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Decision Making Autonomy for Health Care Service Utilization and Its Associated Factors Among Married Women in Ambo Town Oromia Ethiopia 2022 a Mixed Methods Cross Sectional Study

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Keywords: Decision-making, married women's autonomy, health care decision, Ethiopia

Posted Date: November 9th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11173948/v1

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Additional Declarations: No competing interests reported.

DECISION MAKING AUTONOMY FOR HEALTH CARE SERVICE UTILIZATION AND ITS ASSOCIATED FACTORS AMONG MARRIED WOMEN IN AMBO TOWN OROMIA ETHIOPIA 2022 A MIXED METHODS CROSS SECTIONAL STUDY

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JULY, 2026

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Abstract

Background: Decision making autonomy of Women's health care service utilization is defined as the ability of women to make decisions on their freedom of movement, extent of decision-making power and their financial control without seeking permission from other. So, assessing healthcare service utilization decision making autonomy sheds lights on factors associated with women's decision-making autonomy in family and community as well.

Objective: To assess Decision-making autonomy of women's health care service utilization and its associated factors among married women of Ambo town, West Shoa zone, Oromia, Ethiopia, 2022.

Methods: In 2022, 404 married women from Ambo town, West Shoa zone, Oromia, Ethiopia, participated in a mixed method community-based cross-sectional study. Data was gathered by an Interviewer administered questionnaires. Variables with a P-value of 0.2 and below at bivariate analysis were chosen for Multivariable analysis. Odds ratios with 95% confidence intervals were used to identify association. Thematic analysis was employed for the qualitative portion. Finally, variables with P-value ≤ 0.05 declared as statistically significant. Quantitative data was presented by chart, table, graph, figures and qualitative data presented in narrative text.

Result: According to our study more than three fourth 305(77.2%) of married women have health care service utilization decision making autonomy. Having average monthly income of 3000ETB-6000ETB (AOR =3.418(1.731-6.747)), lacking regular access to money (AOR =0.193(0.044-0.848), Lacking decision power over their earnings (AOR =0.123(0.031-0.484)), self-employee husband (AOR = 0.379(0.149-0.963)), and lacking husbands discussion with health care provider about health care (AOR=0.450(0.218-0.929)) were identified as associated factors with women's health care service utilization decision making autonomy.

Conclusion: This study revealed that about three fourth of married women have high autonomy on health care service utilization decision-making. Women's average monthly income, Regular access to money, Decision on their earnings, self-employee husband and husband not discussing with health care provider were factors associated with women's health care service utilization decision making autonomy.

Key words: Decision-making, married women's autonomy, health care decision, Ethiopia

Introduction

Women's health care service utilization decision making autonomy is defined through social, traditional and religious views of each society (1). Women's ability to request health services and visit health care institutions depends on their decision-making autonomy(2). However, in developing countries, their status within society primarily limits their decision-making power with respect to their own lives.

Recently, International Organizations focus heavily on women's empowerment and reproductive health. Since the 1994 Cairo International Conference on Population and Development (ICPD) settled improving women's roles as a priority for sustainable development(3). The conference reached at a consensus to ameliorate women's status, improve reproductive health, and secure reproductive rights. This shifted the paradigm to emphasize individual reproductive autonomy(4).

Recently, women's autonomy in health care service utilization decision-making is extremely crucial for improving maternal and child health outcomes and women's empowerment (5). Globally, about 830 women die each day from complications related to pregnancy and childbirth. Nearly all of these deaths occurred in low and middle-income settings, and most of them were preventable (6). Across the globe, the status of women often limits their ability to decide many aspects of their own lives(7). Women's autonomy affects the use of maternal and child health (MCH) services (6).

In many cultures around the world, women are denied the right to participate in decision-making and to decide their lot. This is especially serious for women with a husband or partner. In this respect, power inequalities at the household level between husbands and wives may limit women's autonomy in health decision-making. This limits their use of health services that impact reproductive health outcomes and creates challenges for their families, communities and nations as a whole (8).

According to multilevel analysis done in high fertility countries in sub-Saharan Africa, 58% of married women had no role in health care service utilization decision making autonomy (9). In Ethiopia 40.9% of study women has no health care service utilization decision making autonomy(10). The wealth gap between men and women is substantial, and women have little or

no control over resources or say in reproductive decisions (11). The active participation of women in family decisions, such as the number of children and the use of resources, is not welcomed by their husbands. For women, the decision to seek health care depends largely on the goodwill of their husbands and extended families (11).

Gender impartiality gives women less decision-making power as well as better health outcomes, such as a lower fertility rate, more family planning use, and a lower level of unmet contraceptive needs (12). Power imbalances in marriage could make it difficult for couples to communicate clearly on reproductive health problems and women's access to services and it can negatively impact the health of the woman, her child, her family, the community and the country as a whole (13).

The strong health care service utilization decision-making autonomy of women is crucial in reducing the magnitude of maternal and child mortality rate(14). Because, limited women's health care decision-making autonomy impedes maternal healthcare utilization such as antenatal care (ANC), postnatal care (PNC), and delivery at a facility(15). Besides, the lower autonomy of women affects the socio-economic, emotional, fertility decision, contraceptive use, and the sexual life of the women (16-18).

Even though gender equality gives women more health care service utilization decision-making autonomy and better reproductive outcomes, millions of them in many cultures and tribes have little autonomy, so it's critical to learn more about the factors that influence decision-making autonomy and disparities across socio-cultural contexts (19).

Even though, few studies have been conducted in Ethiopia they were quantitative in nature and they miss the unquantifiable idea of different stakeholders that have contribution on women's decision making. So, this study will include the deep ideas of HEWs, gender office head, kebele managers and religious leaders by the qualitative study.

Most of previous studies done in the Ethiopia focuses on women's autonomy on reproductive health care and family planning; studies have not been done on married women decision-making ability to address the gender inequality and husband un limited power on couple decision making ability.

Therefore, this study will assess health care service utilization decision making autonomy and associated factors among married women of Ambo town, West Shoa zone, Oromia, Ethiopia, 2022.

The result of the study has an important contribution for health professionals, families and communities for improvement of health care service utilization decision making autonomy. It will also have an important contribution for health policy makers regarding women's health care service utilization decision making autonomy. This study will also be an important input for researchers to study on women's care service utilization decision making autonomy.

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Methods and materials

Study area and period

The study was conducted from September 1, 2022 to September 30, 2022 in Ambo town, West Shoa, Oromia, Ethiopia. Ambo town is located about 114 km west of the Addis Ababa.

Study Design

A Mixed method community based cross-sectional study was conducted.

Source population

All married women living together with their husbands in Ambo town.

Study population

- For quantitative study all selected married women in randomly selected kebeles of Ambo town.
- For qualitative study key informants for IDI (HEW, gender office head, kebele managers and religious leaders) were considered.

Sampling unit

- Selected married women who fulfill inclusion criteria and recruited for the study during study period for quantitative study and
- Purposively selected individuals for IDI (HEW, gender office head, kebele managers and religious leaders) were considered.

Inclusion and exclusion criteria

Inclusion criteria

- All married women lived in the area for over 6 months.

Exclusion criteria

- Married women who were critically ill and those who have communication problem.

Sample size determination

Sample size was determined by using single proportion formula and by considering the health care service utilization decision making autonomy of married women to be 66.2% ,95% C.I and 5% margin of error from previous study (26). Then sample size will be 380, by adding 10% of non-respondent rate.

For the second objectives (identifying associating factors) most significant variable associated with health care service utilization decision making autonomy of married women was considered and computed by using EPI info as follows:

Table 1. Double population proportion-based sample size associated factors of health care decision making autonomy among married women of Ambo town, Oromia, Ethiopia, 2022.

Factors considered	Proportions	Odds ratio	Sample size	10% non-response rate
Wealth index (Richest)	Proportion exposed= 52.4%	AOR=0.62(24)	367	404
	Proportion non-exposed= 62.8%			
Occupation (Merchant)	Proportion exposed= 65.5%	AOR=1.66(24)	334	368
	Proportion non-exposed= 55.9%			
Husbands' education status (≥ secondary)	Proportion exposed= 66.2%	AOR=1.91(24)	331	365
	Proportion non-exposed= 52.3%			

From both objectives, the sample size for second objective gives the highest sample size which becomes 367. So, after considering 10% non- response rate the final sample size will be 404. For qualitative part, four key informants were participated. Those participants were HEWs, gender office head, kebele managers and religious leaders.

Sampling technique and procedure

A total of 404 married women in Ambo town kebeles were selected using systematic random sampling technique from the 6 kebeles in the town. First, two kebeles were selected randomly using lottery method. Sample size was distributed proportionally to the size of the population in the selected kebeles to assure representativeness. After getting the list of eligible women through health extension workers (HEWs), the total sample size was allocated proportionally to the size of the selected kebeles. Then, study subjects were selected by systematic random sampling technique with the respective K^{th} values. So, K=8590/404=21, so that K= 21; then the first women will be selected by lottery method from 1-21 interval and continue every 21 married women. For the qualitative in IDI key informants like HEWs, gender office head, kebele managers and religious leaders were purposely selected.

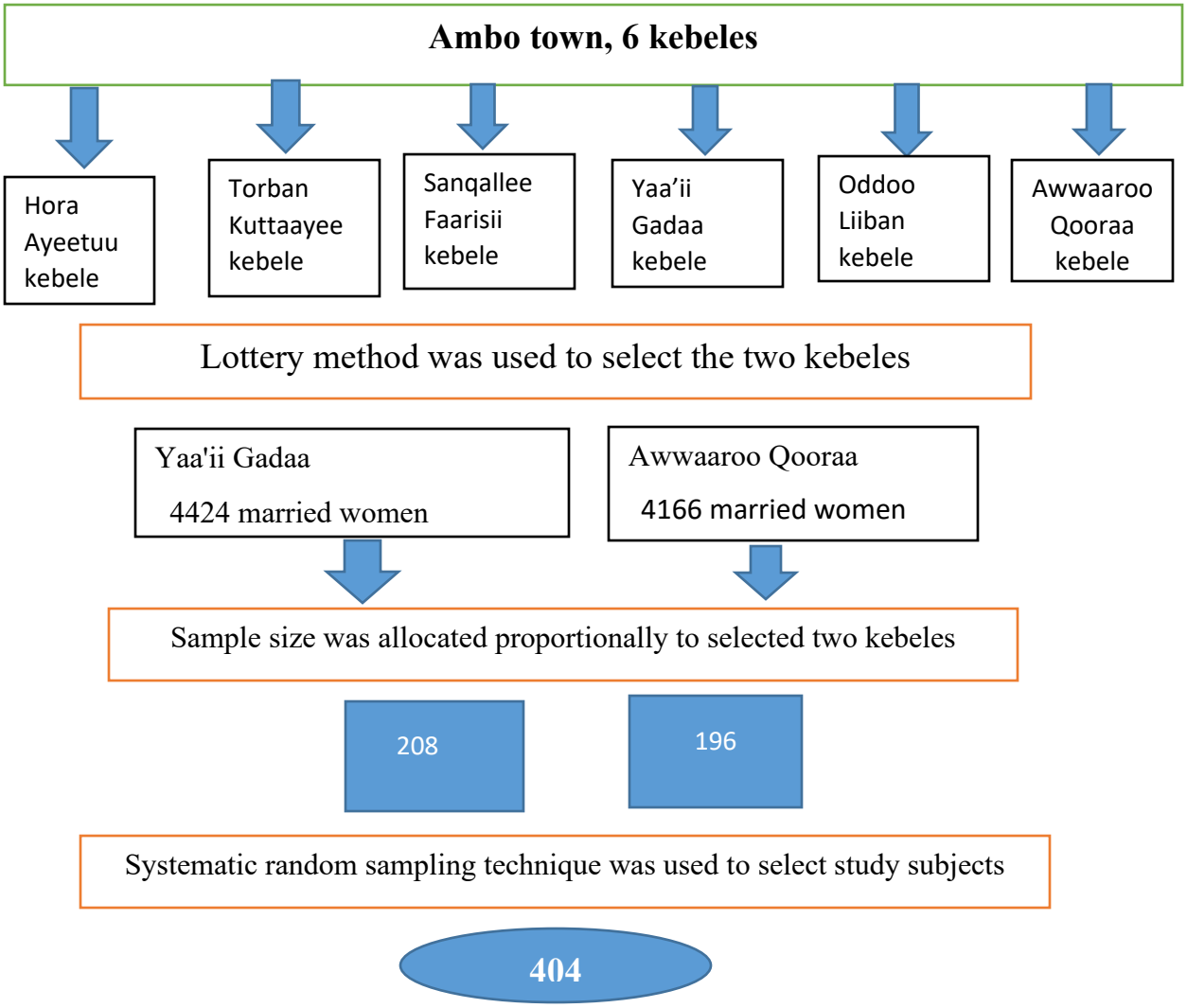


Figure 1: Schematic presentation of the sampling procedure which was used to enroll respondents to this study

Variable

Dependent variable

- Women's health care service utilization decision making autonomy

Independent variables

- Socio-demographic characteristics
- Economic and behavioral characteristics among women
- Husbands educational and behavioral characteristics

Operational Definition

Women's health care service utilization decision making autonomy: was calculated by computing from women's control over finance, decision-making power and extent of freedom of movement (26).

High health care service utilization decision making autonomy: when the women answered greater than or equal to the mean value it was considered as a high level health care service utilization decision making autonomy (26).

Low health care service utilization decision making autonomy: when the women answered less than the mean value it was considered as a low level health care service utilization decision making autonomy (26).

Women's decision making power: The total score from question on decision making power was computed and those women who had score mean and above was categorized as high decision making power whereas those scored less than mean was categorized as women with low decision making power (25).

Freedom of movement: Autonomy regarding freedom of mobility was estimated from questions related to woman independent ability. Those with score of mean and above were considered as high freedom of movement whereas those who had score less than mean were categorized as low freedom of movement (26).

Control over financial resources: The index for control over finance was computed from the question related to control over financial resources. Those women with a score of mean and

above was considered as having high control over finance, while those women had a score less than mean have low control over finance (26).

Wealth index: households was given scores based on the number and kinds of consumer goods they own, ranging from a television to a bicycle or car, in addition to housing characteristics such as source of drinking water, toilet facilities, and flooring materials. So, the index has been calculated using principal component analysis into five quantiles.

Data collection tool and techniques

After reviewing relevant literature, interviewer administered structured questionnaires (for quantitative), has been developed. The structured questionnaire contains socio-demographic characteristics of the women, socioeconomic characteristics of the respondents and their husband's educational and behavioral characteristics. For qualitative study IDI guide was developed and the guide contains probing topics related to women's autonomy. Data collection was conducted by one BSC and three diploma holders of health care providers and one supervisor was assigned.

Data quality control and management

Questionnaires initially prepared in English and then translated to Afan Oromo and then back-translated to English to check for consistency. Cronbach's Alpha (0.726) was computed to estimate internal reliabilities of the tools. Data collectors and supervisors were trained for one day on objectives of the study and ways of data collection.

Before actual data collection, pretest was done on the questioner in 5% (20) of the total sample size in the neighbor district (Gudar district, kebele 01) to check the internal consistency of items, to ensure clarity and logical sequence of the tool. During data collection supervisors have checked for completeness and consistency of administered questionnaires daily and timely corrections were be made.

Data processing and analysis

After checking its completeness, the collected data were entered using Epi data version 3.1 and exported to statistical package for social science (SPSS) version 20.0 for analysis. Appropriate descriptive analysis was done for socio-demographic characteristics, socioeconomic

characteristics of the respondents and their husband's educational and behavioral characteristics. For the categorical variables proportion and frequency was computed and for numerical variables mean and standard deviation were calculated. Bivariate logistic regression was used to identify candidate variables of women's autonomy in health care service utilization decision making. Thereafter, all explanatory variables having a p-value of ≤0.2 in the bivariable analysis were included in the multivariable logistic regression analysis to handle the effect of possible confounders and to identify independent factors affecting women's decision-making autonomy. The important predictors of health care decision making autonomy were determined using multivariable logistic regression. Odds ratios (ORs) along with CIs were used to determine the association between predictor variables and health care decision making autonomy of study subjects, considering significant association at alpha, 0.05. Model fitness for the final model was checked using Hosmer and Lemshow's goodness of fit. Multicollinearity was assessed by variance inflation factor (VIF≤10). Finally, data for frequency and proportion were presented in the form table.

Data from the qualitative part were transcribed, translated to English, coded and categorized accordingly to main thematic areas manually. Then after repeatedly reading the data, finally the findings were triangulated with the quantitative findings.

Ethical and Legal Consideration

Ethical clearance was obtained from Ambo University College of health sciences and referral hospital Research Ethic review board to conduct the study. The study subjects were informed about the objective and purpose of the study and written consent was obtained. Confidentiality was secured by informing and giving awareness to the data collectors not to record identifiers of the client and disseminate any information obtained from the respondents.

Dissemination plan

The finding of the study was disseminated to the pertinent bodies such as Ambo University School of graduate study as a partial fulfillment of the requirement for the degree of masters of public health, Western shoa zonal health office, through submission and presenting the reports at different seminars, workshops and conferences. Additionally, possible publication of the study will be considered.

Results

Socio-demographic characteristics of the respondents

Out of 404 women, 395 women completed the questionnaires resulting in 97.7% response rate. The respondents' mean age was 38.15 (SD±8.447). One hundred thirty-four (33.9%) of the respondents were 31-40 age group. From the participants, 123(31.1%) of them have diploma and above and 81(20.5%) of them have secondary school educational background. Regarding their jobs 134(33.9%) of married women have no job or housewife and 65(16.5%) of them were self-employed. From the participant 170(43%), and 137(34.7%) of respondents were orthodox and protestant respectively. The respondents' mean average monthly income was 4453.62(SD±1813.37) ETB. The mean family size of the participants was 4.83 (Table 2).

Table 2: Socio demographic characteristics of married women in Ambo town, Ethiopia 2022

Variables	Category	Frequency(n=395)	Percent (100%)
Age	21-30	68	17.2
	31-40	134	33.9
	41-50	99	25.1
	51-60	46	11.6
	>60	48	12.2
Educational status	Cannot read and write	74	18.7
	Can read and write	64	16.2
	Primary school	53	13.4
	Secondary school	81	20.5
	Diploma and above	123	31.1
Occupation	Government employee	44	11.1
	Merchant	54	13.7
	House wife	134	33.9
	Self-employee	65	16.5
	Student	52	13.2
	Others*	46	11.6
	Orthodox	170	43.0

Religion	Muslim	53	13.4
	Protestant	137	34.7
	Catholic	22	5.6
	Waaqeffataa	13	3.3
Average monthly income of the family	<3000	212	53.7
	3000-6000	125	31.6
	>6000	58	14.7
Family size	<5	200	50.6
	5-6	91	23.0
	>6	104	26.4

Others*: Religious leader, Poultry production

Economic and behavioral characteristics of married women

From the study participants, 60 (15.25%) and 98 (24.8%) of married women were from the poorest and poor household wealth quintiles respectively, whereas 78 (19.7%) of women were from rich wealth quintiles. Regarding exposure to media, 374 (94.7%) of participant were not read newspapers, whereas 295 (74.7%) of married women had heard radio. Almost all (99.2%) of married women had watched a television. (Table 3)

Table 3: Economic and behavioral characteristics of married women, Ambo, Ethiopia, 2022

Variables	**Category**	**Frequency (n=395)**	**Percent (100%)**
Women's household wealth index	Poorest	60	15.2
	Poor	98	24.8
	Medium	81	20.5
	Rich	78	19.7
	Richest	78	19.7
Women's exposure to media			
Have you read newspapers?	Yes	21	5.3
	No	374	94.7
Have you ever heard radio?	Yes	295	74.7
	No	100	25.3
Have you ever watched a	Yes	392	99.2

television?	No	3	0.8

Husband's educational and behavioral characteristics

One hundred thirty-six (34.4%) of women's husband were among 41-50 age group and the mean age of women's husband was 44.77 (SD±8.369). From the husbands, only 5 (1.3%) of them cannot read and write. Regarding their occupation 163(41.3%) of the husbands were self-employed. Almost half 202(51.1%) of husband didn't go to health facility with their wives during health care seeking and more than two third 309(78.2%) of husbands provide transport/gave money for health facility during the go to the facility. Half (50.9%) of husbands discuss about their wives health care with care providers (Table 4).

Table 4: Husband's educational and behavioral characteristics, Ambo, Ethiopia, 2022.

Variables	**Category**	**Frequency(n=395)**	**Percent (100%)**
Age of husband	21-30	44	11.1
	31-40	55	13.9
	41-50	136	34.4
	51-60	82	20.8
	>60	78	19.7
Husband's educational level	Cannot read and write	5	1.3
	Can read and write	58	14.7
	Primary school	39	9.9
	Secondary school	132	33.4
	Diploma and above	161	40.8
Husband's occupation	Government employee	61	15.4
	Merchant	64	16.2
	Daily laborer	41	10.4
	Self-employee	163	41.3
	Others*	66	16.7
Did your husband go to health facility with you?	Yes	193	48.9
	No	202	51.1

Did your husband provide transport/gave you money for health facility?	Yes	309	78.2
	No	86	21.8
Did your husband discuss about your health with care provider?	Yes	201	50.9
	No	194	49.1

Others*: Religious leader, Land dealers

Dimensions of married women's health care service utilization decision making autonomy

In this study, 190(48.1%) of women on control over financial resource had higher financial control, 277(70.1%) of women had high decision-making power, 320(81.0%) of women had higher freedom of movement. (Figure 3)

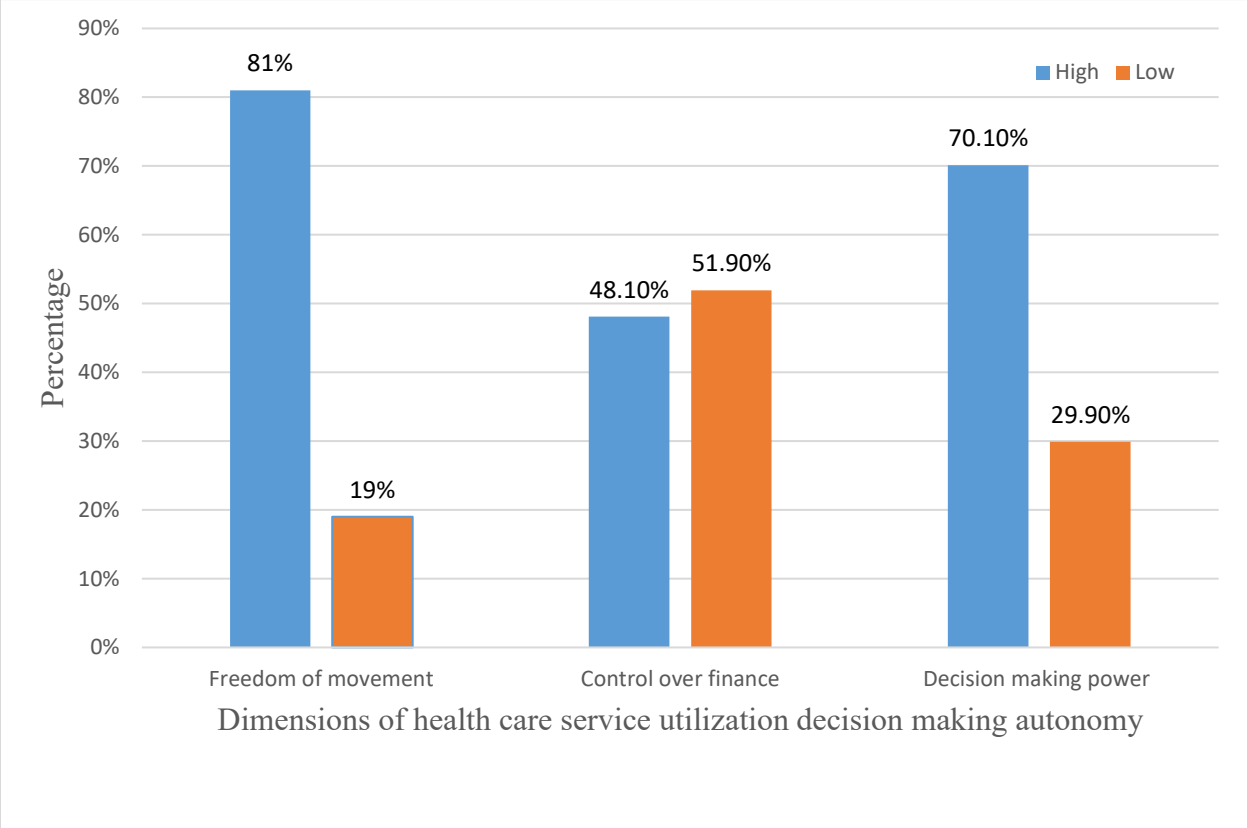


Figure 2: Dimension of health care service utilization decision making autonomy of married women in Ambo town, Oromia, Ethiopia, 2022

Married women's health care service utilization decision making autonomy

When we see the overall women's health care service utilization decision making autonomy, 305(77.2%) of the women had higher health care service utilization decision making autonomy (Figure 4).

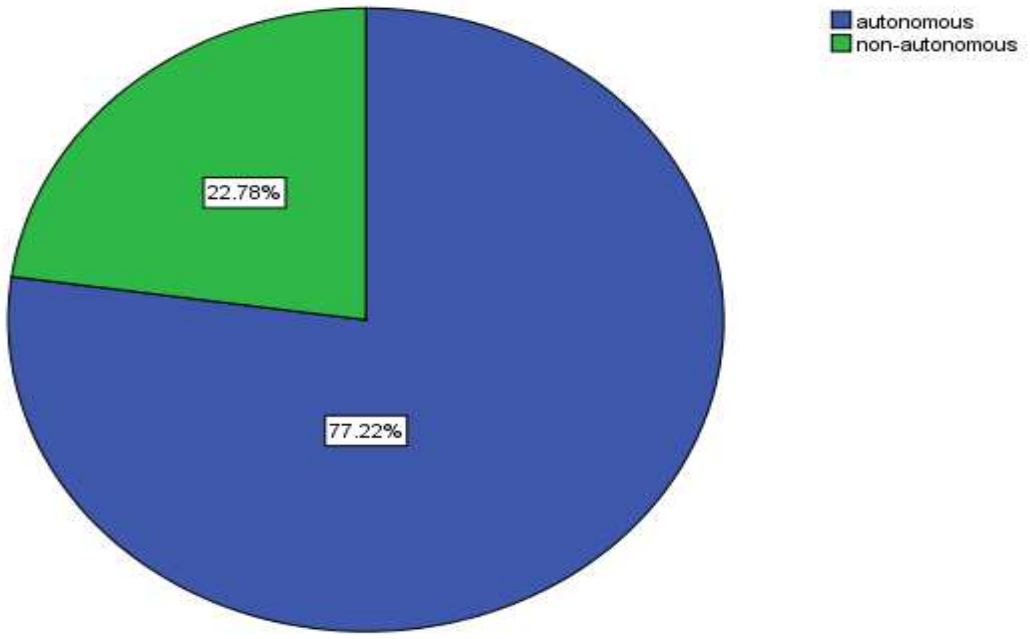


Figure 3: Health care service utilization decision making autonomy of married women in Ambo town, Oromia, Ethiopia, 2022.

Factors associated with health care decision making autonomy

To identify factors associated with married women's health care decision making autonomy, data were analyzed using binary logistic regression. In bivariate analysis, nineteen variables show a significant association with women's health care decision making autonomy.

In multivariate analysis, only five variables revealed sustained significant associations with women's healthcare decision making autonomy. From the multivariable logistic regression analysis average monthly income of the family (3000-6000), women's regular access to source of money, who decides on the money women earnings, husband's occupation and husbands' involvement on women's health care service with health care providers had a significant association with women's decision care decision making autonomy.

Those women from average monthly income of the family (3000ETB-6000ETB) were 3.4 times more likely to have had higher health care decision-making autonomy compared to the reference group (<3000ETB) (AOR = 3.418; 95% CI: 1.731, 6.747). The odds of having higher health care decision-making autonomy among women who have not had a regular access to source of money was 81% lower as compared to women who had a regular access to source of money (AOR = 0.193; 95% CI: 0.044, 0.848). Similarly, those women whose money earnings were decided by only their husbands were 86% lower to be autonomous in making decision on their health care as compared to those women who decide their money earning by themselves alone (AOR = 0.123; 95% CI: 0.031,0.484). The participants from IDI also support this result indicates:

"…in our area, its observable that household income is decided only by husbands. Because the main source of income in this area is husbands and it is owned by husband, because they didn't owned this household income they haven't have autonomy on making decision on their own health care… there is also a case came to our office once upon a time that the women has no access to source of money and for any single occasion she ask her husband. So, one day when she asked him after a day he gave her money, he refused and asked her what about the money that I gave you yesterday and it made a big conflict between them..." ***(30 years old female gender office head).***

"...Women may consult with their husbands before making a major purchase, but their husbands always have the last word. If the wife makes the decision alone, the husband feels less valuable in society…" ***(40years old Protestant religious leader, IDI).***

Women with a self-employed husband had a 62% lower chance of participating in health care service utilization decision making as compared to women with a government employed husband (AOR =0.379; 95% CI: 0.149,0.963). Those women whose husbands didn't discuss about their health care with health care providers during they seek health care were 55% lower to be participating in health care decision making as compared with those whose husband discuss about their health care with health care providers (AOR = 0.450; 95% CI: 0.218,0.929). Most of the participants in IDI agreed that even if joint decision making becomes familiar in the community there is a situation in which women's health care decision-making autonomy is violated. Also, they mention that women are not fully autonomous to decide on their health care and it depends on their husbands' characteristics (Table 5).

"…women are not exercising their autonomy on their own health, regarding decision on desired number of children, and contraceptive utilization that means, they decided their autonomy either by help of their husband or jointly with them especially women whose husband are unemployed can't made their health care service autonomously and they need a consult from their husbands. Those women have freedom to go anywhere without asking permission from their husbands. But those from unemployed and uneducated daily laborer husbands have no freedom to go somewhere, even to go to market they ask permission from their husbands…" ***(24years old HEW, IDI).***

"...women whose husbands' jobs are government employee and merchants are free and autonomous to seek health care by their own, this is due to that those government employees are more educated and give them more freedom than those whose job is daily laborer and unemployed…" ***(35years old Awwaaro Qooraa Kebele manager, IDI).***

Table 5: Bivariate and multivariable logistic regression analysis of factors associated with married women's health care decision making autonomy in Ambo town, Ethiopia, 2022

Variables	Women's autonomy		COR (95% CI)	AOR (95% CI)	P value
	High	Low			
Average monthly income of the family					
<3000	191(62.6%)	21(23.3%)	1	1	1
3000-6000	61(20.0%)	64(71.1%)	9.543(5.391-16.891)	**3.418(1.731-6.747)**	**0.001**
>6000	53(17.4%)	5(5.6%)	0.858(0.309-2.383)	1.953(0.517-7.373)	0.418
Do you have regular access to source of money?					
Yes	107(35.1%)	86(95.6%)	1	1	1
No	198(64.9%)	4(4.4%)	0.025(0.009-0.070)	**0.193(0.044-0.848)**	**0.029**
Who decides on the money you earned?					
Me alone	90(29.5%)	84(93.3%)	1	1	1
Both of us	41(13.4%)	1(1.1%)	0.026(0.004-0.194)	1.020(0.097-10.751)	0.987
Husband alone	174(57.0%)	5(5.6%)	0.031(0.012-0.079)	**0.123(0.031-0.484)**	**0.003**
Husbands' occupation					
Government employee	42(13.8%)	19(21.1%)	1	1	1
Merchant	53(17.4%)	11(12.2%)	0.459(0.197-1.069)	0.348(0.116-1.043)	0.059
Daily laborer	37(12.1%)	4(4.4%)	0.239(0.075-0.766)	2.234(0.418-11.933)	0.347
Self-employee	134(43.9%)	29(32.2%)	0.478(0.244-0.939)	**0.379(0.149-0.963)**	**0.041**
Others*	39(12.8%)	27(30.0%)	1.530(0.737-3.179)	1.080(0.382-3.052)	0.885
Husband discusses with health care providers					
Yes	130(42.6%)	71(78.9%)	1	1	1
No	175(57.4%)	19(21.1%)	0.199(0.114-0.346)	**0.450(0.218-0.929)**	**0.031**

Others*: Religious leader, Land dealers

Discussion

This study assessed health care service utilization decision making autonomy of married women in Ambo town, Oromia, Ethiopia. According to this study 77.2% (95% CI: 72.8, 81.3) of the married women have high health care service utilization decision making autonomy.

This finding is in line with the study conducted in Ghana which showed that 75% of the women reported exercising health care service utilization decision making autonomy either alone or jointly with their partners(22). It is also consistent with a study conducted in Debretabor, Northwest Ethiopia, on married women's decision-making autonomy in the household and on maternal and neonatal healthcare utilization and associated factors, which is 75.1%(27). This similarity may be due to that both studies were conducted in town.

The study is higher than those studies conducted in three countries on women of reproductive age group of South Asia, 27.3% of ever-married women in the reproductive age group in Nepal, 45.7% in Bangladesh, and 51.5% in India had taken the decisions alone or jointly with their partners regarding care for their own health(20). On the other hands it is higher than that of the studies conducted in Wolayita and Dowaro zones, southern Ethiopia, which is 58.4%(24) and the study conducted in western Welega zone, 66.2%(26). This difference may be due to this study was conducted in urban areas and it was may be due to the difference in socio-demographic characteristics and study population.

This study found that higher monthly income of the family had a direct association with women's health care decision-making autonomy which indicates average monthly income of the family (3000ETB-6000ETB) were 3.4 times more likely to have had higher health care decision making autonomy compared to the reference group (<3000ETB). This finding is in agreement with the study conducted in Debretabor, North west Ethiopia(27) and Wolayita and Dowaro southern Ethiopia(24). This result is also consistent with the study conducted in Bale district(25). This may result due to that, when their monthly income increases it boosts their confidence on decision making autonomy. In this study, women who have had regular access to sources of money are more likely to participate in their health care decision making autonomy as compared to those who have not had regular access to source of money. This finding is in line with the study conducted in western Ethiopia, which indicates women who have had access to sources of money had 3.4 times more likely to participate in women's health care decision making

autonomy(26). Husbands' involvement in women's healthcare services has been strongly associated with women's decision-making autonomy. Thus, women whose husband had no involvement in their health care services were 55% lower to be participating in health care decision making as compared with those whose husband discuss about their health care with health care providers. This finding is in line with the study conducted in Debretabor, Northwest Ethiopia, which is women who got husband involvement in health care services were 2.36 times more likely to have had higher decision-making autonomy as compared to women who hadn't get husband involvement(27). So, studies elsewhere reported that husband involvement encourages women's health care decision making autonomy. This study showed that husbands occupation was directly associated with women's health care decision making autonomy. This finding is also in consistent with the study conducted on women's autonomy and maternal healthcare service utilization in Ethiopia(29).

The findings from the in-depth interview also show that the husbands' involvement in women's health care seeking is the most crucial. But even if it is very important women cannot practice it autonomously without a consult of their husband. Some in-depth interview participant also states that husbands' occupation and educational status influence women's decision making. This implies that the more the husband educated the more they give freedom for their wives to practice their healthcare autonomously.

Strength and Limitation

Strength

- Most of the studies conducted on married women's health care decision making autonomy are only quantitative but this study triangulate quantitative with qualitative study.
- The study is also community based which made it more representative than facility-based studies.

Limitation

- Since its interview administered questionnaire, it has a recall bias.
- Autonomy was not specific services like for Antenatal care, delivery, post-natal care or family planning.
- This study was conducted in urban areas and it may not represent those from rural areas.

Conclusion

This study revealed that about three fourth of married women have high autonomy on health care service utilization decision-making.

Average monthly income, no regular access to money, women who didn't decide on their money earnings, self-employee husband and husband not discussing with health care provider were factors associated with married women's health care service utilization decision making autonomy in the study area. These factors were supported by the qualitative finding. The findings from the in-depth interview also show that the husbands' involvement in women's health care seeking is the most crucial.

Recommendation

Depending on the above findings the following recommendations will be considered for the following stakeholders:

To Ambo town health department to work along with HEWs to improve the women's health care service utilization decision making autonomy.

To Family to improve husband's discussion with healthcare providers on how the women enhance their decision making and encourage women to practice in income generating activities.

For future researcher to carry out study including the husbands' idea on the women's health care decision making autonomy.

Lists of Abbreviations

AOR _____ Adjusted Odds Ratio

ANC _____ Ante Natal Care

CI _____ Confidence Interval

COR _____ Crude Odds Ratio

FGD _____ Focused Group Discussion

HEWs _____ Health Extension Workers

ICPD _____ International Conference on Population and Development

IDI _____ In-depth Interview

MCH _____ Maternal and Child Health

OR _____ Odds Ratio

PNC _____ Post Natal Care

SDG _____ Sustainable Development Goal

SPSS _____ Statistical Package for Social Science

UN _____ United Nation

Declarations

Data Availability Statement

The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Ethics statement and accordance

This study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki and the national research ethics guidelines of Ethiopia. Ethical clearance was obtained from the Ethical Review Board (ERB) of the College of Medicine and Health Sciences, Ambo University (**Reference Number: AU/PGC/423/2014;Approval date: 24 August 2022; Expiry date: 24 November 2022**). The protocol was approved in accordance with the standard international and national scientific ethical guidelines. Informed consent was obtained from all individual participants included in the study. All participants were assured of the confidentiality of their responses and their right to withdraw from the study at any time without any consequence.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no competing interests.

Funding and their roles

No special grant or funding reviewed

Acknowledgments

I gratefully acknowledge all study participants, data collectors and supervisors for their willingness and cooperation during the time of data collection.

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