also during FGD discussion session still a bit influence were seen during the discussion session this might also fails to get full information exhaustively what women's really feel about the problem

however to maximum effort attempted to participate all and managed to disclose and response as much as possible.

1.6 DEFINITIONS OF CONCEPTS AND TERMS

Antenatal care attended: Pregnant women who had attended antenatal clinics during the recent pregnancy at least once

Skilled attendance: to people with midwifery skills (doctors, midwifes, nurses and TTBAs) who have been trained in the skills necessary to manage normal delivery, diagnose and refer Obstetric complications.

Traditional birth attendants: A birth attendant who initially acquired the ability by delivering babies herself or through apprenticeship to other TBAs.

Reinforcing Factors - are usually societal feedback that encourage or discourage behavior change

Predisposing factor- any characteristic of an individual which facilitate or hinder behavior related to health.

Health Education- Any designed combination of methods to facilitate voluntary adaptation of behavior conducive to health

Enabling Factors – are usually thought as barriers to behavior changes created by societal factors. Example .limited facilities, lack of income ….

Social beliefs and values: The social environment encompasses social and economic factors such as income, education, employment status and working conditions, social networks and community cohesion. The physical environment includes the natural environment (clean air, water and soil), the environment (land use patterns, zoning and community design) and living conditions, such as the availability of safe and affordable housing, transportation and nutritious food .Income and education are among the most potent determinants of health.

Cultural beliefs and practices: Cultural beliefs and practices refer to integrated patterns of belief and behavior which is varies from local group to group coexisting

with members. Individual distinctness is valued, endures and evolves. Cultural acts as a template for the organization of social and psychological processes, much as a genetic system provides such a template for the organization of organic process..

Skilled attendant: are doctors, Midwifes, Nurses or Health assistants Auxiliary

Midwives, who undergo formal education in educational program, and successfully completed the qualification to be registered and legally licensed to practice midwifery,.

Maternal death: Deaths of women while pregnant or within 42 days after termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Reinforcing factors: are influences of significant people that encourage or discourage behavioral change.

1.6.1 INDICATORS FOR OUTCOME MEASURES

- What are the socio-cultural beliefs and practices on child births that the women and their relatives hold? (The indicators to explore cultural & social meanings and beliefs and practices around pregnancy, childbirth and postpartum held by the women and their relatives (husband, mother-in-laws); and birth attendants (traditional birth attendants and trained persons).
- What are the gender aspects of child birth practices in Gedeo zone? The indicators for power relations on: i) the difference between the women's decision making on child delivery and postpartum Gedeo women practices from their husbands or male relative and older female relatives, ii) the sexual health and rights of women with regards to gender, to explore women's experiences on unwanted sexual intercourse during birth practices.
- Why do Gedeo women still give birth at home? The indicators for reasons include accessibility, availability of staff and equipment, affordability, lack of privacy and confidentiality

1.7 ORGANIZATION OF THE PAPER

The paper is organized in five chapters .The first chapter consists the introduction part which includes statement of the problem ,objectives of the study, definition of key terms in the study ,scope & limitation of the study ,significance of the study .The second chapter develop on review of the literature ,theoretical and empirical literature in different parts of the world .Chapter three discuss research design and methods employed while undertaking this study.it also describes and explains the universe of the study in terms of the target population ,study site and time period for collecting pertinent quantitative as well as qualitative data .including the sample size ..The next chapter presents the analysis in the light of addressing the study questions and objectives .the study puts together those threads of discourse on the major issues considered throughout the research undertaking .the last chapter five draws conclusion to answer the questions and then to address those objectives .it therefore, suggests plausible interventions to be accomplished by different stakeholders in various contexts at different level s in the study area.

CHAPTER TWO: LITERATURE REVIEW

It is well established that giving birth in a medical institution under the care and supervision of trained health-care providers promotes child survival and reduces the risk of maternal mortality Despite the many benefits associated with institutional delivery, Ethiopia's maternal and child health programs have not aggressively promoted institutional deliveries, except in high-risk cases. The reason is that providing facilities for institutional delivery on a mass scale in rural areas is viewed as a long-term goal requiring massive health infrastructure investments. In recent years, however, there has been a shift in this policy with the establishment of the Child Survival and Safe Motherhood (CSSM) and the Reproductive and Child Health (MCH) programs. The new programs aim at expanding existing rural health services to include facilities for institutional delivery. Existing maternal and child health services at primary health centers (PHCs) are being upgraded, and new first-referral units (FRUs) are being set up at the community level to provide comprehensive emergency (FMOH 2011) .

In Ethiopia, 94% of rural women give birth at home without assistance of skilled birth attendant, 28% of women attend health facilities for antenatal care during pregnancy and only 6% of them came for delivery to health facilities. Most of these women live in remote areas that are too far from a road, no maternal health services and emergency obstetric care. In general, 61% of home deliveries are assisted by a relative or some other untrained person and 5% are delivered without any assistance (UNICEF 1996). As the consequence of these practices 24,000 women and girls die each year and 480,000 suffer from disabilities including obstetric fistula caused by complications seeking care for delivery is very low in rural area of the country even compared to urban. Data from 58 countries that account for 76% of births in the developing world show that the use of a skilled attendant at delivery (the key feature of first-level care) increased significantly, from 41% in 1990 to 57% in 2003. This is a 38% increase in the number of women with a skilled birth attendant between 1990 and 2003 (WHO 1997). The greatest improvements occurred in Southeast Asia (from 34% in 1990 to 64% in 2003) and North Africa (from 41% in 1990 to 76% in 2003). These trends represent an increase in the number of women with a skilled birth attendant of more than 85% in both regions. Hardly any change was observed,

however, in sub-Saharan Africa, where rates remained among the lowest in the world at around40% (WHO, 2007). Within these regional averages, there are significant differences between countries and between urban and rural areas which often represent rich and poor sections of the population (WHO, 2005). Almost all of the increases in births with a skilled attendant are driven by increases in the presence of medical doctors at birth. The explanation of this diversity is complex. Utilization of health services is affected by a multitude of factors including not only availability, distance, cost, and quality of services, but also by socioeconomic factors and personal health beliefs. .Another factor affecting women's health-seeking behavior, especially as related to pregnancy and childbirth, is that traditionally in rural Ethiopia pregnancy is considered a natural state of being for a woman rather than a condition requiring medical attention and care. Such perceptions and beliefs constitute a "lay-health culture" that is an intervening factor between the presence of a morbidity condition and its corresponding treatment. Anti natal care and infant and child health care are similarly affected by this culture, with the result that women often do not avail themselves of preventive and curative medical services intended to safeguard their own and their children's health and well-being. The lay-health culture presumably has substantial effects on utilization of maternal health services in regions of the country where poverty and illiteracy are widespread. This culture is difficult to measure directly, but it is possible to include socioeconomic factors that are correlated with it when analyzing utilization of maternal health services .In fact most regions, with the exception of sub-Saharan Africa, show decreasing use of other types of professional assistance .Some factors contributing are poor infrastructures related to transportation, inadequacy of health facilities, shortage of health workers, weak in health information, cultural beliefs, illiteracy, gender inequality, financial accessibility and quality of health services (ORHB 2002).

There are many reasons which influence decision to seek care for delivery which is main cause for maternal mortality and morbidity in the country. Because of most of maternal death occur during delivery, emergency obstetric care, postpartum care and skilled birth attendant is necessary, but these services are limited in rural area of the country. In Ethiopia, capacity to provide emergency obstetric care is 36 out of 100. Generally access to safe mother hood services in Ethiopia is 29% which is 19% in rural area and 39% in urban settings (USAID, 2005).

In rural area of Ethiopia, mostly men are decision maker and control over resources and they decide when were women should seek health care. Educational status of mother is also one of main causes for delay in seeking care for delivery. Educated mother are more likely to seek care than less educated women (UNFPA ,2008). Traditional beliefs in the rural area of the country also have impact on health seeking behavior of women during delivery (ORHO, 2002).lack of decision making power such as getting permission from their husbands or parents may discourage them from seeking health care (USAID ,2005). A study from India have pointed out that the low utilization of maternity services seems to be due to low levels of household income, high illiteracy and ignorance, and a host of traditional factors. (Sharif and Geeta,2002). A similar study in Pakistan described poor socio-economic status, lack of physical accessibility, cultural beliefs and perceptions, low literacy level of the mothers and large family size as the leading causes of poor utilization of primary health care services (Babar et al, 2004). In another study from Ethiopia, it was observed that the use of maternal health services can be influenced by the socio demographic characteristics of women, the cultural context, and the accessibility to these services (Yared, 2002).

In India, a study of analysis of choice of delivery location showed that maternal and, paternal education, and scheduled caste status were the predisposing factors that determined the choice of private facilities, public and home deliveries (Thind, et al. 2008). In a similar way, a study from Pakistan showed that family size, parity, educational status and occupation of the head of the family were also associated with health seeking behavior in addition to age, gender and marital status (Barber 2004) . (Sharif and Geeta 2002). A study from rural Tanzania identified that ethnicity, gender of the household head, mother's education, mother's age at child birth, socio-economic and quality of services status were important independent factors in determining the choice of delivery place Sudden onset of labor or short labor were affecting decisions towards selecting the delivery place. Selecting health facility for delivery was perceived to be more desirable for prolonged labor (Mishra, V et al 2007).

2.1 MATERNAL HEALTH CARE & SERVICE UTILIZATION

Maternal health care coverage as measured by antenatal care, delivery service, postnatal care, and family planning increased from 2002/3 to 2006/7 by 24.73%, 7.39%, 10.56% and 11.84% respectively. Despite these achievements, several studies have identified that maternal health service utilization in the country is low. Some of these studies have also tried to explore the determinants of this low utilization of services. Yared et al. illustrated that the majority (94%) of births are delivered at home. Among these, 28% were assisted by TBAs, 61% by relatives or others and 5 % delivered without any type of assistance at all (Yared et al, 2002). In another study based on a national census survey,28% of mothers received antenatal care from a health professional for their most recent birth; Priorities activities/measures to improve maternal health.

1. Strengthen reproductive health and family planning policies and improve planning and resource allocation
2. Increase access to reproductive health and family planning services, especially in rural area.
3. Increase access for education about family planning.
4. Increase access to high quality antenatal care.
5. Increase access to skilled delivery care.
6. Provide quality of postpartum care, counseling, and access to family planning.
7. Improve post abortion care.
8. Strengthen prevention and promotion activities.

Determinants of low utilization of maternity care in Ethiopia include low educational level and income, residence, lack of women empowerment, poor access to maternal health care service and poor knowledge on maternal health care services (Yared et al, 2003). Women with no education were less likely to be attended delivery by a health professional than women with some secondary or higher education (DHS, 2005). Another study in north Gondar Zone identified that the use of skilled birth attendants was significantly influenced by the level of education. Women with higher level of education (secondary and above) were

10.6 times more likely to use safe delivery services that those with lower education levels (Nigussie 2004). Place of residence has also been shown to influence delivery services.

In the capital city, Addis Ababa, three in four babies were delivered in a health facility while in the rest of the country (with the exception Harari, Dire Dawa and Gambela) only about 5% of babies were delivered in a health facility (DHS, 2005).

Utilization of safe delivery services has been significantly associated with previous obstetrics complications. It was five times higher among those who had previously developed one of the lives threatening obstetric complications compare with those who had not (Nigussie et al, 2004). Marital status, parity, and number of children under five were also common predictors for the utilization of maternal health care services. Higher parity women, together with greater responsibilities within the household and for child care, have been suggested as explanatory factors for their tendency to use services less frequently (Yared et al, 2002). As the HSDP III midterm review indicated, poor health status of pregnant women and their newborns in Ethiopia included a high fertility rate, widespread poverty, low female literacy, low nutrition status, and poor access to health services. Additionally, early marriage, gender in equality, female genital cutting and closely spaced pregnancies aggravated the problem (HSDP-III 2008).

As stated above, the Government has given a priority to improve maternal health services. Accordingly, various measures have been taken to increase skilled attendance at antenatal, delivery and postnatal care as well as access to emergency obstetric care, early referral system and training of TBAs and community health workers. Measures are tailored to address societal and cultural factors that influence women's health and their access to maternal health services. Evidence-based interventions during labor and delivery can make the difference between life and death for women and their infants. It is critical that women with serious complications receive care from a skilled birth attendant in an emergency obstetric care facility with the facilities, drugs, and supplies needed to save women's lives. A Skilled attendance at birth has been described as a partnership of skilled attendants and an enabling environment of equipment, supplies, drugs and transport for referral.

Because most maternal deaths occur at labor and delivery or within the first week following birth, Emergency obstetric care is the most important action that can be taken to reduce maternal mortality. Emergency obstetric care (EOC) is the term used to describe the elements of obstetric care needed for the management of normal and complicated pregnancy, delivery and the postpartum period lack of access and availability of emergency obstetric care is a contributing factor to slow progress in maternal mortality reduction in Ethiopia. Emergency obstetric complications include hemorrhage, prolonged or obstructed labor, postpartum sepsis, abortion complications, pre-eclampsia or eclampsia and ectopic pregnancy and ruptured uterus. When these complications arise, it is a lifesaving situation to get emergency obstetric care. The basic emergency obstetric care (BEOC) includes parental antibiotics, oxytocic drugs, sedatives for eclampsia, manual removal of retained products and basic neonatal life support and the Comprehensive Essential Obstetric Care (CEOC) all those in BEOC plus obstetric surgery, anesthesia and blood transfusion (Nadew 2007). However many pregnant women have difficulties to access emergency obstetric care,, especially in rural areas, due to the 3 delays: delay in deciding to seek care, delay in reaching care in time, and delay in receiving adequate treatment. The first delay is on the part of the mother, family, or community not recognizing a life-threatening condition. The second delay is in reaching a health-care facility, and may be due to road conditions, lack of transportation, or location. Many villages do not have access to smooth roads and many families do not have access to vehicles. The third delay occurs at the healthcare facility. Upon arrival, women receive inadequate care or incorrect treatment, and a lack of supplies to provide critical care.

Another factor affecting women's health-seeking behavior, especially as related to pregnancy and childbirth, is that traditionally in rural India pregnancy is considered a natural state of being for a woman rather than a condition requiring medical attention and care. Such perceptions and beliefs constitute a "lay-health culture" that is an intervening factor between the presence of a morbidity condition and its corresponding treatment. Postnatal care and infant and child health care are similarly affected by this culture, with the result that women often do not avail themselves of preventive and curative medical services intended to safeguard their own and their children's health and well-being. The lay-health culture presumably has substantial effects on utilization of maternal health services in regions of the country where

poverty and illiteracy are widespread. This culture is difficult to measure directly, but it is possible to include socioeconomic factors that are correlated with it when analyzing utilization of maternal health services. Several studies have attempted to identify and measure the effects of the factors that contribute to differential use of maternal health services. Based on data from NFHS-1, a multivariate analysis of utilization of maternal and child health services in India and four major northern states concluded that utilization of maternal and child health services in rural areas is driven primarily by socioeconomic factors, such as education, media exposure, and standard of living, that create a demand for services and much less so by physical access to and availability of health and family welfare services (Das et al; 2001) . Another study, also based on data from NFHS-1, found that woman's education is a major factor affecting utilization of maternal health services in both north and south India (Govindasamy, P. and B. M. Ramesh. 1997)

A number of other studies have stressed the role of socioeconomic and demographic factors in influencing demand for and utilization of maternal and child health services (Ray ,et al 1984) (Kanitkar, T. and R. K. Sinha 1989) (Elo 1992) (Swenson 1993) (Abdalla 1993) (Khan, Z et al; 1994) ; (Barlow, R. and F. Diop 1995) ; (Ahmed and Mosley 1997) ; (Regmi, G. P. and M. Manandhar 1997). Many of these studies have also shown that utilization of maternal and child health services are strongly affected by woman's education. Other socioeconomic factors usually found to be important are urban-rural residence, woman's work status, woman's status relative to men, religion, caste/tribe membership, household standard of living (or economic status of the household),and community development .

2.2 PLACE OF DELIVERY

An important component of efforts to reduce health risks to mothers and children is increasing the proportion of babies that are delivered in health facilities. According to DHS recent study fifteen percent of births in Ethiopia are delivered at health facility - 14 percent in a public facility and 1 percent in private facility .Even though the percentage of facility births continue to be low in Ethiopia ,there has been remarkable progress in the last three years .The percentage of births delivered in health facility 50 percent is higher, from 10 percent reported in 2011 .(DHS,2014).first births are much

more likely than births of order six or higher to be delivered in health facility (36 percent versus 7 percent).delivery in health facility is more common is more common among births to mothers below age 35 ,births to mothers who had at least four ANC visits ,and births to highly educated mothers and mothers in higher wealth status .Urban births are six times more likely than rural births to be delivered in health facility (63 percent versus 10 percent).The percentage of births delivered in health facility ranges from 6 percent in Affar to 87 percent in Addis Ababa .(DHS.2014)

2.3 GLOBAL EXPERIENCE FROM THE PREVIOUS STUDIES CONDUCTED REGARDING PLACE OF CHILD BIRTH

The safety and women‘s right of choice to home delivery verses hospital delivery is continuously debated in the developed countries but undesirable outcome of home delivery such as high maternity and prenatal mortality is documented in developing countries .A study in Netherlands examined that women‘s of high socio-economic states delivered more often at home irrespective of other factors (Habib:, . S.S. Mahdi and O.S 2010).

The rate of home births with in the UK remains low at approximately 2%, but it is believed that if women had true choice the rate would be around 8-10%.Furthermore, the studies into women's descriptions of home birth experiences have produced qualitative data on increased sense of control, empowerment and self-esteem, and an overwhelming preference for home birth. As a trend, the demand for birth centers and midwifery services varies in different countries. Birth centers and midwifery services grew substantially over the last decades of the 20th century in the United States of America (USA).In Turkey, home delivery represents only a small fraction of the total reported deliveries, while in Tunisia, community health centers staffed by university-educated midwives are well dispersed throughout the country and most deliveries are in these health centers, or in local hospitals or clinics (Habib:, . S.S. Mahdi and O.S 2010).

The Tanzanian health system comprises a well-established network of health facilities throughout the country, and the government encourages all pregnant women deliver at health facilities. The government has also mandated that maternal and child health services, including deliveries, be exempted from fees at any government facility. The

reality, however, is that women are asked to bring delivery kits, such as razorblade, gloves and cotton wool.

In Tanzania, although health facilities are closer to rural households than in many African countries, more than half of children are delivered at home despite a high coverage (94%) of antenatal care (ANC) (Margaret E, et al : 2009).

Data from the Ghana Demographic and Health Survey (2003) show that medically trained providers assisted with 47% of deliveries, traditional birth attendants (TBA) assisted with 31%, and relatives or friends attended to 19% of deliveries. Although maternal health care utilization is essential for further improvement of maternal and child health little is known about the current magnitude of use and factors influencing the use of these services in Ghana (Edward N: 2009).
In Nigeria only 13.5% of the estimated annual birth took place in health facility even 53.6% of those in facility deliveries taking place in private health facilities there is considerable preference delivering in church mission houses or spiritual homes in cross-river and for home deliveries supervised by an older women in the northern – west region (Margaret E, et al : 2009).

In Ethiopia, only 18.4% of the deliveries are attended by health professionals. The rest 81.6% deliveries took place at home. This situation well explains the maternal mortality ratio of 673 per 100,000 live births, which is one of the highest in the world. Studies revealed that hemorrhage, hypertensive disorders and ruptured uterus were among the causes of maternal deaths (Mihret H 2008).

In Bangladesh 52.5 percent of the adolescents received antenatal care services, only 14.4 percent sought assistance from skilled birth assistance during childbirth and 10.7 percent of the babies were delivered at medically-facilitated places. Women and their families were reluctant to spend money on something that was perceived to be a natural event that can be practices at home at negligible expanse (Kamal,S. Mostafa M: 2009).

In Sri Lanka, over 93% of the women have access to basic health care. Health services were provided free of charge. Maternal and child health services were available at the community

In Sri Lanka, over 93% of the women have access to basic health care. Health services were provided free of charge. Maternal and child health services were available at the community level as part of an integrated reproductive health service. This has contributed immensely to a reduction in maternal and infant mortalities. Women from the poorest quintile were three times more likely than women in the richest quintile to undergo home delivery without trained attendants (Falkingham 2003).

Globally, it is estimated that 34% of the mothers deliver with no skilled attendant; this means there are 45 million births occurring at home without skilled health personnel each year. Skilled attendants assist in more than 99% of births in developed countries compared with 62% in developing countries. In five countries including Ethiopia the percentage drops to less than 20%.

The study conducted in Tigray, Ethiopia demonstrated that institutional delivery service utilization was very low. In the last five years only 4.1% of mothers gave birth in the health facility for their recent child. The majority of births 95.9% took place at home compared to 4.1% births at different health facilities of the district (Yalem 2010).

A study conducted on Syrian women‘s preferences for birth attendant and birth Place, a minority of women (5–10%) expressed no preferences related to childbirth .Most women (65.8%) preferred to give birth in hospital, and a similar majority preferred to be attended by doctors compared with midwives (60.4% vs 21.2%) (Hyam.B, PhD and Asmaa.A, MD, 2006).

Study on factors influencing choice of delivery sites in Rakai district Uganda noted that 44% of the sample delivered at home, 17% at traditional birth attendant‘s place, 32% at public health units and 7% at private clinics (Nuwaha, F. and Amooti-Kaguna, B.: 2002)(23).

A study conducted in Nepal on114 women‘s shows that Sixty seven (58.8%) women had planned for home delivery whereas only 47 (41.2%) had chosen hospital delivery and delivered at home due to various reasons (HeerT. 2009).

Traditionally, children in Ghana are delivered at home with the assistance of birth attendants or elderly women of the community. An important component of efforts to reduce the health risks of mothers and children is to increase the proportion of babies delivered under medical supervision. The level of assistance a woman receives during the birth of her child has important health consequences for both mother and child. Births delivered at home are more likely to be delivered without professional assistance, whereas births delivered at a health facility are delivered by trained medical personnel. Medically assisted deliveries continue to be low in Ghana, with less than 50%benefiting from professional delivery assistance over the past 15 years.

2.4 FACTORS INFLUENCING UTILIZATION OF SKILLED ATTENDANT AT BIRTH

In Ethiopia according to EDHS, 2005, 2011 antenatal care coverage is, 27.6%, 34% respectively and professionally assisted deliveries were 6%,10% (EDHS ,2011) Thirty-four percent of pregnant mothers who gave birth in the five years preceding the survey received antenatal care from a skilled provider, that is, from a doctor, nurse, or midwife, for their most recent birth—28 percent from a nurse or midwife and 5 percent from a doctor. Another 9 percent of women received ANC from a health extension worker (HEW). By comparison, in 2005, 28 percent received antenatal care from a skilled provider. This improvement in the last five years is impressive, particularly since between 2000 and 2005 there was hardly any improvement in antenatal coverage. (EDHS, 2011). In most studies antenatal follow up of pregnant mother have been found to have strong positive correlation with institutional delivery. In Andhra Pradesh India, pregnant mothers who received an antenatal checkup are found several times more likely to give birth in a medical institution than mothers who didn't receive any antenatal checkup, even after controlling for a number of potentially confounding variables. With age, birth order, religion, and tribe controlled by holding them constant at their mean values in the underlying logistic regression, the odds of giving birth in a medical institution is 5.4 times higher for mothers who received an antenatal checkup than for mothers who did not receive on antenatal checkup (Sugathan 2001) .

2.4.1 SOCIO DEMOGRAPHIC FACTORS

Several factors affecting maternal care in general and safe delivery service utilization in particular had been identified through many studies. Most of the studies conducted on maternal care utilization in developing countries identified those mothers who are younger than 35 years, attended at least primary education, employed, reside in urban are more likely to use safe delivery service than their counterparts. Moreover, mothers whose husbands attended at least primary and employed had higher odds of giving birth at health facilities compared to those whose husbands are uneducated and unemployed. Furthermore, living standard and cultural rituals were said to be inhibiting mothers from using safe child birth services (Idris S., et al. 2006) .

Women aged 18 or younger were less likely than women aged 19–23 to use either antenatal care or delivery care, or both. Besides, women over 35 years of age were in a better position to access health care because they were more empowered to voice their needs and had more control over family resources. On the other hand younger women are more likely to give birth at health facilities than those older than 35 years According to surveys conducted between 1996 and 2005 in 57 developing countries, 81per cent of urban women deliver with the help of a skilled attendant, versus only 49 percent of their rural counterparts. Similarly, 84 percent of women who have completed secondary or higher education are attended by skilled personnel during childbirth, more than twice the rate of mothers with no formal education (UN 2007) Mothers with some education are more likely to use maternal health care than their counter parts . The use of institutional facilities and/or trained providers for obstetric complications was positively associated with women's education and their husband's education (Shameem, A;et al 1996) . In addition, a study in India indicated maternal education results in improved child survival because health services that effectively prevent fatal childhood diseases are used to a greater extent by mothers with higher education than by those with little or no education (pavlavali and Ramesh 1997) .

A study in rural Nigeria showed the likelihood of a health care institution delivery tripled among mothers with post primary education compared to mothers with no schooling.

There was a 1.7 times higher likelihood of institutional delivery among mothers in petty trades and a 2.3 times higher probability among farming women than women with no occupation (Nwakoby 1994).

Consistent with most developing countries, maternal education, age, occupation, residence, economic status were the most common socio demographic determinants of maternal care utilization, particularly safe delivery service utilization in Ethiopia (CSA 2005).The nationwide EDHS showed delivery in a health facility is more common among younger mothers (age less than 35). The proportion of births delivered in a health facility is only 2 percent among uneducated mothers, compared with 52 percent among pregnant women's who are educated women.

2.4.2 PREDISPOSING FACTORS

Some studies have presented evidence that the effect of knowledge of women about delivery complications have influence on skill attendant utilization. With regard to access to information women and community members often do not know how to recognize, prevent or treat pregnancy complications, or when and where to seek obstetric help. The study in Ghana shows that, 64% of women who died of pregnancy complications sought help from a traditional birth healer before going to a health facility and had no information with regard to pregnancy related complications (www.familycareintl.org n.d.). Study conducted in India in four states, shows that, mothers who are regularly exposed to electronic mass media are several times more likely to give birth in a medical institution than mothers not exposed

2.5 REASONS FOR CHOICE OF DELIVERY PLACE

A qualitative study conducted by IMCC and SAVE-in west region of Ghana reported that, during women's interviews, it was said that the health staff sometimes has a rough behavior towards the women e.g. slapping their thighs during labor, yelling at them when they come in a late stage of labor or do something wrong etc. The women said this keeps them away from coming to deliver at the clinic. I will not go to the clinic because of the nurses there. They are not kind to pregnant woman. If traditional birth attendants are giving the same treatment, why should I go to the clinic? (Sissala RC: 2009).

The various dimensions of autonomy, such as position in the household, financial independence, mobility and decision-making power regarding one's own healthcare, may all impact on health facility use. In many countries, women cannot decide on their own to seek care, but have to seek permission from a husband or mother-in-law. Furthermore, women may lack control over material resources needed to pay for expenses, their mobility may be restricted or they may lack access to vehicles or even bicycles or donkeys'. However, women's informal power in the household may mitigate some of the above. The interpretation of various measures of autonomy depends on the context – women who take decisions alone in a context where this is unusual, "might be relatively isolated, unsupported individuals and not autonomous agents" As such they may have resource constraints and be less likely to use service (S.S. Mahdi and O.S Habib 2010).

In a cross-sectional population-based survey to determine the utilization of approved health facility for delivery by mothers in IIe-Ife, Nigeria 49% delivered outside the health facility. The prominent reasons given for the non- utilization of health facilities were time of occurrence of labor, and difficulty with transportation. (Essien,E. et.al: 2003.).

A cross-sectional study in Basra 353 women, 16.1% delivered at home, while 83.9% delivered in hospital. The main reasons for choosing hospital delivery were safety and security (96.6% of the women), better hygiene (66.6%) and because of medical advice (63.2%).The main reasons for the choice of home delivery were social support and privacy (98.2%). The women were consistent in their choice of delivery place across different pregnancies, previous, present and future (Koblinsky M.A,Campbell O&heicheleim J: 2001).

The attitude of health workers is one factor that significantly influenced the choice of place of delivery. In a study on obstetric services utilization in northern Transvaal, South Africa, revealed that negative staff attitude contributed 9.8% to the reasons for home delivery. In a study on socio-economic factors responsible for poor utilization of the primary health care in rural Nigeria, found that unfriendly attitude of health workers contributed 3.6% of the major factors that cause non-utilization. Positive interaction between expectant women and health care providers however lead to client confidence and compliance. In a study on the role of skilled birth attendants in

increasing supervised delivery in the West Gonja district of Northern region, Ghana shows that the women complained about the unfriendly behavior of some health providers. They mentioned being harsh, insolent and abusive during labor as common behavior. The providers give preferential treatment to clients who were expensively dressed up (Esimai OA, Ojo OS and Fasubaa OB.: 2002:).

The educational status of the women and that of their partners had strong relationship with the choice of delivery place. Educated women presumably have better sense of appreciation and concern for their health. The study conducted in Tigray shows that mothers who had educated family member/s were positively influenced to select health facility as a delivery place. The probability of a mother who had a family member who at least attended a secondary education of giving birth at a health facility was 11 times higher than those who did not have. One interesting finding is that women with secondary education (38%) were more likely to use the health facility for delivery place than illiterate mothers (3%). Mothers with secondary education were more likely to select a health facility for delivery place than those who were illiterate .Receiving ANC has appeared as a significant predictor on the use of institutional delivery and skilled assistance. Mothers who attended antenatal follow up for the recent pregnancy have five times higher chances of delivering at a health facility and approximately 2.8 times higher chance to be assisted by skilled birth attendants (Barber 2004)

Study conducted in Nigeria shows that women‘s with formal education tend to deliver in the hospital while those with no formal education tend to deliver at home. The husband‘s occupational status was also found to be another determinant of place of delivery as wives of employed husbands tend to deliver at the hospital Among 137 mothers who delivered in the Hospital, 126 of them (92%), their husbands are engaged in one occupation or the other (S.H.Idris,U,M.D.Gwarzo and A.U.Shehu, Determinant of place of delivery among women in semi-urban settlement in Zaria, Annals of African Medicine, 2006) .

Study conducted in Syrian women indicate that the demographic variables that were statistically related to stated preference for a hospital delivery included the woman‘s education (82.6% of literate women preferred a hospital delivery compared with 65.5% among illiterate women, husband‘s education (80.4% of women whose

husbands were literate preferred hospital delivery compared with 70.5% of women whose husbands were illiterate, and the woman‘s age (89.1% of younger women age <20 years preferred hospital delivery compared with 60.7% of women age ≥40 years (Hyam.B, PhD and Asmaa.A, MD, 2006).

Maternity is viewed variedly in culture. The health of the pregnant woman is managed traditionally based on several pre-determined and experienced beliefs within specific cultural settings (Malin, M. and Gissler, M.: 2009).A qualitative study conducted in Ghana shows that, women‘s says that, a woman will have to prove herself to a "real" woman by delivering alone. This is thought to be a sign of true womanhood. Women who do not utilize the facility for delivery they use that as a way of proving their true women status and try to look down upon those who utilize the facility and consider them as very lazy and inferior. Some men also consider women who deliver at the facility as inferior, and also men think that he is lucky if his wives deliver at home. The society is built up in a way that men are the decision makers. However when it comes to pregnancy and delivery the mother in laws have the largest mandate "all we know about pregnancy and delivery is that when our wives are pregnant, the first person to know is the mother in law, and if possible the husband is also made to know that the wife is pregnant. It is the mother in law that takes charge of her until she gives birth (Essien,E. et.al: 2003.).

In many settings, the physical distance between services and women is associated with service utilization. A significant influence of distance to the health centers on prenatal visits as well as child delivery has been found by many studies. The physical distance from their house to the health care centers imposes another cost to the pregnant women that is opportunity cost time spent obtaining these services and accessibility of health service in terms of location and distance is very important in the use of reproductive health services, also argued that the distance to the maternity hospital as having causal role for the place of delivery. In Tanzania, 84% of women who gave birth at home intended to deliver at a health facility but did not due to distance and lack of transportation .In Kenya, a study showed that the most important significant predicators of choosing an informal delivery setting (home) are the household‘s distance from the nearest maternity center (Dechen.Z, : 2006)

Study on women‘s in semi-urban settlement of Zaira, Northern part of Nigeria shows that financial problem was the most common reason followed by ignorance and transportation problem. High proportion of women (87.6%) was attended by an untrained family member, friend or neighbor, and 7% of women delivered completely unattended. Women were brought to the hospital by family member 59.6% other than husband and 8.8% were accompanied by neighbors/friends. Most of these women were brought with retained placenta, primary postpartum hemorrhage? (Sissala RC: 2009). Study done in Kalimantan Indonesia where preference to home delivery among pregnant women was high was found due to poor quality of care which was an important contributor to excessive maternal mortality in many countries (Samuel. G, : 2002) .

In India, a study of analysis of choice of delivery location showed that maternal and, paternal education, and scheduled caste status were the predisposing factors that determined the choice of private facilities, public and home deliveries (Amardeep Thind, A et: Al 2008). In a similar way, a study from Pakistan showed that family size, parity, educational status and occupation of the head of the family were knowledge of maternal health also associated with health seeking behavior in addition to age, gender and marital status (Babar T. 2004). A study from rural Tanzania identified that ethnicity, gender of the household head, mother‘s education, mother‘s age at child birth, socio-economic and quality of services status were important independent factors in determining the choice of delivery place Sudden onset of labour or short labour was affecting decisions towards selecting the delivery place. Selecting health facility for delivery was perceived to be more desirable for prolonged labour (Mwifadhi Mrisho, M. & Joanna A. Schellenberg et al 2007).

An explorative study of factors influencing mother‘s choice of place of delivery in rural Malawi shows that unsatisfactory availability of skilled delivery care in terms of distance, transport, cost and poor approach of health workers were found to be among the most consistent associated factors with the choice of health facilities for delivery. One of the health workers explained:―Most of the women, they stay very far from the hospital, Some places there are no labor transport, no buses they use bicycles, so it‘s a problem when the mother starts the labor. That is why most of the women just

deliver at the TBA‘S (traditional birth attendant), they can‘t reach the hospital‖ (.Line, S. Johanne, S., and Jane, C 2006).

Study done in Bhutan shows that age is seen to be positively associated with the place of delivery. The women in the age group 35-49 years are expectantly seen to deliver two times

More in the health centers than those of age group 15-24 years. Compared to the women aged between 15-24 years, the women who are 25-34 years old are just 1.24 times more likely to deliver in health institutions. Without much significance, the older women are found to be more likely to deliver in health centers than their counterpart (Dechen.Z, : 2006) .

In Bangladesh 52.5 percent of the adolescents received antenatal care services, only 14.4 percent sought assistance from skilled birth assistance during childbirth and 10.7 percent of the babies were delivered at medically-facilitated places. Women and their families were reluctant to spend money on something that was perceived to be a natural event that can be practices at home at negligible expanse (Hyam.B, PhD and Asmaa.A, MD, 2006) .

2.5.1 CULTURAL PRACTICES AND WOMEN’S DECISION MAKING POWER

Another important factor in the utilization of maternal healthcare services, especially in Africa, is the cultural background of the women’s. Women’s powerlessness and their unequal access to (Omar 1994.).Materials and other resources, and their inabilities to make informed choices are the fundamental causes of maternal death and disability. A range of barriers related to women’s powerlessness could harm their health directly or by limiting their access to the services. This includes ignorance of good health practices, as well as lack of awareness of danger signs during pregnancy or is interpretation (for instance that obstructed labor is associated with women’s infidelity.(WHO, 1994).

The cultural perspective on the use of maternal health services suggests that medical need is determined not only by the presence of physical disease but also by cultural perceptiveness of the illness. In most African rural communities maternal health

services coexist with indigenous health care services, therefore, women must choose between the options (Jepson C 1992).When obstetric complications are seen as the reflection of the ”will of God” or the influence of evil spirits, families often resort to traditional healers and diviners for care, and only take women to health facility at last resort when it may be too late (WHO\UNICEF ;1996).Studies in rural Bangladesh showed the vast majorities believed that childbirth is an act of God and is a natural event. For this reason, they do not expect delivery complication or problems and therefore use TBAs for childbirth. Villagers also select TBAs because of tradition, convenience and special attention they receive. Traditional birth attendants (TBAs) are trusted, highly accessible and affordable members of the community (Bihata ; 1986) (Nancy 1999))Women’s lack of control over their own life means that other family members husbands, mother-in law) often make decisions about where a woman should deliver (WHO, 1990). In Pakistan, for example, a study found that two-thirds of women delivered at home because the husbands or other family members forbade hospital deliver (Kwast B 1992).

Many women in developing countries need a husband’s permission to visit a health facility, or must be accompanied, particularly when the husbands are away from home. This tradition can severely limit women’s ability to use even nearby health facilities. Women have very little control over their own or the family income; their ability to use the services especially when fees are involved is further constrained. Studies in Swaziland and Kenya, for example, found that many women who did not deliver in a facility cited their husbands’ refusal to meet expenses as the main reason (WHO ;2001).In many parts of the world women’s power to make decision is limited even matters directly related to their own health (UNICEF; 1996) In Bangladesh, it is usually the mother- in law and the husbands who make decision to seek (or not seek) care (Nancy P, Ubaidur R Khan M.E 1999) They are often the least likely to know about pregnancy related complications and their possible fatal consequences. Moreover, in many parts of Africa, women’s decision-making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decisions about maternal care are often made by husbands or other family members (UNICF\FMOH. 1987-1998)Availability of women’s time is also important. In developing countries, women spend more time on their multiple responsibilities for

care of children, collecting water or fuel, cocking, cleaning, growing food, and trade than on their own health (Guilleromo C 1992).

2.5.2 QUALITY OF HEALTH SERVICES

Quality of care is an important consideration in the decision to seek care. A study in the Guatemalan highlands, revealed that, government health posts seemed to be conveniently located, yet that proximity did not guarantee utilization, probably the facilities understaffed and underequipped and thus unable to provide quality care (Dana A. 2003). The role that quality of care plays in the decision to seek care is related to people's own assessment of service delivery, which largely depends on their own experiences with the health system and those of people they know. The two mechanisms through which quality of care affects the decision to seek care are satisfaction or dissatisfaction with the outcome (e.g. effectiveness of the treatment and remedies prescribed), and satisfaction or dissatisfaction with the service received (e.g. staff attitude, long waiting time, hospital procedure, and availability of supplies, efficiency) (Kloos H. et al 1987). These factors will act as inhibitors of future utilization, thus affecting the decision to seek care. As several studies from developed and developing countries indicate, health services barriers and women's perception of quality of ANC were important factors affecting women's attendance during pregnancy (WHO\ UNICEF 1990-2001) Studies on quality of ANC are scarce in Ethiopia and other developing countries.

2.5.3 BELIEFS, ATTITUDES AND PERCEPTION OF WOMEN ABOUT SKILL ATTENDANT UTILIZATION

In a study done in southern Ethiopia, professionally assisted delivery was very low. A medically trained person attended only 3.3% of the women during the study period (Yared 2003).for this low coverage Cultural norm, perceptions and practices of mothers may negatively impact on skill attendant care at delivery. Studies indicated that the perception of health and risk during pregnancy, birth and postpartum periods strongly influence health seeking behavior. On the other side, formal health services also can conflict with ideas about what is normal or acceptable including preference for privacy, modesty of female attendants. The Saraguro Indians in Ecuador did not use the affordable, accessible maternal care because they feel that hospitals violate

women’s privacy during childbirth and because many health professionals are men (Leslie and Gupta 1989).This is also true in Ethiopia where only 6% of women deliver with a skilled attendant and 8% postnatal care with 48 hours of delivery (DHS, 2005).

2.6 CONCEPTUAL MODEL THE HEALTH BEHAVIOR MODEL

Andersen's Behavioral Model of Health Services Utilization was used as the conceptual framework. This model has been used extensively in both developing and developed countries to understand health services utilization. The model classifies factors that affect health services utilization into three groups: predisposing, enabling and need factors. Among the predisposing factors, demographic characteristics (age, gender, marital status) reflect the tendency of individuals to use services. Social structure (education, occupation, and race/ethnicity) measures the ability of the individual to cope with the problem, the resources available in the community, and the state of the physical environment. Health beliefs are values and knowledge about health and the health care system that influence utilization and these include general attitudes towards medical care, physicians, and disease. Enabling factors, both personal and organizational, must be present for service utilization, and these represent the actual ability of the individual to obtain health services. Personal enabling factors include income, regular source of care, travel and waiting times; organizational enabling factors include the availability of health care providers and their spatial distribution. The most immediate cause of health services utilization is need. This judgment about need can be made by the individual himself or family caregivers (perceived need), and can be estimated by a self-assessment of health status, symptoms experienced during a period of time, or number of symptoms during a period of time.((Anderson 1995).

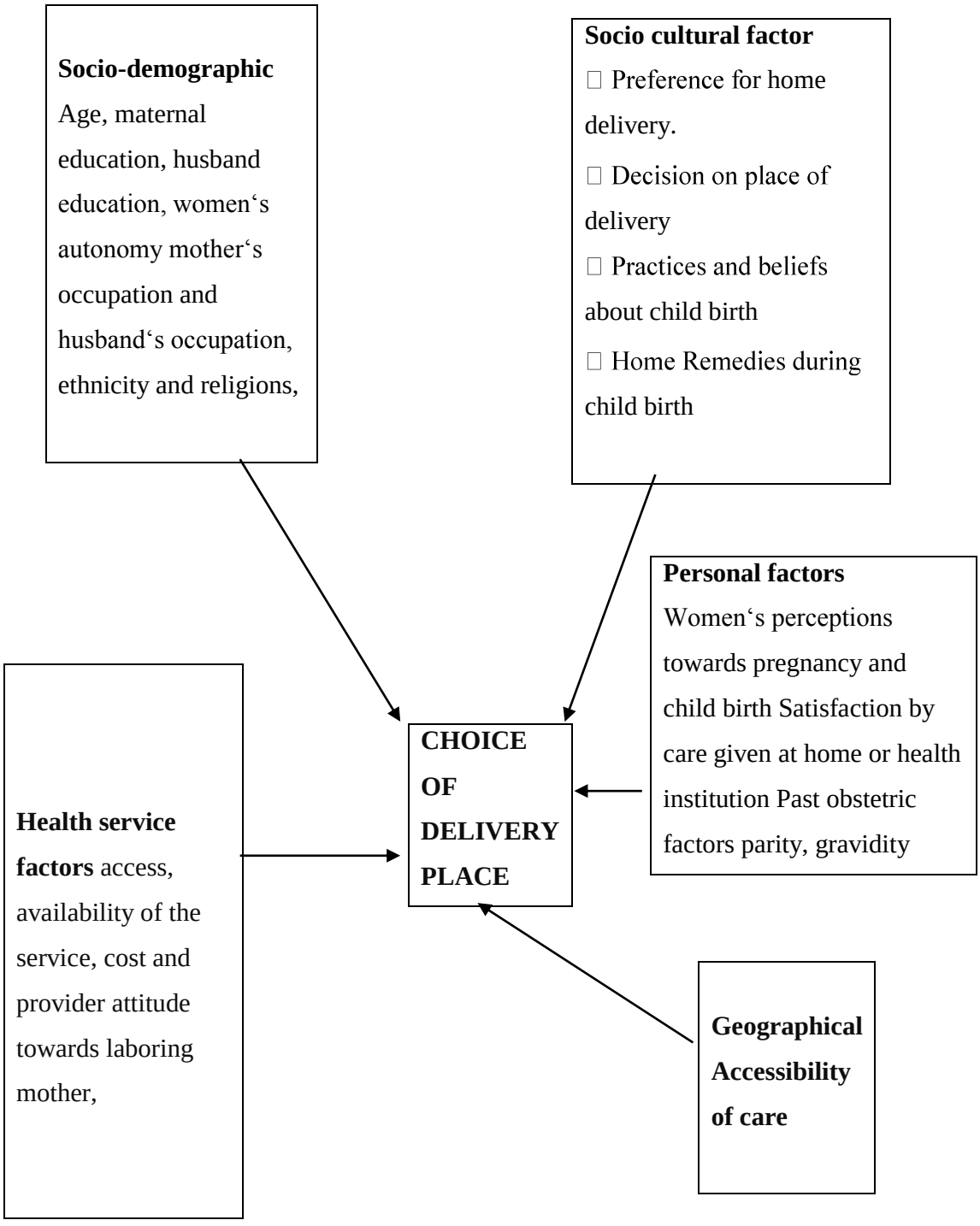

Fig.1. Conceptual frame work on factors affecting women‘s choice of delivery place (Anderson, 1995)

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 DESCRIPTION OF THE STUDY AREA

The study district, Dilla zuriya, is located in the regional sate of SNNP, Ethiopia. This wereda is one of the biggest wereda in Gedeo zone of SNNP Regional state which is located to the main road of Moyale and 375 K.M from Addis Ababa has 5 kebele (sub-districts) and . It has an estimated population of 122,337 with 51% females (census of 2007). The majority of the populations are farmers by occupation and there religious is Christians. Women of reproductive age constitute approximately (24%) of the Population. Annual delivery is estimated to be 3624 births.

Each kebele has its own health post with two HEWs. There are five HCs & 27 HPs in the rural area & about 150 health extension workers deployed in charge of 17 health extension packages.

Fig.1 Map of the study Area

Qualitative& Quantitative research methods were used in this study in order to explore and gain better understanding about the reasons for choosing home delivery, the patterns of traditional child birth practices and rituals, and the influence of women husbands and other family members on home delivery and traditional child birth practices.

3.2 SAMPLING PROCEDURE

The study was conducted in the rural communities of three health centers around Dilla zuriya wereda where likely identical ethnic women live for. The reason Dilla zuria were purposively selected that relatively low institutional delivery recorded from the privies studies. Three HCs were selected among the total 5 HCs in the respective wereda.

The population is made up of lowland and upland Gedeo tribal groups:).In Dilla zuria wereda, Sisota, Chichu and Andida HCs were selected because two of has likely geographically dispersed population and away from health facilities and the other is denser and concentrated around the health facility and almost proximity to the town &it is much better than thus both can provide useful socio-demographic indicators.

Dilla zuria wereda encompasses 122,337 population, and 5 HCs. The estimated number of pregnant women is around 3624 and follows ANC service at least once is 3156 out of this 1572 were delivered at health facility.

3.3 Sampling Technique

The FGD participants were selected purposively from the community after discussion with the district health offices, health centers and head villagers. Women were recruited through the network of health centers and head villagers as well as snowball sampling technique that women were asked to nominate or to contact their friends or relatives, who had experienced home delivery or health facility with or without complications, and who would be interested to participate in the study. Based on this 3 FGDs with 36 participants were conducted by recruiting from community includes pregnant women's, community elders, HEWs, Traditional birth attendant and

community volunteers who have had deep understanding about the community social and cultural settings participated.

In quantitative studies, 94women who gave birth at home or health facility prior to the study incorporated for the interview. The sample size calculation for the study was estimated for a descriptive study using tables for estimation of a proportion with specified absolute precision. Previous community based Studies in Ethiopia have shown a prevalence of institutional delivery of 6%. An anticipated Population proportion of 6%, a confidence level of 95%, and an absolute precision of 2 percentage points (4%-8%), with a design effect of two to correct for the effect of cluster Sampling was used. The sample size (n) was calculated using the formula n= z2 (p) (100-p) x DEFF/d2. Applying the formula, the required sample size obtained was n=1.962 (5) (100-5) x

3/22 =94 total participant for this study including FGD is 130.

3.4 DATA ANALYSIS

The qualitative data were analyzed using content analysis. Information from the interview consists of the women's description and explanation of their cultural & social childbirth practices and reasons for giving birth at home or health facility. Raw notes and tape recordings were used to generate transcripts in the local language. The investigators read the transcripts many times in order to gain better understanding of the context, and then coding, identifying categories and major themes. For quantitative part Place of delivery was categorized as home if the mother gave birth at home and health facility if the mother gave birth at health center considered as a dependent variable. Logistic regression was employed to analyze the data at SPSS 20 version.

Crude and adjusted Odds ratios were computed for each explanatory variable to determine the strength of association and to control the effect of confounders Assistant of deliveries were categorized as skilled delivery if the recent delivery was assisted by nurses or midwifes and unskilled delivery if the recent delivery was assisted by TBA, mother, mother-in-law and other relatives.

3.5. DATA COLLECTION: TOOLS AND PROCEDURES

According to the study objectives framed, main focuses were grass- root local cultural and social situations with aspect of seeking for institutional delivery of rural women who gave birth previously and subsequently, community leaders, health extension workers, health promoters and traditional birth attendants who directly or indirectly closer to this topic are among the list in according to their degree of significance. Additionally, interview schedule has been prepared .The questionnaire designed to be asked to women's who delivered prior to the study be structured close-ended.

In the questionnaire designed, common local practices adopted when women give birth and the reasons why this is followed and to what consequences. If husbands and community roles, women's autonomy, health professionals and promoters motives, has been included in the open &close ended questionnaire. If International& local partner support involved in public awareness, or community mobilization program and frequency of health education session by HEWS, community health promoters, the attitude of traditional birth attendant on local skilled health professionals, women attitude on privacy maters and skills of professionals designed and included data collection tools. Other relevant information in the form of case summary also included.

3.6. ETHICAL CLEARANCE

Permission to carry out the study was obtained from the SNNP Regional Health Bureau and Dilla zurIya wereda health office. Each respondent gave informed verbal consent after being told the purpose and procedures of the study. All responses were kept confidential and anonymous. Informed verbal consent was also obtained from all individuals participating in the FGDs.

CHAPTER FOUR: RESULTS AND DISCUSSION

4. QUANTITATIVE RESULTS

In this study a total of 94 women who gave birth prior to the study were interviewed& 3 FGD conducted for qualitative part in three catchment HCs around the wereda named Chichu, Tumticha and Andida kebeles where likely prudent number of home delivery existed. All eligible women in the selected samples responded to the questionnaire. The study findings show that majority of mothers attended home during their first and second child birth , only a few of them delivered at the health facility through trained and skilled birth assistant . Firstly, even if they are aware of the importance of being delivered at health facility and already have knowhow providing health education during their ANC follow up time & home tom visit of HEWs unless otherwise the pregnancy is may get some complication or feels sense of ill mothers decided to deliver home. This may be even indicated from the previous studies conducted in previous countries, the Lao Reproductive Health Survey (2005) found that 28.5% of births were from women who received ANC and 84.8% of children were born at home. Husband educational status was found as one of significant predictors on choice of delivery place.

4.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

60(63.8%) of the respondents were in the age group of 20-25 years, followed by age group 26-31 which is comprise (29.8%). Majority of women's (74.5%) of the respondents were unable to read and write, about (25.5 %) had formal education which is elementary and secondary level. Out of the total respondents (56.4%) were protestant and (30.4 %) were orthodox. The majorities were Gedeo (56.4%) followed by Amahara ethnic group (24.6%). (Table 1)

Regarding the women respondents' occupation almost majority of them figured (62.8%) unemployed with house wife role and the rest (37.2%), deployed with daily laborer and other employment sector. The majorities, (88.3%) were married and the rest are not belonged with marriage due to separation or being widowed. Regarding

husbands educational level almost half of them has a formal education and the rest 50 % joined at primary & more than primary level education.

Table1.Socio-demographic characteristic of study participants on the Dilla zuriya wereda, SNNP Region, 2014.

Variable		Frequency	Percent	Valid Percent	Cumulative Percent
Age of the women	14 - 19	6	6.4	6.4	6.4
	20-25	60	63.8	63.8	70.2
	26-31	28	29.8	29.8	100.0
	Total	94	100.0	100.0	
Marital status	Married	83	88.3	88.3	88.3
	Single	1	1.1	1.1	89.4
	Divorced	6	6.4	6.4	95.7
	Widowed	4	4.3	4.3	100.0
	Total	94	100.0	100.0	
Religion	Orthodox	29	30.9	30.9	30.9
	Catholic	5	5.3	5.3	36.2
	Protestant	53	56.4	56.4	92.6
	Muslim	7	7.4	7.4	100.0
	Total	94	100.0	100.0	
Ethnicity	Gedeo	53	56.4	56.4	56.4
	Amhara	23	24.5	24.5	80.9
	Guji	7	7.4	7.4	88.3
	Borana	4	4.3	4.3	92.6
	Gurage	7	7.4	7.4	100.0
	Total	94	100.0	100.0	
women occupation	not employed	59	62.8	62.8	62.8
	employed	35	37.2	37.2	100.0
	Total	94	100.0	100.0	
Husband occupation	Not employed	7	7.4	7.5	7.5
	Employed	87	91.5	92.5	100.0
	Total	94	98.9	100.0	
			1.1		
Total		94	100.0		
Husband education	No formal education	47	50.0	50.0	50.0
	Formal education	47	50.0	50.0	100.0
	Total	94	100.0	100.0	
Women's education	No formal education	70	74.5	74.5	74.5
	Formal education	24	25.5	25.5	100.0
	Total	94	100.0	100.0	

About 55 out of 66 women who had delivered at home has not formal education or illiterate,. Most of them were mainly house wife's and they didn't have economic autonomy so that it is husband the one who permit or not for that matter even she has economically empower nothing could done in terms of decision . Similarly, in the National Demography Health Survey (2010), women with at least a lower secondary education were by and large more likely to deliver in a health facility compared to women with less or no education.

This study finding showed that women who were in the middle age were more likely to choice health facilities as delivery place as compared to women who were below 19 and above thirty five years of age. The finding appeared to be inconsistent with other study done in Bhutan (Dechen.Z 2006). The difference may be due to different socio demographic and socio cultural characteristics of the study participant. Women who were illiterate were less likely to choice health facility as delivery place compared to women who were secondary and above education. Other studies have shown comparable results with this finding. Study conducted in Syrian women (Hyam.B, PhD and Asmaa.A, MD, 2006)indicated that the demographic variables like woman's education were statistically related to preference of delivery place. Literate women preferred hospital delivery compared with illiterate women which was similar with a study done in Tigray (Ethiopia) and Nigeria (Yalem. T 2010) Educated women were more likely to seek modern health care than those who are not. Education is likely to improve the general status of women and help them to build up confidence to make decisions about their own health. Educated women could have better access to information through reading and following media about maternal health care and they could have better knowledge about the advantages of maternal health care and pregnancy related complications. Husband educational status was found as one of significant predictors on choice of delivery place.

Those women whose husbands illiterate were less likely to choice health facility as delivery place when compared to women whose husbands were receive secondary education and above. This finding was comparable with other study conducted in Syrian. Educated husbands maybe more open toward modern medicine, aware of the benefits of health facility delivery and more able to communicate with health workers and demand appropriate care. Women's whose husband occupation were farmer less

likely to choice health facility as delivery place compared to women whose husband were governmental employee this finding was comparable with the study conducted in Nigeria (Idris S., et al. 2006). Presences of traditional remedies or cultural ceremonies done during child birth at home decrease the probability of selecting health institution. Decision making power had a key influence on the choice of delivery place. Majority of women requests permission from their husbands and relatives to go to the health facilities. In any case the husband seems to be the most key person in the decision-making process. The participant also stated that unless labor is complicated and decided by TBA, their husband would not allow her to go health facilities. This finding has also been described in many studies like study conducted in Tanzania and in Malawi (Mwifadhi Mrisho, M., Joanna A et al 2007).The approach of delivery service provider toward laboring women at health unit was found an important predictor on choice of delivery place. Women who said the approach of service providers were poor less likely to choice health facility compared to those women who replied the approach were very good.

Maternal education was observed as important factor that influences women's healthcare seeking behavior on the use of health facility for birth. Educated women relatively had high institutional births as compared to their peers with no formal education in Dilla zuriya wereda. Similar findings on education and its effect on utilization of skilled delivery services have been reported in previous studies for example in Butajira,Ethiopia, women with secondary education and above were three times more likely to use SBAs for delivery as compared to their colleagues with no formal education (Hagos, et al. 2014). Agha and Carton (2011) also found strong association between the use of institutional delivery services and maternal education above primary school level in Pakistan.

This suggests that women's educational status affects their socio-economic status and further play a role in parity, age at pregnancy and subsequent health seeking behavior. It is assumed that more educated women are better able to know where to seek services and as well being able to internalize health information and counseling provided by midwives at ANC and therefore appreciate the importance of skilled birth attendance. This is an important finding that puts forward the significance of girl child education on matters that border on reproductive health. Uneducated women may be

less empowered because of poverty and Dependency. This is an important factor that affects the use of skilled delivery service. It is also worthy to add that uptake of health facility for birth further increases when husbands are also educated especially in the context of Gedeo where societies have ascribed many roles such as decision making and source of household income to the husband.

Table 2.Women's Knowledge about pregnancy and delivery service provided at HC by professional health worker

		Frequency	Percent	Valid Percent	Cumulative Percent
Are there any HC provide pregnancy and delivery service	Yes	94	100.0	100.0	100.0
ANC service	Yes	94	100.0	100.0	100.0
professional Delivery service	Yes	93	98.9	100.0	100.0
Missing	System	1	1.1		

4.2 KNOWLEDGE ABOUT MATERNAL SERVICE PROVIDED

Almost 100 % of women responded that they know at least two packages primarily provide with the skilled birth attendant at Health facility level mainly with related to Anti natal follow up & safe delivery service. In addition to this majority (95 %) of women's responded that they know about the importance of delivery at health center for maternal & child health.(Table :2).from this study women's have not a knowledge gap about the service provide even to the extent of what type of services under maternal and child health service the problem is that they are not insisted to go and utilize it .

Table3: Women's reason to attend home delivery assisted by delivery assistance

		Frequency	Percent	Valid Percent	Cumulative Percent
First birth	at Home	66	70.2	71.0	71.0
	Health facility	28	28.7	29.0	100.0
	Total	94	98.9	100.0	
Total		94	100.0		
second birth	Health facility	30	31.9	31.9	31.9
	Home	64	67.0	67.0	98.9
	Total	94	100.0	100.0	
Reason to attend home delivery	I thought being attending home is safe	2	2.1	3.0	3.0
	I feel more comfortable just being at home	12	12.8	17.9	20.9
	close attention from relatives & my family members	13	13.8	19.4	40.3
	I don't like the service in the HC	9	9.6	13.4	53.7
	Unwelcoming approach of health professionals	4	4.3	6.0	59.7
	facility is too far	8	8.5	11.9	71.6
	was not delivery service when i gave birth	19	20.2	28.4	100.0
	Total	67	71.3	100.0	
Missing	System	27	28.7		
Total		94	100.0		
By whom assisted when attended home	Husband relatives	18	19.1	27.7	27.7
	neighbors	23	24.5	35.4	63.1
	TBA	15	16.0	23.1	86.2
	Mother	7	7.4	10.8	96.9
	Health professional	2	2.1	3.1	100.0
	Total	65	69.1	100.0	
Missing	System	29	30.9		
Total		94	100.0		

4.3 DELIVERY PLACE AND REASON TO ATTEND HOME & HEALTH CENTER DELIVERY

The study attempts to explore the delivery place giving birth at their first and second time, based on this the following results found. Women's who attend at home during their first child birth is 70.2 % where as 67.0 % gave birth at home during their

second child .Regarding health facility child delivery 27% of the women gave birth at health facility at their first child delivery and 32 % of the respondent who gave birth at their second delivery .from the summary table 35.4% women's who gave birth at home assisted by relatives followed by 27.7 % assisted by husband relatives .Regarding the reason why preferred to give birth at home 28.8 % of the respondent in favor of home delivery because of they feel comfortable with their family or thing that being delivered at home is safe and only 4.5% respondents said their reason that unwelcoming approach of health professionals. The rest responded that there were not child delivery services while they gave birth by the time. From Respondents who gave birth at health facility why they attend at health facility during their child birth underlined that 17 % because of they taught that better service is provided & others 7% responded that due to health education already they received tends to give birth at health center (Table 3)

Among the women who had delivered at home during the last year, a majority of them delivered without the assistance of skilled TBAs; only husbands and grandmothers helped the women during delivery. Similarly, the National Demography & Health Survey (DHS, 2011) revealed that in the last 5 years, most births were delivered with assistance of relatives (57.4%) and traditional birth attendants (28%). Health professionals assisted in 10% of births – 4% were assisted by a doctor, 7% by a nurse or midwifes less % by a health extension workers (HEWs). In urban areas, health professionals delivered 51. % of births compared to the 49% .the proportion of births assisted by skilled provider ranged from 6% to in SNNP region to 84% in Addis Ababa.(DHS,2011).

Given the large percentage of deliveries that take place in the home, it is believed that the great majority of maternal deaths occurred in the home, and that many of these deaths go unreported (WHO, 1997). Previous studies have reported that perinatal mortality in births delivered without a trained TBA was three times higher than that for births in a hospital or dispensary with trained attendants.

Perception of delivery as a normal phenomenon was also found to be an influential factor for uptake of skilled delivery care. The study found that women failed to use a health facility for delivery because they deemed it less important. In Gedeo, TBAs

have been the main birth attendants over the years and their achievement is well recognized by the majority particularly in rural areas. The new trend of care (skilled birth) is therefore considered by some women to be for the affluent and the rich in society. Lack of awareness on risks associated with pregnancies and the possible complications that could arise at any time during childbirth may be influencing this behavior. This therefore suggests the importance of maternal education and improved socio-economic status of women.

4.4 CULTURAL BELIEFS AND PRACTICES OF COMMUNITY ON UTILIZATION OF HEALTH FACILITY FOR CHILD DELIVERY

The study tries to explore major cultural beliefs and practices done which is inherited from the previous customs of the community among the women particularly being deliver by her and assisted by health professionals which enormously influence to attend at health facility based on this 64.9% of women's responded that there is a strong belief among the community which perceived negatively to those who give birth at health facility through professional assistance only 35 % responded that as if nothing is known about it .Mean while 83% of women responded that about practices done during women gave birth which is home made things provide like 53 % responded that given honey and 24.4 % of women said given hot juicy preserved from wheat and maize .They underlined also why this given and the importance as well ,here 51.1 % women's responded that it is given because believing that important for mother health and the rest 48.7 % responded it is given why makes the mother strong since she feels exhaustion and fatigue during her pregnancy time &labour.(Table 4)

Table 4: Factors on cultural practices and beliefs during child delivery in Dilla zuriya wereda

Variable		Frequency	Percent	Valid Percent	Cumulative Percent
Is there any belief being delivered by herself and those assisted by health professionals	Yes	61	64.9	64.9	64.9
	No	33	35.1	35.1	100.0
	Total	94	100.0	100.0	
Is there any homemade drinks or edible things provided to women or baby right after delivery	Yes	78	83.0	83.0	83.0
	No	16	17.0	17.0	100.0
	Total	94	100.0	100.0	
what are things provided	Honey	41	43.6	52.6	52.6
	milk	17	18.1	21.8	74.4
	butter	1	1.1	1.3	75.6
	hot juice preserved by wheat and maize	19	20.2	24.4	100.0
	Total	78	83.0	100.0	
Missing	System	16	17.0		
Total		94	100.0		
for what purpose this things thought to be provided for	for mother health	40	42.6	51.3	51.3
	to make mother strong after delivery	38	40.4	48.7	100.0
	Total	78	83.0	100.0	
Missing	System	16	17.0		
Total		94	100.0		

4.5 WOMEN'S DECISION MAKING POWER WHERE TO DELIVER CHILD

Women's are less likely decided where to deliver while husbands are most likely to decide where the delivery shall take places. Women's decision making on the need where they seek to deliver is insignificant from the response of women's the odds of decision made by husbands where to deliver is less likely gave birth at health center (AOR =0.99,CI,.038 -2.5).Table 5

Table 5: Decision where to deliver child

Women's delivered at HC [a]	B	Std. Error	Wald	df	Sig.	Adjusted OR	95% Confidence Interval for Exp(B)	
							Lower Bound	Upper Bound
Intercept	.938	.393	5.695	1	.017			
Decision by husband	-.010	.486	.000	1	.983	.990	.381	2.568
Decision by the wife	0[b]			0				

a. The reference category is: HC.

b. This parameter is set to zero because it is redundant.

The findings also provided evidence that women's decision making about the place of delivery were influenced by socio-economical, accessibility, and socio-cultural factors. Advice from their husbands, parents and care providers are important factors influencing the choice of the place of delivery which was similarly to previous research carried out in rural Tanzania (Mwifadhi Mrisho, et al 2007). Even though women are responsible for the health status of their households, the decision making of the choice of health service utilization was made by their husband and parents (Tanner M & Vlassof 1998). Women have to consult their husbands, mother-in-law and the elderly before seeking care. According to previous researches, the decision about the place of delivery was made by nurses, while husbands and parents made the decision regarding the place of delivery when complications arose (Urassa E et al

1997). In Gedeo tribe, the roles of husbands are enormous spanning from decision making to bread winning. The choices made by women require their husband's approval and this is not different in selecting a place of birth. A multivariate analysis done in rural Dilla zuriya wereda noted that women married to educated husbands are more likely to use SBAs for delivery .A similar finding has been reported in other SSA countries. For instance in Zambia, women who employed the services of TBAs for deliveries were found to be wives of husband's who had less than secondary education (Mwaliko, E, Downing, R, Wendy O"Meara 2014). However, no association was found between husband's education and the use of skilled delivery services in Nigeria (Chubike, NE & Constance 2013)

Table 6 Relationship between home delivery and homemade practices during delivery

where you delivered first child		B	Std. Error	Wald	df	Sig.	Adjusted OR	95% Confidence Interval for Exp(B)	
								Lower Bound	Upper Bound
at Home	Intercept	-1.012	.584	3.002	1	.083			
	homemade=yes	2.366	.648	13.345	1	.000	10.656	2.994	37.926
	homemade=no	0[b]			0				

a. The reference category is: Health facility.

b. This parameter is set to zero because it is redundant.

From the response indicated in table 6 those who responded there is homemade edible and drink provided to delivered women during birth particularly at first birth more likely gave birth at home with a significant predictor of odds ratio (AOR =10.6 and CI 2.9-37.9 with 95%).

Home level cultural practices like preserving edible and form of drink are factors to attend delivery at health center because relatives and family members are not comfortable at health center to do this and even in some health facility not enough

accommodation because of this family and other community members can influence to give birth at home .

4.6. FACTORS THAT AFFECT THE UTILIZATION OF FACILITY FOR CHILD DELIVERY

Husband education was a strong predictor of preference to place of delivery. Husbands whose educational status was primary or above were about 50 times more likely to give birth at health institutions than women with other levels of education (OR= 50.2., 95% CI: 6.7, 16.7). Husband educational status was found as one of significant predictors on choice of delivery place. Those women whose husbands illiterate were less likely to choice health facility as delivery place when compared to women whose husbands were receive secondary education and above.

Table 7 Association of socio- demographic variables and place of delivery

		HD	ID	P Value	Adjusted OR	95% Confidence Interval for Exp(B)	
						Lower Bound	Upper Bound
home	Intercept			.478			
	Age of Respondents						
	14-19	4	1	.613	*2.057	.125	33.748
	20-25	45	15	.341	1.828	.528	6.325
	26-31	17	12	1	1		
	women's occupation						
	Not employed	41	18	.110	.261	.050	1.354
	Employed	25	10		1		
	women's Education						
	Formal education	11	13	.170	.312	.059	1.650
	Non formal Education	55	15		1		
	Husband occupation						
	Not employed	5	2	1.000	*1.000	.114	8.780
	employed	60	26				
	Husband Education						
	No formal Education	46	1	.000	**50.195	6.034	417.545
	Formal Education	20	27		1		

a. The reference category is: HC.

b. This parameter is set to zero because it is redundant.

This finding was comparable with other study conducted in Syrian (Hyam.B, PhD and Asmaa.A, MD, 2006). Educated husbands maybe more open toward modern medicine, aware of the benefits of health facility delivery and more able to communicate with health workers and demand appropriate care. Women's whose husband occupation were farmer less likely to choice health facility as delivery place compared to women whose husband were governmental employee this finding was comparable with the study conducted in Nigeria (.S.H.Idris,U,M.D.Gwarzo and A.U.Shehu 2006). High status occupations are associated with greater wealth, making it easier for the family to pay costs and better understanding about the delivery care is associated with choice of delivery place.

4.7 ATTITUDE OF WOMEN'S ON PROFESSIONAL ASSISTED CHILD DELIVERY

Table8 Awareness of women's towards the importance of health facility delivery assisted by health professionals

variable		Frequency	Percent	Valid Percent	Cumulative Percent
being attended by a skilled delivery attendant beneficial to my wellbeing	I agree	94	100.0	100.0	100.0
being attended by a skilled delivery attendant beneficial to new born wellbeing	I agree	94	100.0	100.0	100.0

From the above table almost 100% has good attitude for being attended at health facility to women's health and baby as well. They agree the benefit of being giving birth at health facility through professional assistant. From this study still women's has good attitude for institutional delivery service even the importance of being delivered at health center even some times they articulated well the bad part of home delivery which is assisted by traditional birth attendant but practically they didn't put in practice .

4.8 FOCUS GROUP DISCUSSION SUMMARY

4.8.1 SATISFACTION WITH HEALTH SERVICES

Women also have positive experiences with the health system and viewed as encouraging factors to use health facilities for delivery. Furthermore, the perceived associated benefits of giving birth in a health facility were also highlighted and were mentioned as motivating Factors too. Some of the issues raised included:

"Hospital or health center (meaning any medical facility) delivery is the best…… You can be helped to deliver quickly" FGD2, participant

4.8.2 HANDLING COMPLICATIONS

The delivery at the health facilities was the alternative choice. If the delivery is prolonged or if there were some complications during delivery such as bleeding, breech presentation, or vaginal tears, they would like to deliver at the hospital because the health providers can handle the complication.

"Unless serious complication occurs during giving child birth no women seeking to attend at health facility, even I myself feel and share this sentiment"
36 year old women FGD participant

4.8.3 PERCEIVED QUALITY OF CARE AT FACILITIES

Some women viewed facilities as the safest and most respectable location for a delivery believing that facilities were able to ensure positive outcomes Furthermore, women who respected the competence of professional health workers and viewed them as "competent, and compassionate" "experts "who provided "effective management of emergencies" were likely to overcome various barriers to deliver in facilities.

"I feel comfortable during I gave birth at health facility which given by professionals the y treat me friendly and committed to safe delivery even to the extent of provided net dress to hug the baby and minimize the risk of bleeding "21 old women FGD participant .

However, women reporting negative interactions at facilities and lacking confidence in the Health workers' abilities, who they considered incompetent and inexperienced, were less inclined to desire facility deliveries. Women's during FGD mistrusted the way they manage delivery procedure particularly during expelling of placenta instead of doing once they grabbed in addition to this the way making massage which is clinical procedure & they call it with their local expression language "**Angoragurte**" makes them uncomfortable and painful

"when I gave birth at home the process of expelling placenta has just at a time & easy however in health facility the nurses getting it out turn by turn which is leads to fear that followed risk if may not fully expelled &remained inside of the uterus " 27 old women FGD participant

"From the regular provision of health education from HEWs I know the importance of giving birth at health facility through professionals assistance however some procedures which they practice during labor makes me uncomfortable particularly grabbing and sneezing my stomach painful because of this I prefer to deliver at home through traditional birth assistance "

"I did not like to deliver at the hospital because I was afraid that the health staff would cut the major labia and I could not stay on the fire or hot bed and I was afraid of bleeding and…The other medical procedure was the frequency of the vaginal examination at the health facilities compared to the delivery at home where there was no vaginal examination."
(Woman who had delivered, 24 years old)

Poor quality of maternity care Women have reported receiving poor quality maternity care. Bolivian women who selected home birth spoke about being on display at hospital: "One doctor comes along, then another and another. It's like we're a video them to watch."26 Maternity care can be disrespectful and inhumane, 27 or even exploitative.28 Offensive and Demeaning language by health personnel, and ridiculing of women's poverty, clothing, parity, smell, hygiene, cries of pain, or desire to remain clothed is not only disrespectful, but abusive.29 Procedures during labor can be undertaken with little discussion, but might be considered shameful or disgusting to women, and unnecessary by international standards, including episiotomies.

This finding has also been described in many studies like study conducted in Tanzania and in Malawi (Mwifadhi Mrisho, M., Joanna A et al 2007).The approach of delivery service provider toward laboring women at health unit was found an important predictor on choice of delivery place. Women who said the approach of service providers were poor less likely to choice health facility compared to those women who replied the approach were very good.

4.8.4 LACK OF PRIVACY AND CONFIDENTIALITY

The lack of privacy and confidentiality was also the major issues while conducting FGD and this one of disgusting condition to not gave birth at health facility Because there were many health staff present during delivery, the women felt shy and uneasy having to expose themselves to the staff. Hence, this is one of the contributing factors for delivery at home.

"In health facilities, there were many health staff during delivery and I was shy, so I preferred to delivery at home."
FGD, 2(Woman who had delivered, 25 years old)

Privacy during child birth has given predominant emphasis in view of social and cultural aspect of the community the finding was seen across several studies and settings. Many women felt that they had more control over maintaining their privacy when delivering at home compared to the facility. Privacy is greatly valued by parturient women, yet it may not be well-maintained in a facility due to a lack of cultural sensitivity and dismissive attitudes towards poor women, coupled with the lack of private labor wards

4.8.5 TRADITIONAL AND CULTURAL PRACTICES& BELIEFS

During FGD session 2, raised by participants that because of restriction & inconvenience to in &out at HC to relatives and neighbors less likely to use homemade traditional things (edible or drink) which is given to the mother right after delivery prefers to attend at home than at health facility.

"if I gave birth at home I feel comfortable because of accessing me honey, homemade hot juice preserved from wheat and maize that makes me strong and supports to feel get on "27 old women FGD participant

Socio-cultural factors have a direct influence on the decisions of mothers to seek healthcare or not to seek healthcare (Gabrysch 2009a). According to the recent Demographic and Health Survey of Ethiopia (ECSA 2012), 61% of women believed that delivery at a health facility were not necessary, while 30% stated that it was not customary. The decision by mothers to seek skilled birth attendance is also influenced by their level of education. Highly educated mothers (i.e. those who have received tertiary education) are most likely to give birth assisted by a skilled provider (74%) (ECSA, 2012). The decision to take mothers to a health facility may also be made by a husband or relatives, and requests to go to a health facility by mothers who are experiencing difficulties in labor may be ignored.

Cultural influence on place of birth is not peculiar to only in Gedeo women, similar findings have been reported in Uganda, where women were more likely to use facility-based delivery services when they had a high confidence that health workers will treat their placenta with dignity by giving it a befitting burial(Anyait, , et al. 2012). This is because Ugandan women have a strong belief that the placenta is the second child and the survival of the child and outcome of subsequent pregnancies of the mother depend on how well the placenta is handled (Anyait, et al, 2012)

4.8.6 PLACENTA DISPOSAL

In previous time the placenta was not buried or removed until three days' time with belief that into the earth by the husbands beneath house because it was dirty and they could not just throw it away

However currently they aware that nothing is wrong with if it get rid of as soon as the birth occurs based on this they buried right after the delivery.

"I buried the placenta in the ground floor near the home waiting for three up to four days but after we received health education from professionals removed immediately after fully expelled. It is believed that if we bury the placenta far from the house, the child would go away.

"Usually I manage to expel the placenta with normal procedure first I massage with butter her back side then after I tied with her leg to keep attached with her in order to fully expel "

Traditional birth attendant, FGD participant

4.8.7Community Belief Versus professional assisted delivery

In almost all of FGD session conducted being delivering alone is considered as heroine woman in Gedeo tribe & still more emphasized given to this norm among the community.

"Stretching from our descendants the women expected to deliver by her unless otherwise extraordinary things happened to her this is sign of real womanish and a sign for self-sufficiency & full-fledged "FGD participant

This study also try to explore about beliefs of the community that women should deliver by her instead of health professional assistance .According to the qualitative and quantitative findings of this study women have strong influence if she seek medical support during delivery and expected to resist the pain of labor in order to recognize her motherhood autonomy in general .

Maternity is viewed variedly in culture. The health of the pregnant woman is managed traditionally based on several pre-determined and experienced beliefs within specific cultural settings .A qualitative study conducted in Ghana shows that, women's says that, a woman will have to prove herself to a "real" woman by delivering alone. This is thought to be a sign of true womanhood. Women who do not utilize the facility for delivery they use that as a way of proving their true women status and try to look down upon those who utilize the facility and consider them as very lazy and inferior. Some men also consider women who deliver at the facility as inferior, and also men think that he is lucky if his wives deliver at home. The society is built up in a way that men are the decision makers. However when it comes to pregnancy and delivery the mother in laws have the largest mandate "all we know about pregnancy and delivery is that when our wives are pregnant, the first person to know is the mother in law, and if possible the husband is also made to know that the wife is pregnant. It is the mother in law that takes charge of her until she gives birth.

4.8.8 UNFAMILIAR AND UNDESIRABLE BIRTH PRACTICES IN FACILITIES

When faced with the prospect of facility birth, some women may fear unfamiliar or undesirable procedures, such as unfamiliar birthing positions and intrusive vaginal exams. Hospital providers were sometimes perceived to conduct too many digital vaginal laminations, which women found uncomfortable and dehumanizing. Some women also preferred delivering at home with a TBA because they had more control over their birth position than delivering at a facility.

: *"I have never delivered in a hospital…… my mother- in- law is a TBA…… She …… rub my stomach, gave me some to drink and in the process praying when my baby is not well positioned……this is very helpful……such care you know I will not get it in health facilities"* (FGD3, participant)*"I have not delivered in the health facilities before, I do not know why but know that I have a woman at home who helps me a lot during labor and delivery."*

Even if some harmful traditional beliefs & practices now get improved and avoided which was customarily done in favor of home delivery particularly provision of herbal medication among the study community because of health education and awareness creation session provided by the health extension workers and health development army .However still there is some traditional beliefs and practices among the community which is remained unresolved particularly with gender aspect and less empowering women's for decision making even for their own sake within the household influence the child birth practice and choice of the place of delivery. As indicated from above if she decided and to seek health professional assistant during labor appear considered as if she is incapable and something is missing provided with while god create her. . In the Gedeo culture, child bearing is a normal event in women's life & still practiced traditional child birth including birth preparedness, umbilical cord cutting, practices and beliefs. Most mothers during FGD also reported that they delivered at home because the labor started earlier than expected or at night, which mean that delivery could be unplanned or inconvenient. My findings were similar to previous studies (Amooti-Kaguna & Nuwaha. 2000). The factor - previous habit, was identified as the reason for delivering at home. Habit means one's "previous behavior" which is expected to influence one's current expectations a

repeated behavior could turn into a habitual behavior. Also argued that a previous experience could result into a habitual one instead of a seasonal behavior. Similarly, Bandura (1986) suggested that the habitual choice of delivery may be a result of modeling which was proposed as an indispensable aspect for learning behavioral patterns.

4.9 DECISION MAKING ON PLACES OF DELIVERY

4.9.1 HUSBAND AS MAIN DECISION MAKER

Most of the women mentioned their husbands and mothers or grandmothers influenced their choice on the place to deliver their baby. Most of the husbands mentioned that they are the one who made the decision that their wife should deliver at home or the hospital.

"*My husband decided where I should deliver. However, he also mentioned that it is up to me and I decided to deliver at home."*
(Woman who had delivered, 28 years old)

"I would like my wife to deliver at home because it is convenient, cheap and our relatives can stay with us. In addition, I could like to be close to my wife during labor and delivery."
(Husband, 32 years old)

It is suggested that the women are powerless when it comes to making a decision within the household, even the place of delivery. Women had to ask their husbands first to get an agreement and their husbands would then bring them to the hospital when the need to deliver in the hospital arises.

4.9.2 HEALTH EDUCATION AND ACCESS FOR INFORMATION

From the discussion most of FGD participants assure that provided information or maternal health education in different time by HEWs.
"Frequently HEWS provided us the importance of health facility delivery and the risks of home delivery as well during their visiting our house and at the Kebele association meeting session, I got this very important to the mother & baby wellbeing**"**

4.10 UNPREDICTED FACTORS AND CIRCUMSTANCES

During FGD different contextual and non-contextual possible factors were raised among the participants particularly in the study area that affects institutional delivery and why women's prefer to attend home, for example ministry of health this days assigned one ambulance service for each wereda to curb transportation problem during women's are in labor however because of lack of awareness and their psychological makeup to women's in the rural setting make them worried and terrorized while they hear ambulance siren and tends to keep home .

"Previously Our women's terrorized and worried while hearing ambulance siren seems them that the sign of emergency and something is wrong happen because of this they fear to go with ambulance for institutional child birth however currently a little bit they aware and adapted this and less likely a factor "

4.11 INFORMATION ACCESSIBILITY & UTILIZATION OF SERVICES

From the this study most of the respondents access health related information particularly about maternal child birth and related issues from the door to door education session through HEWs and sometimes from community volunteers during kebele assembly called them for community public agenda furthermore during their ANC visit information is provided by nurses or midwifes to follow pregnancy checkup at least four times and the importance of using related health service utilization.

Utilization of services is more often than not preceded by awareness of the services. In rural Ethiopia, instead of mass media health extension professionals (HEWs) door to door education is the most common means to access information. It is argued that people's lives are more likely to be influenced by the kind of information presented or made available to them. No literature was found in Ethiopia on influence of information on use of skilled delivery services during the review, however other studies in SSA have reported on this subject. (Worku, 2013) pointed out in a study conducted in Ethiopia that women who were aware of existing health facilities for delivery utilized it during child birth. On the other hand, (Onasaga, Afolayan and

Bukola 2012) in their study found that in spite of high awareness level of women about existing maternal health services, only few of the respondents were abreast with the main components of the service. This information gap is more likely to have an Influence on utilization especially in the case of birthing. Furthermore, a study done in Mali, Kenya and Tanzania found that women who were informed about family planning through mass media utilized a health facility for delivery ((Stephenson, Bascheri and Madise 2006).There is no doubt from this review that women's awareness of existing services can influence their choice of Place of birth.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

This study identified socio-cultural factors such as maternal education, parity, cultural, and traditional practices and husband education as predictor for utilization of institutional delivery services in Dilla zuriya wereda. Social factors for example, husband's occupation, husband's education and women's education &perception of safer pregnancy were also found to be influencing place of birth for women in this study. In addition, health services-related factors including perceived negative attitude of some SBAs, and low quality of services were also identified. Lessons can therefore be drawn from evidenced-based interventions discussed in in this study.

This study provided an evidence-based research to advocate the taking into account of the socio-cultural contexts of child birth practices and highlight the traditional child birth and postpartum beliefs and practices on child birth among rural women. The findings also provided a deep understanding of the reasons for delivering at home by considering the complexity of certain frameworks such as the socio-cultural, accessibility, traditional belief, and gender relations. This information will assist in planning interventions and focused on reducing maternal mortality. In addition, the result of this study underscores the gender perspective of Dilla zuriya wereda community regarding child birth practice. This information should be discussed among policy makers; Regional zonal and wereda health personnel and planners at different stage to guide and develop skilled birth attendants were unable to find a systematic review of the impacts of cultural adaptations to birthing services.

Health Professionals approach and maternal education content is not contextual it is just business as usual type of information is provided to women's during their ANC follow up even the content of job aids are similar instead of updating with the local context. From this study it is revealed that women's are not aware of why some scientific delivery procedure should be done and what type of importance has for them particularly in assisting the natural labor particularly in minimizing pains. Rather they feels distrust about the pros and cons of being giving birth at health facility .further more professionals knowingly or unknowingly neglects community values and morals particularly in terms of privacy this also another major factor for

tendency of giving birth at home .even if health education is frequently given by HEWs and other health professionals still needs to do more creating awareness the gender mainstreaming issues among the a community in able to women's deciding what is important to her, in this regard apart from the community and HEWs other stakeholders also should be involve and intervene about parity issues like religious fathers ,synods& government bodies should actively participate apart from awareness creation and dissemination of information focus on imparting policy , regulation and legal packages to manifest the decision power of women's for their Owen sake .

Care providers at all levels should receive ongoing education and training in culturally appropriate service delivery and/or culturally competent curriculum should be developed for health care providers. Dissemination of information about the size of the problem, with relevant comparisons should be updated according to the local context.

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PROFORMA FOR SUBMITION OF M.A (RD) PROPOSAL FOR APPROVAL

Signature:

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Title of the project: Analysis of social and cultural factors on uptake of institutional child delivery: The case in Gedeo zone, SNNPR, Ethiopia

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List of Acronyms

TBA: Traditional birth Attendant

HEW: Health extension worker

NGO: Non-Governmental organization

MDG: Millennium Development Goal

BenMOC: basic emergency and obstetric care

WHO: World Health organization

SNNP: Sothern nation and nationalities people

CSSM: Child Survival and Safe Motherhood

MCH: Maternal& Child Health

FGD: Focal Group Discussion

HSDP: Health sector Development plan

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CHAPTERONE: INTRODUCTION

1.1. BACKGROUND

The Ethiopian health care system is amplified by the rapid expansion of private practitioners, NG s engaged for non-profit and other partners who were involved in the sector. They had played significant role in boosting the health service coverage, thus, enhancing the public and NGOs partnership in the delivery of health care services in the country .Different bodies under the umbrella of the ministry of health take part in decision making process. The Federal Ministry of Health stretches its engagement to regional and woreda level in sharing roles and responsibilities by providing vital technical support and in managing and coordinating pending public health issues. Particularly, due attention were given for maternal health care service by embarking on essential service package.

The ministry formulates different health care reforms. Under this package, institutional child delivery had been provided significant focus area in the MDG, to minimize maternal mortality rate which results from risks during prolonged labor and related incidences .Based upon this fact, the government had taken different measures and had formulated different interventional strategies in addition to policy reforms. .Currently the Ethiopian government has put considerable investment outlays in terms of technical and financial support to achieve the target set and to scale up the sector. Procurement of equipment for clean delivery and basic emergency and obstetric services had also been undertaken. With collaborating partners, staff was trained in Basic Emergency and Obstetric Care (BeMOC) which is equipped health workers with the major delivery skill at master level. Pre- service training were provided to HEWs in MCH has been introduced and become functional in all regions. In addition, primary health care services were built everywhere ,as much as possible, to curb distance problems particularly to pregnant women and to those families or communities accompanying the labored women. Furthermore, under health care financing schemes in order to avoid out of pocket expenses, delivery services were exempted from payments. Gedeo zone is one of the populous zones in SNNP regional state, endowed with cultural and social customs and comprises prudent number of reproductive age group with homogenous kinship relations who shares similar social

and cultural practices. This zone relatively produces cash crops and is also rich in livestock products. Currently, rural infrastructure and social amenities are accessible in most of the rural areas. In this zone alone 32 HC and 160 HPS are available with trained midwives and nurses at HC and health extension workers at health post level, who were trained in clean and safe delivery .In 2012, 36,567 pregnant women were recorded among 236,667 women who are in reproductive age group(FMOH, 2012). There is not clear evidence supported by empirical study for the reason of low institutional child delivery across this zone .This study therefore, primarily focuses on the specific cultural and social factors which impedes seeking professional assistance for giving birth at health institutions at this zone. It is well known that harmful traditional practices have been very slow to change over time, particularly given past national and international reluctance to confront problems that are ‘‘cultural’’ in nature (United Nations, 2008). In addition, longstanding customary and societal practices have continued in the zone. Women often do not have access to adequate transportation to health facilities or the cash to pay for it. They have to negotiate for transportation with men, other family members, or elders in the community. As different studies shows lack of transportation can cause delays in emergency situations. Absolute and relative poverty can pose a serious barrier to women's demand for and access to health care.

Thaddeus and Maine (1994) has described three principal causes of delay in scenarios that resulted in maternal death: (1) delay in deciding to seek care; (2) delay in arriving at a suitable health-care facility; and (3) delay in receiving appropriate care at that facility.

In many poor countries, childbirth is regarded as natural phenomenon that should take place outside of the hospital/clinic setting. Most births in sub-Saharan Africa takes place at home, generally in the presence of family members or a traditional birth attendant. Specific duties and responsibilities will vary greatly among different cultures. When an obstetric complication such as prolonged labor arises, the immediate questions that need to be asked are: Is this a problem? What is causing it? What should be done about it? The assumptions from which one starts in trying to answer these questions have a direct impact on what happens subsequently. For example, in many parts of Africa trouble in childbirth is often attributed to some kind

of moral failure on the part of the laboring woman. Difficult labor is frequently seen as retribution from God or the ancestors for adultery or some other moral lapse, rather than being the product of faulty obstetrical mechanics. In such cases the efforts of the birth attendants may well be directed toward getting the woman to confess ‘‘what she has done ‘rather than to seek medical attention. The decision to seek care for an obstetric problem involves economic costs, both the costs of transportation and the ‘‘opportunity costs’’ (lost wages, lost time working in the fields, etc.) that may be incurred. Often, particularly in cases of prolonged labor, the easiest decision is just to ‘‘wait and see what happens ‘in the hope that the woman will eventually deliver the baby by herself and that everything will come out all right in the end. Once labor has lasted over 24 hours, it is particularly dangerous. In many parts of Africa (particularly in northern Nigeria), women are normally expected to stays excluded within the family compound and are not normally allowed to travel without male accompany mentor permission. If the appropriate male authority figure is not present during obstructed labor, delays may be encountered before permission can be secured to take the woman to a health-care facility. Once the decision has been made that some kind of intervention is appropriate, the intervention that is chosen may still not lead to appropriate treatment. In many parts of southern Nigeria, for example, charismatic ‘‘spiritual churches’’ run maternity homes where the primary services provided are prayer and religious rituals rather than advanced obstetric care. Whatever the moral or spiritual value that such services may have, they are not effective in relieving the mechanical obstacle to delivery in obstructed labor. This only leads to further delay. In some cases the therapy chosen may actually be directly harmful to the laboring woman. For example, some recipes used by traditional healers in treating women in prolonged labor in parts of Africa do appear to have oxytocic properties that enhance uterine contractility and result in more forceful contractions.(Thaddeus S, Maine D, 1994).

1.2 STATEMENT OF THE PROBLEM

Ethiopia has vast ethnic diversity endowed with different cultural and social norms which affects decent life style positively and negatively. Among the needs to follow in normal situations, health is the prominent service in certain social group in order to achieve productive and sustainable all round development through maintaining

prudent and quality way of life. Currently the government attempted health care system more accessible by collaborating with different partners. Under MCH service package, due attention must be given in providing basic maternal care service in rural and urban setting on demand .Even in hard to reach kebeles and geographically inconvenient areas health posts are available ,staffed with at least 2 trained health extension workers and health promoters who serve the communities on voluntary terms.

Despite of all these provisions of facilitation, institutional delivery coverage is at insignificant level. (EDHS, 2011).studies had revealed that 10 percent of births in Ethiopia are delivered at health facilities (9 percent in public facilities and 1 percent in private facility). Thus, most pregnant women didn't get professional medical support when pregnant and obstetric complication occurs and which results to maternal morbidity and mortality, accounting to 676 of 100,000 live births. From DHS result, in nine women out of ten had delivered at home .The figure is lowest at SNNP which was only 6.2% ,institutional coverage was 10 % and 93.2% were not given post - natal check-up. In SNNP social and cultural practices has been common affecting directly or indirectly their daily livelihood situations in all aspects. Even if pregnant women's are well informed of the free service and are aware of the importance of being delivered at facility in avoiding risks they tend to attend at home level delivery than go to public health facilities. Social restrictions on women's movement may also reduce their autonomy to seek care. For example, in Northern Nigeria, the purdah system may mean that a husband has to accompany his wife to use services and she may not be able to access services in his absence (Oxaal Z, Baden S, 1996). Gendered attitudes toward maternity-related problems in some communities may also limit access to care. In addition, in some African societies, prolonged labor may be ascribed to marital infidelity and assistance may be withheld until the woman confesses to this (Oxaal and Baden, 1996).

Previous studies primarily focuses for factors affecting low institutional delivery, mainly supply side and demand side aspects, like proximity of primary health care, availability of trained professionals and affordability to pay for some services etc. are mentioned. .However, even with those facilities accessible and with mother friendly services, institutional delivery coverage is insignificant .Pregnant women must have

antenatal follow -up at least once out of four expected visit .Therefore, only accessibility as such had not been crucial problem, instead the problem is may be manifested immensely from the demand side or acceptability of the service given to the client who needs the service. According to DHS (2011) report, 64.8% had responded “not necessary “and 26.4 exclaimed “not customary “ regarding the need for attending health facility .This figures just indicates the coverage but not an indication of the very real contextual cause .Therefore, it is important to investigate what specific factors are responsible at the side of clients who seek care.

Fulfilling of material and man power needs of the facilities by itself not the solution to curb the problems .The focus of strategies should rather include identifying priori major contextual factors and identifying the root cause of the problem. The extent of the problem varies from region to region, and even across zones and regional setting because of unique cultural and social values attributed. Particularly in the southern region, cultural practices and social settings has a strong bond among different tribal societies which strongly influences the community, particularly the rural women who are the domains of the community most likely be dominated by societal belief and customs bestowed from early generations. .In this regard, one needs to identify and graft -out specific social and cultural practices and beliefs to the extent of its seriousness which significantly exacerbate the problem of seeking home delivery. .Eventually one needs to act on the findings in the local context in order to take remedial action to increase institutional delivery.

1.3 OBJECTIVES OF THE STUDY

1.3.4 GENERAL OBJECTIVES

The study mainly will focuses on identifying major cultural and social factors which affects institutional delivery in view of local setting and community context to in the selected wereda.

1.3.5 SPECIFIC OBJECTIVES

The followings are specific objectives of the study which primarily focuses on:

1. To gain a better understanding about the socio-cultural background of women on issues pertaining to home delivery and traditional child birth practices.

2. To identify the socio-cultural, economic and health service factors contributing to low institutional delivery service through a quantitative survey
3. To explore the gender perspectives influencing home delivery.
4. To envisage possible contextual strategies and community behavioral education based on major findings.

CHAPTER TWO: LITERATURE REVIEW

It is well established that giving birth in a medical institution under the care and supervision of trained health-care providers promotes child survival and reduces the risk of maternal mortality Despite the many benefits associated with institutional delivery, Ethiopia's maternal and child health programs have not aggressively promoted institutional deliveries, except in high-risk cases. The reason is that providing facilities for institutional delivery on a mass scale in rural areas is viewed as a long-term goal requiring massive health infrastructure investments. In recent years, however, there has been a shift in this policy with the establishment of the Child Survival and Safe Motherhood (CSSM) and the Reproductive and Child Health (MCH) programs. The new programs aim at expanding existing rural health services to include facilities for institutional delivery. Existing maternal and child health services at primary health centers (PHCs) are being upgraded, and new first-referral units (FRUs) are being set up at the community level to provide comprehensive emergency (FMOH, 2011).In Ethiopia, 94% of rural women give birth at home without assistance of skilled birth attendant, 28% of women attend health facilities for antenatal care during pregnancy and only 6% of them came for delivery to health facilities. Most of these women live in remote areas that are too far from a road, no maternal health services and emergency obstetric care. In general, 61% of home deliveries are assisted by a relative or some other untrained person and 5% are delivered without any assistance (UNFPA, 2008). As the consequence of these practices 24,000 women and girls die each year and 480,000 suffer from disabilities including obstetric fistula caused by complications seeking care for delivery is very low in rural area of the country even compared to urban. Data from 58 countries that account for 76% of births in the developing world show that the use of a skilled attendant at delivery (the key feature of first-level care) increased significantly, from 41% in 1990 to 57% in 2003. This is a 38% increase in the number of women with a skilled birth attendant between 1990 and 2003 (WHO, 2007). The greatest improvements occurred in Southeast Asia (from 34% in 1990 to 64% in 2003) and North Africa (from 41% in 1990 to 76% in 2003). These trends represent an increase in the number of women with a skilled birth attendant of more than 85% in both regions. Hardly any change was observed, however, in sub-Saharan Africa, where rates remained among the lowest in the world at around40% (WHO, 2007). Within

these regional averages, there are significant differences between countries and between urban and rural areas which often represent rich and poor sections of the population(WHO, 2005). Almost all of the increases in births with a skilled attendant are driven by increases in the presence of medical doctors at birth. The explanation of this diversity is complex. Utilization of health services is affected by a multitude of factors including not only availability, distance, cost, and quality of services, but also by socioeconomic factors and personal health beliefs. .Another factor affecting women's health-seeking behavior, especially as related to pregnancy and childbirth, is that traditionally in rural Ethiopia pregnancy is considered a natural state of being for a woman rather than a condition requiring medical attention and care. Such perceptions and beliefs constitute a "lay-health culture" that is an intervening factor between the presence of a morbidity condition and its corresponding treatment. Ante natal care and infant and child health care are similarly affected by this culture, with the result that women often do not avail themselves of preventive and curative medical services intended to safeguard their own and their children's health and well-being. The lay-health culture presumably has substantial effects on utilization of maternal health services in regions of the country where poverty and illiteracy are widespread. This culture is difficult to measure directly, but it is possible to include socioeconomic factors that are correlated with it when analyzing utilization of maternal health services .In fact most regions, with the exception of sub-Saharan Africa, show decreasing use of other types of professional assistance .Some factors contributing are poor infrastructures related to transportation, inadequacy of health facilities, shortage of health workers, weak in health information, cultural beliefs, illiteracy, gender inequality, financial accessibility and quality of health services(ORHO, 2002). There are many reasons which influence decision to seek care for delivery which is main cause for maternal mortality and morbidity in the country. Because of most of maternal death occur during delivery, emergency obstetric care, postpartum care and skilled birth attendant is necessary, but these services are limited in rural area of the country. In Ethiopia, capacity to provide emergency obstetric care is 36 out of 100. Generally access to safe mother hood services in Ethiopia is 29% which is 19% in rural area and 39% in urban settings (USAID, 2005).

Economic status of women is important indicator of seek care from health facilities. In rural area of Ethiopia, mostly men are decision maker and control over resources and they decide when were women should seek health care. Educational status of

mother is also one of main causes for delay in seeking care for delivery. Educated mother are more likely to seek care than less educated women (UNFPA, 2008). Traditional beliefs in the rural area of the country also have impact on health seeking behavior of women during delivery (ORHO, 2002).lack of decision making power such as getting permission from their husbands or parents may discourage them from seeking health care (USAID,2005).

Important terms in the study (operational definitions)

A. **Social beliefs and values**.

The social environment encompasses social and economic factors such as income, education, employment status and working conditions, social networks and community cohesion. The physical environment includes the natural environment (clean air,water and soil),the environment (land use patterns, zoning and community design) and living conditions, such as the availability of safe and affordable housing, transportation and nutritious food .Income and education are among the most potent determinants of health.

B. **Cultural beliefs and practices**

Cultural beliefs and practices refer to integrated patterns **of** belief and behavior which is varies from local group to group coexisting with members. Individual distinctness is valued, endures and evolves.

Cultural acts as a template for the organization of social and psychological processes, much as a genetic system provides such a template for the organization of organic process..

C. **Institutional delivery**.

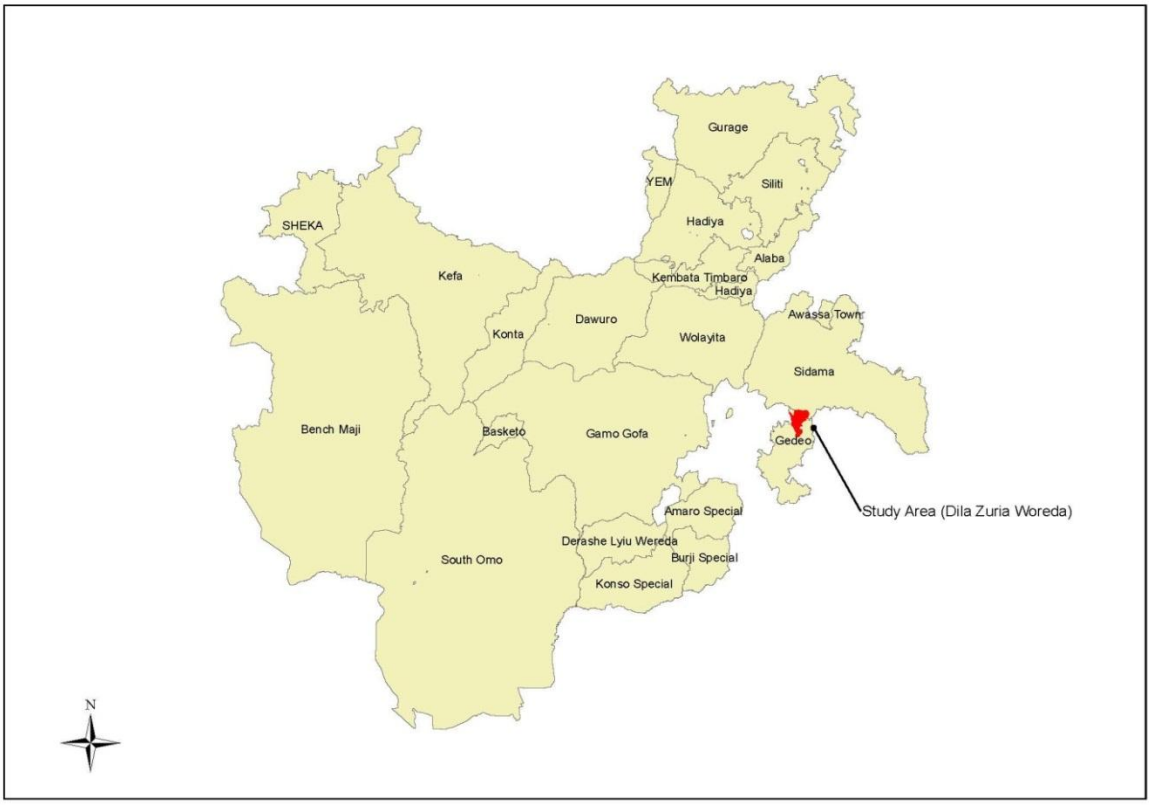
Health sector has been experiencing a regular increase in shift from non-institutional deliveries over the years. Institutional delivery refers to the child birth at technology - equipped medical facility under supervision of skilled medical staff .In an institutional delivery, medical tools and technologies are used to ascertain that health of neonate or mother is not compromised.

CHAPTER THREE: METHODOLOGY OF THE STUDY

3.1: DESCRIPTION OF THE STUDY AREA

The study district proposed, Dilla zuriya, is located in the regional sate of SNNP, Ethiopia. This wereda is one of the biggest wereda in Gedeo zone of SNNP Regional state which is located to the main road of Moyale and 375 K.M from Addis Ababa has 5 kebele (sub-districts) and . It has an estimated population of 122,337 with 51% females (census of 2007). The majority of the populations are farmers and Christians. Women of reproductive age constitute approximately xx (24%) of the Population. Annual delivery is estimated to be 3624 births.

Each kebele has its own health post with two HEWs. There are five HCs & 27 HPs in the rural area & about 150 health extension workers deployed in charge of 17 health extension packages



Qualitative& Quantitative research methods will be used in this study in order to explore and gain better understanding about the reasons for choosing home delivery, the patterns of traditional child birth practices and rituals, and the influence of women husbands and other family members on home delivery and traditional child birth practices.

3.2: SAMPLING PROCEDURE

The study will be conducted in the rural communities of three health centers around Dilla zuriya wereda where likely identical ethnic women live for. The reason Dilla zuria purposively selected that relatively low institutional delivery recorded from the privies studies. Three HCs will be involved among the total 5 HCs in the respective wereda.

The population is made up of lowland and upland Gedeo tribal groups:).In Dilla zuria wereda, Sisota, Chichu and Andida HCs will be selected because two of has likely geographically dispersed population and away from health facilities and the other is denser and concentrated around the health facility and almost proximity to the town&6 is much better than thus both can provide useful socio-demographic indicators.

Dilla zuria wereda encompasses 122,337 population, and 5 HCs. The estimated number of pregnant women is around 3624 and follows ANC service at least once is 3156 out of this 1572 were delivered at health facility.

3.3 SAMPLING TECHNIQUE FOR QUALITATIVE STUDY

The FGD participants will be selected purposively from the community after discussion with the district health offices, health centers and head villagers. Women will be recruited through the network of health centers and head villagers as well as snowball sampling technique that women were asked to nominate or to contact their friends or relatives, who had experienced home delivery or health facility with or without complications, and who would be interested to participate in the study

3.4 SAMPLING TECHNIQUE FOR QUANTITATIVE STUDY

In quantitative studies, 94women who gave birth at home or health facility prior to the study will be incorporated for the interview. The sample size calculation for the study estimated for a descriptive study using tables for estimation of a proportion with specified absolute precision. Previous community based Studies in Ethiopia have shown a prevalence of institutional delivery of 6%. An anticipated Population proportion of 6%, a confidence level of 95%, and an absolute precision of 2 percentage points (4%-8%), with a design effect of two to correct for the effect of cluster Sampling will be used. The sample size (n) calculated using the formula n= z2 (p) (100-p) xDEFF/d2. Applying the formula, the required sample size obtained was n=1.962 (5) (100-5) x
3/22 =94

3.5 DATA ANALYSIS

The qualitative data will be analyzed using content analysis. Information from the interview consists of the women's description and explanation of their cultural & social childbirth practices and reasons for giving birth at home or health facility. Raw notes and tape recordings will be used to generate transcripts in the local language. The investigator will read the transcripts many times in order to gain better understanding of the context, and then coding, identifying categories and major themes. For quantitative part Place of delivery will categorized as home if the mother gave birth at home and health facility if the mother gave birth at health center considered as a dependent variable. Logistic regression will be employed to analyze the data at SPSS 20 version.

Crude and adjusted Odds ratios will be computed for each explanatory variable to determine the strength of association and to control the effect of confounders Assistant of deliveries categorizing as skilled delivery if the recent delivery was assisted by nurses or midwifes and unskilled delivery if the recent delivery was assisted by TBA, mother, mother-in-law and other relatives.

3.6 DATA COLLECTION: TOOLS AND PROCEDURES

According to the study objectives framed, main focuses will be grass- root local cultural and social situations with aspect of seeking for institutional delivery of rural women who gave birth previously and subsequently, community leaders, health extension workers, health promoters and traditional birth attendants who directly or indirectly closer to this topic are among the list in according to their degree of significance. Additionally, interview guide will be schedule .The questionnaire designed to be asked to women's who delivered prior to the study be structured close-ended.

In the questionnaire designed, common local practices adopted when women give birth and the reasons why this is followed and to what consequences. If husbands and community roles, women's autonomy, health professionals and promoters motives, has been included in the open& close ended questionnaire.

CHAPTERIZATION

The paper is organized in five chapters .The first chapter consists the introduction part which includes statement of the problem ,objectives of the study, definition of key terms in the study ,scope & limitation of the study ,significance of the study .The second chapter develop on review of the literature ,theoretical and empirical literature in different parts of the world .Chapter three discuss research design and methods employed while undertaking this study.it also describes and explains the universe of the study in terms of the target population ,study site and time period for collecting pertinent quantitative as well as qualitative data .including the sample size ..The next chapter presents the analysis in the light of addressing the study questions and objectives .the study puts together those threads of discourse on the major issues considered throughout the research undertaking .the last chapter five draws conclusion to answer the questions and then to address those objectives .it therefore, suggests plausible interventions to be accomplished by different stakeholders in various contexts at different level s in the study area.

Chapter one: Introduction

1.1. Background

1.2 Statement of the problem

1.3 Objective of the study

Chapter two: Literature Review

Chapter three: Methodology of Research

Chapter four: Results and discussion

Chapter five: Conclusion & Recommendation

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Questionnaire I

This is a study to be conducted for fulfillment of Master's thesis at Indira Gandhi Open University with the objectives of identifying specific cultural and social factors which may affects or discourage pregnant women who are living in Gedo Zone, to deliver in health facilities. As the study is directly focuses related to those women who are previously delivered at healthy facility and home based on this you are one of the women who are selected to participate in this study, therefore you are kindly requested to participate in this study and provide the information required from you. Your participation in this study is completely on voluntary basis and you have the right to refuse from participating. Your responses will be kept confidential and there will be no way of linking your individual responses to the final results of the study findings.

We would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study, but also for producing relevant information which will be helpful improving the delivery service utilization.

Appendix

Part one: For all women who previously gave birth prior to the study

Socio demographic factors

01. **Age in Years _____**

02. Marital Status

1. Married 2.Single 3. Divorced 4. Widowed

03. Religion

1. Orthodox 2.Catholic 3.Protestant 4.Muslim 5. Others

04 .Ethnicity

1. Gedeo 2. Amhara3. 4. Guji 5.Borana 6. Other

05. Occupation

1. Housewife 2.Government employee 3.private employees 4.other

06 .Educational Status

1. Illiterate 2. Read and write3.Primary Education4. 2nd and above

07. Husband's occupation

1. Not employed 2. Government employee 3.private 4. Other

08. Husband's educational Status

1. Illiterate 2. Read & write3.Primary education. 4. 2nd and above

Knowledge related to delivery

09. What are the major health problems in your community?

1. Pregnancy related problem
2. Nutritional problems
3. Inadequate health care 4. No problem 5. DK

10. Where you delivered your first child?

1. at home 2.Health facility (if your answer is home)

11. What was your reason to attend home?

1. I thought being attending home is safe
2. I feel more comfortable just being at home
3. Close attention from relatives & my family members
4. I don't like the service in the HC.
5. Unwelcoming approach of health professionals
6. Facility is too far
7. No female providers at facility
8. Other specify

12. If you at attend at health facility, what was the reason to attend to delivery at health facility?

1. Better service 2. Health facility near home

3. Poor outcomes from HD 4. Received health education 5 .no fees 6.family allowed 7.other….

13 . If pervious birth was not your first birth Where you to attend the second birth

1. HC 2.Home

14. If you gave birth at home who assist you

1. Husband relative 2.nigbouers 3.TBA 4.mother 5.health professional 6.Any----

15. What was your reason to attend home?

1. I thought being attending home is safe
2. I feel more comfortable just being at home
3. Close attention from relatives & my family members
4. I don't like the service in the HC.
5. Unwelcoming approach of health professionals
6. Facility is too far
7. No female providers at facility
8. Other specify

16. If you at attend at health facility, what was the reason to attend to delivery at health facility?

1. Better service 2. Health facility near home

3. Poor outcomes from HD 4. Received health education 5 .no fees 6.family allowed 7.other….

17. Are there any health facilities which provide pregnancy & delivery services?

. 1. Yes 2. No 3. Do not know

If yes, which health services are provided?

18. ANC

1. Yes 2. No 3. Do not know

19. Attending Normal delivery

1. Yes 2. No 3. Do not know

20. Do you participate in any awareness creation session at your locality regarding the need for delivering at Health facility?

1. Yes 2. No (if No skip to Q 17)

21. If yes who were provided or organized this session

1.HEWs

2.Community Elders

3.NGO

4.Health Development Army

5. Community Health volunteers

6. I don't know

22. Where the awareness creation session provided?

1. At kebele hall
2. Local gathering place
3. Health facility waiting room
4. Health post

23. Are you were satisfied with the information disseminated?

1. Yes 2.No 3.indifferent

BELLEFS AND AITITUDES

24. Being attended by a skilled delivery attendant may be beneficial to my wellbeing.

1. I agree 2. I disagree 3. Indifferent

25. Being attended by a skilled delivery attendant may be beneficial to the newborns wellbeing.

1. I agree 2. I disagree 3. Indifferent

Beliefs and cultural practices

26. Is there any cultural belief which hinders you to give birth at Health Facility?

1. Yes 2.No

27 .Do you think that has any good Implication for the family or the new born baby of "future fate "Being gave birth at home ?

1. Yes 2.No

28. Do you think that sun or moon Exposure has dangerous during labor?

1. Yes 2.No

29. Is there any belief in your locality being delivered by her and those through professional assistance during labor?

1. Yes 2.No

30. Is there any Home Made drinks or Edible things provided to delivered women or baby just Immediately after birth?

1. Yes 2.No

31.If yes can you mention this drinks or edible things?

1.Hany 2.Milk 3.Butter 4. Any -----

32. If there for what purpose thought to be used the given drink or edible thing? Probe

1. To make baby strong 2. For mother health 3. Any----------

REINFORCING FACTORS

33. Preference of husband to place of delivery

1. HD 2. ID 3. Do not know

34. Preference of husband as your deliver attendant

1. Skilled DA 2. TTBA 3.TBA 4.Relatives of family members 5. Do not know

35. Preference of other family members as your place of delivery

1. HD 2. ID 3. Do not know

36. Preference of other family members about your delivery attendant

1. Skilled AD 2. TTBA 3.TBA 4.Relatives or family members 5. Do not know

37. Preference of other community members as your place of delivery

1. HD 2.I D 3. Do not know

38. Preference of other community members as your delivery attendant

1. Skilled DA 2. TTBA 3.TBA 4. Relative or family members

5. Do not know preference of pregnant woman

39. Who decide where you shall be gave birth?

1. My self-2.My Husband 3.Relatives 4.community 5.mother in low

FGD Guide

Name of Facilitator ……Name of Note taker ……...

Date…… Place of discussion …….

Time discussion started…… ……..Time ended……

Number of Participant …… Women……men……

Occupation of participants, Farmers……..Merchants……daily laborer……

Governmental employer….. ……..House wife……

Age of participants, 15-25 years……26-36 years…..37-47 years …….> 48years……

Introduce moderators, not takers, participants and introduce the objective of the discussion and topics.

I am interested to in know about the practice, experience, concerns and problems of the community about maternal health. I am especially interested to understand the issues of socio cultural situations pertaining delivery and birth assistance. I hope that your answers to my questions will important to understand the situation and it will help full to improve maternal health care in this area. I expect our discussion to last

about 40-60 minutes. Thank you. Agree on group norms and Confidentiality. First, I would like to ask you some general questions about your community:

1. What are the major maternal health care problems of the community? Can you give some? Example of the problems?

2. How does the community get information about maternal health care? Can you give some e? Examples?

3. Who is responsible for making decisions in seeking delivery service? What about husbands role?

4. What are the main reasons to women's at this kebele that contribute to deliver at home? Why?

5. What is the difference between giving birth at health facility or home? How? Eating? Drinking? Other practice

6. What are the religions, traditional and cultural practices of the community during child birth at home? How instructional deliveries affect this?

7. Is there anything related to culture said about burial of placenta?

8. Before we finish, I would like to hear what did you think about the subjects we have discussed were important? Do you think that this group covered issues that are important to mothers? What has been done here to improve mother's health? Is there anything the government or any partner can do?

PERFORMA FOR SUBMITION OF MRDA PROPOSAL FOR APPROVAL FROM ACADAMIC COUNSELLOR AT THE CENTER

Enrolment No.:_____

Date of submission:_____

Name of the study Center: St. Mary's University post graduate studies

Name of Guide: wondimagegne checkol (Ph.D.) :_____

Title of the project: ANALYSIS OF SOCIAL AND CULTERAL FACTORS ON CHILD DELIVERY SYSTEM, THE CASE OF DILLA WEEREDA, SNNP, ETHIOPIA

Name of the student: _____

Approved /Not Approved

Signature _____ Name and address of the student: _____

Name and address of Guide: _____

Date: _____

CARRICULUM VITAE

I. PERSON SPECIFICATION

Name	Wondimagegne Chekol
Date of Birth	January 20, 1957
Place of Birth	Gonder, Ethiopia
Nationality	Ethiopian
Sex	Male
Marital Status	Married
Language	Amharic, English, German

II. EDUCATION

PhD in Agriculture, Goettingen University, Germany, 1989-1994

MSc in Agriculture, Goettingen University, Germany, 1983-1987

BSc in Plant Science, Addis Ababa University, Alemaya College of Agriculture, Alemaya, Harar, 1977-1980

Bahir Dar Secondary School, 1969-1972

Bahir Dar Elementary School, 1963-1969

II. TRAINING and Study Visit

Leadership and Management at St. Mary's University College (2011)

Soft ware package for social science at St, Mary's University College (2011)

Project Cycle Management at St. Mary's University College (2010)

Three-month researches leave at Bonn University, DAAD, Germany (2013)

Three-month researches leave at Bayreuth University, DAAD, Germany (2009)

SAQA (South African Qualification Authority (2008)

Quality Assurance Mechanism in Higher Education Institutions, Addis Ababa (2007)

Management of Vocational Education, Tianjin University of Technology and Education, Tianjin, Peoples Republic of China (2007)

Leadership and Management, Ethiopian Management Institute, Addis Ababa (2003)

Three-month researches leave at Bayreuth University, DAAD, Germany (2005)

Project planning and Monitoring, ASARCA, Nairobi, 2004

Monitoring and Evaluation, EARO, 2002

Identifying and calcifying local indicators of soil fertility, CIAT, Arusha, Tanzania

SAS Software and Basic Biometry, EARO, 2002

Three-month researches leave at Bayreuth University, DAAD, Germany (2005)

Three-month researches leave at Osnabrueck University, DAAD, Germany (2001)

Three-month research leaves at Osnabrueck University, DAAD, Germany (1999)

Addis Ababa Teacher Training Institute, 1973, Ethiopia

III. WORK EXPERIENCE

Assistant Professor and Dean of Institute of Agriculture and Development Studies, School of Graduate Studies , St. Mary's University, March 2014 to date

Assistant Professor and Director of Center for Educational Improvement, Research and Quality Assurance, St Mary's University College since September, 2009 to 2014

Member of the task force to produce "The Ethiopian National Qualification Frame work", Representative of Higher Education Sector. Produced Ethiopian National Qualification Framework and Implementation Documents for the Ministry of Education

Senior Expert and team Leader Quality Audit in Higher Education Relevance and Quality Agency, since December, 2006

Worer Research Center Director, 2003 -2006

Associate Researcher I EARO, Worer Agricultural Research Center 1999-2006

- Soil research Section Head, Worer Agricultural Research Center 1999-2003
- Dry land natural resource management research program coordinator, EARO, Worer Agricultural Research Center, 2001-2006
- Drainage Research Project Coordinator, 2001-2004

Team leader of Prosopis juliflora management task force at Worer Research Center 1999-2006

Assistant Lecturer, Alemaya College of Agriculture, 1982

Assistant Administration Head of the Department of Plant sciences, Alemaya College of Agriculture, 1982

Graduate Assistant, Alemaya Agricultural University, 1981, Ethiopia

Guest Lecturer Awassa College of Agriculture, 1981/1982, Ethiopia

Graduate student, International Live stock Center for Africa (ILRI), 1988, Addis Ababa, Ethiopia

High school teacher, Arbaminch Secondary School, 1974-1976, Ethiopia

V. RESEARCH

Publications

Wondimagegne Chekol, 2014: *Prosopis julifor*a Management in Afar Regional State, Stakeholder Analysis: Paper Presented on IGAD International Workshop May 1-3, 2014 Submitted for publication, July 30, 2014

Wondimagegne Chekol and Imfred Neumann, 2014: Prosopiss , Parthenium Elements for an Integrated Strategy of Alien Species (IAS) Control in Afar Region State: Paper Presented on IGAD International Workshop May 1-3. 2014, Submitted for publication on July 30, 2014

Wondimagegne Chekol and Abere Menalu, 2012: Selected Physical and chemical characteristics soils of irrigated farm lands, Ethiopia, Ethiopian Journal of Agriculture 127-141

Wondimagegne Chekol 2013: Soil Dynamics and Ecological change in middle Awash and lower Awash basin (unpublished)

Wondimagegne Chekol and Daneil Alemayehu 2013: Physical Characteristics of natural resources and land use patterns of Awash Basin (unpublished)

Wondimagegne Chekol and Tigist Belay 2010: State of Educational Quality in Ethiopian Higher Education Institutions, Proceedings of the national conference on Quality of Education in Ethiopia, 2010: 48-61.

Wondimagegne Chekol, Solomon Alemu, Sisay Tekele, Bob Campbell et al 2008: Gonder University Institutional Quality Audit Report. HERQA Publication Series 029

Wondimagegne Chekol, Solomon Alemu, Kassahun Kebede , H. Kevin et al 2008: Jimma University Institutional Quality Audit Report. HERQA Publication Series 031

Wondimagegne Chekol, Solomon Alemu, Kassahun Kebede , H. Kevin Asefa Abegaz et al 2009: St Mary's University College Institutional Quality Audit Report. HERQA Publication Series 035
Wondimagegne Chekol, Solomon Alemu, Kassahun Kebede , Asefa Abegaz et al 2009: Addis Ababa University Institutional Quality Audit Report. (Unpublished)

Wondimagegne Chekol, 2009: Constructing the Third – Generation Ethiopian National Qualifications Framework, Proceedings of the national conference on Linking Higher Education with Industry, 2009: 48-61.

Wondimagegne Chekol, Asmare Demelelew, Keevy James et al: 2008 Concept and implementation framework of Ethiopian Qualifications, Ministry of Education of Ethiopia

Wondimagene Chekol and Heluf G/Kidane et al, 2006: Chemistry, Properties, Evaluation Management and Reclamation of salt affected soils and irrigation Waters in Ethiopia, ERO Publications

Wondimagegne Chekol, 2005: The effects of NP fertilizer on the yield of cotton, annual research repot, EARO.

Wondimagegne Chekol and Alemayehu Eshete, 2005: Impact of Irrigation on socio economic and environment in the middle and lower Awash River basin, annual research report, EARO.

Wondimagegne Chekol, 2004: Characterization of the soils of Lower and Upper Awash Basin, Ethiopia, annual research report, EARO.

Wondimagegne Chekol, 2003: Characterization of the soils of Southern Hledeghe Range Land in Middle Awash Basin, Ethiopia, annual research report, EARO.

Wondimagegne Chekol, 2002: Soil types: their potential and constraint for crop production in the Middle Awash Basin, Ethiopia, annual report, EARO.

Wondimagegne Chekol and Engida Mersha (eds) 2000: Proceedings of the fifth conference of the Ethiopian Society of Soil Science, Addis Ababa, Ethiopia.

Wondimagegne Chekol, 1994: Boden-catenen der basaltruecken-intramontanebenen-landschaft in der fusszone des Choke-bergmassives in hochland Aethiopian province Gojjam (PhD Desertation), Goerg-August University, Goettigen, Germany.

Wondimagegne Chekol, 1987: Das Boden-Brennen (Guie) in Aethiopian untersuchung zur veraederung der boden-eigenschaften insbesondere der naehrstoff reakitivitaet. MSc Thesis) Georg-August University, Goettingen.

Tamire Hawando, Wondimagegne Chekol et al, 1982: Soil fertility studies on major soils occurring in Hararghae Highlands (published in summary results of a soil science research program).

Tamire Hawando and Wondimagegne Chekol and et al, 1982: Effects of soil and water conservation on the yield and growth of sorghum in Hararghae Highlands, annual report soil science research program, Alemaya College of Agriculture.

Tamire Hawando, Wondimagengne Chekol et al 1981: Land use planning, soil fertility and soil conservation studies in Harerghe Highlands; summary research report, Alemaya College of Agriculture, Ethiopia

Extension work, Legambo Project (FAO funded), main activities were: soil classification and mapping, Land use planning, soil conservation and Agro-forestry, Alemaya College of Agriculture 1979-1982, Ethiopia

VI SKILL and ATTITUDE

Computer literate, Word and Excel

Aware of HIV/AIDS and Gender Equality

Familiarity with Afar community and culture and their way of working

VII OTHER ACTIVITIES

Vice President of the Ethiopian Soil Science Society since 2010

Editor in chief of the Ethiopian Society of Soil Science, since 2000

Chairman of the African and Asian Academician, George-August University, Germany (1990-1994)

Coordinator in the scaling up of modern Agricultural Technology in Afar Regional State (2003-2006)

Serves as Advisor and Co-advisor of MSc students at Hawassa and Haremaya Universities, since 2003 to date)

Member of the screening committee for German Academic Exchange Service (DAAD) PhD Scholarship candidates

Member of the advisory committee of the DG of Ethiopian Agricultural Research (2003) Institute

Partner for the implementation of Afar Livestock Recovery Project of FAO Funded by Norwegian Development Fund (2003- 2006)

Resource Person of Farm Africa Projects in Afar Regional State (1999-2006)

Partner for the implementation of PCDP Project in Afar Regional State (2003-2006)

Partner for SASAKA Global Rice Research and seed production since 2005 to date

Vice Chairman of the Ethiopian Soil Science Society since 2010
Secretery of the Ethiopian Soil Science Society since 2010 -213

Member of Ethiopian Agricultural Society

Member Ethiopian Soil Science Society

Member of German Soil Science Society

Reference:
Dr. Tareke Berehe, ATA
Dr. Berga Lemga, ATA
Dr. Kidane Georgis