MARRIED WOMEN'S DECISION MAKING POWER ON MODERN CONTRACEPTIVE USE IN TERCHA TOWN AND RURAL AREAS OF DAWRO ZONE, SNNPR

BY

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Abstract

Back ground: The socially defined gender roles of men and women gauge the power balance between the two sexes. In developing countries most communities afford inferior positions to women. In effect women are either under collective decision-making with their partners or completely rely on the male partner's decision on issues that affect their reproductive live. Studies to reveal the extent women involved in modern contraceptive decision making and comparative difference between urban and rural areas with contributing factors were scanty. Hence identifying the major barriers of married women's decision-making power on contraceptive use and exploring the effect of women's socio-economic and decision-making status on their contraceptive behavior has significance for planning contextually appropriate family planning interventions.

Objective*:* The study is to determine current modern contraceptive practice and decision making power among married women in Tercha Town and surrounding rural areas of Dawro zone, SNNPR, 2010

Methods: Community based comparative cross-sectional study design with both quantitative and Qualitative data collection technique has been employed from March to April 2010. The respondents were 699 married women's with in child bearing age who were identified by using prior census and sampled using simple random sampling technique.

Result: Current modern contraceptive practice among married women in the Town is 86% and 72.8% in rural setting. Married women who reside in urban area privileged to decide on use of MC method two and a quarter times more likely than their rural counterparts. Having better knowledge about modern contraceptive methods, gender equitable attitude, better involvement in decisions related to children, socio-cultural and family relations in the Town and, better knowledge, fear of partner's opposition or negligence, involvement in decisions about child and economic affairs in the surrounding rural areas were important and significant contributing factors for better decision making power of women on the use of modern contraceptive methods.

Conclusion: high level of current MC practice with reduced urban rural difference as compared to regional & national figures. Urban residents have better power to make decisions on MC than rural counterparts and contributing factors were differing for both settings.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Authority
DHS	Demographic and Health Survey
DPFH	Department of Population and Family Health
EDHS	Ethiopian Demographic and Health Survey
FGD	Focus Group Discussion
FM	Frequency Modulation
FP	Family Planning
HEW	Health Extension Worker
HIV	Human Immune Virus
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IUD	Interauterine Device
JU	Jimma University
MC	Modern Contraceptive
MCH	Maternal and Child Health
MPH	Master of Public Health
NGO	Non-Governmental Organization

PCA	Principal Component Analysis
SNNP	Southern Nations Nationalities people’s
SNNPR	Southern Nations Nationalities people’s Region
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNPD	United Nation Population Division
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION

1.1 Background

As world population has risen from 2.5 billion in 1950 to 6.7 billion in 2008, the proportion living in the developing countries of Africa, Asia, and Latin America and the Caribbean has expanded from 68 percent to more than 80 percent. Africa's population, currently growing faster than any other major region, is projected to account for 21 percent of world population by 2050, up from just 9 percent in 1950. While Europeans opt to have one or two children at most, sub-Saharan Africans have more than five children, on average, and Asians have between two and three[1].

The 2007 Population and Housing Census results show that the population of Ethiopia grew at an average annual rate of 2.6 percent and a total population of 73.9 million. Southern Nation Nationalities and People's Region (SNNPR), where the study area located, the annual growth rate is moderately higher than the national average at 2.9 percent .[2]

Relatively high fertility in Ethiopia (TFR of 5.4, SNNPR=5.5) as compared to other developing countries, which puts the country in a middle of its neighbor countries, is contributed, in part, because women continue to marry and give birth at a young age, have polygynous unions, and have their children close together. Urban women have their first birth later (at a median age of 20.7) than rural women (median age 18.8.) Women with no education have their first child at a median age of 18.7, while women with a secondary or higher education level have their first child at an average age of 22.9[3, 4].

Fertility is one of the principal components of population dynamics that determines the size and structure of the population of a country, and has a powerful effect on its health and economic success[1]. Rapid population growth is the domain of developing countries because, if not all, most developing countries are suffering from the wave of unchecked population growth that further compromised their development opportunity[5].

Family planning method use can help ensure healthiest timing and spacing of pregnancy, hence, regulating fertility. As fertility falls, so do infant, child, and maternal mortality. Women spend decreasing proportions of their lifetimes giving birth and caring for young children[6].

According to Ethiopian Demographic and Health Survey (EDHS) 2005 report, the maternal mortality ratio for Ethiopia is 673 deaths per 100,000 live births[4]. Addressing unmet need in Ethiopia could be expected to avert 12,782 maternal deaths and more than 1.1 million child deaths by the target date of 2015[7].

It is widely asserted that increased gender equality is a prerequisite for achieving improvements in maternal health. The Programme of Action adopted at the 1994 International Conference on Population and Development claimed that "improving the status of women also enhances their decision- making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction."[8]

However, Gender-based power inequalities can contribute to poor health outcomes— for example, by hindering communication between partners about reproductive health decisions, by constraining women's access to reproductive health services, by preventing women's and men's attainment of sexual health and pleasure, and by increasing their risk of contracting HIV infection and other STIs[9,10]. The socially defined gender roles of men and women gauge the power balance between the two sexes. In developing countries most communities afford inferior positions to women. In effect women are either under collective decision-making with their partners or completely rely on the male partner's decision on issues that affect their reproductive live[11, 12,13].

Here, married women's decision-making refers to women's ability to express their opinion and influence on family decision processes including independent decision to use contraceptives[14]. There is an argument that the use of family planning has some "liberating" effect on women, in the sense that it is associated to a certain extent, with attitudes that enable women to free themselves from the dictates of behavior that are closely linked with "gender."[15]

Therefore, women's empowerment helps to grant gender equality. In the context of family planning, the concept of women's empowerment is generally associated with a variety of elements that range from delayed marriage, smaller families, access to accurate information, the ability to discuss freely about their family planning needs with spouses and other members of the household and the community, and being able to make independent decisions on fertility regulation including going out of living boundaries to seek contraceptive supplies[16].

1.2 Statement of the problem

Contraception plays a key role in attaining women's health. Its strongest impact on reproductive health is when it is used to prevent pregnancies that are too early, too close, too late and too many. Contraceptives prevent maternal death by reducing the number of times women go through pregnancy and childbirth. They also provide significant protection for women by preventing unintended pregnancies, which often end in unsafe abortions[17.]

Acquiring knowledge about family planning is an important step towards gaining access to and using a suitable contraceptive method in a timely and effective manner. Individuals who have adequate information about the available methods of contraception are better able to make choices about planning their families. Despite the high level of knowledge (88 % of currently married women and 93% of men knowing at least one method of contraception), the contraceptive prevalence rate (CPR) for married Ethiopian women is 15 % (SNNPR=11.4%), which is far below the nation goal of the Ethiopian Population Policy to be attend by the year 2015(44.0%) [18]. In addition to these, the contraceptive prevalence is more than four times higher in urban than in rural areas [4]. A study done in 2005 on the same community to this particular study revealed that 35% of the respondents are using despite 82% of them had knowledge and mentioned at least one contraceptive method [19].

Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies. Greater gender-based power differentials may be associated with lower contraceptive use; conversely, joint decision-making norms tend to characterize societies with high contraceptive prevalence and low fertility. A basic tenet in reproductive health program management and policymaking is that joint decision-making helps realize women's empowerment and health goals. However, Joint decision-making may be more heavily influenced by the man's preferences than woman[20].

\When the discordance occurs in a situation of male authority, men's opinions about these issues may overrule women's, even though the women often must implement the decisions made on these matters. In some cases, husbands fear that if they approve of family planning and allow their wife to use it, they will lose their role as head of the family, their wife may be unfaithful or they may lose face in their community. As a result, women may sacrifice their own wishes to those of their partners—or their perception of their partners' wishes[9].

A study conducted in Southern remote community in Ethiopia in 1999, reported that because of the male dominance in the culture, women would be forced to bear large number of children, and this was major obstacle in the fertility regulation decisions by women[21].

It is reported that, in a rural community where women's literacy status is very low and economic dependence is high, individual decision making might be impossible since influences from husband and other relatives are common[19]. But EDHS 2000 reported the opposite that rural women are more likely than urban women to make an independent decision on current use (29 % versus 19 %) [3]. The reason may be due to that urban women are more likely to discuss about contraception use with their partners than rural women hence making joint decision. For example, a study in Mareqa woreda of the zone showed those couples who decide husband and wife in common about utilization of FP were found to use contraceptives 2 times more likely as compared to those women who decide by themselves. And also couples who used to discuss about FP were found to use, contraceptives four times more than those who did not[19].

Women secrete use of contraceptive methods is one of the clearest examples of the potential consequences of unequal power in sexual relationships. A recent review estimates that secrete use among women accounts for between 6 and 20 % of all contraceptive use (based on studies in sub-Saharan Africa) [22], practicing contraception openly in defiance of a partners wishes can be difficult for women, especially for women who are economically dependent on their partners and for those whose partners can threaten them with taking another wife, or with separation, divorce, or violence. Although some men acknowledge and even justify women's covert use, initiating such use is not an easy decision for women[23].

The actual method of choice may be affected by decision making as the proportion of women using injectables methods of hormonal contraception is much higher in the group reporting lower decision making power. This may indicate that women are choosing an "invisible" method of contraception where there is no evidence of method use at home such as taking a contraceptive pill. Male condom use was slightly higher in women who had higher decision-making powers[24].

Therefore, this study will attempt to reveal married women's decision making power in use of modern contraceptive method, factors affecting and their comparative difference in the Town and rural areas of the zone.

CHAPTER TWO: LITERATURE REVIEW

2.1 Contraceptive Prevalence

The report on world contraceptive use by United Nations Population Division (UNPD), nine out of every 10 contraceptive users in the world rely on modern methods. Short-acting and reversible methods are more commonly used than other methods in developed countries, pill (16%) and the male condom (14%), whereas longer-acting and highly effective clinical methods, female sterilization (22%) and the IUD (17%), are used more frequently in the developing countries[25]. As it is true to most sub Saharan countries, injectables remain the most popular method, with 10 percent reporting use which is followed by pills with 3 percent[3, 4]

2.2 Knowledge of Contraceptive Methods

It is obvious that Individuals who have adequate information about the available methods of contraception are better able to make choices about planning their families[4]. Knowledge of modern method of FP is generally high among both husbands and wives, variations by country are substantial as noted by the analysis of 18 developing country DHS results. The proportion of husbands who know at least one modern method ranges from 57% in Burkina Faso to 100% in Brazil and wives from 57% in Cameroon to 100% in Bangladesh, Brazil and Egypt[26].

The EDHS 2005 survey indicated the wide gap of knowledge among men and women which probably is a verification of power difference. Among couples in which only one partner knows of a method, husbands are more likely to know the method than their wives and the discrepancy may be highly attributed to some specific type. For instance, condom, which is 41 percent among married women versus 84 percent to their counterparts[4].

Contraceptive knowledge is a major factor in influencing decisions to use contraceptives currently or in the future among rural women in SNNPR since with knowledge increases the use. Women who participate with their husbands in family decision making are found to be more knowledgeable about family planning and are more likely to be contraceptive users[21]. The lack of knowledge about contraceptive methods (what are they, how to use them or where to get them) and husbands' will against fertility control is higher among women at lower level of autonomy and decision making in Mexico[14].

2.3 Factors Affecting Contraceptive Use and women's decision making power

There are a number of factors which affect the use of modern contraceptive and women's decision-making power in its utilization. Socio-demographic and economic factors of the wife or husband is associated with a male-centered decision-making attitude. In Honduras, women who lived in less urban areas, had less than a secondary education or were of medium or low socioeconomic status had elevated odds both of believing that men alone should make reproductive decisions and of living in a household in which the man made those decisions. Men of medium socioeconomic status, less educated, were in a consensual union are more likely than others to have a male-centered attitude[9].

As levels of education rise among rural women, their decision-making attitudes and behaviors may change[9]. It is hypothesized that highly educated women are likely to enjoy personal autonomy, hold decision making power in the household including family planning. Consequently, as compared to women with no or little education, these women are more likely to choose to limit the size of their family and/or use modern contraception. The increase in women's education is consistent with increased gender equity with in household which have a major role in fertility decision making[27].

One mechanism through which education affects fertility behavior is through delayed entrance into marriage. In southern Philippine, "Wife's education" is a key factor in the allocation of power in the household and equations indicate that women with more education have significantly more power in decision items including modern contraceptive use. Besides women, educated men are less likely to be patriarchal and may themselves be the ones to encourage their wives to use modern contraception because they desire a quality life for their children[15]. In couples with both partners educated and in couples in which women work for pay, both partners were significantly more likely to report that both of them participate in the final decisions than was the case in couples without education or in which the wife did not work for pay in Jammu and Kashmir[28].

Power differentials in sexual relationships directly influence women's access to and use of reproductive health services when male partners control financial resources and women's mobility[23]. The power of women to decide increases if they are economically independent, has got self-earned money or contributes to the household income.

In fact, Women tend to make minor decisions but in decisions involving larger expenditures, the husband has a greater influence[15]. The analysis by Firew about Perceived economy of respondents when compared to their neighbors indicates that those who consider themselves as medium economic status when compared with those who have poor perception showed a statistically significant difference in contraceptive use[5].

Gambella Town comparative study depicted that, indigenous women didn't have the right to decide on family income expenditure and they also lack decision making capacity on limiting their family size. About 74% of the indigenous women reported that family income expenditure was controlled by males while 75.5% of the non indigenous group noted as they decide jointly with their partner[29].

Among Honduran mothers, the attitude of Male-centered decision making decreased as their number of children rose and are aged (40-49 than early 30s)[9]. In contrary the argument that having more children increases the power of women in their respective households over a particular decision item is not supported by Philippians finding[15]. The data from Mexico point out that there are some significant differences when comparing the ideal number of children by women's level of decision-making power: it goes from a mean of 4.41 among women with a low level of power to 3.65 among women with a high level of power[14].

In addition to women's decision-making power, contraceptive use is associated with the number of living children a woman has; it is highest among currently married women with one or two children (17 %) and lowest among women with no children (12 %) [4]. The Jimma Town study also says history of child death had negative influence on couple's contraception use[30]. In Gambella's urban population survey, it was found that the likely hood of using modern contraception decreases as the number of intended children increase[29]. The study in a rural community of Mareka Woreda declared statistically significant association of number of living sons, decision on and discussion about contraceptive use by both husband and wife were with contraceptive utilization[19].

A study from southern Philippines revealed that tradition, culture, and religion give little decision-making power to Muslim women[15]. In southern Ethiopia, protestant missionary churches have advocated women's involvement in decisions to be made in family matters,

established experimental programs to promote literacy and improve women's ability to earn money which activity promoted contraception use so that higher level of contraceptive utilization than others[21].

Urban women have lower fertility because of superior educational attainment, working in the modern economy, and exposure to new ideas and values through the mass media and ease of access to family planning[27]. A study from Nigeria reflects that current contraceptive use was consistently and statistically higher in urban areas than in the rural (14.6% vs. 10.1%)[31].This discrepancy is much higher in Ethiopia where in urban areas, close to half (42 percent) of currently married women use modern contraception, compared to only 11 percent in rural areas[4].

The intention of contraceptive use either to limit or space birth matters in decision-making power of married women. In Mexico, the percentage of women using contraceptives for limiting is larger among women with a high level of decision-making power (index power value 12 to 15) than among women with low level of power (index power value 5 to 8): 85.45% and 75.71% respectively[14].

2.4. Spousal Agreement

An assessment which included 18 developing countries discovered that spouses for the most part agree about whether they want more children. More than 70% of couples are in agreement on this subject, with little variation by country. However, in 10-26% of couples, partners disagree; usually, the husband wants more children but the wife does not. Furthermore, when marital partners agree to have another child, they may differ about whether they want the child within two years or later. As it is depicted there, this type of disagreement occurs in 21-40% of these couples, and more often husbands want to have the next child sooner than their wives do[26].

2.5 Women's Autonomy and Contraception Use

Autonomy has been defined by many scholars; Basu 1992, Dyson and Moore 1983, Miles-Done and Bisharat 1990 which was referenced by Shelah and colloquies[32], as the capacity to manipulate one's personal environment through control over resources and information in order to make decisions about one's own concerns or about close family members. Women's autonomy thus can be conceptualized as their ability to determine events in their lives, even though men and other women may be opposed to their wishes [32].

Many literatures tried to assess the degree of women's autonomy by using different areas of concern: control over finances, decision-making power, access to and control over resources such as house hold assets and land ownership, and extent of freedom of movement[21, 30, 32, 33]. Equality of autonomy between men and women is seen as "equal decision making ability with regards to personal affairs"[33].

Women who have some decision-making power and autonomy often are better able than other women to meet their reproductive health goals including contraceptive use to space or limit child bearing[9]. Study from Okpoma community in Nigeria On family decisions came up with the finding that, 65% of the respondents are of the view that the man stands out as the traditional head of the home and therefore the decision maker including reproductive decisions. Sometimes important issues are never discussed with wives. Even when discussed, the man still takes final decision. As many as 30% of married women in Nigeria insist that as couples, both ought to discuss important issues in the home before decisions are taken .Some of these issues are number of children , when to or when not to use contraception and other family matters[31].

2.6 covert use of contraception

When married women were asked about husband's knowledge of their use of contraception**,** an overwhelming majority (87 %) of users reported that their husbands know about their use of contraception but 8 % not which is relatively higher in Tigray, SNNP and Benishangul-Gumuz regions. Uneducated women are three times as likely to conceal the use of a method of family planning as women with secondary or higher levels of education. Concealment of use is also higher among women in the two lowest wealth quintiles and among those residing in rural areas[4].

Qualitative studies in Kenya and Zambia have shown that women are afraid to ask their husbands permission to use a family planning method. If they practice family planning without their husbands consent, they worry about being discovered. In Nigeria, qualitative study done to assess women's perception to their husband's attitude towards modern contraceptive use showed that women fear that they may be forced to leave their husbands homes if they caught. Some worry that a contraceptives side effect will expose their secret use to their husbands. In Uganda disagreement between husbands and wives carries a high social cost including violence, divorce or husbands "bringing in" another wife[34].

Contraceptive use either to space or to limit family size is likely to be initiated by wives rather than their husbands. But success in achieving a smaller family will depend on how responsive husbands' fertility preferences are to the changes in their spouses' preference and on the influence of husbands' preferences on couples' reproductive behavior[26].

2.7 Significance of the study

It is well recognized that one of the potential challenge in the effort towards development in Ethiopia is the high growth rate of the population. The country has a population policy aiming at balancing the pace of growth rate of population with the corresponding socioeconomic development. Increasing the practice of contraceptive for fertility regulation is one of the most important strategies to meet the objectives in the population policy.

Available literature reviews show that contraceptive use helps not only to reduce fertility thereby reducing population growth rate, but also improves health of both mothers and infants. However, contraception practice in the country is very low, even compared to neighboring nations, where it cannot significantly affect the growth rate of population. Moreover, the relatively low practice in contraception among rural women as compared to their urban counterparts, where more than 85% of people reside, favor the problem to remain long - standing.

Among various reasons for under utilization of modern contraception, the one with great variability among rural and urban residents is because of gender difference which results in lack of women's decision making alone or jointly with their husbands for effective and sustained use. But still, studies which tried to see the contributing factors for low level of married women's decision making power and its overall effect on contraception adoption and use is lacking.

Hence, identifying the major factors that affect married women's decision-making power on modern contraceptive use and exploring the effect of women's socio-economic and decision-making status on couple's contraceptive behavior has significance for planning contextually appropriate family planning interventions.

Therefore, this study is to come up with the factors affecting, extent and comparative difference of married women's decision making power in modern contraception use between the Town and the surrounding community.

CHAPTER THREE: OBJECTIVE OF THE STUDY

3.1 General objective*;* To determine current modern contraceptive practice and decision making power among married women in Tercha Town and surrounding rural areas of Dawro zone, SNNPR, 2010.

3.2 Specific objectives;

- To assess married women's knowledge on modern contraceptive in the Town and rural areas of Dawro Zone, SNNPR.
- To assess married women's attitude about modern contraceptive use in the Town and rural areas of Dawro Zone, SNNPR.
- To assess current modern contraceptive practice among study groups.
- To determine the extent of decision making on modern contraceptive use among rural and urban married women.
- To identify factors affecting women's decision making power on modern contraceptive use in the Town and rural areas of Dawro zone.

CHAPTER FOUR: METHODS AND MATERIALS

4.1 Study Area and period

Dawro Zone is one of the 13 zonal administrations in SNNPR state which is newly structured in October 2000. The capital of the zone is Tercha Town which is located 505 km south-West of Addis Ababa, the capital of Ethiopia, and 275 km away to the West of SNNPR capital-Hawassa. The total area of the Zone is estimated to be 4430 Sq. km with diversified agro- climatic region and altitudinal variation ranging from 550 meters to 2820 meters above sea level. According to the zonal good governance study commissioned by Action Aid Ethiopia (2003) the land area share of Qolla agro-climate accounts the highest proportion(54%) followed by Woyna-Dega (45%) and Dega(1%).

Administratively, Dawro zone is divided in to five woredas and one Town administration with a total population of 492,742 of which, 242,000 are females across 164 kebeles (small administrative units). The estimated women population of reproductive age group was 114,808 (2).

Majority of its population (457, 711) resides in rural villages while the rest live in rapidly growing small Towns. Tercha Town is the capital of the Zone showing rapid growth as witnessed by the regional & federal state of Ethiopia last year.

Study Period: The study was conducted from March to April 2010.

4.2 Study Design:

The study design was *community based comparative cross-sectional* with quantitative data collection technique using interviewer administered pre tested questionnaire. FGD has been employed to complement the quantitative findings.

4.3 Populations

*4.3.1 Source Population*s

For quantitative study: - the source population was residents of Tercha Town and rural (with in 10km from zonal hospital) married women of childbearing age [15-49 years old] at the time of the survey.

Rural kebeles with in the specified radius are assumed to have similar characteristics to other rural parts of the zone since the Town taken as reference was established recently (not more than 10 years) in which it influenced in a significant way.

For qualitative study: - married women at the time of survey and aged between 15-49 and married men whose wife was meeting the requirement stated for inclusion above.

4.3.*2 Study Population*

***For quantitative study*: -** comprised of those currently married women in childbearing age (15-49), randomly selected from the source population.

***For qualitative:* -** those purposively selected from source population in both urban and rural settings by the supervising health professionals

4.3.4 Sample Size Determination

The sample size was determined by using Epi Info version 3.3.2 with the following assumptions:

Level of significance (α) =0.05

Power=80%

P_1 =19% [Proportion of independent decision making on MC use by urban married women] [3]

P_2 =29% [Proportion of independent decision making on MC use by rural married women] [3]

The ratio of Urban to Rural (n_1/n_2) =1

Accordingly, the estimated sample size for Urban and Rural area became:

n_1 =305 (for urban center)

n_2 =305 (for rural areas)

Considering 10% non response rate, the required total sample size, therefore, is 336 each for the Urban and rural married women of reproductive age group making the overall sample size 672.

4.4 Sampling procedure

For the study, Tercha Town is selected purposively and for additional reason of its ideal setup to meet the objective of the study. Rural areas (rural kebeles apart from city administrations) within 10km radius from the zonal hospital in Tercha Town were included in the sample due to logistic reasons and an assumption that all women residing within the specified radius can get family planning services.

4.4.1 Sampling Procedure for rural Areas

There are 5 rural kebeles within 10km radius of Tercha zonal Hospital which were included in the study. Prior to the actual data collection, census was carried out to identify households with married women of reproductive age group in those five kebeles in order to use as sampling frame.

By applying simple random sampling Procedure, the name/address of married women in reproductive age group has been specified from prior census result and location identified in collaboration with kebele leaders. The eligible identified married women of child bearing age were interviewed in each kebele till the number of sampled populations by simple random sampling completed. In some conditions like married women of reproductive age group were away from home, the interviewer re-visited the household at least three times and if failed to get the respondent, it was excluded from the survey and noted as non- response.

4.4.2 Sampling procedure for Tercha Town

Tercha Town administration has two kebeles and the whole Town was considered for this study. Prior to the survey, married woman of reproductive age group were identified by conducting census. After development of sampling frame, simple random sampling by using SPSS random number generator has been used to pick study units. By applying simple random sampling Procedure, the name/address of married women in reproductive age group was selected and location identified using prior census coding.

Inclusion-Exclusion criteria

Inclusion criteria

- Women in a marriage or consensual union
- In a reproductive age (15-49)

- Who stayed at least for six months in the area
- Rural residents within 10 km radius from Tercha Hospital and Tercha Town administration.

Exclusion criteria: Those who are critically ill and non-communicative

4.5 Tools for data collection

- Interviewer administered questionnaire
- FGD guide

4.6 Methods of Data Collection

4.6.1 *Quantitative data*:

The data were collected by structured pre tested questionnaire which was first prepared in English and translated to the local language (Dawrogna/Dawrottua) and gathered using interviewer administered questionnaire to feet majority of the respondent's characteristics. The study subjects were interviewed about their socio demographic variables, utilization of modern contraceptive methods, decision making power on its use and factors affecting their ability to make decision.

4.6.2 *Qualitative Data*

- ***FGD***

Eight sessions of focus group discussions were undertaken among married men and married women from both urban and rural settings. Each focus group discussion consisted of 6-12 members. Individuals of roughly the same age group, educational status, occupational and those who reside in the study area for at least six months were involved in the same group. The members of each FGD were selected by the supervising health professional and moderated by principal investigator with the assistance of one trained recorder/note taker.

Guiding questions were posed to initiate the discussions. Snacks and drinks were provided during the discussion, which lasted approximately an hour. The words of each discussant have been taken both through writing and tape recording in order to backup the written note. The purpose of the FGD is to maximize the quality of data and to look for different and multiple sources of information in order to complement the finding of the quantitative survey.

4.7 Data Quality Assurance

To assure the quality of the data, properly designed data collection instrument was developed after thoroughly revising related literatures and adopting questionnaires used in other similar studies by considering local conditions. The English version of the questionnaire was translated to Dawrogna (the communities' local language) and back translated to English to check consistency by medical professionals from Tercha Hospital who is familiar with both languages.

Before the actual data collection, the questionnaire was pre tested on 5% (34 women) of similar populations which are not included in the survey and necessary modifications were made specifically on the understandability of specific item.

Ten data collectors were recruited for prior census and actual data collection who can speak Dawrogna fluently after public notice followed by screening exam. All were Female and Diploma Nurses who graduated from private colleges and currently not engaged in other responsibility. Three supervisors who were senior Nurses from the Town Health center and Woreda health Office whose responsibility was checking whether the data collection instrument was correctly completed or not and supervising the data collectors and reporting problems encountered immediately to the principal investigator.

Three days intensive training was given to data collectors and supervisors on the general data collection technique and tool used for the survey. During this time, the enumerators and supervisors were given training on procedures, techniques and ways of expressing the questionnaires to collect the necessary information. The training included pretesting of the instrument.

Every day the collected data reviewed and checked for completeness and consistency by supervisors and principal investigator. Discussions were made with the interviewers at the end of the day and in the morning corrective actions were taken timely to minimize errors committed during interview. Repeated visit with appropriate time adjustment was made when study households were found to be closed or respondents were unavailable to minimize the non-response rate. The non response rate is very small in this research. The principal investigator and supervisors re interview few selected married women in reproductive age group to check validity of the data.

4.8 Study Variables

4.8.1 *Dependent Variable*

Married women’s decision-making power on modern contraceptive use

4.8.2 *Independent Variables*

Socio demographic variables

- Age
- Occupation
- Education
- Husband’s educational status
- Husband’s occupation
- Religion
- Ethnicity
- Place of residence
- Economic status
- Type of partnership/marriage

Reproductive History and women’s place

- Intended number of children
- No of alive children
- Number of pregnancy
- Knowledge of modern contraception
- Communication of FP among partner
- Desired sex of children
- Wife’s perception on Husband's approval of family planning use
- Wife’s perception on her partners support for contraception use
- Women attitude on gender equality
- Women’s Household decision-making power

4.9 Data Entry and Analysis

The collected data were cleaned, coded and fed to Statistical package for social sciences (SPSS) version 16.0.The data were also explored again for inconsistencies and missing values. After categorizing and defining variables, descriptive analysis was carried out for each of independent variables and their frequency& percentage were presented by table.

Principal component analysis was done after testing for their internal consistency to some of the independent variables to develop composite scores. To measure Socio-economic status, wealth Index was developed by using this analysis method.

Chi-square test used to determine the presence of association between explanatory variables and the outcome variable. Odds ratio with 95% confidence interval and P-value at <0.05 was computed to assess the presence and degree of association and statistical significance between the dependent and independent variables. Bivariate analysis was run for each predictor variable with the outcome variable to see the independent effect.

Variables which remain statistically significant in Bivariate were entered to Multivariate Logistic regression model to get final model. Based on the findings the results were presented in text, figures and tables.

Qualitative data which were tape-recorded from FGD were transcribed to English and categorized accordingly to main thematic areas. Finally the findings were presented in narrative ways by triangulating with quantitative data.

4.10 Ethical Consideration

Ethical clearance was obtained from the Ethical Committee of college of Public Health and Medical Sciences of Jimma University. Official letter of cooperation has been get hold of from JU and communicated to respective administrative bodies in the study area. After getting letter of permission to carry out the study from each administrative body, informed verbal consent was attained from each study subject prior to interview after the purpose of the study is explained. The respondents have been told as the data collectors are trained only to collect information but apart from this particular research, the data will not be passed to anybody. Confidentiality of the information obtained (personal identification and idea was not used in the way which might threat the respondent) was assured and privacy of the respondents were maintained.

There is no incentive paid in participating but just after the interview with each study subject is completed, the interviewers informed on methods of child spacing and its health benefit to the mother and child. The use of modern contraception has been also advocated.

4.11 Operational Definition and Definition of Terms

Family Planning- refers to the use of fertility control methods that will help individuals (men and women) or couples to have the number of children they want when they want them in order to assure the well- being of the children and the parents.

Unwanted Pregnancy- Pregnancy that comes beyond the intention or need of the couples for different reasons.

Child Spacing- refers to the interval between two successive births, which is about three to five years as recommended by World Health Organization.

Modern contraceptive methods- refer to methods of child spacing or birth control other than natural methods (abstinence, basal body temperature, cervical mucosa, and symptom-thermal and withdrawal methods).

Total Fertility Rate- is the measure of children a women would have over her life time if she were to follow current age-specific fertility rates

Sex- refers to the biological and physiological differences between men and women

Gender-refers to the different roles that men and women play in society and also the rights and responsibilities that come with these roles

Current users- refer to women who were found using modern contraceptive method at the time of the survey.

Non current users- refer to women who were found not using modern contraceptive method at the time of the survey.

Ever user-these are women who were used modern contraceptive methods at some time in their life but not during the survey.

Nonuser-these are women of reproductive age group who have never used modern contraceptive methods in their past life for one or other reasons

Urban- refers to an area/Town administratively run by the municipality

Rural areas- kebeles which are not administratively under the Town municipality within 10km from the zonal hospital at Tercha Town.

Zone- Government administration hierarchy next to regional state.

Woreda- Government administration hierarchy that exists between kebele and zone.

Kebele- the lowest Government administrative hierarchy that exists next to woreda.

Married women's decision-making power in modern contraceptive use- to measure married women decision making power particularly to modern contraception use, composite scores have been developed for three set of women: current users, Ever users and Never users. For current users, six questions were asked to make mean score. Questions like who decided mainly the use of your current modern contraceptive? Who mainly made decision on the specific type you currently adopted? And able to decide the use of modern contraceptive method has three response options and given respective scores: The husband decides only score =0, Joint decision-making score =1 and the wife decides only score =2. If the response indicates as the decision is made by others, the score given was similar with husband decides score since it is taken by another party not the woman. The use of current specific method in defiance of partner/husband, unescorted movement to get family planning services and money provided to cover such costs were yes/no questions and scored 1 for positive and 0 for negative replay. After computing altogether, score above mean is said to have better decision-making power. Those who used some time past in their life time but currently not using, six set of questions were asked and value given accordingly. Who decides finally whether you have to use modern contraceptives or not? (Was three response question and score given as; the husband decides only score =0, Joint decision-making score =1 and the wife decides only score =2). The rest items assess whether they have switched a method by the reason not to be discovered by their partner or family, ever used without the knowledge of husband or partner, ever stopped for the opposition from husband or relatives and their perception whether they do not have a right to get out from living areas to seek contraception provided with money to cover related expenses and score assigned 1for those who said no and 0 if otherwise.

For non-users, if their main reason for non-use is opposition from others the value was assigned as 0 and 1if otherwise. Eventually, married women's decision-making in contraceptive use among study units was set as binary outcome variable by merging the three groups of women together those scored above the mean can make decision on modern contraception use after developing mean score independently for each.

Household/Domestic decision-making: To measure the degree of women's involvement in domestic decision-making, under three subheadings: decisions regarding children, Economic decisions and decisions related to Social, Cultural and Family Relations, which comprises 18 questions were used to construct composite score. Each question has three response options on degree of women's involvement in the decision-making. Based on the responses each question will be scored as follows: -

- The husband decides only score =0
- Joint decision-making score =1
- The wife decides only score =2

For each sub headings, value greater than or equal to the number of item included were said to have better involvement, since in any of the decisions, there is an opportunity to have a say. Therefore, score greater than or equal to five for decisions related to children and economic affairs, score greater than or equal to eight for socio-cultural and family relation decision making were consider as better involved in domestic decision making.

Attitude on Gender Equality:

To measure married women's gender equitable attitude, ten questions were used to construct composite score. Each question has three response options based on degree of agreement on the statements about women equality. Based on the responses each question has been scored as follows: -

Disagree on the statement about women equality score =0

Neutral on the statement about women equality score =1

Agree on the statement about women equality score =2

Based on the summative score, score above 80% of the distribution were considered as having gender equitable attitude.[30]

Knowledge on modern family planning: To measure knowledge on modern family planning nine knowledge questions were used to construct composite score. Each of the six questions is scored as follows: -

- Type of modern female contraceptive methods she knows? Response from non-to all the six was scored from 0-6 accordingly.
- Which advantage of family planning does she know? Responses from none of them to all of the four advantages listed were scored from 0-4 accordingly.

- How many sources of contraceptive methods does she know? Responses from none of them to all of the seven sources of FP listed were scored from 0-7 accordingly.
- Does she know presence of modern family planning methods for males? If yes, score = 1, if no, score = 0. And the two specific type for men also scored 0-2.
- Does she know how long two consecutive children should be spaced? If response is correct score =1, if the response is not correct score meaning response other than 'three to five years) = 0.

Based on the summation score, score above 70% were considered as having better knowledge on family planning. [30]

The Wealth Index- is a composite measure of the cumulative living standard of a household. The wealth index is calculated using easy-to-collect data on a household's ownership of selected assets, such as ownership of agricultural land, cattle, television, radio and bicycles, materials used for housing construction, and types of water access and sanitation facilities. Generated with a statistical procedure known as principal components analysis, the Wealth Index places individual households on a continuous scale of relative wealth.

Each household asset for which information is collected is assigned a weight or factor score generated through principal components analysis. On final iteration, five components which can express 69.8% of the variability were retained. After computing these components together, an index was developed and used to create the break points that define wealth tertiles as: Lowest, Middle, and Third/Highest.

*4.*12 Dissemination and Utilization of the Results

The study findings will be presented to Jimma University community and copies will be submitted to Graduate School and Population and Family Health Department of JU, Dawro Zone Health Department and other stakeholders. It will also be presented to the community by planning meetings in collaboration with administrative bodies and probably through FM radio. Eventually attempts will be made to publish on local and international journals in order to communicate to scientific community.

CHAPTER FIVE: RESULT

SOCIO-DEMOGRAPHIC CHARACTERISTICS

The total response rate of the study was 99.5%. Out of 672 married women of reproductive age, 335 (99.7%) and 334 (99.4%) in urban and rural were interviewed, respectively.

The median age of the respondent is 26 with standard deviation of 5.6 in urban setting and 27 with standard deviation of 6.2 in rural areas. Most of the respondents in both settings fall in the age group 25-29. Dominant ethnic group in both settings is Dawro (89.3% versus 93.6%) in urban and rural areas respectively. Other ethnic group in the area accounts for less than 14 %.

More than half of the study participants were legally married and the only wife to their partner and 30.1% and 45.2% at urban and rural area lives together in consensual union (live together for more than 6 months but not signed legally). Only 3.9% of the respondents in the rural areas live in polygamous union.

Out of 699 interviewed married women in reproductive age, 95.2% and 54.6% of the respondents are house wife by occupation in rural and urban areas respectively. 107(31.9%) of married women are government employee in Urban areas.

The educational status of women included in the survey shows that 55.7% in rural and 5.1% urban were unable to read and write while more than 30% of them has got at least diploma in the urban settings. Majority of the respondents, 65.1% in urban and 76.6% in rural are protestants by their religion followed by orthodox (25%).

In rural areas, 76.6% of the household's wealth falls in the lowest tertile where as 69.9% of urban dwellers were in the third/highest tertile.

The respondents were also interviewed about their husband's educational attainment and current occupation. Accordingly, 75.1% of rural men/husbands were farmer by occupation and 39.5% attended formal education from grade 1 up to 6. Over 55.8% of urban husbands have at least having diploma hence 52.5% of them were employed in government organizations. (Table-1)

Table 1: socio-demographic variables of married women in reproductive age in Tercha Town and rural areas of Dawro zone, SNNPR, 2010.

Characteristics	Urban (%)	Rural (%)	Total (%)
Age Group			
15-19	31(9.3)	27(8.1)	58(8.7)
20-24	90(26.9)	73(21.9)	163(24.4)
25-29	123(36.7)	118(35.3)	241(36.0)
30-34	54(16.1)	50(15.0)	104(15.5)
35-39	28(8.4)	49(14.7)	77(11.5)
40-44	7(2.1)	15(4.5)	22(3.3)
45-49	2(.6)	2(.6)	4(.6)
Ethnicity			
Dawro	299(89.3)	327(97.9)	626(93.6)
Amhara	12(3.6)	2(.6)	14(2.1)
Others	24(7.2)	5(1.5)	29 (4.34)
Religion			
Orthodox	110(32.8)	57(17.1)	167(25.0)
Protestant	218(65.1)	256(76.6)	474(70.9)
Catholic	4(1.2)	0	4(.6)
Others*	3(.9)	21(6.3)	24(3.6)
Respondent's Educational status			
Illiterate	17(5.1)	186(55.7)	203(30.3)
1-6	77(22.9)	95(28.4)	172(25.7)
7-10	119(35.5)	46(13.8)	165(24.7)
10/12 completed	21(6.3)	3(0.9)	24(3.6)
10/12+	47(14.03)	0	47(7.03)
OCCUPATION			
House wife	183(54.6)	318(95.2)	501(74.9)
Government employee	107(31.9)	9(2.7)	116(17.3)
Merchant	33(9.9)	3(0.9)	36(5.4)
Others**	12(3.58)	4(1.2)	16(2.39)
WEALTH INDEX			
Lowest	18(5.4)	256 (76.6%)	274(41.0)
Middle	83(24.8)	45(13.5)	128(19.1)
Third/Highest	234(69.9)	33(9.9)	267(39.9)
HUSBAND'S OCCUPATION			
Farmer	9(2.7)	251(75.1)	260(38.9)
Government employee	176(52.5)	36(10.8)	212(31.7)
Private/ NGO employee	55(16.4)	6(1.8)	61(9.1)
Merchant	34(10.1)	29(8.7)	63(9.4)
Others***	61(18.2)	12(3.6)	73(10.9)
HUSBAND'S EDUCATIONAL STATUS			
Illiterate	14(4.2)	96(28.7)	110(16.4)
1-6	31(9.3)	132(39.5)	163(24.4)
7-10	79(23.6)	69(20.7)	148(22.1)
10/12 complete	24(7.2)	4(1.2)	28(4.2)
10/12+	187(55.8)	33(9.9)	220(32.9)

*Mana, Wolayita, Gurage**Muslim, traditional ***students, Daily Laborers, preachers

REPRODUCTIVE CHARACTERISTICS

The interview on the subject of age at first marriage illustrate the minimum for Rural areas about 9 year with median (standard deviation) age of 17(±2.48) while it is 15 years with median (standard deviation) age of 18 (±3.23) for urban dwellers. Early marriage is reported to be high in rural than urban as expected with 62.1% and 37.9% which has significant difference ($p=0.000$).

From the total 669 women interviewed who were currently in wedlock 91.8% were given birth at least once in their life time. Of which 11.7% encountered at least one child death, 89% were in rural community, with the maximum death of seven children in a single rural family.

When asked about which sex they prefer to have, in both groups male child is preferred to female (50.7%) and significant number of the respondents (45.6%) doesn't mind. Overwhelming number of respondents said their husband desire the same number of children as they wish. (Fig.1)

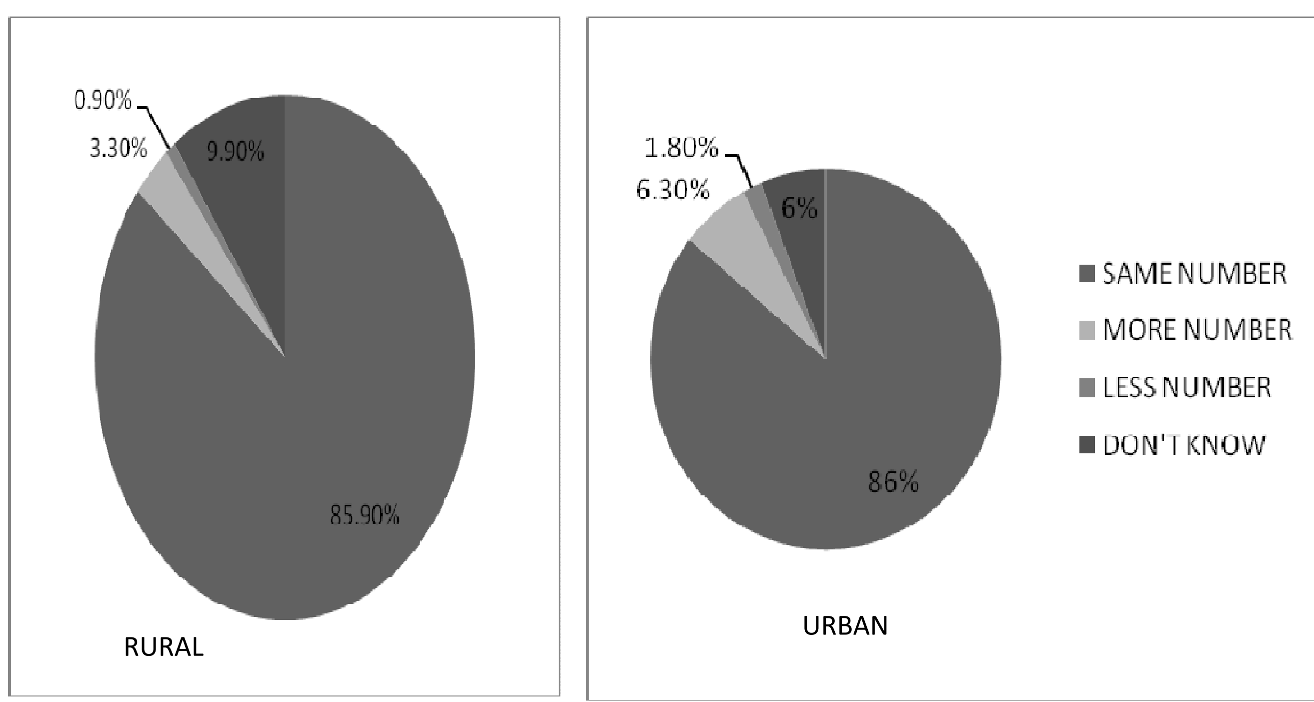

Figure: 1. Wife's perception of their partners' needed number of children in relation to themselves, Dawro zone, SNNPR, 2010.

KNOWLEDGE, ATTITUDE AND PRACTICE ON MODERN CONTRACPTIVES

Knowledge of MC Method

Respondents were asked about whether they have heard and able to mention MC methods, 99.4% urban and 98.8% rural claim that they have heard about modern contraceptive methods and know at least one female method. From specific modern type used by females, without prompting, frequently mentioned type was injectables (86.9% and 95.5%) in urban versus rural followed by pills (52.1% and 67.2%) respectively. The least known method in both setting is spermicidal, Jelly, foam and female condoms. Long term and/or permanent contraceptives like IUCD (13.7%), Tubal Ligation (6.4%) and Norplant (33.2) were mentioned by urban women where as less than five percent of the respondents mentioned those types at rural areas except Norplant (33.8%).

When asked about presence of modern contraception for male, 77.4% of urban and only 36.9% of rural women responded yes. Out of those who know the presence of male modern contraceptive types, 95% mentioned condom only at both settings.

Both urban and rural women have been asked about how many years to space between successive child births. Accordingly, 55.3% of urban and 35.1% of rural women perceive it should be three to five years. More than 46% & 27% rural and urban respondents respectively said it should be more than five years where as over fifteen percent recommend one to two years gap in both settings. During FGD, both urban and rural men and women rose as they do not agree how many years to space or when to use MC. "*Men say, having child must be at young age to grow up them as friend, but this is a burden to a woman becoming pregnant each year. It is good to a mother to give birth to the next child when first able to fetch water, gather fire wood….I want to stay seven years between two successive pregnancies*."-a mother of four children and currently using MC method said helplessly.

The major source of information in both settings is health professionals with 92.8% & 63.6% at rural and urban respectively followed by mass media (23.9%).Without probing, hospital (95.5%) followed by health center (11.5%) mentioned as source of MC method in urban while Health Post (72.8%) and Hospital (37.8%) by rural women.

The overall Knowledge about modern contraceptive methods has been assessed after asking 9 knowledge measuring questions as defined operationally above. According to the result, 46.3% of the urban and 36.8% of rural married women of reproductive age group fulfill the criteria to be called as knowledgeable. Here after, this will be used in further analysis.

Almost all, 98.2% of urban and 96.1% of rural women supports the use of modern contraceptives. When asked about their perceptions whether husband/partner support method adoption or not, 95.2% of urban and 86.7% of rural believe as it is positive. Almost all the female discussants in both settings underlined the benefit of modern contraceptive use to themselves as well as to their children and family as a whole. A mother of five children from rural area said that "*If I had used it before, I would have not born this all children looking alike and getting tired for me.… My children have been stronger and I also stayed younger*". Men also discussed about MC use and majority supported its adoption.

For those who claimed the presence of male method, their attitude whether they wish their partner/Husband to use in place of them or alternately, 81.1% and 85.5% of urban and rural women responded as they did not want.

Modern Contraceptive use

Current modern contraceptive use among interviewed urban married women of reproductive age group is 87.8% and 72.8% for rural settings. Bivariate analysis shows that, rural women are three times more likely not to use MC [OR at 95% CI] =2.688(1.780, 4.060).

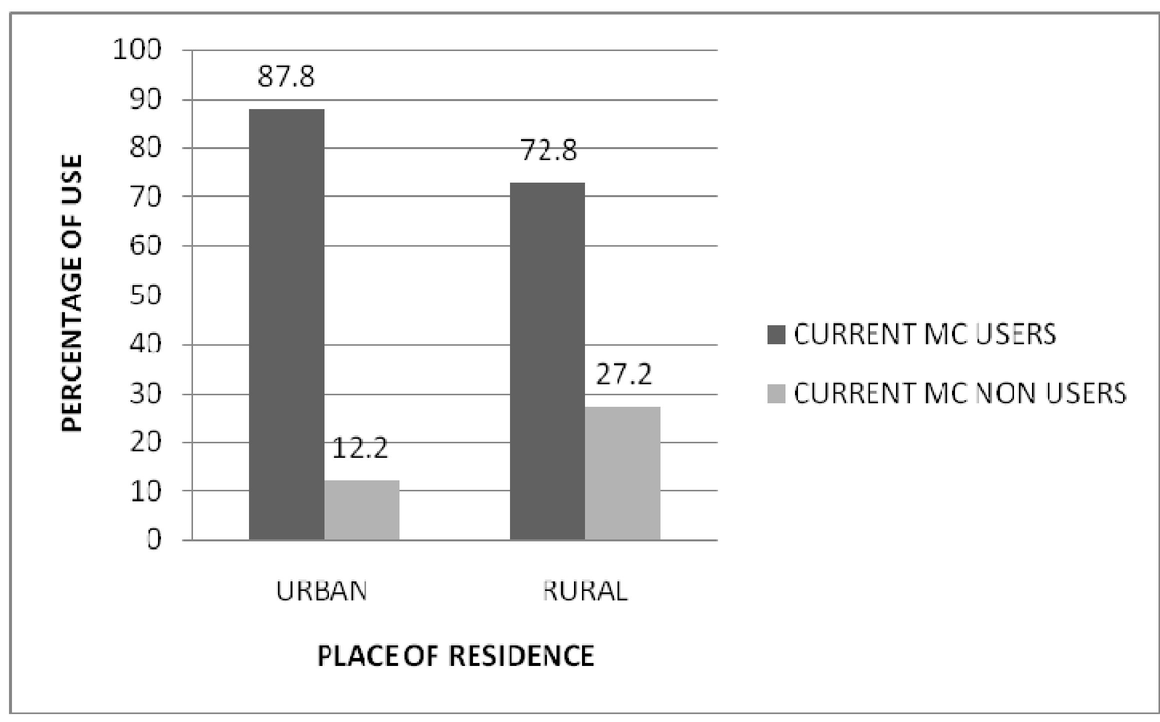

Figure 2. Modern contraceptive use by place of residence, Dawro zone, SNNPR, 2010.

Out of 648 married women who are currently eligible for MC use, 83.7% uses Injectables followed by 11.5% pills and 4.6% Norplant. Only a single user of IUCD reported from the urban setting showing no long term and or permanent method has been used in the area. Urban women are more likely to use Pills and Norplant than rural (16% versus 6%, 6.2% versus 2.6%) but majority, 91.4% of rural women use Injectables as compared to their urban counterparts. At a time FGD held on different sites, Women were let to discuss on specific type they know and whether they have an intention to use specifically long term and permanent methods. Most of the urban discussants know various types of modern contraceptives with their term of use while the rural women understand the word equivalent to "Injectables". Some of the rural women aggressively opposed the use of permanent methods as it is an act against God. "*Health extension workers told us about cutting off the Uterus but I think this is making some one crippled….I want to die with my whole organ intact*!" said 36 years old woman from shina kebele. This is most of the discussant share as they going to lose their organ if attempt to use "Tubal Ligation". This idea also raised by male discussants as it is immoral act and using Injectables let them be free since they are not carrying on their body or feel lost an organ. The following graph shows the specific type in use currently in both settings.

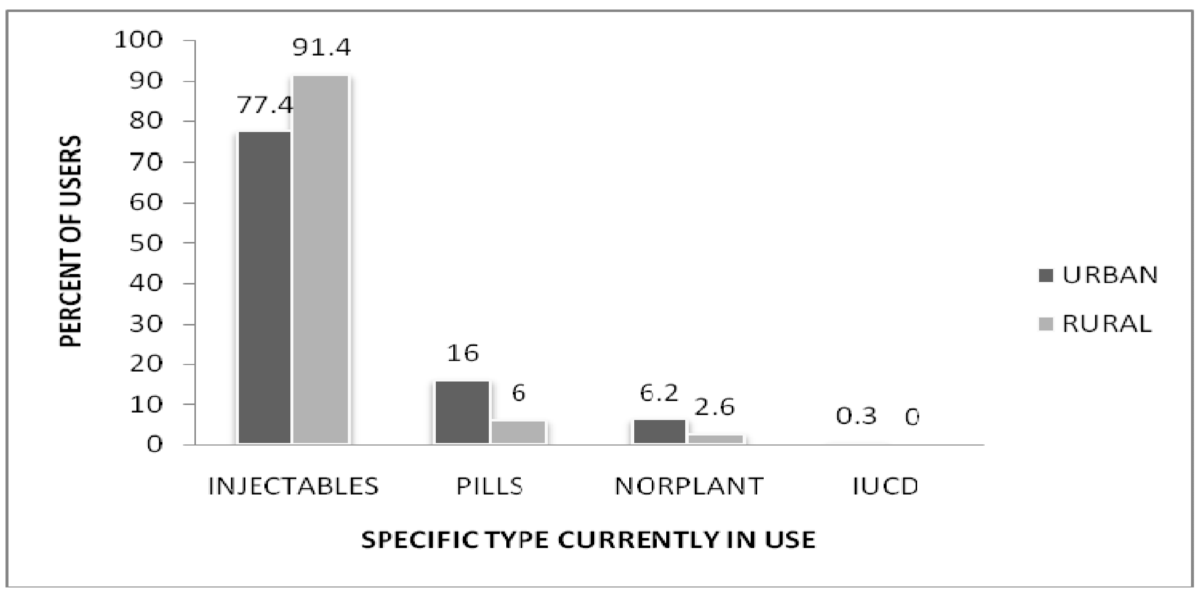

Figure: 3. Specific modern contraceptive method use in urban and rural areas of Dawro zone, SNNPR, 2010.

Covert use

Married Women who are currently using MC where asked whether their husband or partner know as they adopted it or not, almost all, comparably 97.6% in urban and 96.1% in rural replied as they use in compliance. Sixteen individuals, 7 in urban and 9 in rural reported as they are using in defiance of their husband. The specific type preferred for the covert use was majorly Injectables (87.5%). The FGD discussants were argued on this issue. "*I used without my husband's knowledge for three years and in the mean time I failed to take the pills regularly and became pregnant. When I become sick, he took me to health post and the health extension worker told him as I did not used the method properly, he was too angry even to live with me any more since I told him for those years as it was by nature, but not due to contraception use*." a mother of seven children and currently pregnant women said. She backed up again every woman should use in compliance of her husband since if things get worse; "*he is the one who take responsibility"*.

What if the woman want to use but her partner opposes? Majority of rural women perceive as they have to accept his decision! Some of them replied as they will use without his knowledge by taking Injectables for three month till he raise the issue and try to convince him privately or with people whom he respect most.

But many from urban and some from rural areas worried about the consequence if discovered their covert use since men take it as an act to destroy their race. The urban women pointed about accusation of violation of their personal right but cautious if the woman is economically dependent on her partner.

Only in 6.2% of the urban and 3% of rural women who currently practicing MC, the husband initiated her adoption in the rest of the cases, it is the woman. About only 3% of the woman in rural areas said it was primarily a recommendation by health extension workers. But it is reported that the final decision is usually made in joint (92.4% in urban versus 91% in rural) whereas, 7.3% urban married women claim that they decided by themselves which is 8.6 in rural case. The finding from qualitative data was in line with this notion. As 46 year old men said "*Now everybody accepted limiting family size since the economy worsens while every child has to learn and be supported financially till they stand up by themselves. However, the final say should lie on the hands of men. If the neighbors here that the woman is using modern contraception without the permission of her husband, he will be seen as weak in the community which no man allow in his life…therefore, she must follow his decision, this is the tradition we lived and become old*".

To uncover what will happen if the wife uses without the permission of husband/partner and discovered latter, respondents expressed their perception as shown below.

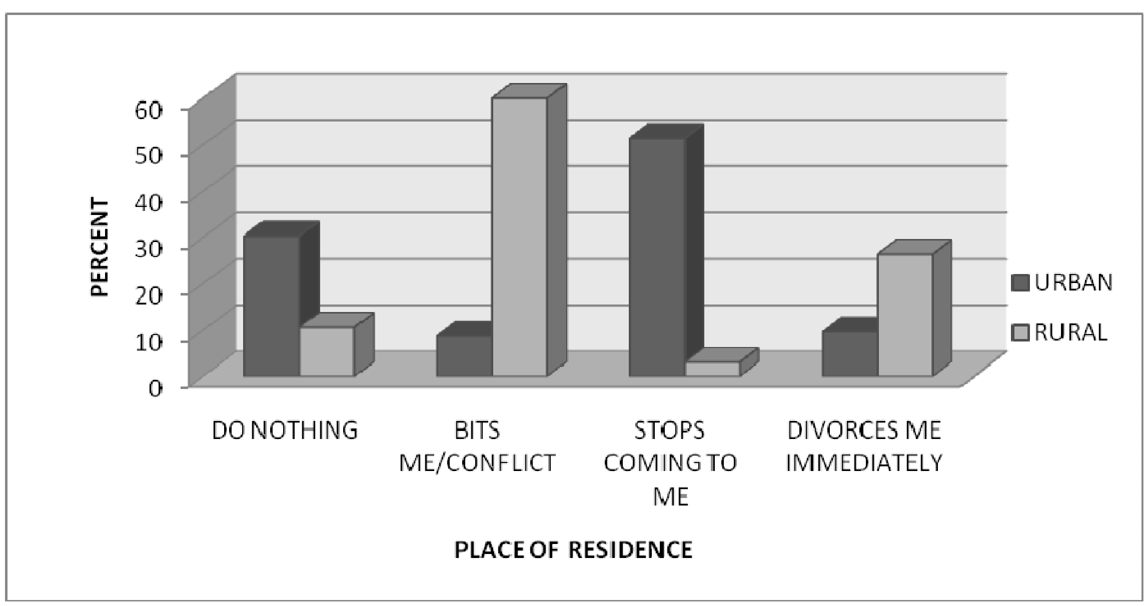

Figure: 4. Wife's perception of husband's response if she uses in defiance by place of residence, Dawro zone, 2010.

Domestic Decision making power of married women

Domestic decision making ability of married women treated in three categories: children related, economic related and socio-cultural and family relations. The overall decision-making power in urban areas tends to be joint (67.06%) but in rural areas it is the husband without involving his wife (45.83%). Small but about proportional amount (6.45%) of respondents replied they can independently decide in children related issues in both settings. Economic decisions taken by wife only shows relatively higher percentage in rural than urban on other hand decisions related to socio-cultural and family relations is reversed. Urban women are more likely to decide by themselves on matters of socio-cultural and family relations where as Economic decisions in case of rural women. For those who said joint decision making, In conditions where their idea doesn't coincide or their decision is in conflict, the husband's decision override (98.7% in rural and 91.2% urban). When discussion point raised about the general decision making power of married women in their locality, in both settings, they agreed as it is better than before. In peri urban community, men believe that if the wife has her own earning or anything brought from her family during marriage and any asset which was included at the time of legal marriage can be decided jointly or by herself, unless it is the responsibility of the head of the household. One of female discussant pointed as "*It is obvious that if there is a mule in the house, women went too far market places by foot…it is not allowed to use it! Similarly, any crop cultivated which is used as food in a family considered as the wife took her portion and usually larger amount will be sold out and wife has no right on the money obtained*."

Another main point of discussion was to look in to the perception and presence of Women's decision-making power difference in urban and rural dwellers. Majority of the urban women said that they perceive they can decide better than their rural counterparts because they lived in a Town. The main reason they raised was the economic dependence and traditional belief that still exists in agriculturalist society about large number of children as a sign of wealth and respect in the community.

A mother of two children said "*I used MC to space child birth for seven years and conceived the second one. If I was a wife of Farmer in rural areas, it cannot be like this since the purpose of marriage is believed to give him many children. Otherwise another wife will take my place.*

It is also true for urban woman who look the hands of her husband, she cannot decide. …Even if women have right to day, whatever the situation, final decision falls under the husband. But discussion on the matter prior to do anything is mandatory.” which is shared by majority of the participants.

Table: 2. Domestic decision-making among married women of reproductive age group in Urban and rural areas of Dawro Zone, SNNPR, 2010.

Settings	Decisions	Number	Who make decisions (%)		
			Wife only	Jointly	Husband only
Urban	Children related	335	6.45	75.58	17.97
	Economic	335	11.1	72.17	16.73
	Socio-cultural & family relations	335	19.7	53.43	26.87
	Total	**335**	**12.42**	**67.06**	**20.52**
Rural	Children related	334	6.45	61.13	32.42
	Economic	334	19.2	32.11	48.69
	Socio-cultural & family relations	334	18.5	25.15	56.35
	Total	**334**	**14.71**	**39.46**	**45.83**

CONTRACEPTION DECISION MAKING

The decision making power of married women in a reproductive age group was assessed by asking the respondents a set of questions and categorizing them as current users, Ever users and Non-users. For those three groups of women, by using criteria defined operationally above, more than half of the respondents (53.8%) claim that they can decide on the use of modern contraception.

Considering the difference with respect to place of residence, it is 64% for urban and 43.1% for the rural women with OR at 95%CI= 2.395(1.754, 3.270) which is also statistically significant at P=0.000. This implies that, married women who reside in urban area privileged to decide on use of MC method two and a quarter times more likely than their rural counterparts.

Table: _3_ Decision Making on Modern Contraceptive use among Urban and Rural Married Women, Dawro zone, SNNPR, 2010.

variable	**N**	**Women has power on MC Decision making**		X^2	**p**
		YES	NO		
Place of residence				31.592	<0.001
URBAN	335	217(64.8%)	118(35.2%)		
RURAL	334	144(43.1%)	190(56.9%)		
TOTAL	**699**	**361**	**308**		

The ability to make decision on MC use do not show uniform increment or decrement across the age groups. Women at the age of 45-49 were the highest followed by between 40 and 44. The inter-age group difference was not statistically significant at p<=0.05. Similarly, ethnicity and marital condition of the study subjects were also checked either it significantly influenced or not their ability to make decision on the use of modern contraception as a co-wife or living in a consensual union without legal marriage but not.

Catholic followers are twice more likely to be MC decision makers as compared to the reference religion. Being protestant or other religious group member was found to have less influence to be a decider as compared to Orthodox Christians of which 61.7% able to make decision on its use. This was found to be statistically not significant with OR (95.0% CI) = 0.654(.456, 0.937), 0.621(0.263, 1.467), respectively.

The Bivariate analysis of the respondent's educational status points that the ability to decide on use of MC increases from no education to those completed grade 10/12 then it falls. The finding was statistically significant when compared to the highest level of education (P=0.000, 95% CI).

In both Urban and rural areas, the effect of current occupation on their decision ability was tried to be assessed in reference to the widely dominating occupation of women, House wife or not working outside for pay. It was significantly influenced their power to decide on the use of MC. Government employee and other occupation category depicted two fold chance to be MC use decision maker as compared to House wife's OR (95.0% CI) = 2.044(1.336, 3.129), 2.191(.750, 6.398). This finding is also statistically significant at p=0.005.

Women who live in a family whose relative wealth is highest were three times more likely to make decision on MC use than those with in lowest tertile.

Partners/husband's background information was also asked and analysis made on its effect on the spouse's ability to make decision. According to the result, Husband's/partner's current level of education showed a direct relationship when moved up from grade 1-6 to those completed and with additional certificate. Out of 110 unable to write and read individuals, 43.6% have power to decide but it is found to be 62.3% less likely as compared to 10 or 12 plus at (95.0% CI= 0 .235,0.603),p=0.000).

As to the occupation, being a wife or partner of farmer let them to fail to decide on Mc use when compared to any other occupation. Women's whose husband's/partner's work in private or NGO, government institutions or as a business man are better to decide [OR (95.0% CI) = 3.821(2.072, 7.046), 2.870(1.969, 4.185), 1.430(.823, 2.485)] correspondingly.

Table: __4__ socio-demographic variables showing significant association in Bivariate analysis among urban and rural married women, Dawro zone, SNNPR, 2010

variable	Able to decide on MC use N (%)	Unable to decide on MC use N (%)	Crude OR (95% CI)	Adjusted OR (95% CI)
PLACE OF RESIDENCE				
Urban	216(64.5)	119(35.5%)	2.395(1.754,3.270)**	1.296(0.766,2.194)
Rural	144(43.1)	190(56.9%)	1	
HUSBAND'S EDUCATIONAL STATUS				
Unable to read &write	48(43.6)	62(56.4)	0.377(0.235, 0.603)**	0.709(0.336,1.493)
1-6	67(41.1)	96(58.9)	0.340(0.223, 0.517)**	0.756(0.388,1.475)
7-10	79(53.4)	69(46.6)	0.557(0.363, 0.855)**	1.024(0.566,1.854)
10/12 complete	18(64.3)	10(35.7)	0.876(0.385, 1.994)	0.723(0.287,1.818)
10/12+	148(67.3)	72(32.7)	1	
RESPONDENT'S EDUCATIONAL STATUS				
Unable to read / write	90(43.1)	119(56.9)	0.355(0.181, 0.694)	0.508(0.193,1.340)
1-6	77(46.4)	89(53.6)	0.406(0.204, 0.804)**	0.487(0.195,1.220)
7-10	99(60.0)	66(40.0)	0.703(0.353, 1.399)**	0.788(0.328,1.894)
10/12 completed	62(75.6)	20(24.4)	1.453(0.657, 3.214)**	1.541(0.677,3.508)
10/12+	32(68.1)	15(31.9)	1	
RESPONDNT'S OCCUPATION				
House wife	251(50.1)	250(49.9)	1	
Gov't employee	78(67.2)	38(32.8)	2.044(1.336,3.129)**	0.629(0.315,1.256)
Merchant	20(55.6)	16(44.4)	1.245(0.631, 2.458)	0.823(0.376,1.802)
Others+	11(68.8)	5(31.2)	2.191(0.750, 6.398)	1.314(0.422,4.092)
HUSBAND'S OCCUPATION				
Farmer	105(40.4)	155(59.6)	1	
Gov't employee	140(66.0)	72(34.0)	2.870(1.969,4.185)**	1.435(0.699,2.945)
Private or NGO employee	44(72.1)	17(27.9)	3.821(2.072,7.046)**	2.356(1.017,5.454)*
Merchant	31(49.2)	32(50.8)	1.430(.823, 2.485)	1.144(0.584,2.240)
Others+	40(54.8)	33(45.2)	1.789(1.060,3.020)*	1.206(0.591,2.464)
WEALTH INDEX				
Lowest	117(42.7)	157(57.3)	1	
Middle	63(49.2)	65(50.8)	1.301(0.854,1.982)	0.869(0.528,1.432)
Third/Highest	181(67.8)	86(32.2)	2.824(1.988,4.012)**	1.473(0.872,2.488)

*p<=0.05 **p<=0.01; +students, Daily Laborers, preachers; crude OR=1 is reference category

Women who were knowledgeable about MC in urban areas were two and a half times more likely to be modern contraceptive decision maker as compared to less knowledgeable. This showed even higher odds (more than seven times more likely) in rural areas. Urban women who have gender equitable attitude were two times whereas rural counter parts were one and half times more likely able to make contraception decision than those women who have gender inequitable attitude.

Women who get married after 18 years were found to be more likely being able to decide on modern contraception use than those married earlier in both rural and urban areas. Other variables such as husband wife communication about MC, Intended number of children, number of alive and dead children, unintended pregnancy and sex preference were not revealed statistically significant association.

Table: _5_ knowledge, gender equitable attitude and reproductive history of the respondents versus ability to decide on the use of modern contraceptive methods in urban and rural areas of Dawro zone, SNNPR, 2010.

variables	URBAN		CRUDE OR(95%CI)	RURAL		CRUDE OR(95%CI)
	Able to decide on MC method use N (%)	Unable to decide on MC method N (%)		Able to decide on MC method use N (%)	Unable to decide on MC method use N (%)	
Knowledge on MC METHOD						
Less knowledgeable	96(53.5)	84(46.5)	1	34(16.3)	177(83.7)	1
Knowledgeable	115(74.4)	40(25.6)	2.527(1.595,4.004)	72(58.8)	51(41.2)	7.340(4.227,12.746)
Women's Gender Attitude						
Gender inequitable	100(55.9)	79(44.1)	1	126(41.9)	175(58.1)	1
Gender equitable attitude	116(74.4)	40(25.6)	2.291(1.439,3.647)	18(54.5)	15(45.5)	1.667(0.809,3.432)
Age at First Marriage						
Early marriage	66(56.4)	51(43.6)	1	69(35.9)	123(64.1)	1
Late marriage	151(69.3)	67(30.7)	1.742(1.094,2.773)*	75(52.8)	67(47.2)	1.995(1.282,3.105)**
Experienced Unintended Pregnancy						
YES	12(48.0)	13(52.0)	0.459(0.201,1.047)	11(40.7)	16(59.3)	0.926 (0.415,2.065)
No	181(66.8)	90(33.2)	1	167(57.4	167(57.4)	1
Child Death In The Family						
No child death	186(65.5)	98(34.5)	1	117(46.2	136(53.8)	1
At least one death	7(58.3)	5(41.7)	0.738(0.228,2.385)	18(27.7)	47(72.3)	0.445(0.245,0.809)
Sex Preference Of The Respondent						
Female	9(60.0)	6(40.0)	1	5(50.0)	5(50.0)	1
Male	86(57.3)	64(42.7)	0.896(0.303,2.644)	71(37.6)	118(62.4)	0.602(0.168, 2.151)
Do not mind	122(71.8)	48(28.2)	1.694(0.572,5.018)	68(50.4)	67(49.6)	1.015(0.281, 3.667)
Partners Intended No. Of Children						
Same Number	184(63.9)	104(36.1)	1	126(43.9	161(56.1)	1
More Children	16(76.2)	5(23.8)	1.809(0.644,5.079)	6(54.5)	5(45.5)	1.533(0.457, 5.139)
Less Children	4(66.7)	2(33.3)	1.130(0.204,6.277)	0(.0%)	3(100.0)	0.000(0.000.
Don't know	13(65.0)	7(35.0)	1.050(0.406,2.714)	12(36.4)	21(63.6)	0.730(0.346, 1.540)
Discussed With Partner About MC METHOD						
No	18(66.7)	9(33.3)	1	40(53.3)	35(46.7)	1
Yes	199(65.0)	107(35.0	0.930(0.404,2.141)	104(40.8	151(59.2)	0.603 (0.359,1.011)
Partner's Reaction						
Supports my decision	173(60.7)	112(39.3	1	114(40.0	171(60.0)	1
Opposes my decision	10(90.9)	1(9.1)	6.474(0.817,51.27	7(63.6)	4(36.4)	2.625(0.751, 9.172)
Don't mind	30(90.9)	3(9.1)	6.474(1.930, 21.719)*	3(75.0)	1(25.0)	4.500(0.462, 43.800
Don't know	6(100.0)	0(.0%)	1.046E9 (0.000,	20(66.7)	10(33.3)	3.000(1.354,6.645*

** P-value less than 0.01, *P value less than 0.05; Crude OR=1, reference category

WOMEN PLACE AND DECISION-MAKING POWER

Table: _6_ married women's house hold decision-making power versus ability to decide on modern contraceptive method use in urban and rural areas of Dawro zone, SNNPR, 2010

variables	URBAN		CRUDE OR(95%CI)	RURAL		CRUDE OR(95%CI)
	Able to decide on MC METHOD use N (%)	Unable to decide on MC METHOD N (%)		Able to decide on MC METHOD use N (%)	Unable to decide on MC METHOD use N (%)	
Domestic Decision-Making						
Low involvement	63(50.8)	61(49.2)	1	76(29.7)	180(70.3)	1
Better involvement	154(73.8)	57 (27.0)	2.616(1.643,4.165)**	10(12.8)	68(87.2)	16.105(7.871,32.952)**
Decisions Related To Children						
Low involvement	65 (50.0)	65 (50.0)	1	62 (25.6)	180 (74.4)	1
Better involvement	152 (74.1)	53 (25.9)	2.868(1.802,4.564)**	82 (89.1)	10 (10.9)	23.806(11.621,48.769)**
Economic Decisions-Making						
Low involvement	67 (58.8)	47 (41.2)	1	73 (30.9)	163 (69.1)	1
Better involvement	150 (67.9)	71 (32.1)	1.482(1.928,2.366)*	71 (72.4)	27 (27.6)	5.872(3.484,9.897)**
Socio-Cultural And Family Relation Decision-Making						
Low involvement	60 (52.6)	54 (47.4)	1	68 (31.2)	150 (68.8)	1
Better involvement	157 (71.0)	64 (29.0)	2.208(1.382,3.528)**	76 (65.5)	40 (34.5)	4.191(2.598,6.761)**

** P-value less than 0.01, *P value less than 0.05

FACTORS AFFECTING MODERN CONTRACEPTIVE DECISION MAKING POWER

After selecting all variables which were significant during Bivariate analysis, multiple logistic regressions was used to fit the final model. The independent variables which can significantly predict the decision making power of married women in urban setting were presented in table_7 below. Women who are knowledgeable about the over all aspects of modern contraceptive methods relative to the local situation are more likely to decide on its use (more than three and a half times).

Gender attitude of women varied across place of residence however it maintained its significance only in urban setting where (53.4%) has gender equitable attitude.

Women with gender equitable attitude are four times more likely to decide on the use of modern contraceptives as compared to those who still reflected inequitable attitude[OR (95% CI)=4.006(2.355,6.814)].

Ability to decide on other personal, family and social relations greatly influence MC use decision making. A woman who has better involvement in decisions about children, socio-cultural and family relations are more likely to decide on use of MC not less than two fold in urban areas. (Table_7)

Table: 7_ Factors contributing for modern contraceptive decision making power to urban residents, Dawro Zone, SNNPR, 2010

variables	**Adjusted OR**	**95.0% CI**	
		Lower	Upper
MC Knowledge			
Less knowledgeable	1	1	1
Knowledgeable	3.624	2.133	6.156
Gender Attitude			
Gender inequitable attitude	1	1	1
Equitable attitude	4.006	2.355	6.814
Decisions Related To Children			
Low involvement	1		
Better involvement	2.959	1.582	5.534
Decisions related to socio-cultural and family relations			
Low involvement	1	1	1
Better involvement	2.139	1.186	3.858

In rural areas, respondent's perception about their partner's reaction if they want to use the method, decisions related to children and knowledge maintained significant association with the ability to decide on MC use.

In rural areas, if wife perceive as her husband or partner might oppose or if they don't know their status, they are more likely be MC decision makers. A group of women who worry as their partner opposes method use were more than four times while those do not know their reaction were eleven times more likely to be modern contraceptive decision makers than those perceive as they support. [OR (95.0% CI) =5.425 (1.203, 24.1468), 11.121(4.182, 29.568)].

Among all domestic decision making variables which were significant on Bivariate analysis, decisions related to children in rural areas retained significant association with contraception decision making. Women who were better involved in decisions related to children were 23 times more likely to make decisions on modern contraceptive use than those who involved less.(Table_8)

Table: _8_ Factors contributing for modern contraceptive decision making power in rural areas, Dawro Zone, SNNPR, 2010

variables	**Adjusted OR**	**95.0% CI**	
		Lower	Upper
Knowledge on MC			
Less knowledgeable	1		
Knowledgeable	6.755	3.281	13.908
Partner's Reaction			
Supports my decision	1		
Opposes my decision	5.425	1.203	24.468
Don't mind	2.988	0.268	33.353
Don't know	11.121	4.182	29.568
Decisions Related To Children			
Low involvement	1		
Better involvement	23.272	9.516	56.912

CHAPTER SIX: DISCUSSION

Knowledge about modern contraceptive method is found to be high in both settings with 99.4% urban and 98.8% rural respondents have heard and can mention at least one. This figure exceeds the country average reported on EDHS 2005 which was 88% this may be attributed to HEW since 92.8% & 63.6% at rural and urban respectively of women has got information from Health professionals (4). In urban areas women are more likely to list available female methods without prompting than rural areas still majority know Injectables (86.9%). During FGD, rural women used "*Injectables*" interchangeably with "*modern contraceptives*" which was again reported in quantitative study (95.5%). Norplant was stated by 33.8% of rural women due to the reason that, as observed by principal investigator, campaign has been conducting in the study area during the data collection time. Because of less knowledge about long term MC method**,** majority of rural women and men discussed as they developed a negative attitude towards them. One of the discussant said "*…I want to die with my whole organ intact*!!" when complaining about female sterilization. Men also rose during discussion but perceive as it is "*an act against creator*"

Similar to national report, Condom is frequently mentioned male type in both settings (4). Despite, more than 96% supports MC use but 81.1% and 85.5% of urban and rural women who claim as they know at least one male method did not wish their husband use. This may be related to the negative attitudes towards male and permanent method use due to low level of knowledge about how those specific types used.

Couples agree in most of the times about family planning but the discordance occurs mainly on when to use it. During discussion, it was pointed out that men want to have children with in short period of time and quit in urban areas. Whereas rural women want to space more than five years which was stated during FGD as they want the older should able to help her during the second pregnancy. Over 46% reported in the same area as it should be spaced more than five years.

Current modern contraceptive practice among married women in the Town is 86% and 72.8% in rural setting which is comparably higher than the National average of 15% (3). In 2005, a community based research in similar area was reported 35% use (19). Relatively higher practice and narrow urban rural difference is contributed due to the introduction of HEWs and Community Health Agents in all rural kebles of the study area.

As it is true in most African countries, (3, 4, 25) more than 91% in rural and 77.4% in urban areas, currently using Injectables. This might be due to availability or acceptability of other methods by the community. In this project, it is possible to talk about acceptability since majority of rural residents have little knowledge about other types especially long term and permanent methods hence showing no interest on its use. There is also no reported use of male type in both urban and rural settings.

Covert use was also assessed but minimal in this case as compared to other African countries which was estimated to be between 6-20% (22). But similarly to the South African report, the specific type preferred for the covert use is injectables in 87.5% of the cases. It is difficult to say they preferred it because it left no evidence of method use since there is little method variability in all users. There is no comparable difference in using in defiance of husband among the two groups. As reported by researchers (26), wife is the one who initiate method adoption but the final decision is made by the good will of the husband/partner. Despite 92.4% of women in urban and 91% in rural reported joint decision, they wait the final say from them to adopt. This was also supported by qualitative finding "*…she must follow his decision, this is the tradition we lived and become old*" as 46 year old man said.

Early marriage is reported to be high in rural areas with 62.1% already married before their 18th birth-day. This let them to various reproductive health problems, low decision-making on domestic and reproductive health conditions.

Gender is socially constructed role of men and women. The attitude of women towards socio-cultural norms and values, particularly in Africa, which give men the decision- making role over women, matters in involvement of domestic decision and decisions particularly related to contraceptive use. Majority of rural women already gave up and living in a community which perceives men as superior and sole decider in a family which hinders communication between partners letting them only to implement the decisions made. In this study, gender equitable attitude of married women greatly varied among the compared group which is in agreement with other findings from different parts of the world (9, 21). The fact is usually because of low educational attainment, economic status with deep rooted cultural belief in the rural areas than the urban women who is better educated, working for pay and contributes their part for family income in presence of their partner's gender equitable attitude (15, 19, 28).

The difference in gender inequitable attitude greatly contributed to low level of communication between partners hence low involvement in domestic decision-making among rural women as compared to urban counterparts. In decisions related to children, socio-cultural and economic matters, urban women has better chance to be involved than the rural in which men only decide or women take independent decision in minor home activities. As reported by Andrzej Kulczycki, joint decision in this study also heavily influenced by men in conditions where there is conflict of idea (20). Here it should be noted that, joint decision merely might not indicate women's got power but can have a say before the husband came up with final conclusion.

Ethiopian Demographic and Health Survey of 2000 reported the independent decision making on use of modern contraceptive was higher in rural areas than urban with 29% versus 19%. This particular survey revealed similar result but comparably lower figure and urban rural difference with only 7.3% and 8.6%. The finding goes in line with low level of communication between partners in rural than urban women. This survey attempts to measure broadly than what is mentioned above by including other parameters which could have prevented women to make decision on the use of modern contraceptives. It also included exploring non current users as if they are not used or stop using due to lack of power to make decisions. Generally over half of the respondents have power to decide on modern contraception use with significant difference in urban and rural areas. This implies that, married women who reside in urban area are privileged to decide on use of MC method two and a quarter times more likely than their rural counterparts. It can be understood in line with the more egalitarian society in urban and patriarchy in rural in which majority of the decisions including family planning is taken by husband due to women's economic dependence, low educational level and existing culture. Similar finding has been reported from Honduras (9).

In order to identify what factors are contributing to the difference in decision making power on use of modern contraceptive methods among rural and urban, socio-demographic, reproductive and domestic decision making power variables were assessed.

From socio-demographic variables, maternal and husband/partner's high educational attainment was positively contributed to MC decision making in both settings independently. This is revealed in different parts of the world as an important variable to increase family planning practice (9, 27).

Unlike a study done in Jimma Town, the independent effect of education does not appear as a predictor of contraception decision making in a final model after confounding variables were controlled. The decision making did not vary significantly among different age groups, and occupation difference was also not significantly predicted in the final model at the two settings. The finding from Honduras depicted as women get older and have more children, male centered decision shown reduction (19) which is was also not supported by Philippians study similar to this finding(15).

Reproductive conditions of the two compared groups were also attempt to be looked whether it affected women's decision making power or not. The age at first marriage has shown variability in women's decision making power at both areas. Women who married after 18 years of age were two times more likely to be able to decide which was statistically significant. When the effect of early marriage is seen with other variables in the final model, it did not maintained its significance. Number of pregnancy, number of alive children, and sex preference and child death has no statistically significant association with contraception decision making. However, perception of women about their husband's decision if they decide to adopt a method remained significant predictor for rural women. The finding states to the contrary that women who perceive their husband could oppose their decision find to be able to make decision on MC use along with who don't know his measure and feel as he don't mind as compared to who perceives as their husband support their decision. In presence of low level of communication between couple's in rural areas, if they perceive the husband could not support their idea, they independently decide since it is impracticable if it reaches to his ear. FGD discussants rose as it is difficult to convince men about issues in their community if they perceive primarily their husband could reject.

Women's decision making in other domestic issues have direct and significant influence on decisions particular to modern contraceptive use. This finding is similar with the finding from SNNPR that women who participate in decision making are more likely to make decision and use the method (21). The three components of domestic decision making were independently influenced in both settings as expected. In rural area, better involvement in decisions related to children and economic conditions of the house hold significantly associated with modern contraception decision making.

In addition to better involvement in decisions related to children, socio-cultural and family relations decision making is again remained significant predictor in urban settings. Generally involving women in other household decisions help to decide on the use of modern contraceptives.

This goes in concurrence with the notion of 1994 ICPD "*improving the status of women also enhances their decision- making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction*"(8).

Out of socio-demographic, reproductive and domestic decision variables treated all together, some common and peculiar predictors remained significant in the final model for the urban and rural settings. Decisions related to children and knowledge appears as common predictors for better decision making power on modern contraceptive use in both settings. Having better knowledge about modern contraceptive methods, gender equitable attitude, better involvement in decisions related to children, socio-cultural and family relations are important and significant predictors for better decision making power of women on the use of modern contraceptive methods in urban areas. Whereas in rural areas, knowledgeable about over all aspects of modern contraceptives, fear of partner's opposition or negligence, involvement in decisions about child were significant contributing factors for better decision making power of women on modern contraceptive use.

STRENGTH AND LIMITATION OF THE STUDY

Strength of the study:

- Data triangulation.
- Prior census led to proper selection of respondents and reduction of non response rate.

Limitation of the study:

- Most researches on family planning focus on couple level since the role of male on its adoption has great impact. This study focuses only on women since in many reports on contraception use, the discrepancy between husband and wife about who decide in adopting or rejecting family planning method is high, that is, male reporting more egalitarian decision than women do. Excluding men response and relying only on women does not mean that women's report only could definitely reveal the problem.
- The supplier side was not entertained.
- Social desirability bias may compromise the finding since many of gender sensitive responses may be over masked.
- The study design by itself limits to clearly establish cause-effect relationship of the factors which contributed to low decision making of married women on contraception use.
- The surrounding rural community may be different from other typical rural areas in the Zone because NGOs were acting in the areas for long time, which may inflate the result.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

Conclusion

- Current practice of modern contraceptive method is higher than national and regional figures and the urban rural difference is also reduced in comparison to the regional and national data. The specific type in use in both settings was injectables showing poor method mix.
- The presence of Health Posts and community and health extension workers in each kebele contributed to the high prevalence in rural areas since almost all has got the method from Health Posts and informed by the HEWs.
- Knowledge of specific method is high but the general knowledge about various female and male methods, recommended years of birth spacing, place to get and source of information options known differ in the two groups.
- Less interest has shown towards male and permanent method use which was significantly high in rural areas. Male method use is also not supported by majority of the urban dwellers.
- Relatively comparable number of women responded as their husband agreed with them about number of child to have but differ in when to have.
- Child spacing particularly in rural areas reported to be higher than the WHO recommendation of 3-5 years.
- Early marriage was higher among the residents of rural areas than urban.
- In rural areas, majority of women have gender inequitable attitude but it has shown no significant association as predictor of modern contraceptive decision making. In urban setting, gender equitable attitude contributed to relatively higher decision making on modern contraceptive use.
- Modern contraceptive decision making power found to be higher in urban than rural areas. Urban women who are currently in wedlock were two and a half times more likely to be able to decide on use of modern contraceptive than their rural counterparts. Domestic decision making power also shown significant difference among the study groups.

- Women who are knowledgeable about modern contraceptive, have gender equitable attitude, and can better be involved in decisions related to children, socio-cultural and family relations are in a position better to decide on modern contraceptive use in urban setting.
- In rural areas, wife's perception of her husband's approval of method use has an association with contraception decision making power. Women having better knowledge about modern contraceptive, who do have an involvement in domestic decisions related to children, have modern contraceptive decision making power.

Recommendation

- The current high level of modern contraceptive practice should be maintained and promoted.
- To improve method mix and create awareness to solve negative attitude towards male and long term/permanent methods should be worked on by using existing HEWs, community health agents in the area and local FM radio. This also has to include the recommended years of child spacing in respect to the total number desired to have. The Woreda health Office should further strengthen Health extension workers to give more information to rural women to widen the overall knowledge about modern contraceptive, especially permanent and long acting effective methods including male methods.
- Advocacy on uplifting the age at first marriage should be critically seen and health education should be given and appropriate IEC strategy has to be set to reach majority. Education sector and health bureau has to work better to let female stay at school before they engaged in to marriage.
- Through community gathering and by using various media, NGOs & governmental organizations should create awareness on gender equality at both settings. Women gender equitable attitude should be strengthened specially in rural areas to enhance reproductive health communication between couples and make common decisions.

- Health extension workers in rural areas and urban, other health workers as well as health institutions providing the methods should consider giving information to husbands/partners about modern contraceptive use hence the woman can have informed decisions.
- Effort to improve status of women needs to be accompanied with interventions targeted to address socio-cultural norms and values that give women inferior position in general domestic and modern contraceptive use decision-making. NGOs working on gender equity, women's affair and other governmental organization should work to minimize gender inequitable attitude of women and to bring women on decision making front.

References

1. Population Reference Bureau (PRB). The 2008 world population data sheet. Washington, DC; Aug 2008.
2. Federal Democratic Republic of Ethiopia, Population Census Commission. Summary and statistical report of the 2007 population and housing census results. Addis Ababa, Ethiopia; Dec 2008.
3. Central Statistical Authority, ORC Macro. Ethiopian demographic health survey 2000. Addis Ababa, Ethiopia and Calverton, Maryland, USA; May 2001.
4. Central Statistical Authority, ORC Macro. Ethiopia demographic and health survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA; Sep 2006.
5. Tafesse F. Assessment of Factors Influencing Utilization of Modern Contraceptive Methods among Women in the Reproductive Age Group in Oromia Zone, Amhara National Regional State. MPH Thesis (unpublished), Department of Community Health, Faculty of Medicine, Addis Ababa University; 2005.
6. World Bank. Effective Family planning programs. Washington DC, USA; 1993;1-16.
7. USAID Health Policy Initiative. The contribution of family planning: achieving MDGs in Ethiopia; July 2009.
8. United Nations International Conference on Population and Development (ICPD). Programme of Action, Cairo, Egypt, Sep 1994. Available at <http://www.unfpa.org/icpd/icpd_poa. htm>, accessed in 10/11/2009.
9. Ilene S. Speizer, Lisa Whittle and Marion Carter. Gender Relations and Reproductive Decision Making in Honduras. International Family Planning Perspectives 2005; 31(3): 131-139.
10. Population Council and Interagency Gender Working Group (IGWG). Power in sexual relationships: an opening dialogue among reproductive health professionals. Population Council, New York; 2001.
11. Elishsa PR. Gender ideology and fertility strategies in an Ekiti Yoruba Village. Studies in Family Planning 1993;24(6):343-353.
12. Kimuna SR, Adamcak DJ. Gender relations: Husband wife fertility and Family planning decision in Kenya. Journal of Biosocial Science 2001;33(1): 13-23.

13. Ezeh A. The influence of spouses over each other's contraceptive attitude in Ghana. Studies in Family Planning. 1997;24(3):355-368.
14. Casique I. What difference does it make? Women's autonomy and power and use of contraception in Mexico. Paper Presented at the XXIV IUSSP General Population Conference, Salvador, Bahia; Aug 2001.
15. Magadalena C Cabarabana, Beethoven C Morales. Social and economic consequences of family planning use in south Philippines. Research institute for Mindanao culture (RIMCU), Xavier University, Caragayan de Oro city, Philippines; Nov 1998.
16. Sylvia Osayi Osemwenkha. Gender issues in contraceptive use among educated women Edo state, Nigeria. African Health Sciences 2004;4(1):40-49.
17. Elizabeth I Ranson and Nancy V Yinger. Making Mother Hood Safer; overcoming obstacles on the pathway to care. Population Reference Bureau, Washington DC, USA; 2002.
18. Ethiopian Office of Prime Minister. National Population Policy of Ethiopia. Addis Ababa, Ethiopia; Apr 1993.
19. Bezabih T. Assessment of the determinants of modern contraceptive use In a Dawro community (mareka woreda), Dawro zone, SNNPR. MPH thesis (unpublished), Department of Community Health, Faculty of Medicine, Addis Ababa University, Addis Ababa, Ethiopia; Apr 2005.
20. Andrzej Kulczycki. Husband-Wife Agreement, Power Relations and Contraceptive Use. International Family Planning Perspectives 2008;34(3):127–137.
21. Dennis P Hogan, Betemariam Berhanu, and Asefa Hailemariam. Household organization women's autonomy and contraceptive behavior in southern Ethiopia. Studies in family planning 1999;30(4):302-314.
22. Biddlecom, Ann E and Bolaji M Fapohunda. Covert contraceptive use: prevalence, motivations and consequences. Studies in family planning 1998;29(4):360-372.
23. Ann k Blanc. The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. Studies in family planning 2001;32(3):189-213.
24. Department of Health, Medical Research Council, OrcMacro. South Africa Demographic and Health Survey 2003. Pretoria: Department of Health; 2007.
25. Hubacher D, Mavranezouli I, McGinn E. Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it. Contraception 2008; 78:73-78.

26. Akinrinola Bsnkole, Susheela Singh. Couple's Fertility and Contraceptive Decision-Making in Developing Countries: Hearing the Man's Voice. International Family Planning Perspectives 1998;24(1):15-24.
27. D Walter Rasugu Omariba. Women's educational attainment and intergenerational patterns of fertility behavior in Kenya. Population Studies Centre, Department of Sociology, University of Western Ontario, Ontario, Canada; Nov 10, 2003.
28. Muzamil Jan and Shubeena Akhtar. An Analysis of Decision-Making Power among Married and Unmarried Women. Stud. Home Comm. Sci. 2008;2(1): 43-50.
29. Tafese Z. Comparative study on utilization of modern child spacing Methods and factors affecting its use among indigenous and non-indigenous women of reproductive age group in Gambella Town, south west of Ethiopia. MPH thesis (unpublished), Department of Community Health, Faculty of Medicine, Addis Ababa University, Addis Ababa, Ethiopia; Apr 2003.
30. Amaha Haile, Fikre Enqueselassie. Influence of women's autonomy on couple's contraception use in Jimma Town, Ethiopia. Ethiop.J.Health Dev 2006;20(3):1-7.
31. Boniface A et al. Community-based Study of Contraceptive Behavior in Nigeria, African Journal of Reproductive Health 2006;10(2):90-104.
32. Shelah S Bloom, David Wypij, and Monica Das Gupta. Dimensions of women's autonomy and the influence on maternal health care utilization in a North Indian city. Demography 2001;38(1):67–78.
33. Agatha N T Eguavoen, Sims O Odiagbe and Godfrey I Obetoh. The status of women, sex preference, decision-making and fertility control in Ekpoma Community of Nigeria J. Soc. Sci. 2007;15(1): 43-49.
34. Lisa M Williamson, Alison Parkes, Daniel Wight, Mark Petticrew and Graham J Hart. Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research, Reproductive Health 2009, 6:3. <http://www.reproductive-health-journal.com/content/6/1/3> accessed in 12/10/2009.

Annexes

Conceptual frame work of the study

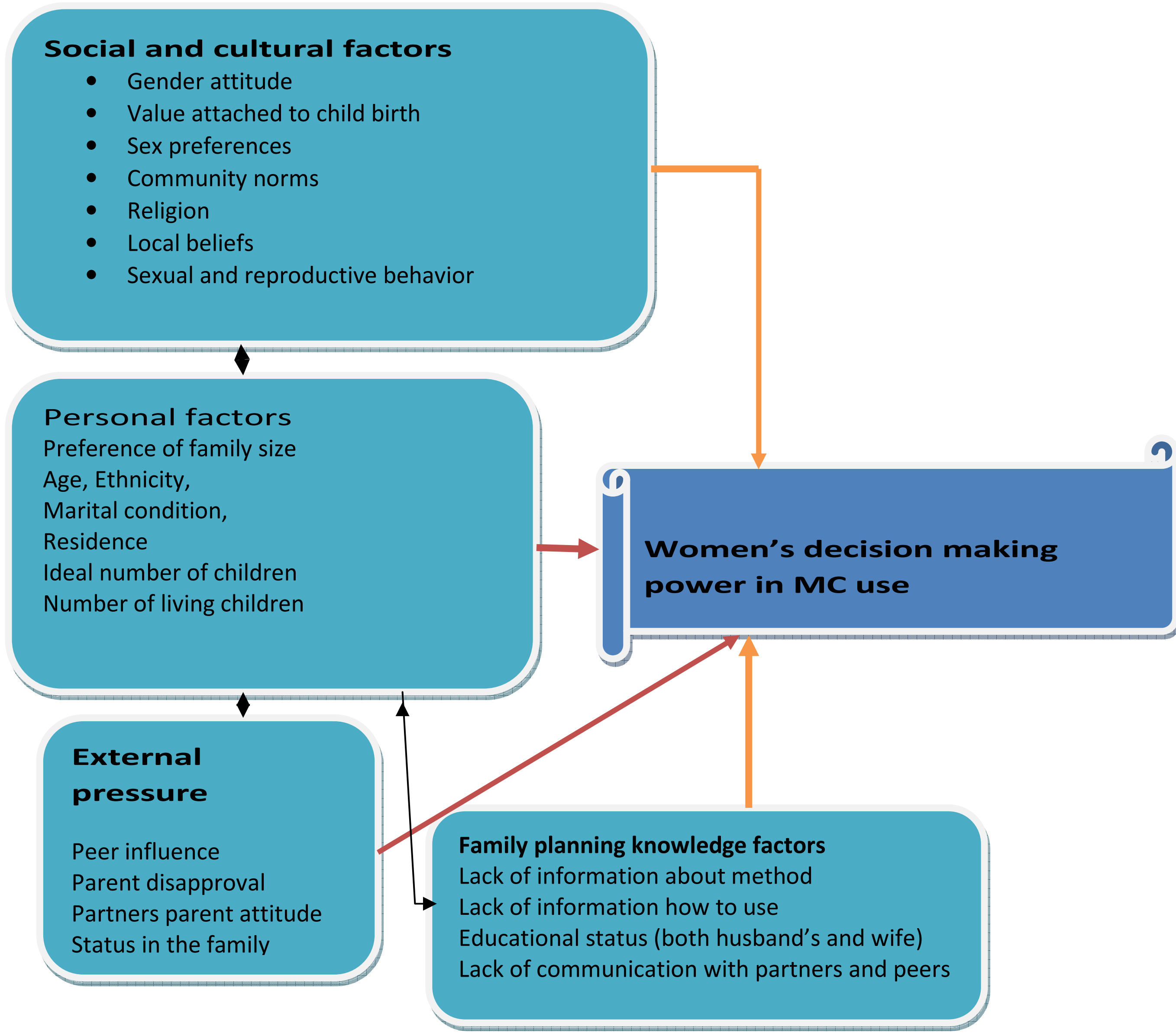

Fig5. Conceptual framework of the study

ENGLISH QUESTIONNAIRE

Jimma University College of Public Health and Medical Sciences, Department Of Population Studies and Family Health

A questionnaire prepared on the title; Married Women's Decision Making Power on Modern Contraceptive Use in Tercha Town and rural Communities of Dawro Zone, SNNPR.

INTRODUCTION

Hello, my name is ______________________ and I am working with Mr. Binyam Bogale from Jimma University. He is doing a research on married women's decision-making power on Modern contraceptive use as partial fulfillment for Master's Degree in Public Health/ Reproductive Health.

You have been randomly selected to participate in this study. We would like to ask you some questions about your life and your family, the children you have had, and your ability in making-decisions regarding domestic activities and contraception use. This interview will probably take a while. If you do not have time to do the interview right now, we can arrange to come back at a later time. You can refuse to answer any questions or series of questions if you are uncomfortable. However, I would like to assure you that all that is said during the interview will be strictly confidential and that the information collected from you will be used only in scientific reports without any mentioning of your personal identification including your name . There is no harm to you in participating or no incentive paid but finally we will give you information about modern contraceptives and its benefit, how and from where you can get them.

Information gathered from the study will be used to improve programs that promote the wellbeing of women. So we hope you will give accurate answers! We appreciate your help in responding to this survey questions.

Do you have any questions?

Can I proceed with the Questions?

Yes__________ (Thank and continue)

No ____________ (Thank and stop)

	First visit	Second visit	Third visit
Present			
Absent			

Kebele _____________ Time started___________

Questionnaire code_______________ Time finished__________

Name and Signature of interviewer _________________________, __________________

Date of interview________________________

Part I: Socio-Demographic Characteristics of the respondents

s.No	Question	Responses	Instruction
101	Age of the respondent	……………years old	
102	Religion	1. Orthodox 2. Protestant 3. Muslim 4. Catholic 5. Others, specify…………………………	
103	Ethnicity	1. Dawro 2. Menja 3. Amhara 4. Tigre 5. Gurage 6. wolayita 7. Others [specify]_______________	
104	Educational status	1. Unable to read and write 2. Able to read and write but no formal education 3. Grade 1-6 4. Grade 7-10 5. Grade 10-12 6. Grade 10/12 completed & above (specify the highest educational level achieved)_______	
105	Occupation	1. House wife /Not employed and not working for pay 2. Governmental employee 3. Employed in private organization or NGOs 4. Merchant 5. Day laborer 6. student 7. Others (specify)_________________	
106	What is the occupation of your husband?	1. Government employee 2. Private/NGO employee 3. Farmer 4. Merchant 5. Driver 6. Daily laborer 7. Others………………………	
107	Did your (last) husband/partner ever attend school?	1. Yes 2. No	If no, Skip to Q.109
108	What was the highest grade he completed?	1. Grade …………………………………… 2. Tech./Voc. Certificate 3. University/College Diploma 4. University/College Degree 5. Don't Know	
109	Type of marriage	1. Consensual union/Partnered but not legally married	

		2. Legally/ formally married and the only wife 3. Legally/ formally married and husband has another wife	
110	How do you rate your family economic status/living standard as compared to your neighbors	1. Better off 2. Middle 3. Poor 4. Very poor	
111	Do you earn monthly (regular) income by your own?	1. Yes 2. No	
112	Is there any person other than unmarried children and parents who lives with the family? /it doesn't include house maids/	1. Yes 2. No ⟶	Skip to Q.201
113	What is his/her relation with the family?	1. Married children 2. Grand mothers 3. Grand fathers 4. Husband's mother 5. Husband's father 6. Other relatives 7. Other non relative	

Part II. Wife's Desired & Achieved Level of Fertility

S. No	**Question**	**Responses**	**Instruction**
201	At what age did you get married to your current husband?	…………………years old	
202	Have you ever given birth?	1. Yes 2. No ⟶	Skip to Q.205
203	How many children ever born to you?	……………(enter number)	
204	How many of them are alive?	1. Male ____ 2. Female____ 3. Both sex ____	
205	How many children do you want to have?	1. Male ____ 2. Female____ 3. Both sex ____	
206	Have you experienced unintended pregnancy in your life?	1. Yes 2. No	If no, skip to Q. 208
207	How many of your pregnancies were unintended?	……………………(enter number)	
208	Which sex do you prefer to have	1. Male 2. Female 3. Don't mind	
209	Do you think your partner wants the same number of children that you want, or does he want more or fewer than you want?	1. Same Number 2. More Children 3. Less children 4. Don't Know	
210	Have you ever encountered child death?	1. Yes, how many______ 2. No	

Part III. Wife's Knowledge on Modern Family Planning

S. No	Question	Responses	Instruction
301	Have you ever heard of MODERN family planning or methods used to delay or avoid pregnancy?	1. Yes 2. No ⟶	Skip to Q. 305
302	From where or whom you have heard about it?	1. Mass media(Radio, Television) 2. Husband 3. Peer 4. Health professionals 5. Others [specify]………………	
303	Which type of FEMALE contraceptive methods do you know? /multiple response is allowed and read from the list and mark all that apply/	1. Pills 2. Intrauterine device (IUCD) 3. Injectables (Depo-Provera) 4. Norplant (buried under skin) 5. Spermicidal/ Diaphragm, Foam Or Jelly 6. Tubal ligation/female sterilization 7. Others [specify]_______	
304	Do you know if there is any family planning method for men?	1. Yes 2. No	
305	Which type of MALE contraceptive methods do you know?	1. Condom 2. Vasectomy/male sterilization 3. Others specify……………..	
306	Which advantages of FP do you know? /multiple response allowed mark all that apply/	1. To Limit family size 2. To avoid unwanted pregnancy 3. To Space child birth 4. For the mothers / child health 5. I don't know 6. Others (specify)-------------------	
307	Between two consecutive children, how many years of intervals do you think is good? (How long they should be spaced)	1. Less than one year 2. One to two years 3. Three to five years 4. I don't know 5. Others (specify)------------------	
308	Do you know where to get modern contraceptive methods?	1. Yes 2. No ⟶	Skip to Q.401
309	Which one do you know/mark all that apply/	1. Health center 2. Health post 3. Pharmacy 4. Hospital 5. Social markets 6. Private clinics 7. At home from CBD and outreach service agents 8. Others,[specify]__________	

Part IV. Wife's Attitude and Practice of Family Planning

S. No	Question	Responses	Instruction
401	What do you feel about using **MODERN** contraceptive methods/FP?	1. Supports contraceptive method use 2. Oppose contraceptive method use 3. Don't mind	
402	Have you ever discussed about family planning with your partner?	1. Yes 2. No →	Skip to Q.405
403	How frequent in the last 6 month?	1. none 2. Once 3. Twice 4. Three times 5. More than three times	
404	What reason have you discussed to use FP method?	1. To space birth 2. To limit birth 3. To prevent STD 4. Others specify_______________________	
405	What do you think is your husband's attitude towards contraception use?	1. Supports contraceptive method use 2. Oppose contraceptive method use 3. Don't mind 4. Don't know	
406	What would be your husband's reaction if you want to use contraceptive methods?	1. Supports my decision 2. Oppose my decision 3. Don't mind 4. Don't know	
407	What do you think is your closer relatives (mother, father, father or mother of your partner) attitude towards contraception use?	1. Supports contraceptive method use 2. Oppose contraceptive method use 3. Don't mind 4. Don't know	
408	Have you ever used contraceptive methods?	1. Yes 2. No →	Skip to Q.410
409	Which contraceptive method did you used?	1. Pills 2. Intrauterine device (IUCD) 3. Injectables (Depo-Provera) 4. Norplant (buried under skin) 5. Condom 6. Spermicidal/Diaphragms/jelly 7. Tubal ligation/female sterilization 8. Vasectomy/male sterilization 9. Others [specify______	
410	Do you use any contraceptive methods currently?	1. Yes 2. No → 3. NOT APPLICABLE{infertile, recently gave birth}	Skip to Q.418
411	Which type of contraceptive methods are you using?	1. Pills 2. Intrauterine device (IUCD) 3. Injectables (Depo-Provera) 4. Norplant (buried under skin)	

		5. Condom 6. Spermicidal/ Diaphragms/Jelly 7. Tubal ligation/female sterilization 8. Vasectomy/male sterilization 9. Others [specify____________________	
412	Why do you use this method?	1. To Limit the number of children 2. To Space pregnancy 3. others, (SPECIFY) ______________	
413	Where did you get it?	1. Health center 2. Health post 3. Pharmacy 4. Hospital 5. Social markets 6. Private clinics 7. At home from CBD and outreach service agents 8. Others, specify________________	
414	Who initiated the use of MC which you adopted?	1. I my self 2. My husband 3. Do not remember	
415	Who made final decision to use the method you adopted?	1. I myself alone 2. Jointly with my husband 3. My husband alone 4. Others specify................................	
416	Is the current modern contraceptive type you are using your choice?	1. Yes→ 2. No	Skip to Q.418
417	If not, what is the reason you failed to use the type you preferred to use?	....	
418	Can you move out of your residence area to get contraception unescorted?	1. Yes 2. No	
419	Can you be provided with money to get contraception from your partner?	1. Yes 2. No	
420	Have you ever switched from using one contraceptive method to another?	1. Yes 2. No →	Skip to Q.420
421	For the most recent switch, what is the main reason you switched methods?	1. Side effects from previous method 2. Forgot to take previous method 3. Previous method inconvenient 4. Wanted a longer term method 5. Afraid to be discovered by partner 6. Husband/partner didn't like the method 7. Method failed 8. Provider persuaded me to switch 9. Method no longer available/supply problem 10. Others, (SPECIFY)__________________	
422	Does your husband/partner know that you are currently using modern contraception?	1. Yes 2. No →	Skip to Q.422

423	If do not know, why is that?	……………………………………………… ……………………………………………… …………………………………………	
424	Have you ever used modern contraceptives without the knowledge of your husband/partner?	1. Yes 2. No	
425	What would happen if you have used contraception without the knowledge of your husband?	1. Divorce me immediately 2. Bits me 3. Stops coming to me 4. Others, specify______________________	
426	Would you like your husband/partner to use family planning?	1. Yes 2. No 3. Did not thought about that	
427	What is your main reason not to use/intend to use modern contraceptives? [FOR NON USERS]	1. Fear of side effect 2. Husband opposition 3. Lack of knowledge 4. Religious prohibition 5. Opposition from relatives 6. Desired number of children not achieved 7. Decreases sexual pleasure 8. Others, specify………………..........	
428	Have you ever-encountered opposition from your partner for using /intending to use contraceptive methods?	1. Yes 2. No 3. I never used or intended to use	
429	Have you ever-encountered opposition from your close relatives (mother, father, father or mother of your partner) for using/intending to use contraceptive methods?	1. Yes 2. No 3. I never used or intended to use	
430	Have you ever stopped using a FP because your husband/partner or another person wanted you to stop?[for current or ever users only]	1. Yes 2. No ⟶	Skip to Q.501
431	Why did that person make you stop using the method of family planning?	1. wanted me to have more children 2. worried about my health 3. Religious opposition to family planning 4. Others (SPECIFY)…………………………… ……..	

Part V. Attitude on Gender Roles

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There is no right or wrong answer.

S.No	Question	Agree	Neutral	Disagree	Remark
501	A man should have the final say in all family matters				
502	A good wife obeys her husband even if she disagrees				
503	A woman needs her husband's permission to do Paid work				
504	It is a woman's job to take care of the home and cook for her family				
505	A woman need her husband's permission to use any contraceptive method				
506	It is the husband who should decide the number of children the couples should have				
507	Husband shouldn't allow his wife to discuss family planning with him				
508	A wife should tolerate being beaten in order to Keep her family together				
509	It should be the husband who should decide how to spend the family income				
510	Wife shouldn't have ownership and authority on the family wealth				

Part VI: Domestic Decision-making

Who decides on the following? Is it you, your husband, or the two of you, or other persons? (**IF RESPONSE IS BOTH ASK:** If you and your husband's decision do not coincide or your decisions are in conflict, whose decision will prevail? **Put "√"under the column as responded**)

S. No	Question	Wife	Husba	Both	Others	Whose decision will prevail
Decisions related to children						
601	Who decides on the number of children to have					
602	Whether or not to use family planning method					
603	Who discipline children					
604	Who makes the decision Whether a child is sick enough to go for treatment?					
605	Whether to send children to school or not?					
Economic Decision-making						
606	Who decides what food item to buy and cook					
607	Who makes the decision If you need to buy/sell large household items? E.g. furniture/cattle					
608	Buying personal items/ grooming/jewelry					
609	Selling/buying family possessions (house)					
610	Who make the decision how to spent the families income					
611	Who makes the decision whether you should work outside of the home					
612	Giving assistance/support to your or his families/relatives					
613	Who makes the decision when your Children have stationeries /school needs to be addressed?					
Social, Cultural and Family Relations Decision-making						
614	Initiates reconciliation after quarrel					
615	Who makes decision if you have to participate in community meetings					
616	Who usually makes decisions about visits to your family or relatives?					
617	whom to vote for during elections					
618	Who usually makes decisions about health care for yourself?					

Part VII: Socio-economic characteristics of respondents

S. NO	QUESTION	*RESPONSE*	*Instruction*
701	What is the main source of drinking water for members of your household? **[PROBE AND MARK ALL THAT APPLY, MULTIPLE ANWER IS POSSIBLE]**	1. piped water I. piped into dwelling II. piped into compound III. piped outside compound 2. protected Dug well 3. unprotected dug well 4. protected spring 5. unprotected spring 6. Rainwater 7. Tanker truck 8. Surface water (River) 9. other________________________	
702	What is the main source of water used by your household for other purposes such as cooking and hand washing? [**PROBE AND MARK ALL THAT APPLY, MULTIPLE ANWER IS POSSIBLE]**	10. piped water IV. piped into dwelling V. piped into compound VI. piped outside compound 11. protected Dug well 12. unprotected dug well 13. protected spring 14. unprotected spring 15. Rainwater 16. Tanker truck 17. Surface water (River) 18. other________________________	
703	Do you treat your water in any way to make it safer to drink?	1. Yes 2. No	
704	What do you usually do to the water to make it safer to drink?	1. Boil 2. Add bleach/chlorine 3. Strain through a cloth 4. Use water filter (ceramic/ Sand/composite/etc.) 5. Solar disinfection 6. Let it stand and settle 7. Other ____________________________	
705	How does your household primarily dispose of household waste?	1. collected by municipality 2. collected by private establishment 3. dumped in street/open space 4. dumped in river 5. burned 6. other (specify) _________________	
706	What kind of toilet facility do members	1. flush or pour flush toilet 2. ventilated improved pit latrine (VIP)	

	of your household usually use?	3. pit latrine with slab 4. pit latrine without slab/ open pit 5. No facility/bush/field 6. other (specify ____________________	
707	Does your household have: **[PROBE AND MARK ALL THAT APPLY, MULTIPLE ANWER IS POSSIBLE]**	Yes No 1. Electricity/generator? 2. A watch? 3. A radio? 4. A television? 5. A mobile telephone 6. A non-mobile telephone? 7. A refrigerator? 8. A table? 9. A chair? 10. A bed? 11. An electric mitad? 12. A bicycle ? 13. A motorcycle? 14. A car?	
708	What type of fuel does your household mainly use for cooking?	1) electricity 2) biogas 3) kerosene 4) charcoal 5) wood 6) straw/shrubs/grass 7) animal dung 8) other (specify ________________________	
709	Do you have separate room which is used as kitchen?	1. Yes 2. No	
710	Main material of the floor **RECORD OBSERVATION**	1) earth/ mud 2) wooden 3) ceramic tiles 4) cement/bricks 5) other [specify]______________	
711	Main material of the roof **RECORD OBSERVATION**	1. thatch/leaf 2. plastic sheets 3. corrugated iron sheet 4. cement 5. other [specify]_______________	
712	Main material of the walls **RECORD OBSERVATION**	1) wooden and mud 2) wood/sticks 3) Cement 4) Stone with lime/cement 5) Bricks 6) WOOD plank/SHINGLES 7) other [specify]_____________________	
713	Type of windows	1. any windows 2. windows with glass 3. windows with screens 4. windows with curtains or shutters	

714	How many household members are sleeping in one room?	________________	
715	Does any member of this household own any land that can be used for agriculture?	1. Yes 2. No	
716	Does this household own any livestock, herds, or farm animals?	1. Yes 2. No	
717	How many of the following animals do this household own? **[PROBE AND MARK ALL THAT APPLY, MULTIPLE ANWER IS POSSIBLE]**	1. Milk cows……… 2. Oxen, or bulls…………………………… 3. Horses/donkeys/ mules…………… 4. Goats……………………………… 5. Sheep ……………………………… 6. Chickens……………………………	

FGD GUIDE

My name is______________________ and this is my partner_____________________. We came from Jimma University and doing a research on married women's decision making power and contraception use in your community. Here you invited to discuss freely issues what we are going to pose. The points are simple and understandable. Whatever you feel and believe on the raised idea is allowed since there is no right or wrong answer. We are going to audiotape your discussion but know that it is confidential and used only for research purpose. Any personal identification will not pass to anybody. We are going to stay about 40 minutes discussing in ordered manner. Thank you for giving your time!

- What do you know about modern contraceptives? Their benefit to mother, children and family?
- How do you see the Decision making power of married women in your community?
- In what household situations does you make decisions and not?
- Does contraception makes you feel guilty or in control of your life?
- Does the use of family planning enhance sexuality discussion between you and your husband?
- Do you see any decision making difference in use of contraception because you lived in urban/rural areas?
- On decision-making in the household, whose decision is always followed in your home?
- When you think your husband's decision is wrong and you think you are right, whose decision prevails?
- What factors hinder you to take your own decision on the use of family planning and contraceptive use?
- What will be the consequence if you use contraceptives without the knowledge of your husband first and revealed later?
- Do you have ways or means how to circumvent his decision so that your own will be followed?
- What are the decisions in which you think there is no need to consult your husband? When do you think you can decide alone?

TRANSLATED QUESTIONNAIRE

Jimma universittiyaan Deretetha faxxatettaninne hakimetetha sayinissiyan, dere asanne golle faxatetha departimenttiya

Soyzwuanna de77iya Macca asa ha77i woddiyan nana yellwua digganaw woy haasi haasi yellenaw maadiya oggiya bolla de77iya wolqa Oyichannaw giigo Oosha

Oggiyaa

Saro geedo, ta sunthay___________________________________geetette. Hache ta Biiniyaama Bogaalanna oothadi77ay. I ha77i woddiyaani naana payidduanne giddonna gam77anaw koshiyaa oggiyan azzinanna de77iya macca asa wolqqay aymallentto xeelanawu koyyedda.
Hintte ha77i ooshettanaw dooretowe qaadadanna. Hinttenna laafa oosha hintte golle naanabba, hintte wolqa xeeliyawanne hewaane hewa mala oochana haneeto.

Ha77i hintenna ta oochishin laafa wodiya akee. Ha77i hintew taananna gam77anaw miikennento hinte go wodiyaan simma yaanaw dand77ay. Ta oochiya ooyshappe hinttew miikennawe de7ooppe zaarikke gannaw hintew maata. Giddoppe attin, koyrotti hintte eranaw koshiya yehuu, ooshetto oyshaw hintte immo zaaru hara asassinne gido hara oosuassi peeshennawa gidiyaawanne hintenattetha erisiyaawappe ittukka (leemisuassi hinte sunthay) xaafettenawa erissay. Yehon kassi hintte tumo zaaruwa immu macca asa bollan de77iya metua diganaw maadiyaawassi maadetoytte geeto.

Hinte zaaro galatidde, ooshettanaw maatayiitee?

Ee……………………(galatinne oochite)
Maatayikke……………..(galatinne essite)

	Koyro galla	La77entho galla	Heezetho galla
De77iino			
Soyan baawa			

Qabalii ______________ Doometo saatii______________

Oosha koodii________________ Ungetto saatii_______________

Ooshancha sunthaynne firimay _______________________, __________________

Oosha qammay_________________________

Shempuwaa 1: Asatethanne Issipe De77ua Ogiya Xeeliyaa Oosha

pay ddu a	Oosha	Zaaruwa	Geeth a
101	Hinttew aapun laythe?	……………………laytha	
102	Hintte ammanu ayee?	1. Ortodokkisiya 2. Ammanuwa/protestanttiya 3. Islaama 4. Kaatolikkiya 5. Hara, qonchissa…………	
103	Hintte yaray/qommu aye?	1. Dawurwa/maala 2. Manjja 3. Amaara 4. Tigiriyaa 5. guraagiya 6. Wollaytha 7. Hara,konchissa……………	
104	Timirttiya dethay?	1. Nababuanne xaafuwa dandayikke 2. Nababuanne xaafuwa dandayishin timirtte keetha gela beeke 3. Kifiliya 1-6 4. Kifiliya 7-10 5. Kifiliya 11-12 6. 10tha/12thappe bolla(wogga dethay qonchetto)	
105	Kiitay/Oosu	1. Golle macca asa/ciggay de77iya kiita oyqqabeeke 2. Kawua Oosancha 3. Gilliyan/maaduwa dirijittew Oothay 1. Nagaadiya/ zal77anchaa 4. Gallassa Oosancha 5. Tamaariya 6. Hara, qonchissa…………..	
106	Hintte asinna oosu aye?	2. Kawua oosancha 3. Gillen/dirijittiyaa oosancha 4. Goshancha 5. Nagaadiyaa/zal77anchaa 6. Makiina laagee 7. Gallassa oosancha 8. Hara, qonchissa…………………	
107	Hintte golle awuu (wursethay) timirtte keetha geli eriino/tamaaredino?	1. Ee 2. Geli beena	2--p109
108	Inttu gakko wogga dethay?	1. Gakko Kifilii……………………. 2. Kushe hiila tamaaredda 3. Universitiyaa/kolleejiya diploma akeeda 4. Universitiyaa/kolleejiya digiriya oykeeda 5. Erikke	
109	Soyzetto ogi	1. Simiimen de7eeto/faramibeeko	

		2. Firimaani aketeedo/ ta xallay au mache 3. Firimaani aketeedo/hara machi de'ee	
110	Hintte keetha de77ua dethay shooruanna xeelode hintew aymalee?	1. Shoorwappe keeka 2. Gidoole 3. Shoorwappe laafa 4. Shoorwappe daro laafa	
111	Hintte giliyaan/kochani aginan ubba wode demiyaa shallu/gabii de77i?	1. De77ee 2. Baawa	
112	Hintte yelaga naanappe hara soyan de7iyaa asay de7ii?	1. Ee de7ee 2. Baawa	2----- p201
113	He uray hintennanna ayan dabotti? **[ittuwappe bolla zaaru danda7etee**]	1. Asinaanna/machatinna de7iyaa nana 2. daayo /Wogga daayo 3. aaba/wogga aaba 4. bollotato 5. bolluwa 6. hara dabotha 7. hara dabbo gidenna asa	

Shempuwaa 2: Macca Asay Qoppowaane Gakko Yelluwa Keesha

pay dua	Ooshaa	Zaarwa	
201	Aapun laythan (koyro) asina geleeditee?	…………………….laythan	
202	Nanna yeledittee?	1. Ee yelaadi 2. Bawa yelabeeke	2----- p205
203	Hachi gakanaw aapun nana yeleeditee?	………………………………	
204	Yelleto naanappe aapunu shemponna de77ii?	1. Attumawe…………….. 2. Maccawe……………… 3. Ubbay………………………	
205	Aapun nana yellanaw koyiitee?	1. Attumawe…………….. 2. Maccawe……………… 3. Ubbay………………………	
206	Hanno gatanaw yeleto nanappe koppenan woyikko koyenan yeleto naanay de77ii?	1. Ee 2. Baawa	2---- p208
207	Aapun naanee qoppenan yeletowe?	1. Attumawe…………….. 2. Maccawe……………… 3. Ubbay………………………	
208	Macca naatiiyee atuma na77ee hinte chori de7anaadan koyiyaawe?	1. Maccawa 2. Attumawa 3. Oona gidoopenne metenna	
209	Hintte qofan, hinte asinay de77anaadan koyiyaa nana payduu hinte koyiyaawa keeshe, dare woykko laafi?	1. Ta koyiyaa nana keesha 2. Ta koyiyaawappe chora 3. Ta koyiyaawappe laafa 4. Erikke	
210	Hintew yeleto naanappe hayqon shaaketowe de77ii?	1. Ee, aapune………………… 2. baawa	

Shempuwaa 3: Macca Asa Era paacanaw

payd dua	Oosha	Zaaruwa	
301	Naana paydua qarayanaw woykko haasi-haasi yelanaw maadiya ha77i wodiya ogiya sisi eriitee?	1. Ee,sisaadi 2. Baawa sisabeeke	2…. p307
302	Haqqappe/Oope siseedite?	1. Eraadooniyappe, televisiiniyaappe,…H.H.M 2. Ta asinappe 3. Lagettappe 4. Haakime keetha Oosanchatuwappe 5. Hara, qonchissa…………….	
303	Macca asaw haniya Hintte eriya qommu haqawee? [**zaariya asay danda77owa keesha zaaranaadan otetto]**	1. Kinnina 2. Yello keethan yegettiyaawa (IUCD) 3. Narppiyaan imetiyaawa 4. Hashiyaan moogetiyaawa 5. Spermisidaaliya, jeliiyaa… 6. Macca asa shukan yello keetha qachiyaawa 7. Hara, qonchissa…………..	
304	Yellwa digganaw woykko haasi-haasi yellanaw dandayissiyaa ogi attuma asaw de77iyaawa eriitee?	1. Ee, eray 2. Bawa erikke	2-------- P306
305	Attuma asaw haniya Hintte eriya qommu haqawee? [***zaariya asay danda77owa keesha zaaranaadan otetto]***	1. Kondomiyaa 2. Attuma asa yello keetha qachiyaawa 3. Hara, qonchissa…………..	
306	Naana paydua qarayanaw woykko haasi-haasi yelanaw maadiya ha77i wodiya ogiya maadu ayentto hinte eriyaawa oditte.	1. Keetha asa qooda naaganaw 2. Koyenna shahaara digganaw 3. Naana haasi/gam7i yellenaw 4. qeeri naananne macca asa payatetha naaganaw 5. Ta erikke 6. Hara, qonchissa………..	
307	Laa7u kaalotta yelluwa giddon aapun laytha haasanaw koshi?	1. Itti laythappe guutha 2. Ittwappe laa7u laytha gakanaw 3. Laa7u laythappe bolla 4. Ta erikke 5. Hara, qonchissa……………	
308	Haqqappe demanaw dandyiitentto eriitee?	1. Ee 2. Erikke	2----- P401
309	Eroope haqappee?	1. Xeena xaabiyaa 2. Xeena kella 3. Faramaasiyaa 4. Hospitaaliyaa 5. Social markeetiyaa 6. Gille haakime keetha 7. Oosanchattu golle gakannaw ahi imiino 8. Hara, qonchissa…………	

Shempuwaa 4: Macca Asa Xeeluwanne Yehwan Oothanaw De77iyaaba Eranaw Giigobaa

pay ddu wa	Oosha	Zaaruwa	
401	Hinttew ha77i woden de77iya yellwa digganaw/gam77ethanawnne haasi haasi yellanaw maadiya ogetttwa go77etanawe aya malatii?	1. Go77etussa akay 2. Go77etussa akike 3. Taw ayenne malatenna	
402	Hintte asinanna ha ogetuawa haasayi eriitee?	1. Ee 2. Erikke	2------ p405
403	Aadho usuppun agina giddon aapu gede haasayeeditee?	1. Baawa haasayibeeko 2. Itti gede 3. Laa7u gede 4. Heezu gede 5. Heezu gedeppe bollaa	
404	Ayaa gaaswan hintte haasayowe?	1. Haasi-haasi yellanaw koyiide 2. Yellu gidee giide 3. Asho gaketethan aadhiyaa sakwa/hargiya diganaw koyiidee 4. Hara, qonchissa……..	
405	Hintte qofan, ha ogetwa go77etussan hinte asina qofay aymalee?	1. Go77etussa akee 2. Go77etussa akenna 3. Aw ayenne malatenna 4. Ta erikke	
406	Hinte go77etanaw koyiitento, hinte asina zaaru aya mala giitee?	1. Ta qanxxwa maadee 2. Ta qanxwaa maadenna 3. Ayenne geena 4. Erikke simmi	
407	Hintte mata dabottwa (aata, aawu, bolotatha, boluu) kofay ay mala giitee?	1. Go77etussa akiino 2. Go77etussa akikinno 3. Ayenne giikkino 4. Ta erikke	
408	Hinte O eri go77etti eriite ha ogetwappe?	1. Ee 2. Erikke	2----- p410
409	Go77eti eroope, aa qommu haqawe?	1. Kinnina 2. Yello keethan yegettiyaawa (IUCD) 3. Narppiyaan imetiyaawa 4. Hashiyaan moogetiyaawa 5. Kondomiyaa 6. Spermisidaaliya, jeliiyaa… 7. Macca asa shukan yello keetha kachiyaawa 8. Attuma asa yello keetha kachiyaawa 9. Hara, qonchissa…………..	
410	Ha77i go77etide77tee?	1. Ee 2. Gidenna 3. Hanenna {yelu baawa, mata yelaadu}	2------ p418
	Oona giya qommuwa?	1. Kinnina	

411		2. Yello keethan yegettiyaawa (IUCD) 3. Narppiyaan imetiyaawa 4. Hashiyaan moogetiyaawa 5. Kondomiyaa 6. Spermisidaaliya, jeliiyaa… 7. Macca asa shukan yello keetha qachiyaawa 8. Attuma asa yello keetha qachiyaawa 9. Hara, qonchissa…………..	
412	Ayaw go77etide77tee?	1. Nana chorisikke gaade 2. Haasa haasa yelanaw koyaade 3. Hara, qonchissa………..	
413	Haqappe demeeditee?	1. Xeena xaabiyaa 2. Xeena kella 3. Faramaasiyaa 4. Hospitaaliyaa 5. Social markeetiyaa 6. Gille haakime keetha 7. Oosanchattu golle gakannaw ahi imiino 8. Hara, qonchissa…………	
414	Oone koyrotti kofa denthowe?	1. Ta tahuupew 2. Ta asinay batalli 3. Ta dogaadi	
415	Oone yaatin wursetha wusaaniya imeedawe/qoffa qachowe?	1. Taani tawkka 2. Ta asinaana ittippe 3. Ta asinay barexalali 4. Hara, qonchissa…………	
416	Ha77i hinte go77etiyaa kommu hinte doorowe?	1. Ee 2. Gidenna	2----p418
417	Giddenan dhayoope aye metu hinte dooro qommua go77etanawa digiyaawe?	……………………………………… ……………………………………… ……………………………………… ……………………………………….	
418	Hintte ha ogiyaa akanaw haakime keetha hinterekka/ hara asay naagenan baanaw dandayiitee?	1. Ee 2. Dandayikke	
419	Hintte gole aawu shaluwa immi yediino ha ogetwua akanaw koyoode?	1. Ee 2. Immikino	
420	Kaadadan, itti qommwappe hara qommwa laami eriitee?	1. Ee 2. Erikke	2-----p420
421	Loytti mata wode laamusaasi gaasu ayee?	1. Kase qommu faxatetha naaqinaade 2. Kase qommwa akanawa dogowaasi 3. Kase qommuu miikibeena 4. Adussa wodiya gam77isiyaa ogiyaa koyaade 5. Ta asinay taape erenaadan koyowaasi 6. Ta asinay he qommwa dosibeena	

		7. He qomuu maadibeena 8. Haakimii laama gowaassa 9. Ta kase akiya qomu baawa/wureeda geetetowaasa 10. Hara, qonchissa………	
422	Ha77i hinte go77etti de77yaawa asinay erii?	1. Ee 2. Erenna	2-----p422
423	Erikinonto gaasu aye?	……………………………………	
424	Hachippe sinta gidoopenne hinte asinay erenan go77eti eriitee?	1. Ee 2. Erikke	
425	Hintte asinay erenaan go77etiitento gollen aye kessee giitee?	1. Taana birshee 2. Shocee 3. Taako yuusa esee 4. Hara, qonchissa…………	
426	Hinte asinay atumma asay go77etiyaawa go77etanaadan koyiitee?	1. Ee 2. Koyikee	
427	Hintte ha ogiyappe go77eteenaadan koyro gaaswa gidobay aye? ***[hanno gakanaw go77eti erienna asay oosheto]***	1. Dhaliyaana yiya metwaape gaadee 2. Ta asinay diginaade 3. He ogi de77iyawakka erikee 4. Ta kaaliya amanu digiyaawassa 5. Dabbo asay diginaade 6. Yelanaw koyo nana paydu biro gakibeena 7. Asho gaketetha laafetiyaawaasa 8. Hara, qonchissa………	
428	Hintte asinaappe go77tussa/ go77etanaw koyussa digetti eriitee?	1. Ee 2. Erikke 3. Ta go77etanaw koppabeeke	
429	Hinte mata dabuaape (aatippe, aawappe, bolotatippe, bollwaappe) go77etanaw koyussa digetti eriitee?	1. Ee 2. Erikke 3. Ta qoppa/koya erikke	
430	Hinte asinay/hara asay koyennawo hinte go77etide77yaa ogiyaa essi eriitee?	1. Ee 2. Essa erikke	2------p501
431	He uray hinte ayaw essanaadan koyeedee?	1. Ta hara naana yelanawa koyiide 2. Ta faxatethaw hirgiide 3. Ta ammanwanna gaasoyiide 4. Hara,qonchissa………..	

Shemppuwaa 5: Maccatethanne Atumatetha Bolan De77iya Xeeluwa

Nu gadiyaaninne gido hara sa77an, chora asaw macca asaynne attuma asay golle giddon kiitetiya kiita bolla dumma dumma qofay de77ee. Hawaape guyen, ta hintew oosha nababana, hint ta nababiyaa oosha akiitentonne akikitento odiita. Likke woykko likke gidenna zaaru baawa, hinte qofa nu qonchissite.

payddu wa	Oosha	akkay	akikke	mettena	geetha
501	Ubba golle yehwan, attuma asay wursethan wossanana/qofa qachana koshee				
502	Lo77o machatta yehwa akekentonne asina qaala/qofa qashuwa bonchanaw koshaw				
503	Macha asay Karen chiga kiita kiitetanaw asina fikaadiya akanaw koshee				

504	Gollen kuma kattusaynne kiita kiitetusay macca asa bagaa/kiita				
505	Yellwa haasanaw woykko digganaw maadiya ogiya go77etanaw asinay fikaadiya immanaw koshee				
506	Aapun naana yelanentto asinay waanati qofa qachanaw koshee				
507	Asinay bare machatta yelwaaba aanana haasayanaadan fikaadiya immanaw koshenna				
508	Macca asay golli laaletenaadan asinay shochishinkka cho77u gaanaw koshee				
509	Gollen de77iya shallu ayan peeshanento wosananaw koshiyaawe/maatay de7iyaawe asina				
510	Macca asaw golle shalwa bollan aawatethaynne maatay imetanaw koshenna				

Shempwa 6: Keethan De77yaa Maata

Oone hawappe guyen oochetiya ooshaw qofa qashwa/wusaaniya immanaw koshiyaawe? Hintene, hinte asinne, laa7u ittippe woykko hara ase? (**ZAARU ITTIPPE GIDOOPE**, hintte qofayinne hinte azinawe dummatiya wodde oowe bollatii?)

payddua	**oyshaa**	**machatta**	**asina**	**ittippe**	**Hara asa**	**Oowe bollatii**
601	Nana paydwa o wosannii/qasho qofa immii?					
602	Nana paydwa woykko haasi-haasi yelwa maadiya ogiyaa go77etanaw o qasho qofa immii?					
603	Naana o seeri					
604	Naanay saketinto oone haakimew afusa wosaniyaawe/qofa qachiyaawe?					
605	Naana timirtew yedanaw woykko diganaw					
606	Oone qumma shammanawnne kathanaw wosaniyaawe					
607	Gollen de77iya shalwa leemiswaasi, miiza,dorsaa…zal77anaw woy shammanaw o wosannii?					
608	Hintew geexiya shammanaw koyiitento					
609	Golliyaanne wolqaama golle shalwa zal77anaw woy shammanaw koyiitento					
610	Golle shallu ayan/waani peeshanento					
611	Hinte golleppe Karen shallu chigettina kiita kiitetanaw koyiitento o wosannii					
612	Hinte dabuwa/asina dabuwa maadanaw koyiitento					
613	Naanay timirttew koshiyaa ba ooychintto					
614	Walassappe guyeen irquwa koyrotti denthiyaawe					
615	Hinte Mabaran/heera shiiqwan beetanaw koyiitento oone wosaniyaawe					
616	Daro wode oonee wusaniyaa immiyaawe hinte hinte dabbwa be77anaw koyiitento					
617	Daro wode oone wosaniyaawe hintte haakime golle					

	baanaw koshintto					
618	Kawua doorwan oona dooranaw koyiitento					

Shemppwa 7: Issipetetaane De77wa Detha Xeeliyaa Ooshaa

pay dwa a	**Ooshaa**	**Zaarwa**	
701	Usha haatha koyrotti haqappe demiitee/duuqiitee?	1. Bombaa 2. Diretto olla 3. Cho de77iyaa olla 4. Naageti wotto pultiyaa 5. Cho de77iyaa pultiyaa 6. Ira haatha 7. Maakinan goosheti yo haatha 8. Shaafa haatha 9. Hara, qonchissa………..	
702	Hara golle kiitaw maadiya haathay haqappe beetii/duuqetii?	1. Bombaa 2. Diretto olla 3. Cho de77iyaa olla 4. Naageti wotto pultiyaa 5. Cho de77iyaa pultiyaa 6. Ira haatha 7. Maakinan goosheti yo haatha 8. Shaafa haatha 9. Hara, qonchissa………..	
703	Haatha pathanaw/ushaw geeshanaw hintte oothiyaa ogi de77ii?	1. Ee 2. Baawa	
704	Haathay ushaw peeshanaadan aya ootiitee?	1. Pentisusaa 2. Shametto dhaliyaa gujjusaa 3. Geisha mayon xilisusa 4. Shafiyaan xillisusa 5. Awan peeshussaa 6. Gam77iide barew xilanaadan bashiyagussa 7. Hara, qonchissa……….	
705	Pittwa haqan oliitee?	1. Mazagaajay shishi afe/qabali 2. Gillen shishi afiya asay de7ee 3. Dembaan cho oletee 4. Shaafan oletee 5. Taman xuugetee 6. Hara, qonchissa………..	
706	Hinte sheesha keethay aya malee? **[xeeli kuntite]**	7. flush or pour flush toilet 8. ventilated improved pit latrine (VIP) 9. pit latrine with slab 10. pit latrine without slab/ open pit 11. No facility/bush/field 12. other (specify ____________________	
707	Hinte keethan kaali xeegetiya bay de7ii?	Ee baawa 1. Corantii 2. Sa'aatii 3. Eradoonii 4. Televisioonii	

		5. Moobaylii 6. Golle silikii 7. Friijii 8. Xarapheezay 9. Wonbaray 10. Algay/arsay 11. Korantiyaa bashii 12. Saykilii 13. Motoriyaa saykilii	
708	Qumma kathanaw ayaa go77etiitee	1. Korantiyaa 2. Biogaasiyaa 3. Lambaa 4. Kasaliyaa 5. Mithaa 6. Duppa, maataa… 7. Kewiyaa 8. Hara, qonchissa…………..	
709	Hintew qumma kathanaw dumma kifili/gollii de7ii?	1. Ee 2. Baawa	
710	Waana golliyaa wuyigii ayan medheteedee?	1. Biithan/ urkaan 2. Mithan 3. Seeramikiyaan 4. Simintwaan 5. Hara…………..	
711	Golli waanati ayan kameteedee?	1. Gathaan 2. Sharaan/ festaale malaan 3. Korakorwaan 4. Simintwaan 5. Hara……….	
712	Waanati girgiday ayaape medheteedee?	1. Mithaapenne urqaape 2. Mithaape/kayxeeriyaape 3. Simintwaape 4. Shuchaape 5. Xuubiyaape 6. Xawulaape 7. Hara…………………..	
713	Maskooti de7oope, aya male?	1. Chooka maskootiyaa 2. Mastootiyaana de7iyaa maskootiyaa 3. Skreene de7iyaa maskootiyaa 4. Kamiyaabay de7iyaa maskootiyaa	
714	Itti kifiliyaan aapun asay gisii?	……………………………………	
715	Goshshaw haniyaa biitay de7ii?	1. Ee, _______boora wolqiya/_______hectar 2. Baawa	
716	Ha keethan booray, miizay, dorsy woy deeshay….de77ii?	1. Ee 2. Baawa	
717	Kaali qonchetwantuppe ha gollew aapunu de7ii?	1. Matha miizay…………………………. 2. Booray/kormay……………………… 3. Faray/hari/baquluu…………………… 4. Deeshay………………………………. 5. Dorsay………………………………… 6. Kuttuu…………………………………	