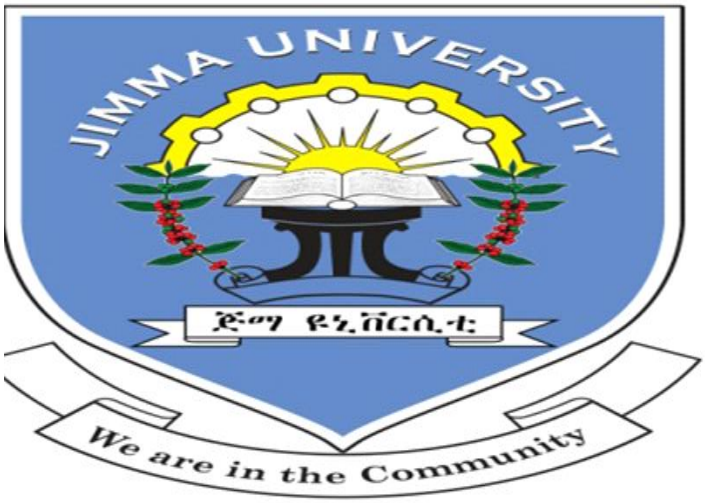

DECISION MAKING POWER ON REPRODUCTIVE HEALTH AND RIGHTS AND ASSOCIATED FACTORS AMONG MARRIED WOMEN IN METTU RURAL DISTRICT, SOUTH WEST ETHIOPIA.

By: Afework Tadele (BSc.)

A THESIS SUBMITTED TO POPULATION AND FAMILY HEALTH DEPARTMENT, SCHOOL OF GRADUATE STUDIES, JIMMA UNIVERSITY; IN PARTIAL FULFILLMENT FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH IN REPRODUCTIVE HEALTH (MPH/RH)

June, 2017

Jimma, Ethiopia

JIMMA UNIVERSITY

INSTITUTE OF HEALTH, SCHOOL OF GRADUATE STUDIES

POPULATION AND FAMILY HEALTH DEPARTMENT

DECISION MAKING POWER ON REPRODUCTIVE HEALTH AND RIGHTS AND ASSOCIATED FACTORS AMONG MARRIED WOMEN IN METTU RURAL DISTRICT, SOUTH WEST ETHIOPIA.

By: Afework Tadele (BSc.)

Advisors:

1. **Mr. Amanuel Tesfay** (MPH/RH, Assistant professor, PhD fellow)
2. **Ms. Alemi Kebede** (MPH/RH)

ABSTRACT

Background: Decision-making is the process of identifying and selecting a course of action to solve a specific problem. Reproductive ill health being much greater for women which represents one-third of the total burden of the diseases among women of 15-44 years, with unsafe sex a major risk factor. Women with lower decision-making power were more likely to have a low birth weight and high rates of unintended pregnancy.

Objective: To assess level of decision making power on reproductive health and rights and associated factors among married women in Mettu Rural District, South West Ethiopia.

Methods: Community based cross sectional study was conducted from March 14 to April 10, 2017. 415 married women's of 15-49 age were identified using family folder at health post and sampled using simple random sampling technique. The data were entered into Epidata v 4.1 then exported to SPSS v 21.0. Binary logistic regression analysis was carried out.

Result: Four hundred five women were interviewed yield a response rate of 97.6%. Among interviewed women, 41.5% had higher decision-making power. Women's primary education AOR 2.62[95% C.I 1.15, 5.97], secondary (9+) education AOR 3.18[95% C.I 1.16, 8.73] and Husband's Primary education AOR 4.00 [95% C.I 1.53, 10.42], secondary (9+) education AOR 3.95 [95% C.I 1.38, 11.26], being knowledgeable about RHR AOR 3.57 [95% C.I 1.58, 8.09], marriage duration of $\geq$ 10 years AOR 2.95 [95% C.I 1.19, 7.26], Having access to micro-credit enterprises AOR 4.26[95% C.I 2.06, 8.80], gender equitable attitude AOR 6.38 [95% C.I 2.52, 12.45] and good qualities of spousal relation AOR 2.95 [95% C.I 1.30, 6.64] were the predictors of women's higher decision making power.

Conclusion and recommendation: Lower than half of rural women have higher decision making power. External pressures (qualities of spousal relation, gender equitable attitude) and knowledge about RHR were found to influence women's decision making power. Public health interventions targeting women's RHR should take into account strengthening rural micro-credit enterprises, qualities of spousal relations and priority should be given to women with no formal education of husband or herself and marriage duration of < 5 years.

***Key words**: decision making, reproductive health and rights, rural district.*

ABBREVIATIONS AND ACRONYMS

ANC: Ante-natal care

AIDS: Acquired Immune Deficiency Syndrome

CHIS: Community Health Information System

EDHS: Ethiopian Demographic Health Survey

ETB: Ethiopian Birr

GBV: Gender Based Violence

HIV: Human Immunodeficiency Virus

ICPD: International Conference on Population and Development

IRB: Institutional Review Board

JU: Jimma University

MCH: Maternal and Child Health

MDGs: Millennium Development Goals

PNC: Post-Natal Care

RHR: Reproductive Health and Rights

RTI: Reproductive Tract Infections

SDG: Sustainable Development Goals

SPSS: Statistical Package for Social Science

SRH: Sexual and Reproductive Health

STDs: Sexually Transmitted Diseases

STI: Sexually Transmitted Infections

WHO: World Health Organization

Table of Contents

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENT

First of all I would like to thanks to my Lord and then Jimma University department of family and population health for its support to carry out the research on this topic. And also Mettu Rural district health office for giving me baseline information regarding the district.

I wish to express my sincere gratitude and appreciation to my advisors Mr. Amanuel Tesfay (MPH/RH, Assistant professor, PhD fellow) and Ms. Alemi Kebede (MPH/RH). And my data collectors and supervisors for their commitments and tolerances in reaching the rural households selected as it is incomparable with the incentives.

My thanks and appreciation goes to my friends attending MPH in different departments since while discussing at different occasions, I got constructive ideas which helped me to finalize my thesis.

CHAPTER ONE: INTRODUCTION

1.1 Background

Reproductive health and rights(RHR) are fundamental to the socio-economic development of one country and a cornerstone of an equitable society(1). "Reproductive health(RH) is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (2).

Reproductive rights (RR) are the rights of individuals to decide whether to reproduce and have reproductive health. This may include an individual's right to plan a family, terminate a pregnancy, use contraceptives, learn about sex education in public schools, and gain access to reproductive health services (3). They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence (4). Reproductive health and rights services are a crucial for women's healthy lives, prevent gender based violence and power relations in their lives and help women's to be autonomous economically (5).

Sexual and reproductive ill health includes death and disability related to pregnancy and childbirth, sexually transmitted infections(STIs), HIV(Human Immunodeficiency Virus) and AIDS(Acquired Immunodeficiency Syndrome), and reproductive tract cancers (6). 36 percent of all healthy years of life lost among women of reproductive age is due to reproductive health problems such as uncontrolled fertility, maternal mortality and morbidity and reproductive tract diseases including HIV/AIDS (7).

Decision-making is the process of identifying and selecting a course of action to solve a specific problem. It can be a complex process, and the ability of women to make decisions that affect the circumstances of their own lives an essential aspect of their empowerment (8). Family decision-making directly or indirectly involve two or more family members. Women access to decision-making power encounter much more challenges just because of their gender difference. Despite several efforts, rural women in Ethiopia still considered inferior to man and does not have an independent identity. If women who are vulnerable holds more power to decide in reproductive

health than instead of the dominant role of decision making among men who prefer for more children, maternal deaths can be reduced (9).

Several study reveals women's decision making improve reproductive health services utilization and those who make independent decision can more likely to timely utilize postnatal services and the services of a skilled delivery (10), emergency obstetric care (11), antenatal care (12), and have longer birth interval (13) than mothers who lack independent decision-making power there by improve maternal reproductive Health outcome. According to a qualitative study in East Malaysia in 2015, most of gender relations are especially in rural areas are patriarchal and maintain a hierarchy where women usually expected to be submissive, obedient and respectful of their spouses (14).

Ethiopia is a multi-ethnic society with diverse cultural and traditional practices, in which gender power difference can affect livelihood and well-being of its population particularly of women. Majority of Ethiopians settled in rural areas in which socioeconomic and gender attitudes toward women negatively affect women's status and participation in the socio-economic and political life. These can adversely affect reproductive health and rights of women.

1.2. Statement of the problem

Maternal mortality is like a litmus test on the status of women. Their lack of power in comparison to men constrains decision-making about their health needs largely due to fundamental gender inequalities and the mistreatment of women's rights which contribute to the maternal morbidity and mortality (15). Despite considerable progress since the ICPD (International Conference on Population and Development), women's Reproductive health and rights problems still encounter resistance in international fora. The underlying reasons involve views about women's social status and unwillingness to recognize women's right to decide about their own reproductive health and rights (16). Rural women constitute a significant part of the world's population but are disproportionately affected by a lack of realization of human rights.

Gender roles and power dynamics between women and men are central in sexual and reproductive health. Even within marriage, rural women in different cultures are at risk of acquiring reproductive tract infections (RTIs) from their husbands, because they are unable to assert on using condoms. It is women who get pregnant and give birth, for which reproductive ill health being much greater for women which represents one-third of the total burden of the diseases among women of 15-44 years, with unsafe sex a major risk factor for morbidity and mortality in low- and middle-income countries (5).

Women often have less power in relationships due to economic, political and sociocultural status may not be in a position to protect themselves from unwanted sex, STIs or Gender Based Violence (GBV) (1). Gender inequalities exacerbate a difference in well-being and ill health, and sometimes life and death due to Poverty. Women constitutes about two-thirds of the 1.4 billion people currently living in extreme poverty, which make up sixty percent of the 572 million working poor in the world. This shows that Female is the face of poverty at household level, community and country level (17).

Married women adopt women's triple role as productive, reproductive and community management role i.e. the role of a wife, mother and caregiver as a primary identity, even when they work outside the home as where and when women ought to seek health care including

reproductive choices decided by husband (18). Rural women's health negatively affected by lack of decision-making power on reproductive health services utilization leading to persistent problems, such as high rates of maternal mortality. States promise to lower maternal mortality by seventy five percent by 2015 through the Millennium Development Goals (MDGs) but have mostly failed to do so (7). It is largely due to gender inequalities, for instance urban-rural disparities of women access to skilled delivery (19).

According to a systematic review of a literature in developing countries in 2016 age, educational status and income affect women's health care decision-making autonomy (20). Most of the working women having greater freedom exercise greater power compared to non-working women with respect to reproductive and family planning matters (21). Polygamous marriages were common among rural women and refusing sexual intercourse makes their husbands turn to other wives (22). Women with lower decision-making power were more likely to have a low birth weight (23) and high rates of unintended pregnancy (24).

In Ethiopia poor reproductive health outcome was one of a well-known potential challenge in the effort towards sustainable development. Although there is good health care system structure to deliver most of reproductive health services up to household level through health extension workers, but women's still suffer from reproductive ill health than men; For instance HIV prevalence in 2012 was 0.8 percent in males and 1.5 percent in females among adults (25) also by the year 2016, 26.4% contraceptive prevalence rate, 1,625,000 unplanned pregnancy among all women and 24.7% unmet need for family planning among married or in-union, in 2016 (26). This is an indicator of women's lower decision making power on their own reproductive health or their decisions constrained by different factors despite accessible health services. According to a report form study in Southern Ethiopia married women's 64.8% of urban women and 43.1% rural women have decision-making power over contraceptive use and among the rural community domestic decision-making were 14.71% by wife while 45.83% husband (27). This shows male dominance on women's decision regarding RHRs especially in rural community. Decisions regarding reproductive health and rights i.e. decide on their own health, whether or not, how and when to have children, power to influence and decide freely and responsibly on matters related

to their sexuality were beyond the services utilization. This is the long term solution to reproductive ill health by ensuring women's reproductive wellbeing.

This study aims at assessing decision-making power on RHR and its predictors among married women of reproductive age group in rural community. It emphasized on women's decision-making power as one dimension of women's autonomy and factors affecting their decision on RHR.

1.3. Significance of the study

Most of developing countries including Ethiopia prioritized that, reproductive health and rights could be one way of eradication of extreme poverty, promoting gender equality as well as realizing women's rights. Exercising reproductive health rights has been recognized as one of the means to sustainable development in many developing countries including Ethiopia. Gender difference results in lack of women's decision-making alone or jointly with their husbands is one of factors affecting under-utilization of RHRs services and also greatly affect effective and sustainable use RHRs. Still studies that tried to see the factors contributing for low level of married women's decision-making power on reproductive health and rights in the rural community is lacking.

Therefore, the study seeks to reveal further considerations in this field to the policy makers, scholars and development agencies. The level of women's decision and major factors identified in this study were essential to all those who work on interventions in the SRH arena. The knowledge gained from the study were crucial to plan contextually appropriate RHR. The findings of the study will be a base line for further studies for the study area.

Mettu Rural district can also gain knowledge from the study to plan contextually appropriate RHR interventions using the findings of the study specifically to see the level of women's decision making power on RHR and rights and its predictors for specific public health interventions aims to improve the extent of decision making power on RHR among married women of reproductive age group. The study participants also get information on the benefit of women's decision making power to fully exercise their reproductive health rights.

CHAPTER TWO: LITERATURE REVIEW

2.1. Women's Reproductive Health and Rights

To finish development policy reproductive health and rights have developed towards a human rights based approach over years. Ensuring RHR has many implications in providing cost-effective development investments, increasing personal, socio-economic benefits, thereby save and improve lives, slow the spread of HIV and AIDS and encourage gender equality. It will also help to stabilize population growth and reduce poverty and also realize women's rights and access to health services to enhance gender equality and women empowerment (26).

Reproductive health and rights realized when everyone has the right to health, the right to decide whether or not, how and when to have children, and the right to have control over and decide freely and responsibly on matters related to their sexuality without violence, coercion and discrimination (16); right to decide about marriage and number of children, well-being throughout life for all matters relating to reproductive system, have a responsible, healthy safe and satisfying sex life. The right to have unrestricted access to information in order to make informed choices, the right to have safe, effective, affordable and acceptable family planning methods of choice (28).

Reproductive health problems occur during the reproductive years is the reflection of earlier reproductive life events. It does not start out from a list of diseases or problems like sexually transmitted diseases, maternal mortality or from a list of programs like maternal and child health, safe motherhood, family planning. It has great contribution to physical and psychosocial comfort, and to personal and social maturation and poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death (2).

2.2 Women's decision-making power

Discussion of sexuality considered as taboo and a woman who discusses sexual issues regarded as a prostitute in different society which can affect women's participation in decisions regarding their RHR especially in rural areas although all couples have equal sexual rights.(29).

The strength of women's decision-making power varies in different countries and with the type of decision they make. According to Ethiopian Demographic Health Surveys (EDHS) in 2011 women's 71.6% of rural women participate in own health care decision(8). Another cross sectional studies in Southern Ethiopia by 2011 and Bale Zone by 2014 reveals that 43.1% of women's have decision-making power on modern contraceptive use (27) and 39.5% regarding maternal and child health care (30) of respectively.

2.3. Factors affecting women's decision-making

2.3.1 Socio-demographic factors

According to study in Pakistan in 2012 Reveals women living in female-headed households as determinants of women's decision making power (10). On the other hand working paper evidence from Egypt in 2015 shows Women in larger households (31) are among the determinants of low decision-making power of married women. women's age AOR: 0.26, [95 % CI: 0.09, 0.47] in Malaysia in 2014 (21) and study in Malawi in 2008 Social backwardness and religious conservativeness can decreases decision-making power of women (32).

Study in Rural Ethiopia in 2015 reported that arranged marriage accepted by the society, the size and type of resource transfers, and women's post-marital residence are the sociocultural determinants of women's decision-making power (33). Women's decision-making power also influenced by own and others experiences, their elders, mother or mother-in-law, father or father-in-law, siblings and even, friends (14). Cross sectional study in Mizan-Aman in 2014 reports that women's decision making differ significantly with age ($r = 0.34$; $p<0.01$) (34). In addition, a cross sectional study in Nekemt Town in 2014, married women's decision-making power significantly associated with duration of marriage that women in marriage for less than five years 61% less

likely decision making than those who were in marital union for ten and above years AOR, 0.39; [95% CI: 0.19 to 0.84]. And also women with seven and above children have three times more decision making power than those who have one to two children AOR 3.20 [95% C.I 1.20 to 8.52](35).

2.3.2 Socio-economic factors

Poverty is the great problem and affect human lives in many different conditions in that by limiting human needs. Several studies show that poverty is the important determinant of married women's decision-making power. According to study in Ghana in 2015 The richer a woman the eight times [OR=8.2, 95%CI= 4.2-16.0] more likely to utilize skilled delivery (36).

Poverty at different level i.e. country, household, can become severe on females and increases their economic dependency. Microfinance has a positive effect on women's income, as there are limits to the income gains (37). Access to microcredits can facilitate both economic and non-economic changes in rural women's lives. Change in basic material possession can also increase confidence, respect, and other forms of autonomy for women beneficiaries. according to a qualitative study in Rural Tanzania in 2012, microcredit can also significantly contribute to the noneconomic aspects of empowerment regardless of whether one has taken a loan or not (38). Another cross sectional study in Kenya in 2013 shows a positive relationships between women's access to credit and reproductive decision-making roles (r=0.13) (39). A systematic review in 2016, on women's or men's decision-making on reproductive right reports that inequalities in access to SRH services, education and information for women's in the lowest two wealth quintiles, those living in rural and hard-to-reach areas have left women and adolescents in, far behind (40).

According to cross sectional study in Bale Zone in 2014, women who live in a family whose monthly income more than or equal to 1100 ETB were about three times AOR 3.32 [95% C.I, 1.62,6.78] more likely to have higher autonomy regarding maternal and child health care utilization than those earning less than or equal to 500 ETB (30).

2.3.4 Women's Knowledge of reproductive health and rights

'Knowledge is power', which is true also for reproductive health and rights (RHR) Knowledge. Education is the bases for acquiring knowledge as several says educational status significance in protecting own health care. Highly educated women are more likely to be knowledgeable about their own health, have more self-confidence, and be more assertive than those with less or no education (20). The other source of reproductive health and rights knowledge is from health extension workers, health workers, women development army the one to five networks and media especially in rural areas television and radio are the source information. A cross sectional study in Nekemte Town in 2014 reveals access to media has significant association with decision making power AOR 0.32 [95% CI: 0.17 to 0.60] (35).

Women's reproductive health rights of affected by their reproductive health and rights knowledge as a study shows knowledge when pregnancy can occur is only 56.0%, having sex once with a man will not result in pregnancy 31.5%, benefits of family planning were 90.0%. Consideration about husband's approval (74.9%) and personal health (86.0%) were major determinants of respondent's use of contraceptives (41).

Although husband has a sexually transmitted disease, or sexual relations with other women, or if women does not give consent she is justified in refusing sexual intercourse. In India, 68% of women agree to all these specified reasons and 13% of women agree to none of the specified reasons. The believe that women is justified in refusing sexual intercourse with their husband varies from 42 % in Tripura to 87 % in Sikkim (42). Self-efficacy is important for women's ability to negotiate sexual activity and condom use. Fulfilment of some fertility-related sociocultural expectations such as son preference required for women self-efficacy. It is context specific and is just a component of intricate relationship dynamics (43)

A cross sectional study in Bale Zone in 2014 reveals women who were knowledgeable [AOR: 6.3 (95% C.I: 3.46-11.43)] and moderately knowledgeable [AOR: 3.0 (95% C.I: 1.94-4.48)] about maternal and child health services respectively were 6 and 3 times higher odds of increased autonomy as compared to their counterparts (30) and another cross sectional study in 2011 in

Southern Ethiopia reveals that knowledgeable women's about the over all aspects of modern contraceptive methods [OR-6.8, 95% CI (3.28,13.91)] were more likely to decide on the use of modern contraceptive (27).

2.3.5 Qualities of Spousal relations

A cross sectional study in rural Uganda in 2013 reveals that qualities of spousal relationships has significant association with women's decision to utilize for family planning, ANC and skilled birth attendance. Open discussion with a partner found to be significant determinant of ANC, skilled birth and family planning utilization. Since communication enhances trust, partners who have honest discussions with each other have positive reproductive health behaviors (44).

A qualitative study in East Malaysia in 2015 revealed that some of the determinant factors in decision-making were men's awareness of his duties and responsibilities as husband and head of family. In most societies cultural customs and religious claims wife should be obedient and submissive to her husband except in things that can cause harm to the wife supports the opinion. Being in a consensual union associated with holding male-centered decision-making attitudes. This shows that communication is plays a great role among spouses for family decision which is affected by qualities of spousal relation (45).

According to a qualitative survey in rural Ethiopia in 2015, almost all of the rural community family is still patriarchal and the limited extent to which women can bargain affect the nature of household decision making. For instance, if bargaining does not result in consensus, the husband's decision takes priority (33).

2.4 Conceptual Framework of the Study

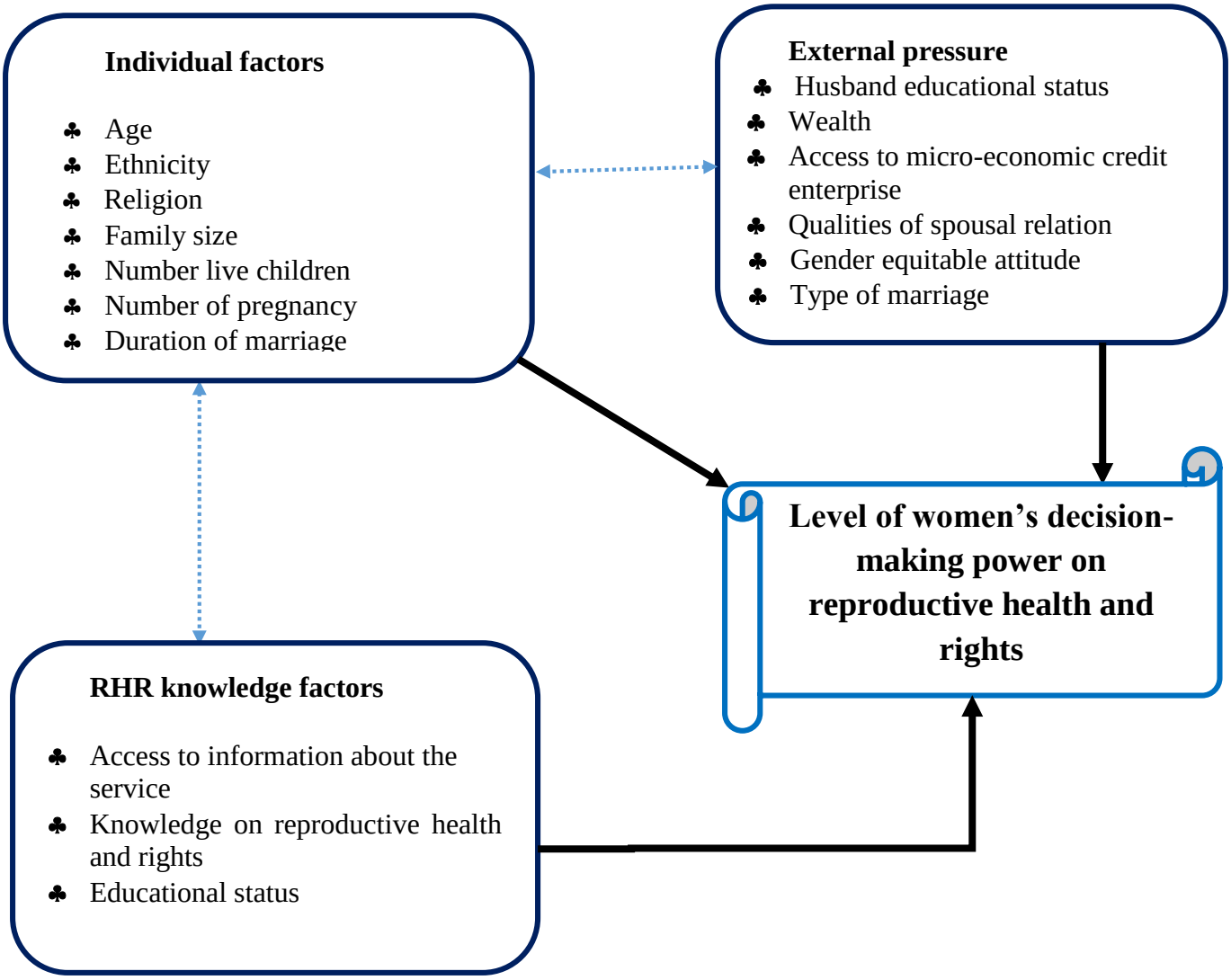

Figure 1 conceptual framework developed after literature review (19, 20, 31- 41, 46, 47)

CHAPTER THREE: OBJECTIVES

3.1 General objective

- To assess level of decision making power on reproductive health and rights and associated factors among married women in Mettu Rural District, South West Ethiopia, 2017

3.2 Specific Objectives

- To determine the level of decision making power on reproductive health and rights among married women's in Mettu Rural District.
- To identify factors affecting married women higher decision making power on reproductive health and rights of in Mettu Rural District.

CHAPTER FOUR: METHODS

4.1 Study area and period

Mettu rural district is one of 13 Districts in Illubabor zone, Oromia Region of Ethiopia. Mettu Rural District is located 600km in the south western of Addis Ababa, the capital city of Ethiopia on the Main road passing from Jimma to Gambella Town. The total area of the district was 67 km^2. The land area shares Woyna-Dega agro-climate which accounts the highest proportion (83%) and Qolla (17%).

Mettu District divided in to **29-kebele** administration with a total population of 80,636 in 16,799 households, out of which 40,358 are females and 17,845 are reproductive age women. The annual population growth rate was 2.57%. There are 29 functional health facilities (five health centers and 24 health posts) in the district. currently some of MCH services utilization the district are: 49.7% of institutional delivery, 93.7% PNC, 80.7% ANC coverage, 76.9% Contraceptive prevalence rate (46).

Study period: The study was conducted from March 14 to April 10, 2017

4.2 Study design: A community based cross sectional study was used.

4.3. Population

4.3.1 Source Populations

All married women of reproductive age group (15-49 years of age) who were residents of Mettu Rural district.

4.3.2 Study Population

Randomly selected married women in reproductive age group (15-49 years of age) residing in Mettu rural District and who fulfill inclusion criteria

4.4 Inclusion-Exclusion criteria

4.4.1. Inclusion criteria

- Women in a marriage or consensual union
- Who lived at least for six months in the area
- Who gave at least one birth ever

4.4.2. Exclusion criteria

- Those who are critically ill, diagnosed mental illness and unable to communicate

4.5. Sample Size Determination and Sampling Technique

4.5.1. Sample Size Determination

Determined using Epi Info™ version 7.1.1.4 with the assumptions of confidence level = 95%, margin of error = 5% and power for the double population proportion= 80%:

Table 1: Sample size determination for outcome variables and associated factors of the study

Population	Proportion	Reference	Sample size	10% non-response	Final sample size
Single population	P_1= 71.6%	(8)	n_1= 312	31	343
	P_2= 39.5%	(30)	n_2 = 367	37	404
	P3= 43.1%	(27)	n3 = 377	38	**415**
Double population proportion	P_{41}= 74.4%, P_{42}= 53.5 %	(27)	n_{41} = 182	18	200
	P_{51}= 74.4% P_{52}= 55.9 %	(27)	n_{51} = 228	23	251

Therefore the largest sample size, **n= 415** was taken.

Were:

- P_1 = proportion of rural women participate in own health care decision
- P_2 = proportion of women have higher decision making power regarding maternal and child health care
- P3= proportion of married rural women who have decision making power to use family planning
- P_{41} = women's decision making power on contraceptive use among knowledgeable
- P_{42} = women's decision making power on contraceptive use among less knowledgeable
- P_{51} = 74.4% women's decision making power on contraceptive use among gender equitable attitude
- P_{52} = 55.9 % women's decision making power on contraceptive use among gender inequitable attitude

4.5.2. Sampling Technique

Nine kebeles with total population of 23,707 selected using Simple Random Sampling (SRS) method among 29 total kebeles of the district; then proportion to size allocated to the selected nine kebeles. The selected nine kebeles with their total population are as follows:

- Allebuya = 4053,
- Boto = 2295,
- Adallebise = 4872,
- Siba = 2590,
- Gabaguda = 1846,
- Tobacha = 1584,
- Agaloeko = 2278,
- Sardo = 2704,
- Madalu = 1485

Total number of married women of child bearing age group obtained from the family folder of the community health information system (CHIS) available at health post and record number listed. Then recoding the record number lists in ascending order to make a frame and use table of random numbers to identify study participants. Their usual place of residence identified in collaboration with kebele leaders.

The eligible identified married women of childbearing age were interviewed in each kebele until the number of sampled populations by SRS 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.

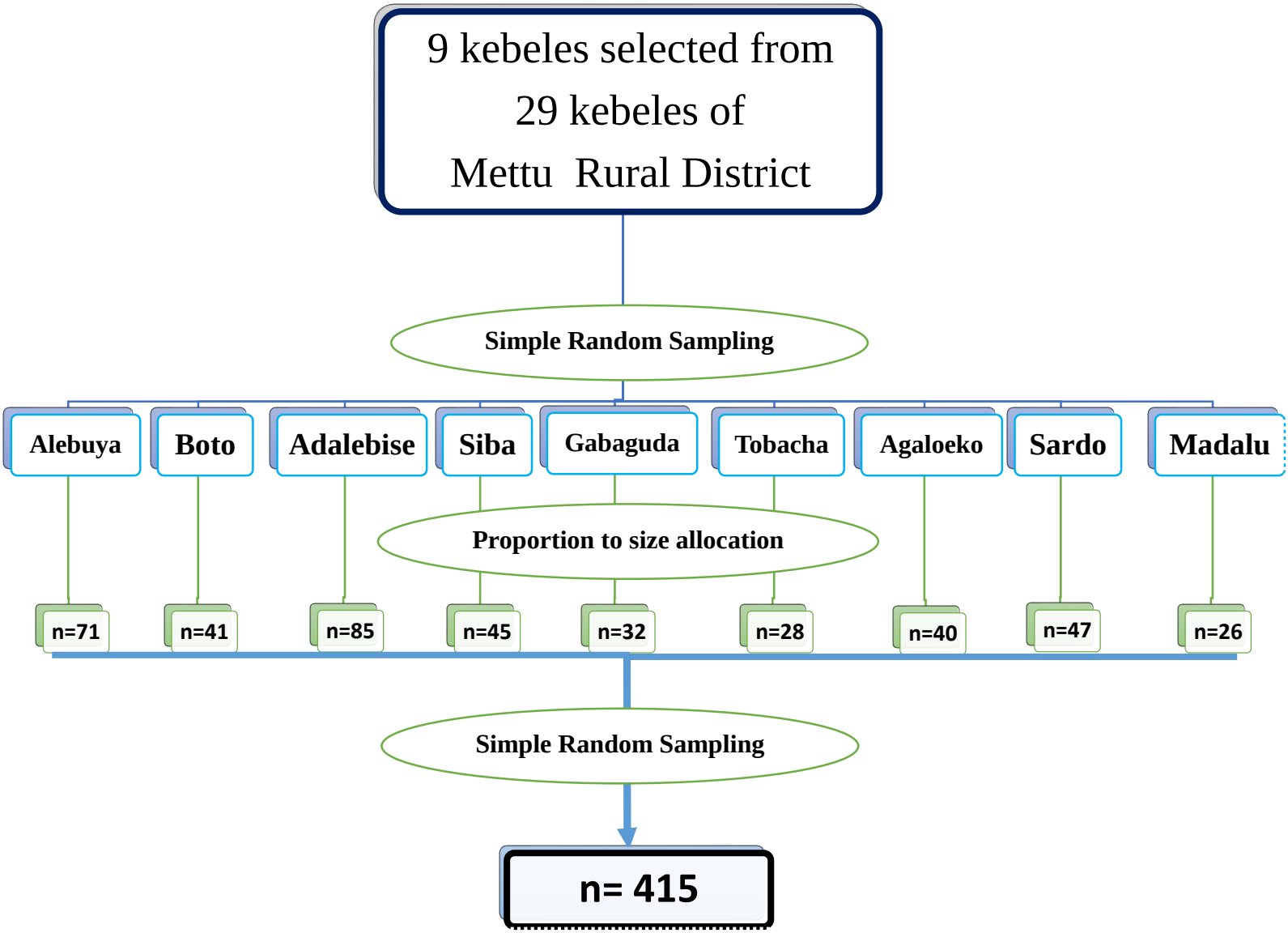

Figure 2: schematic presentation of sampling technique of the study Mettu district, 2017

4.6 Data Collection procedures

The data were collected using structured pre-tested questionnaire. The questionnaire were prepared in English then translated to the local language (Afaan Oromo). The data were collected using interviewer administered questionnaire in a private room. The study subjects were interviewed about their reproductive history and socio-demographic variables, knowledge and gender role attitude about RHR, decision-making power on RHR and factors affecting their ability to make decision.

4.7 Study Variables

4.7.1 Dependent Variable

Married women's decision-making power on reproductive health and rights (as higher or lower decision making power)

4.7.2 Independent Variables

- **socio-demographic variables**
  - Age,
  - Duration of Marriage,
  - Ethnicity,
  - Religion,
  - Educational Status (own and Husband),
- **Socio-economic characters**
  - Family wealth status
  - Access to microcredit enterprises
- **Reproductive health characteristics**
  - Number of pregnancy
  - Number of alive children
  - Type of marriage
  - Reproductive Health and Rights knowledge
  - Qualities of spousal relations
  - Gender equitable attitude

4.8. Measurement

Women's decision-making power were measured using 13 questions to construct composite score on decision-making power on RHR. The women were asked "who in her family usually has the final say on the following decisions: 1. Health care for yourself, 2. When to become pregnant, 3. Number of children, 4. When to have Sexual intercourse, 5. Place of birth 6. To use antenatal care (ANC) service, 7, To use Modern contraceptive, For each items the response was scored as: **2** if a woman made sole decision, **1** if she was involved with someone [husband/partner or someone else] and **0** otherwise; For non-users of modern contraceptives and ANC; if their main reason for non-use is opposition from others (husband, mother in law, relative, religion etc) the value was assigned as 0 and 1if otherwise. For decisions to use condom and right to information on RHR score given as 1 for positive and 0 for negative replay. Eventually, married women's decision-making on RHR among study units was set as binary outcome variable by merging the two groups of women together those scored above the mean categorized as higher decision making power whereas those who score less than mean score categorized as women with low decision making power on RHR after developing mean score independently for each.

Women's knowledge of RHR were assessed by considering knowledge regarding the components of RHR essentially that addresses reproductive health and rights services such as modern contraceptive, safe child bearing, reproductive tract infections, sexually transmitted infections, HIV/AIDS, safer sexual behavior and key danger signs during labor and childbirth. The desired answer was coded as 1; otherwise 0. Totally 32 questions will be asked to assess knowledge on RHR. Therefore, those mothers who scored above 70% (≥23) were knowledgeable, less knowledgeable otherwise (47).

Gender equitable Attitude of married women will be measured using 13 questions to construct composite score. Each question has 5 Liker scale response options based on degree of agreement on the statements about women equality. Based on the summative score, score above 80% of the distribution will be considered as having good gender equitable attitude or gender inequitable attitude otherwise (27).

Qualities of spousal relationship: it can be measured using five questions addressing the qualities of spousal relationship more than mean score shows good qualities of spousal relationship and less than half represents poor qualities of spousal relationship.

The Wealth Index- is a composite measure of the cumulative living standard of a household. The wealth index is calculated using household's ownership of selected assets, such as ownership of agricultural land, cattle, television, radio and bicycles, materials used for housing construction, bank account and amount of deposit on the account and types of water access and sanitation facilities. Wealth Index places individual households on a continuous scale of relative wealth using Principal components analysis.

The collected information on each household asset for which assigned a weight or factor score generated through principal components analysis. After computing these components together, an index was developed and used to create the break points that define wealth tertiles as: Lowest wealth tertile, Middle wealth tertile, and highest wealth tertile.

4.9 Data quality management

To assure the quality of the data, properly designed data collection instrument was developed in English after thoroughly revising related literatures and it was contextualized to suit to the research objective, local situations and language. The English version of the questionnaire was translated to local language (Afaan Oromo) and translated back to English to check consistency by language expert.

Before the actual data collection, the questionnaire was pre-tested on 5% (**21** women) in rural kebele of Alle district (Gogi Bachano) and necessary modifications were made specifically on the understandability of specific item. Reliability test done and cronbach's alfa ≥ 0.7 taken for actual data collection. Five data collectors were recruited for actual data collection who are fluent in Afaan Oromo after public notice then pass screening test. All were Female and Diploma Nurses who graduated from private colleges and currently not engaged in other responsibility were given priority. Two supervisors who were senior Nurses from the Health center to check for completeness of the data collection instrument and reporting problems encountered immediately to the principal investigator. Two-day training was given to data collectors and supervisors on general approach to data collection and on the questionnaires used for the survey including the procedures, techniques and ways of expressing the questionnaires to collect the necessary information. The training includes pretesting of the instrument.

Every day completeness and consistency of the collected data were reviewed and checked 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.

To minimize the nonresponse rate adjusting appropriate time for repeat visit with when respondents are unavailable or study households closed. The principal investigator and supervisors select for re-interview few married women in reproductive age group to check validity of the data.

4.10 Data Analysis procedures

The collected data were cleaned, edited, coded and entered into Epidata version 4.1 then exported to Statistical package for social sciences (SPSS) version 21.0. 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 table and figures Frequency and percentage will be presented.

To measure Socio-economic status, wealth Index using principal component analysis was done after checking for multi-colianearities, complex structures, communalities and internal consistencies of the high loading items, to develop composite scores.

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 less than 0.05 computed to assess the presence and degree of association and statistical significance between the dependent and independent variables. After checking for multi-collinearity for presence of linear association among explanatory variables, bivariate analysis run for each predictor variable with the outcome variable to see the independent effect. Variables that statistically significant at 0.25 in Bivariate (13 variables i.e**.** age category, educational status of both husband and wife, religion, access to micro-credit enterprises, knowledge about RHR, wealth status, marriage type, family size, duration of marriage, spousal age difference, gender equitable attitude and qualities of spousal relation) were entered to Multivariate Logistic regression model to get final model. Finally the results were presented in text and tables.

4.11 Ethical Consideration

Ethical clearance was obtained from the Institutional Review Board (IRB) of Jimma University (JU) Institute of Health, school of Post-Graduate Studies. Official letter of cooperation from JU and Mettu Rural District were used to communicate respective administrative bodies in the study area. After getting letter of permission to carry out the study from each administrative body, informed verbal consent were taken from each study subject prior to interview after the purpose of the study is explained. The respondents were informed that, the data collectors trained only to collect information but apart from this particular research, the data will not be passed to anybody. Privacy of the respondents were maintained and Confidentiality of the information was respected (personal identification and idea will not be used in the way which might threat the respondent). There is no payment/incentive in participating but for the interview. The interviewers informed on RHR benefits to the mother and child. The practice of decision-making power over RHR among married women for their reproductive wellbeing was advocated.

4.11 Operational Definitions and Definitions of Terms

- **Decision making power**: - the ability of women to have a final say or share equally in decisions on what to do for their reproductive health and rights in the household. It is classified as higher or lower decision making power on RHR.
  - **Higher decision making power on RHR** :- refers to women's have higher final say than her husband and other peoples in the household(if any) or she is fully exercising her RHR and/or she can have a decision making power on her own RHR.
  - **Lower decision making power on RHR** :- refers to women's have lower final say than her husband and other peoples in the household(if any) or she is not fully exercising her RHR.
- **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).
- **Access to micro-credit enterprises**: refers to those who are currently the member of micro-credit enterprises

- **Rural community**- Peoples residing in kebeles that are not administratively under the Town municipality.
- **Knowledge of RHR**: knowledge of different components of RHR such as modern contraceptive, safe child bearing, reproductive tract infections, sexually transmitted infections, HIV/AIDS, safer sexual behavior and key danger signs during labor and childbirth.
- **Qualities of spousal relationship:** Refers to free communication on RH issues, respect and help on daily activities of each other among couples.
- **Gender equitable attitude:** refers to household activities and responsibilities of women regarding reproductive health and rights.
- **Zone-** Government administration hierarchy next to regional state.
- **District** – Government administration hierarchy that exists between kebele and zone.
- **Kebele** – The lowest Government administrative hierarchy that exists next to district.

4.12 Dissemination Plan

The findings of the study will be presented to Jimma University community and copies will be submitted to Graduate School and Department of Population and Family Health of the University. The findings of the study will be communicated to the stakeholders and target population through reports, conference, and workshop. Finally, efforts will be made to publish on local or international journals in order to communicate the scientific community.

CHAPTER FIVE: RESULT

5.1 Socio-demographic Characteristics of the Respondents

Four hundred five women were interviewed yield a response rate of 97.6%. The mean (± SD) age of the women was 29.13 (± 6.53) years. Three hundred twenty nine (81.2%) of the women were Oromo by ethnicity. One hundred forty five (35.8%) of the religion of the respondents were protestant followed by orthodox 31.1% and 28.9% Muslim. Two hundred forty (59%) of the respondents attended formal education. Three hundred seventy four (92.3%) of the participants engaged in monogamous type of marriage see table 2.

Table 2: socio-demographic variables of married women of reproductive age group in Mettu Rural District, South-West Ethiopia March 14 to April 10, 2017.

Socio-demographic characteristics	Category	Frequency	Percent
Age group (in years)	15-19	10	2.5
	20-24	94	23.2
	25-29	116	28.6
	30-34	97	24.0
	35-39	56	13.8
	40-44	20	4.9
	45-49	12	3.0
Ethnicity	Oromo	329	81.2
	Amara	44	10.9
	Tigre	17	4.2
	Other*	15	3.7
Religion	Orthodox	126	31.1
	Muslim	117	28.9
	Protestant	145	35.8
	Others**	17	4.2
Educational status of respondent	no formal education	165	40.7
	primary(1-8)	166	41.0
	secondary and above	74	18.3
Educational status of husband	no formal education	112	27.7
	primary(1-8)	165	40.7
	secondary and above	128	31.6

* sheka, kefa, gurage ** traditional, wakeffata

5.2 Socio-Economic and Reproductive Characteristics of the Respondents

Majority of rural women have no access to micro-credit enterprises. Only one hundred thirty two (32.6%) have access to micro-credit enterprises. Nearly half (47.7%) of the participants have 3-4 family size with average (± SD) family size of 4.91(± 1.74). Two hundred eighty (69.1%) of participants were less knowledgeable about RHR. Three hundred thirteen (77.3%) have gender inequitable attitude and 236 (58.3%) have good qualities of spousal relation see table 3.

Table 3: socio-economic and reproductive health characteristics of married women of reproductive age group in Mettu Rural District, South-West Ethiopia March 14 to April 10, 2017.

Variables	Categories	Frequency	Percent
Access to micro-credit enterprises	Yes	132	**32.6**
	No	273	67.4
Wealth index	Lowest	136	33.6
	Middle	134	33.1
	Highest	135	33.3
	Monogamous	374	**92.3**
Marriage type	Polygamous	31	7.7
	1- <5 years	106	26.2
Duration of marriage	5 - < 10 years	95	23.5
	10 years and above	204	**50.4**
	3-4	193	**47.7**
Family size	5-6	145	35.8
	7 and above	67	16.5
	Knowledgeable	125	30.9
Knowledge about RHR	Less knowledgeable	280	**69.1**
	equitable	92	22.7
Gender equitable attitude	Inequitable	313	**77.3**
	Good	236	58.3
Qualities of spousal relation	Poor	169	41.7

5.3 Married women's level of decision making power on reproductive health and rights

The study revealed that women's level of decision making on reproductive health and rights mean (±SD) score was 7.50 (±2.64) indicating that two hundred thirty seven (58.5%) had lower decision making power on RHR while the remaining one hundred sixty-eight (41.5%) of married women's of reproductive age group had higher decision making power on RHR see Figure 3.

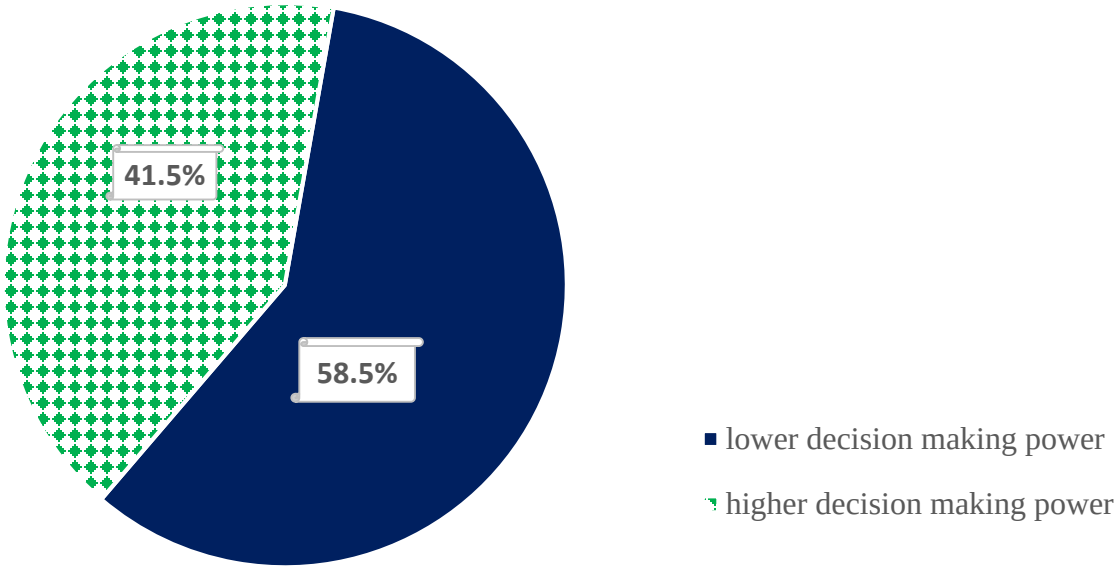

Figure 3: level of women's decision making on RHR among married women of reproductive age group in Mettu Rural District, South-West Ethiopia March 14 to April 10, 2017.

5.4 Independent Predictors of women's higher decision making power on reproductive health and rights.

Bivariate analysis reveals: attending formal education of respondents and their husbands, being in middle and highest wealth tertile, having gender equitable attitude, being a member of micro-credit enterprises, having good qualities of spousal relation, being knowledgeable about RHR, less than 10 years spousal age difference and more than 5 years marriage duration shows statistical significant association see Table 4.

In the multivariate logistic regression after adjusting for potential confounders attending formal education (own and husband), being a member of micro-credit enterprises, having good qualities of spousal relation, gender equitable attitude, being knowledgeable about RHR and ten or more than duration of marriage were found to be significant predictors of women's higher domestic decision making power on RHR see table 4.

A statistically significant difference was seen by education status even after controlling for the other variables. Women's Primary education were two times [AOR 2.62(95% C.I 1.15, 5.97)], secondary (9+) and above education were three times [AOR 3.18(95% C.I 1.16, 8.73)] and Husband's Primary education were four times [AOR 4.00 (95% C.I 1.53, 10.42)], secondary (9+) and above education were about four times [AOR 3.95 (95% C.I 1.38, 11.26)], more likely to be women's higher decision making power than those who had no formal education see table 4.

Having access to micro-credit enterprises were four times [AOR 4.26(95% C.I 2.06, 8.80)], gender equitable attitude were six times [AOR **6.38** (95% C.I **2.52, 12.45)]**, and good qualities of spousal relation were about three times (AOR 2.95 (95% C.I 1.30, 6.64)] more likely to be higher decision making power than their counterparts see table 4.

Duration of marriage and knowledge about RHR, were found to be the predictors of women's higher decision making power on RHR. Ten and more than duration of marriage were about three times [AOR 2.95 (95% C.I 1.19, 7.26)] and being knowledgeable were three times [AOR 3.57 (95% C.I 1.58, 8.09)] more likely to be higher decision making power than their counterparts.

Table 4: Independent of predictors of higher decision making power on RHR in Mettu Rural District, South-West Ethiopia March 14 to April 10, 2017.

Variables	Women's decision making power			
	Lower (%) (n=237)	Higher (%) (n = 168)	COR[95%C.I]	AOR[95%C.I]
Educational status of respondent				
No formal education	138(83.1)	28(16.9)	1.0	1.0
Primary(1-8)	65(41.1)	93(58.9%)	**7.05[4.21, 11.80]****	**2.62[1.15, 5.97]***
Secondary(9+) and above	34(42.0)	47(58.0%)	**6.81[3.74, 12.41]****	**3.18[1.16, 8.73]***
Husband's educational status				
No formal education	93(83.0)	19(17.0)	1.0	1.0
Primary(1-8)	92(55.8)	73(44.2)	**3.88[2.17,6.94]****	**4.00[1.53, 10.42]***
Secondary(9+) and above	52(40.6)	76(59.4)	**7.15[3.90,13.12]****	**3.95[1.38, 11.26]***
Wealth index				
Lowest tertile	105(77.2)	31(12.8)	1.0	1.0
Middle tertile	84(62.7)	50(37.3%)	**2.01[1.18, 3.43]***	1.04[0.36, 2.99]
Highest tertile	48(35.6)	87(64.4)	**6.13[3.60, 10.46]****	1.68 [0.56, 4.97]
Access to micro-credit enterprises				
Yes	36(27.3)	96(72.7)	**4.61[2.64, 8.06]****	**4.26[2.06, 8.80]****
No	80(74.1)	28(25.9)	1.0	1.0
Gender equitable attitude				
Gender equitable	21(22.8)	71(77.2)	**7.52[4.37,12.95]****	**6.38[2.52, 12.45]****
Gender inequitable	216(69.0)	97(31.0)	1.0	1.0
Knowledge about RHR				
knowledgeable	48(38.4)	77(61.6)	**3.33[2.14,5.16]****	**3.57[1.58, 8.09]***
Less knowledgeable	189(67.5)	91(32.5)	1.0	1.0
Qualities of spousal relationship				
Good	116(49.2)	120(50.8)	**2.60[1.71,3.97]****	**2.95[1.30, 6.64]***
poor	121(71.6)	48(28.4)	1.0	1.0
Spousal age difference				
Less than 5 years	67(45.3)	81(54.7)	**3.85[2.14,6.94]****	1.47[0.48, 4.48]
5-9 years	103(60.9)	66(39.1)	**2.04[1.14,3.64]***	1.22[0.35,4.20]
10 years and above	67(76.1)	21(23.9)	1.0	1.0
Duration of Marriage				
1-<5 years	84(76.4)	25(23.6)	1.0	1.0
5-<10 years	59(62.1)	36(52.5)	**1.97[1.07,3.64]***	1.23[0.46, 3.31]
≥ 10 years	97(47.5)	107(52.5)	**3.57[2.11,6.04]****	**2.95[1.19, 7.26]***

*Statistically significant at P-value <0.05, ** statistically significant at P-value <0.001, COR: crude odds ratio AOR: adjusted odds ratio, 1.0 reference category.

CHAPTER SIX: DISCUSSION

Exercising reproductive health rights has been recognized as one of the means to sustainable development in many developing countries including Ethiopia. Reproductive rights are among the human right that should have to be protected. It should be the women who could decide about her own reproductive health and rights especially during reproductive age period. When women's had higher decision maker in the household on their own reproductive health and rights; the health of the family as whole will be protected and thereby contribute for productive forces for the country as whole. In Ethiopia great majority of women's reside in rural areas especially where child bearing related complications endanger maternal health outcomes, empowering women's on RHR is plays a great role to tackle these problems. Women's decision-making alone or jointly with their husbands is one of factors contributing for effective and sustained use of RHRs services there by to early prevention of maternal mortality and to confirm the slogan " no mother should die to give life".

In this study only one hundred sixty-eight (41.5%) of married women's of reproductive age group had higher decision making power on reproductive health and rights; it is comparable with a report of a cross sectional study from Bale Zone by 2014 which is 39.5% of women's had higher decision making power regarding maternal and child health care(30). And also comparable with a report from cross sectional study in Southern Ethiopia by 2011 which is 43.1% of married rural women's have decision-making power on modern contraceptive use (27).

The finding of this study were lower than with the Ethiopian national level study that revealed 71.6% of rural women participate in own health care decision (48). This might be due to this study added other different components of RHR as composite variables.

This study were found different predictors of married rural women's of reproductive age group level of domestic decision making power on RHR. This study revealed that women those in marital union for ten and more were more likely to be higher decision making power on RHR than those who stay less than five years in marital union. This finding was consistent with study from Nekemte, West Ethiopia; which reports that women with less than five years were less likely to be household decision maker than those who were in marital union for ten and more years (35).

In this study having access to micro-credit enterprises were more likely to be higher decision maker. Similarly a qualitative study in Rural Tanzania in 2012, support the finding that microcredit by itself can significantly contribute to the non-economic aspects of empowerment regardless of whether one has taken a loan or not (38). Another cross sectional study in Kenya in 2013 shows a positive relationships between women's access to credit and reproductive decision-making roles (39). That is due to poverty at different level i.e. country, household, can become severe on females and increases their economic dependency. Microfinance has a positive impact on women's income, as there are limits to the income gains (37). Access to microcredits can facilitate both economic and non-economic changes in rural women's lives. Change in basic material possession expected to generate increased self-esteem, respect, and other forms of empowerment for women beneficiaries. This indicates that poverty can affect human lives in many different conditions by limiting human needs.

This study reveals that knowledge and gender equitable attitude were associated with higher decision making power. Study in southern Ethiopia and Bale Zone similarly showed that knowledge and gender equitable attitude were associated with women's decision making power (27, 30).

In this study own and husband's formal education were positively associated with women's decision making power. Women's with primary education were two times and those with secondary (9+) and above education were three times more likely to be higher decision making power as compared with those who had no formal education. And also women with husband primary and secondary (9+) education were about four times more likely to be higher decision maker those with husband no formal education. This finding was supported by a systematic review

on women's autonomy in healthcare decision-making in developing countries in 2016 which reported that highly educated women are more likely to be knowledgeable about their own health, have more self-confidence, and be more assertive than those with less or no education (20). This might be due to men's awareness of his duties and responsibilities as husband and head of family and also makes women could easily influence their husbands and significant others.

In the analysis spousal relation were found to be the predictor of women's higher decision on RHR. Good spousal relations has three times more likely to be higher decision maker. This is also shows that good spousal relation enhance communication which develop a trust among spouses, open discussion, mutual respect of idea for the mandatory decisions.

Strength and limitations of the study

Strength of the study

Although there is no commonly agreed definition for decision making power on reproductive health and rights and its complexity to measure, this study tried to address the most frequently used components on women's decision making power regarding RHR by different scholars (27 30, 35, 44, 45)

Limitations of the study

Social desirability and recall bias may compromise the finding since many of gender sensitive responses may be over masked even if interview conducted in private room and multiple questions used to minimize it.

Excluding men response and relying only on women does not mean that women's report only could definitely reveal the problem.

The study used cross-sectional study design, hence it is not possible to clearly establish cause-effect relationship between the dependent and explanatory variables.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

Conclusion

Less than half of the respondents have higher decision making power on RHR in their households. Married women will not fully exercise their reproductive health and rights equally with their husband due to numerous challenges. Having husband with formal educational status, own formal education, being knowledgeable about RHR, having gender equitable attitude, good quality spousal relationship, being member of micro-credit enterprises and ten and above years marital union were the independent predictors of married women of child bearing age higher decision making power on RHR.

Recommendations

All these factors should be taken into account in designing interventions on women's empowerment through both economic and non-economic aspects especially to decrease the high level of maternal mortality and achieve universal coverage of reproductive health.

- **To policy makers**

♣ To design programs that address rural women through programs that encourage qualities of spousal relations with strategies that Strengthen partner communication and assertiveness skills among couples to improve RHR decision making process.

- **To health managers and stakeholders (FMOH, RHB, ZHO, MOE, and NGOs)**

♣ Scale up and strengthening integration of gender related activities in formal education through working in schools to encourage more balanced relationship dynamics between males and females from an early age. These types of efforts would improve women's and men's abilities to meet their childbearing goals and in combination with other social forces which contribute to broader health improvements associated with gender equity.

♣ Expanding micro-credit enterprises to rural areas with promotion of women membership.

♣ Community based awareness creation should be delivered to increase knowledge about RHR.

- **For scientific communities**

♣ To conduct qualitative studies on longitudinal base to explore the sociocultural factors like taboos, values, believes on sexuality etc. as predictors of women's higher decision making power on RHR

REFERENCES

1. WHO. WHO's strategic vision in sexual and reproductive health and rights Business Plan 2010–2015. 2010. 1 p.
2. ICPD. Program of Action adopted at the International Conference on Population & Development [Internet]. cairo: UN; 1994. 43-53 p. Available from: http://www.un.org/popin/icpd/conference/offeng/poa.html
3. FindLaw. Intelligent legal information [Internet]. Thomson Reuters Business. 2013 [cited 2017 Dec 15]. Available from: http://creativecommons.org/licenses/by-nc-nd/3.0/.
4. WHO. Transforming Health Systems:Gender and reproductive rights. training manual for health managers [Internet]. 2016 [cited 2017 Dec 20]; Available from: http://who.int/reproductivehealth/gender/index.html
5. IPPF. Sexual and reproductive health and rights – the key to gender equality and women ' s empowerment. 2015. 6-10 p.
6. UK. Sexual and reproductive health and rights A position paper. London; 2004.
7. UN. A life of dignity for all: accelerating progress towards the Millennium Development Goals and advancing the United Nations development agenda beyond 2015. In: UN Doc A/68/202. 2013. p. 27.
8. Central Statistical Agency, USAID, UNFPA. Ethiopian Demographic and Health Survey. Addis Ababa, Ethiopia; 2011. 253-254 p.
9. Popphd T, Christian P, Constantinovici AM. Reproductive Decision Making Among The Women. Int Multidiscip Res J [Internet]. 2015;4(10). Available from: www.aygrt.isrj.org
10. Hou X, Ma N. The effect of women ' s decision-making power on maternal health services uptake : evidence from Pakistan. Heal Policy Plan Adv Access Publ. 2012;5.
11. Worku A, Kenie S. Maternal delays in utilizing institutional delivery. 2013;5(6):1026–31. Available from: http://dx.doi.org/10.4236/health.2013.56137 Health
12. Olufunmilayo F, Ikeola A. Women ' s status within the household as a determinant of maternal health care use in Nigeria. Afr Health Sci. 2015;15(1):217–25.
13. Al Riyami A, Afifi M. Women´s autonomy, education and employment in Oman and their influence on contraceptive use. Reprod Health Matters. 2004;12(23):144–54.
14. Khadijah S, Tajuddin A, Shamsuddin K. Decision Making Behaviour Related to Wife ' s Reproductive Health in Bidayuh Men in Rural Part of East Malaysia. IOSR J Nurs Heal Sci [Internet]. 2015;4(1):56–63. Available from: www.iosrjournals.org
15. WHO. Gender and rights in reproductive and maternal health. Kuala Lumpur; 2011. 37 p.
16. Ministry for Foreign Affairs of Finland. Freedom to Choose:Sexual and Reproductive Health and Rights. 2010. 13 p.
17. International Labour Organization. Global Employment Trends for Women. 2009. 43 p.
18. D'Souza MS, Karkada SN, Somayaji G, Venkatesaperumal R. Women ' s well - being and reproductive health in Indian mining community : need for empowerment. Reprod Heal [Internet]. 2013;10(24):1–28. Available from: http://dx.doi.org/10.1186/1742?4755?10?24
19. UNFPA. Messages and Preliminary Findings from the ICPD Beyond 2014 Global Review [Internet]. 2013 [cited 2016 Dec 22]. Available from: availableathttp://icpdbeyond2014.org/uploads/browser/files/initial_findings_of_icpd_beyond_global_survey.pdf
20. Osamor PE, Grady C. Women ' s autonomy in health care decision- making in developing

countries : a synthesis of the literature. Int J Women's Heal. 2016;8:191–202.
21. Sultana AM. Cross Sectional Study on Decision-making Power of Working and Non-working Women in Family Planning and Reproductive Health Care. J Women's Heal Issues Care [Internet]. 2014;3(2). Available from: https://www.researchgate.net/publication/269694914
22. Orubuloye IO, Oguntimehina F, Sadiqb T. Women ' s role in reproductive health decision making and vulnerability to STD and HIV / AIDS in Ekiti , Nigeria *. Heal Transit Rev. 1997;7(October 1996):329–36.
23. Sharma A, Kader M. Effect of Women ' s Decision-Making Autonomy on Infant ' s Birth Weight in Rural Bangladesh. ISRN Pediatr [Internet]. 2013;2013. Available from: http://dx.doi.org/10.1155/2013/159542
24. Ushma D U, Jessica D G, Mellissa W, Lewis S, Ciaraldi EJ, Fraser A, et al. Social Science & Medicine Women ' s empowerment and fertility : A review of the literature. Soc Sci Med [Internet]. 2014;115:111–20. Available from: http://dx.doi.org/10.1016/j.socscimed.2014.06.014
25. FMOH. HSDP IV ANNUAL PERFORMANCE REPORT. Addis Ababa, Ethiopia; 2015. 24 p.
26. UNDP. FP2020 2015-2016 PROGRESS REPORT [Internet]. 2016. Available from: familyplanning2020.org/progress
27. Bogale B, Wondafrash M, Tilahun T, Girma E. Married women ' s decision making power on modern contraceptive use in urban and rural southern Ethiopia. BMC Public Health. 2011;11(342):342.
28. UNFP. MAKING REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH A REALITY FOR ALL [Internet]. New York; 2008. Available from: www.unfpa.org
29. Central Statistical Agency[Ethiopia]. Ethiopia Mini Demographic and Health Survey. Addis Ababa, Ethiopia; 2014.
30. Nigatu D, Gebremariam A, Abera M, Setegn T, Deribe K. Factors associated with women ' s autonomy regarding maternal and child health care utilization in Bale Zone : a community based cross-sectional study. Women's Heal. 2014;14(1):1–9.
31. Samari G, Pebley AR. Individual and Household Determinants of Women ' s Autonomy : Recent Evidence from Egypt. Calif Cent Popul Res. 2015;
32. Bisika T. Cultural factors that affect sexual and reproductive health in Malawi Cultural factors that affect sexual and reproductive health in Malawi. 2008;34(2):79–80. Available from: www.poly.ac.mw/library.html
33. Bilisuma Bushie Dito. Women ' s Intrahousehold Decision-Making Power and Their Health Status : Evidence from Rural Ethiopia. Fem Econ [Internet]. 2015;21(3):168–90. Available from: http://dx.doi.org/10.1080/13545701.2015.1007073
34. Belay AD, Mengesha ZB, Woldegebriel MK, Gelaw YA. Married women ' s decision making power on family planning use and associated factors in Mizan-Aman , South Ethiopia : a cross sectional study. BMC Womens Health [Internet]. 2016;16(12):1–6. Available from: http://dx.doi.org/10.1186/s12905-016-0290-x
35. Teferi E., Garoma S. Married women's access to resources and decision making powerin Nekemte Town, West Ethiopia. El Mednifico J. 2014;2(4):334–40.
36. Doku D, Neupane S, Doku PN. Factors associated with reproductive health care utilization

among Ghanaian women. BMC Int Health Hum Rights [Internet]. 2015;12(29). Available from: http://www.biomedcentral.com/1472-698X/12/29
37. UN. Women's Control over Economic Resources and Access to Financial Resources, including Microfinance. 2009.
38. Shekilango SM. Microcredit and Empowerment of Rural Women Experience from Mbeya Region Tanzania. 2012;(May):1–51.
39. Kabutiei G. Roles in the community among the Njemps in Baringo country. unpublished. 2013;
40. Santhya, K. G., & Jejeebhoy SJ. Sexual and reproductive health and rights of adolescent girls: Evidence from low and middle-income countries. Glob Public Health. 2015;10(2):189–221.
41. Moronkola OA, Ojediran MM, Amosu A. Reproductive health knowledge , beliefs and determinants of contraceptives use among women attending family plan- ning clinics in Ibadan , Nigeria. Afr Health Sci. 2006;6(3):155–9.
42. Banerjee S, Roy A. Determinants of Female Autonomy across Indian States. J Econ Bus Manag. 2015;3(11):1037–40.
43. Atiglo, Yaw D. Gender in Reproductive Decision-making : Issues of Intersectionality and Kyriarchy ? 2016;
44. Nyakato V. Couple Relations , Decision-making Hierarchy and Use of Maternal Health Care in Rural Uganda. 2013;I(6):1216–48.
45. Speizer BIS, Carter M. Gender Relations and Reproductive Decision Making. Int Fam Plan Perspect. 2005;31(3):131–9.
46. Mettu Woreda Health Office. Mettu woreda annual base plan[unpublished]. Mettu,Ethiopia; 2016.
47. Amaha Haile, Enkusilassie F. Influence of Women ' s autonomy on couple ' s contraception use in Jimma town , Ethiopa. EthiopJHealth. 2006;20(3):1–7.
48. EDHS. Ethiopia. 2011.

APPENDIX-I: QUESTIONNAIRE: AN ENGLISH VERSION

Jimma University Institute of Health

School of Graduate Studies, Population and Family Health department

INTRODUCTION

Hello Hi, my name is _____ and I am working with Mr. Afework Tadele from Jimma University. He is doing a research on determinants of married women decision-making power over reproductive health and rights, as partial fulfillment for Master's Degree in Public Health in Reproductive Health.

You have been randomly selected to participate in this study. 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 later. 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 or incentive paid for participation but finally I will give you information about reproductive health and rights.

Information gathered from the study will be used to improve programs that promote the wellbeing of women.

Therefore, I hope you will give accurate answers! I appreciate your help in responding to this survey questions.

Do you have any questions?

Can I proceed with the Questions?

No _____ (Thank and stop)
Yes_____ (Thank and continue)

	First Visit	Second visit	First visit
Present			
Absent			

Kebele _____ Time started _____ Time finished _____

Questionnaire code _____ Date of interview _____ /_____ /2017

PART I: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

S/No	Questions	Responses	Remark
101	Age of the respondent	☐ years old	
102	Age of husband	☐ years old	
103	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Wakefata 99. Others specify……	
104	Ethnicity	1. Oromo 2. Amhara 3. Tigire 4. Sheka 5. Gurage 99. Others [specify]_____	
105	Highest level of education attained	1. Unable to read and write 2. Able to read and write 3. Grade ☐ th complete 4. diploma 5. degree and above	
106	What was the highest grade your husband completed?	1. Unable to read and write 2. Able to read and write but no formal education 3. Grade _____ th complete 4. diploma 5. degree and above	

107	Type of marriage	1. Legally/ formally married on my choice and the only wife 2. Legally/ formally married in the will of our family and the only wife 3. Legally/ formally married and husband has another wife	
108	How long you live with your husband/partner	_____ years and ____months	
109	What is your family size	_____	
110	Is there Micro-enterprises for saving and credit in your area?	1. Yes ⟶ 0. No	Skip to Q.113
111	Are you the member of the enterprise?	1. Yes 0. No	
112	Number of pregnancy	_____	
113	Number live children	_____	

PART II: SOCIO-ECONOMIC CHARACTER OF THE RESPONDENTS

S/No	**Questions**	**Responses**	**Remark**
201	What is the main source of water for members of your household?	1. piped water 2. protected well 3. unprotected well 4. protected spring 5. unprotected spring 6. Surface water (River) 99. other specify _____	✓ multiple answer is Possible ✓ probe and mark all that apply
202	What kind of toilet facility do members of your household usually use?	1. ventilated improved pit latrine (VIP) 2. pit latrine with slab 3. pit latrine without slab/ open pit 4. No facility/bush/field	

		99. other specify _____	
203	Does your household have:	1 A bed 2. A bicycle 3. A motorcycle 4. A car 5. A table 6. A chair 7. A watch 8. A radio 9. A mobile telephone 10. Electricity 11. Generator 12. Solar 13. Television	✓ multiple answer is Possible ✓ probe and mark all that apply
204	Do you have separate room that is used as kitchen?	1. Yes 0. No	
205	Main material of the floor	1. earth/ mud 2. wood en 3. cement 99.other specify____	**RECORD OBSERVATION**
206	Main material of the roof	1. leaf 2. corruga ted iron sheet 3. cement 99. other specify	**RECORD OBSERVATION**
207	Main material of the walls	1. wooden and mud 2. wood/sticks and Cement 3. Bricks(shekila) 4. other [specify	**RECORD OBSERVATION**
208	How many household members are sleeping in one room?		
209	Does any member of this household own land that can be used for agriculture?	0. Yes 0. No	

210	Does this household own any livestock, herds, or farm animals?	1. Yes 0. No	Skip to Q. 212
211	How many of the following animals do this household own?	1. Milk cows ☐ 2. Oxen or bulls ☐ 3. Horses ☐ 4. Donkeys ☐ 5. Mules ☐ 6. Goats ☐ 7. Sheep ☐ 8. Chickens ☐	
212	Do you have bank account?	1. Yes 0. No	Skip to Q. 301
213	How many birr do you have on the account?	_____ ETB	

PART III: KNOWLEDGE ON WOMEN'S REPRODUCTIVE HEALTH AND RIGHTS OF THE RESPONDENTS

S/No	Questions	Responses	Remark
301	Have you ever heard reproductive health and rights? [*Probe listing reproductive health services possible]*	1. Yes 2. No	Skip to Q. 303
302	From where or whom you have heard of it?	1. health professionals 2. health extension workers 3. peer 4. radio/television 5. husband 99. others specify _____	
304	Do you know Sexually transmitted infection?	1. Yes 0. No	
305	What signs and symptoms of STI do you know in women?	1 . vaginal discharge 2 . genital ulcer 3 . Lower abdominal pain	*mark all that apply*

		4 . I don't know 99. Other specify ……..	
306	Do you have the right to refuse sex if you suspect your husband infected with STI?	1. Yes 0. No	
307	Sexually transmitted infection cause infertility?	1. Yes 0. No 88. I don't know	
308	Sexually transmitted infections cause cervical cancer?	1. Yes 0. No 88. I don't know	
309	Can sexually transmitted infections cause liver disease?	1. Yes 0. No 88. I don't know	
310	Can woman get pregnancy with a single sexual intercourse?	1. Yes 0. No 88. I don't know	
311	Do you know your reproductive rights?	1. Yes 88. I don't know	
312	What reproductive rights do you have?	1 . Right to get information 2 . right to get RH services 3 . decide on childbearing 4 . privacy during RH services 5 . confidentiality during RH services 6 . I don't Know 99. Other specify …….	*read from the list and mark all that apply*
313	Is there family planning for male	1. Yes 0. No →	Skip to Q. 315
314	Which type of MALE contraceptive methods do you know?	1. Condom 2. Vasectomy/male sterilization 3. Others specify……..	
315	Which advantages of FP do you know?	1. To Limit family size 2. To avoid unwanted pregnancy 3. To Space child birth 4. For the mothers well being 5. child health	*mark all that apply*

		6. I don't know 99. other specify	
316	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 99. other _____	
317	Which type of FEMALE contraceptive methods do you know?	1. Pills 2. Intrauterine device (IUCD) 3. Injectables (Depo-Provera) 4. Implanon (buried under skin) 5. Tubal ligation/female sterilization 99. other specify_____	*read from the list and mark all that apply*
318	What shows danger/problem during pregnancy and child-birth?	1. severe headache 2. severe abdominal pain 3. blurring of vision 4. vaginal bleeding 5. I don't know 99. other specify ____	*read from the list and mark all that apply*
320	From where do you get education on reproductive health?	1. health post 2. health center 3. hospital 4. I did received education on RH 99. other specify _____	

PART IV. GENDER EQUITABLE ATTITUDE OF THE RESPONDENTS

Different people have different ideas about RHR and what is acceptable behavior for men and women in the home. I will ask you some questions, you will just tell me whether you generally agree or disagree with the statement. There is no correct or incorrect answer.

S/No	Question	Strongly agree	agree	Neutral	Disagree	Strongly disagree
401	A man should have the final say in all family matters	1	2	3	4	5
402	Woman have not the right refuse sex with her husband if she is not feeling good	1	2	3	4	5
403	A good wife obeys her husband even if she disagrees	1	2	3	4	5
404	Women shouldn't report to police if forced to have sex with her intimate partner	1	2	3	4	5
405	A woman needs her husband's permission to do Paid work	1	2	3	4	5
406	Women should have ask her husband/partner if she needs sex	1	2	3	4	5
407	It is a woman's job to take care of the home and cook for her family.	1	2	3	4	5
408	A woman need her husband's permission to use any contraceptive method	1	2	3	4	5
409	It is the husband who should decide the number of children the couples should have	1	2	3	4	5
410	Husband shouldn't allow his wife to discuss family planning with him	1	2	3	4	5

411	A wife should tolerate being beaten in order to Keep her family together	1	2	3	4	5
412	It should be the husband who should decide how to spend the family income	1	2	3	4	5
413	Wife shouldn't have ownership and authority on the family wealth	1	2	3	4	5

PART V: Qualities of spousal relationship

S/No	**Questions**	**Responses**	**Remark**
501	Do you have open discussion with your husband/partner?	1. Yes 0. No ⟶	Skip to Q. 513
503	Have you had time with your partner in the last 6 months to plan for the family needs?	1. Yes 0. No	
504	Do you feel your spouse treats you with respect	1. Yes 0. No	
505	Do you feel that your spouse treats you fairly	1. Yes 0. No	
506	Do your husband/partner has willingness to help work around home with you?	1. Yes 0. No	

PART VI: WOMEN'S DECISION MAKING POWER

Who has a final say on the following? Is it you, your husband, or the two of you, or other persons? **If Response is Jointly Ask,** if you and your husband's decision do not match whose decision will prevail? **Encircle the number under the column as responded**)

S/No	Questions	wife	Husband	Jointly	Other (specify)	Whose decision will prevail
601	On the number of children to have	2	1	0	99	
602	Do you use/ever used Modern contraceptive?	1. Yes 2. No				if yes Skip to Q 609
603	Who has the final say on Modern contraceptive use	2	1	0	99	
604	What is your main reason not to use/intend to use modern contraceptives?	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 Others, specify……				
605	Own health care	2	1	0	99	
606	When to become pregnant	2	1	0	99	
607	When to have Sexual intercourse	2	1	0	99	
608	Place to give birth	2	1	0	99	
609	Do you use/ever used Modern contraceptive?	8. Yes 2. No				Skip to Q 60 if No
610	Who has the final say on Modern contraceptive use	2	1	0	99	
611	What is your main reason not to use/intend to use modern contraceptives?	1, Fear of side effect 9. Husband opposition 10. Lack of knowledge 11. Religious prohibition				

		12. Opposition from relatives 13. Desired number of children not achieved 14. Decreases sexual pleasure 99. Others, specify……	
612	Did you ever have used ANC?	1 yes 2 no	If yes Skip to Q 60
613	Who has the final say to use ANC	2 | 1 | 0 | 99	
614	What is your main reason not to use/intend to use ANC?	1. Distance of health facility 2. Husband opposition 3. Lack of knowledge 4. Religious prohibition 5. Opposition from relatives 99. Others, specify……	
615	Place to give birth	2 | 1 | 0 | 99	
616	Do you have Freedom of visiting a health facility or other places to get information on RHR?	1. Yes 0. No	
617	Can you ask your husband to use a condom if you suspect your husband has relation with other female or for STIs?	1 Yes 0. No	

APPENDIX-II: UNKA GAAFANNOO AFAAN OROMOO

Yuuniversiitii Jimmaatti Dhaabbata Fayyaa

Kutaa Fayyaa Maatiif Uummataa

Harka Fuune! Akkam bulte/oolte? Ani maqaankoo _____ _____ Jedhama. Kanan Hojjedhu Obbo Afawarqi Taaddalaa Yuunivversitii Jimmaatti qo'annoo Aangoo murtee kennuu Dubartoota erumanii isaaniirratti digrii lammaffaa Fayyaa hawaasaatiin fayyaa walhormataa guutuuf hojjatan waliini.

Kana ati qo'annoo kana keessatti akka hirmaattu filatamte carraadhaani. Gaaffiin kun yeroo muraasa fudhachuu danda'a. amma yeroo hin qabdu yoota'e yeroo siif mijatu deebi'uu dhufuu nan danda'a. wanti aniif ati haasofnu hundiyyuu iccitiin isaa kan eegamefi gabaasni qorannoo kanaas maqaa kee hin dabalatu. Akkasumas miidhaa ykn kaffaltii hin qabu garuu dhuma irratti odeeffaanoo waa'ee Fayyaa walhormaata irratti siifan kenna.

Odeeffannoon qo'annoo kana irraa argamus sagantaalee fayyaa dubartoota foyyessuuf gargaaraniif fayyada.

Kanaafuu, deebii sirrii akka naaf laattu abdiin qaba.

Gaaffii qabdaa?

Itti fufuu dandeenya?

Lakkii _____ (galateeffadhutii dhaabi)

	Daawwanna		
	Jalqaba	Lammaffaa	Sadaffaa
Jirti			
Hinjirtu			

Eeyyee _____ (galateeffadhuutii itti fufi)

Kebele _____

coodii _____

Sa'a itti egaalame _____ sa,a itti xumurame _____

Guyyaa _____ /_____ /2009

KUTAA 1: GAAFFILEE HAWAASUMMAA WALIIN WAL-QABATAN

Lakk.	Gaaffiilee	Deebii	Yaada
101	Umurii		
102	Umurii abbaa warraa		
103	Amantii	1, Ortodoksii 2, Musliima 3, Protestantii 4, Waaqeffataa 99. kan biroo ……	
104	Saba	1, Oromoo 2, Amaara 3, Tigire 4, Sheka 5,Gurage 99.kan biroo (caqasi __	
105	Sadarkaa barnootaa	1.Barreessuuf dubbisuu hin dada'u 2. barreessuuf dubbisuu nan danda'a 3. Kutaa faa xumure 4. dippilooma 5. digriif isaa ol	
106	Sadarkaa barnootaa	1. Barreessuuf dubbisuu hin dada'u 2. barreessuuf dubbisuu nan danda'a 3. Kutaa xumure 4. dippilooma 5. digriif isaa ol	
107	Akkaata Eerumaa	1 waliigalteen seeraan/aadaan utuu hin taane 2. seeraan ykn aadaan fedhii kotiini 3. seeraan ykn aadaan fedhii maatiitiin 4. seeraan ykn aadaaniifi abbaan manaa haadha manaa biro qaba	
108	Abbaa warraa kee waliin hammam turtan	Waggaa ____ ji'a ____	
109	Baay'ina maatii	_____	
110	Waldaan liqiif qusannoo naannoo kana jira?	1. Jira	Gara gaaffii 113

		2, hin jiru ⟶	
112	Ati Miseensa waldichaati?	1 Eeyyee 0 laakki	
114	Meeqa ulfoofte	_____	
115	Amma Ijoollee meeqa qabda	_____	

KUTAA 2: GAAFFIILEE QABEENYA MANAAN WAL-QABATAN

Lakk.	Gaaffiilee	Deebii	Yaada
201	Bishaan itti fayyadamtan eessarra argattu?	1, Tubboo bishaanii 2, Bishaan boolla kan eegame 3, Bishaan boolla kan hineegame 4, Burqituu kan eegame 5, Burqituu kan hin eegame 6, Bishaan yaa'u 99. kan biro	✓ Kan deebii ta'e hundatti mari
202	Mana fincaanii?	1, Sadarkaa isaa kan eeggate 2, Boolla godoo xiqqoo qabu 3, Boolla qofa 4, hinqabu 5, kan biroo_____	
203	Mana keessan keessa kanneen armaan gadii jiru:	1, siree 2, saayikilii 3, motor saaykilii 4, konkolaataa 5, xarapheezzaa 6, teessumee 7, sa'aatii 8, Reediyoo 9, Bilbila moobaayilii 10, Elektrikii 11, Generator 12, Solarii 13, Televizyinii	✓ Kan deebii ta'e hundatti mari

204	Kushiinaan kophaatti jira?	1. Jira 2. Hin jiru	
205	Lafti manaa maalirra hojetame	1, Lafa/ dhoqqee 2, Muka 3, Simmintoo 99. kan biroo_	**ILAALII GUUTI**
206	Ijoon manaa maalirra hojetame	1, Caffee 2, qorqorroo 3, simmintoo 99. kan biro ___	**ILAALII GUUTI**
207	Girgiddaan manaa maalirra hojjetame?	1, Mukaaf dhoqqee 2, Mukaaf simmintoo 3, bilookkettii 4, mulaaf shakilaa 99. kan biro _____	**ILAALII GUUTI**
208	Kutaa tokko keessa miseensa mana nama meeqatu ciisa?		
209	Lafa qonnaa qabduu?	1.Eeyyee 0. Miti	
210	Lafa buna qabduu	1 Eeyyee 0. miti	
211	Horii manaa qabduu?	1. Eeyyee → 0. miti	Gara gaaffii 301
212	Kanneen armaan gadii meeqa qabdu?	1, Sa'a aannanii 2, sangaa / jiboota 3, farado 4, Gaangee 5, Harree 6, Re'ee 7, Hoolaa 8, hindaaqqoo	
213	Herrega baankii qabduu	1, Eyyee 0, Miti →	Gara Gaaffii 301
213	Qarshii meeqa herrigicharra qabdu?	Qarshi _____	

KUTAA 3: GAAFANNOO BEEKUMSA MIRGAAF FAYYAA WALHORMAATA DUBARTOOTAA

Lakk.	Gaaffiilee	Deebii	Yaada
301	Mirgaaf fayyaa walhormaataa dhageesse beektaa? [*tajaajila fayyaa wal-hormaata maqaa dhayuun yadachiisuun ni danda'ama*]	3. Eeyyee 4. lakki →	Gara gaaffii 303
302	Eessaa dhageesse?	1, Ogeessa fayyaa irraa 2, Hojjetota ekstenshinii fayyaa irraa 3, Hiriyaa irraa 4, Reediyoo ykn televizyinii 5, Abbaa warraa 99. Kan biro(ibsi) _____	
303	Abbaa warraa kee dubartii bira waliin yoo shakkite wal-quunnamtii saalaa diduu ni dandeessa?	1. Eeyyee 0. Miti	
304	Dhibee nafa saalaan darban ni beektaa?	1. Eeyyee 0. Miti	
305	Mallattoole Dhibee nafa saalaan daddarbanii maalfa'i?	1, dhangala'a fooli adda ta'e qabu kara nafa saala dubartii ba'u 2, madaa'u nafa saalaa 3, garaa dhukkubbii handhuura gadi 4, hin beeku 99. kan biro ……..	*Kan deebii ta'e hundatti mari*
307	Dhibeen nafa saalaa maseenummaa fiduu danda'u?	1.eeyyee 0. lakki 2. hin beeku	
308	Dhibeen nafa saalaa kaansari afaan gadameessa fiduu ni danda'u?	1. eeyyee 0. lakki 2. hin beeku	

309	Dhibeen nafa saalaa dhibee tiruu fiduu ni danda'u?	1. eeyyee 0. lakki 2. hin beeku	
310	Wal-quunnamti saalaa tokko qofaan ulfaa'uun ni danda'ama?	1. eeyyee 0. lakki 2. hin beeku	
311	Mirga fayyaa wal-hormaataa ni beektaa?	1. eeyyee 0. lakki	
312	Maal fa'i?	1, Mirga odeeffanoo argachuu 2, Mirga tajaajila fayyaa wal hormaata argachuu 3, Daa'ima godhachuu 4, Kutaa qofaa ta'etti tajajila argachuu 5, Iccitii tajaajilamaa eeguu 6, Hin beeku 99. kan biro _____	*Dubbisiifi kan sirrii ta'e hundatti mari*
313	Karoorri maatii dhiiraa jira?	1. Yes ——→ 0. No	Gara gaaffii 315
314	Maal fa'i?	1, koondomii 2, ujummo sanyii dhiiraa dabarsu muruu 99, kan biro _____	
315	Faayidaan karoora maatii maalfa'i?	1, baay'ina maatii murteessuuf 2, ulfa hin barbaachifne dhorkuuf 3, walirraa fageessani daa'ima goadhachuuf 4, fayya haadholiif 5, fayyaa daa'imaaf 6, hin beeku 99. kan biro _____	Kan deebii ta'e hundatti mari
316	Da'ima waggaa meeqa walirra fageessanii godhachuutu gariidha?	1, < 1 2, 1-2 3, 3-5 4. hin beeku 99. kan biro _____	
317	Karoorri maatii dubartii maal fa'i?	1, Pills 2, Intrauterine device (IUCD) 3, Injectables (Depo-Provera) 4, Implanon (gogaa jala kan awwalamu) 5, Ujummo gadameessa guduunfuu 99. kan biro ___	*Dubbisiifi kan sirrii ta'e hundatti mari*

318	Mallattolee balaa cimoo yeroo ulfaafi da'umsaa maalfa'i?	1, Mataa bowwu cimaa 2. Dhukkubbi garaa cimaa 3, Ija dura maruu 4, Dhangal'uu dhiigaa karaa nafa saalaa 5, hin beeku 99. kan biro _____	*Dubbisiifi kan sirrii ta'e hundatti mari*
320	Barnoota fayyaa walhormaata eessarraa argachuu dandeessa?	1, Kellaa fayyaa 2, Buufata fayyaa 3, Hospitaala 4, Hin beeku 99, Kan biro _____	

KUTAA 4: ILAALCHA WAL-QIXXUMMAA KOORNIYAA

Namni garagaraa waa'ee mirgaafi fayyaa wal-hormaataa amala dhiirriif dubartiin mana keessaatti qabdu irratti yaada garagaraa qaba. Gaaffileen sigaafadhuuf akka itti waligaltuuf hin galle natti himta. Deebi sirriin ykn sirrii hintaane hin jiru.

Lakk.	Gaaffiilee	Baay'een itti gala	Waliin gala	Giddu-galeessa	Ittiin walii hingalu	Baay'ee Ittiin wali hingalu
401	Dhimma maatii hunda irratti dhiiratu murtee dhumaa kennu qaba	1	2	3	4	5
402	Dubartii mirga wal-quunnamtii saalaa gochuu didu hin qabdu yoo itti hin tolleyyu	1	2	3	4	5
403	Haati manaa gaariin abba warraa seef abboomamu qabdi yoo yaadichatti itti hin amannes	1	2	3	4	5
404	Dubartiin hiriyaa ishee dhiyoon yoo dirqisiifamtee gudeedamte poolissif gabaasuu hinqabdu.	1	2	3	4	5
405	Dubartiin hojii kaffaltii qabu hojjechuuf abba warra isee eyyamsiisu qabdi.	1	2	3	4	5

406	Dubartiin wal-quunnamtii saalaa yoo feete abba warraa isee gaafachuu hin qabdu.	1	2	3	4	5
407	Hojiin mana keessaaf soorata maatiif bilchessuun ga'ee dubartiiti.	1	2	3	4	5
408	Karoora maatii fayyadamuuf dubartiin abba warra isee eyyamsiisuu qabdi.	1	2	3	4	5
409	Baay'ina daa'ima matiin godhachuu qabu abbaa warraatu murteessa.	1	2	3	4	5
410	Abbaan warraa haadha warraatiif waa'ee karoora matii akka mariyattu eeyyamu hin qabu.	1	2	3	4	5
411	Dubartiin yoo rukutamte akka matiin see hin diigamne callisuu qabdi.	1	2	3	4	5
412	Galii maatii akka baasii ta'u kan murteessu abba warraa ta'uu qaba.	1	2	3	4	5
413	Haati warraa qabeenya manaa irratti abbummaaf aboo hin qabdu.	1	2	3	4	5

KUTAA 5: QULQULLINA HARIIROO ABBAA WARRAAF HAADHA WARRAA

Lakk.	Gaaffiilee	Deebii	Yaada
501	Abbaa warraake waliin iftoominaan ni mariyattu?	1. Yes ⟶ 0. No	Gara gaaffii 503
503	Ji'oota 6 darbaniif Wanta maatiif barbaachisu irratti abba warraakee waliin mariyattanii beektu?	1. Eeyyee 0. lakki	
504	Abbaa warraa kee kabajaan si kunuunsa jette yaadda?	1. Eeyyee 0. lakki	
505	Abbaan warraa kee haala gaha ta'een si kunuunsa jettee yaadda?	1. Eeyyee 0. lakki	
506	Naanna'a manaatti abbaan warraa ke si gargaaruuf fedhii qaba?	1. Eeyyee 0. lakki	

KUTAA 6: ABOO MURTEE KENNUU DUBARTOOTAA

Kanneen armaan gadiirratti murtee xumura eenyutu kenna? Si'I, abbawarrakee, ykn nama biroomo waliini? **waliini yoo ta'e,** murtee abbaa warraakee waliin tokko yoo ta'u baate kan eenyuutu fudhatama qaba? **Lakkoofsa deebii ta'etti mari**)

Lakk.	Gaaffiilee	Haadha warra qofa	Abbaa warraa qofa	Waliin	Kan biroo(barreessi)	Kan eenyutu caala fudhatame Yoo waliin ta'e
601	Bay'ina daa'ima godhatanii	2	0	1	99	
602	Karoora maatii fayyadamtee beektaa?	1, eeyyee		0, lakkii		
603	Hin fayyadamne yoo ta'e maaliif?	1, dhibee isaan walqabate dhufu soda 2, abbaa warraa kootu na dide 3, hin beekneef ture 4, amantii kootu dhowwa 5, firatu na dhowwe 6, daa'Ima waan barbaadeef 7, fedhii wa;quunnamtii saalaa waan xiqqeessuuf 8, kan biro (ibsi) _____				
604	Yoo Karoora maatii fayyadamte beeekta ta'e eenyutu murtee dhumaa kenne?	2	0	1	99	
605	Ofiikeef yoo dhukkubsatte wal'anamuuf	2	0	1	99	
606	Yoom akka ulfa ta'u qabdu	2	0	1	99	
607	Yoom wal-quunnamtii saalaa gochuu akka qabdan eenyutu murtee dhumaa kenna?	2	0	1	99	
608	Hordoffii da'umsa duraa gootee beektaa?	1, eeyyee		0, lakki		
609	Lakki yoo jette maaliif?	1, fageenya dhaabbilee fayyaa 2, abbaa warraa kootu na dide				

		3, hin beeknen ture 4, amantii kootu na dhowwa 5, fira kootu na dhowwa 6, kan biro (ibsi) _____				
610	Eeyyeen yoo jette Hordoffii da'umsa duraa gochuuf eenyutu murte dhumaa kenne?	2	0	1	99	
611	Bakka da'umsaa	2	0	1	99	
612	Waa'ee fayyaa wal hormaata baruuf yoo barbaadde fedhii keetiin dhaabilee fayyaa ykn iddo biro deemtee akka barattu wanti si dhowwu jiraa?					1, eeyyee 0, lakki
613	Abbaa waarrake dubartii biro waliin ykn dhibee nafa saalaaf yoo shakkite coondomi akka fayyadamtan ni gaafatta?					1, eeyyee 0, lakki

DECLARATION

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

Name: Afework Tadele Mekonnen

Signature: _____

Name of the institution: Jimma University

Date of submission: _____

This thesis has been submitted for examination with my approval as University advisor

Name and Signature of the first advisor

_____

_____

Name and Signature of the second advisor

_____

_____