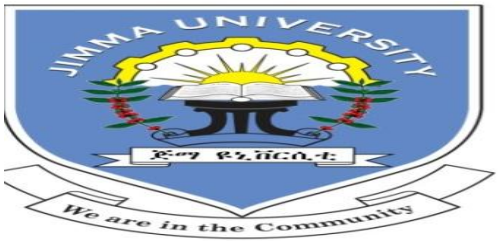

DECISION MAKING POWER ANDASSOCIATED FACTORS TO REPRODUCTIVEHEALTH AND RIGHTS AMONG REPRODUCTIVE AGE WOMEN, JIMMA TOWN, ETHIOPI, 2016

By:

AYSHA ABAJEMAL

A THESIS REPORTTO BE SUBMITTED TO, DEPARTMENT OF HEALTH EDUCATION AND BEHAVIORAL SCIENCE COLLEGE OF HEALTH AND MEDICAL SCIENCES, JIMMA UNIVERSITY; IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR MASTERS OF PUBLIC HEALTH (MPH) *IN* HEALTH EDUCATION AND PROMOTION.

MAY, 2016

JIMMA, ETHIOPIA

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May, 2016

JIMMA, ETHIOPIA

ABSTRUCT

BACKGROUND. In many developing countries most reproductive decisions are made by men although it is, as well, the concern of women. Practicing reproductive health rights is not an individual attribute but an outcome of negotiation between partners. Women in developing countries 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.

Objective; The objective of this study was to determine decision making power and practicing the reproductive health rights among reproductive age women's and to see the relationship between respondents' characteristics and practicing (utilization) of reproductive health rights, in jimma town, south west Ethiopia, 2016.

Methods and materials; an institution based descriptive cross-sectional study, quantitative, supplemented by qualitative was conducted from, January-February, 2016 in Jimma town. The sample size was calculated using a single population proportion, from a sample size of shared decision making , p = 0.81(81% of SRH clients adopted SRH services is taken from a community based survey in Addis Ababa,(EDHS,2005).formula at α 0.05 margin of error at 0.05. Systematic sampling technique was used to select 260 and purposive sampling technique was used for qualitative.

Result. A total of 260 study participants included in the study of reproductive decision making power. Male dominancy economic dependency and culture are associated with decision making power. Gender equitable attitude had significant statistical association with decision making on reproductive health and Women's have fair reproductive rights knowledge deficient. There is no any IEC materials in health facilities related to Reproductive health rights. Omens reproductive health decision making power strongly associated with demographic characteristics of age AOR=0.25CI(0.18,1.18),occupation AOR 7.94CI(1.94,8.68),intention to have more than 5 children AOR 11.28CI(1.56,11.2),knowledge of Reproductive right AOR=4.22(CI3.58,12.4).

Conclusion and recommendation. According to this study there is high Male economic dependency and culture are more factors for decision making power. And Gender equitable attitude had significant statistical association with decision making on reproductive health and rights. And this indicates as it needs multi-sectorial approach to empower women and holds decision making power on reproductive health and rights to reduce maternal mortality and morbidity related to sexual and reproductive health.

Key Words: Sexual reproductive health, Reproductive rights, Ethiopia

Acknowledgement

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LIST OF ABBREVIATIONS

AIDS Acquired Immune Deficiency Syndrome

ARC: American Refugee Committee

BPFA: The Beijing Platform for Action

CEDAW: The Convention on the Elimination of All Forms of Discrimination against Women

CIDA: Canadian International Development Agency

CRC: The Convention on the Rights of the Child

DM Decision making

DHS Demographic Health Survey

EU: European Union

FGAE Family Guidance Association of Ethiopia

JLFSY Jimma Longitudinal Family Survey of Youth**.**

HIV: Human Immunodeficiency Virus

IAWG: The Inter-Agency Working Group on Reproductive Health in Refugee Situations

ICESCR: International Covenant on Economic Social and Cultural Rights

ICPD: International Conference on Population and Development

IEC: Information, Education and Communication

IRC: International Rescue Committee

LAM; lactating amenorrhea methods

MDGs: Millennium Development Goals

PoA: Program of Action

RHRC: Refugee Health Response in Conflict Consortium

SIDA: Swedish International Development Cooperation Agency

SPSS Statistical Package for social science

STIs: Sexually Transmitted Infections

SRH R&S: Sexual Reproductive Health, Rights and Services

UN: United Nations

UNFPA: United Nations Population Fund

UNHCR: United Nations High Commissioner for Refugees

UNIFEM: United Nations Development Fund for Women

WHO: World Health Organization

1. INTRODUCTION

1.1BACKGROUND

Reproductive Healthiest state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the *reproductive system* and to its *functions* and *process* .Reproductive rights (RRs) are fundamental to women's reproductive health(ICPD, 1994; Centre for Reproductive Rights [CRR], 2008), because these rights are inalienable and such as right to life, right to non-discrimination, right to inseparable from other basic rights privacy, right to food, shelter, health, security, livelihood ,education and political empowerment. The aim of sexual and reproductive health programmers has been established that reproductive rights are human rights (CRR, 2008) and many problems have arisen as a result of violations of these RRs denial of human rights causes the death of millions of people every year; unfortunately many people neither know that they possess these rights. Improve the quality of life of all women, men, and young people. To achieve this aim, all services that clients receive must be of consistently high quality, and reflect this ideal. Since the late 1980s, special focus on the concept of quality of care, and an increased attention to its importance, has enhanced client satisfaction and has led to increased demand for, and acceptability of, sexual and reproductive health services, including family planning. A high quality of care ensures that clients are empowered to make informed, confidential and timely decisions about their sexual and reproductive health (ICPD, 1994).

Since access to sexual and reproductive health services and rights family has been recognized as a right of all individuals and couples, quality of care can be understood as a right of the client, extending the definition of the client not only to those who approach the health care system for services, but also to everyone in the community who is in need of such services. The client should be at the center of all sexual and reproductive health and family planning activities. A client-centered approach means that providers of these services should be aware of clients' needs, and must meet and respect their rights (UNFPA, 2004).

In Tajikistan Gender equity is crucial to improving maternal health in developing countries and the necessity of multi-sectorial approach. Policymakers in developing countries therefore need to implement not only direct health interventions but also broader social policies which address women's empowerment and how other socioeconomic factors such as education, working

status, household expenditure, and community health infrastructure are associated with women's uptake of reproductive health care, as well as with female autonomy. This helps policymakers to identify prioritized needs for specific health and social interventions to improve population health and to reduce inequity inside the country.(Yusuke K,2010).Although, in Malawi Lack of involvement of women in the decision making process regarding access to reproductive health services, such as PMTCT services for HIV positive pregnant women. This finding might be due to cultural factors as well as a lack of awareness among men on the availability of PMTCT services in the community and a lack of involvement of men in the delivery of such services. In order to enhance accessibility of PMTCT services for HIV positive pregnant women, increased male involvement is required as men play a significant role in decision making regarding accessibility of reproductive health. (JULIET N and PETER N, 2011).

One out of five women reported in Ghana that they could not refuse their partners' request for sexual intercourse. While one out of four indicated that, they could not demand the use of condoms by their partners. Women aged 35–49 was more likely to make decision on engaging in sexual intercourse compared to those aged 15–24. Furthermore, the higher a woman's education, the more likely that she would make decision regarding condom use. Also, if a woman had primary or secondary education, she is more likely to make decision regarding engaging in sexual intercourse compared to a woman who had no formal education. Women who were in the richest, rich and middle wealth index categories were more likely to make decision regarding engaging in sexual intercourse as well as condom use compared to the) poorest.(Eugene K., Maafo D, David ,Teye D and Kobina E,2014).

In Ethiopian situation respondent's approval to practice modern contraceptive methods was one of the important factors. Those women who had approved to use modern contraceptive were about 7 times more likely to practice than women who had disapproved modern contraceptive. Approvals of respondents, Approval of husbands and spousal communication have positive association with the level of modern contraceptive. (Tigabu K. Getu D, Zelalem B, 2014).

1.2. STATEMENT OF THE PROBLEM

Men and boys often suffer from lack of sexual and reproductive health rights because of inadequate access to information and care. On the other hand, women and young girls are generally more vulnerable to sexual assaults and reproductive ill (ICPD, 1994).

Gender equity is crucial to improving maternal health in developing countries . Policymakers in developing countries need to implement not only direct health interventions but also broader social policies which address women's empowerment and how other socioeconomic factors such as education, working status, household expenditure, and community health infrastructure are associated with women's uptake of reproductive health care, (Yusuke K,2010).

Despite the sound argument based on public health concern, human rights and social justice, in many countries, reproductive health rights and care is still insufficiently applied. This situation is even worse in developing country.

Different studies view that, reproductive health programs are expected to be effective for women only if men have participate, (Drennan, 1998). As in (Mathew et.al.2004).It's therefore in this case that, a husband's disapproval leads to the reduction in the use of family planning services. Involving men and obtaining their support and commitment to reproductive health, is crucial for reproductive health success.

Lack of involvement of women in the decision making process regarding access to reproductive health services, increased male involvement is required. Men play a significant role in decision making regarding accessibility of reproductive health (JULIET N and PETER N, 2011).
The fact that, most of the decisions which affect family lives in homes are made by men, they have a crucial role in influencing the utilization of sexual health services (SRH) by their wives. Various studies have shown that, providing men with information and involving them in couple counseling sessions can keep them to be more supportive to contraceptive use and more aware of the concept of sharing decision making (Wells,1997) as in (Bui et al. 2003).

In Ethiopia 33% of women reported joint contraceptive use DM; 36% of women and 38% of men reported joint maternal health service utilization (MHSU) DM. Women who are older, literate, have fewer children (Tefera D, 2013).

This research aims at assessing the knowledge, decision making power and practice of females on reproductive health and rights and the associated factors. This study focused on women's decision-making power as one dimension of women's autonomy and examined its association with Reproductive health service.

1.3 Significant of the study

Systematic evidence on reproductive health and rights helps to identify factors contributing not to decide for their reproductive health and rights and provide information to government, nongovernmental organization and community based organizations to increase the status of the women, who are the back bone of the society.

The findings of this study will serve as the baseline for the study area, which intends to fill some of the gaps of previously done studies on similar topic, and will help to identify the gaps in order to determine evidence based intervention.

This would help females have awareness on reproductive health and rights and services (RHRS) and holds decision making power on their reproductive health rights. Exercising reproductive health rights has been pointed out as one of the channels to sustainable development in many developing countries including Ethiopia. It has been put in place by most developing countries that, reproductive health and rights could be one way of overcoming the overwhelming problem of poverty, promoting gender equality as well as realising women rights.

This study therefore seeks to demonstrate further considerations in this field to the policy makers, scholars and development agencies. The knowledge produced in this study will be importance to all those who work on interventions in the sexual and reproductive health Arena.The finding of this study will be communicated to the stakeholders and target population through reports, conference, and workshop.

2. LITERATURE REVIEW

The BPFA incorporated much of the ICPD language on reproductive rights. The platform states that "good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility taking it as basic to their empowerment. It further states that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence **(**BPFA, 1995**)**.

International Covenant on Economic Social and Cultural Rights (ICESCR): Article 12 of the ICESCR recognizes the right of everyone to the highest standard of physical and sexual health. In this regard governments are required to take all steps necessary to reduce stillbirths and maternal deaths. (Beijing +5, 2000).

Likewise**,** recognizes the responsibility of governments to promote the rights of children. It also promotes the right to family planning services. Article 24 requires government and to ensure appropriate prenatal and postnatal health care for mothers. Article 34 also requires governments to protect the child from all forms of sexual exploitation and sexual abuse, and asks governments to take all effective and appropriate measures with a view to abolishing traditional practices that harm the health of children. Nearly all governments have signed this convention. It is therefore a strong tool for holding government's accountable Convention on the Rights of the Child (CRC).

In the same vein United Nations Special Reporter on Violence against Women tells that, since the appointment of a Special Reporter on violence against women in 1994, the UN has received regular reports on the prevalence of different forms of violence, the legal responses that exist and recommendations for action.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Article 12 of CEDAW requires states to eliminate discrimination against women in access to health services throughout their life cycle, particularly in the areas of family planning, pregnancy and childbirth. The Convention stressed that access to health care, including reproductive health, is a basic right.47. It also calls on governments to provide appropriate services relating to pregnancy, birth and breast-feeding.

The Convention on All Forms of Racial Discrimination also

Promotes the right to the highest standard of health, including reproductive health in paragraph 5e (IV).

United Nations Population Fund (UNFPA): UNFPA is the world's largest international source of funding for population and reproductive health programmers. UNFPA works with governments World Health Organization (WHO): WHO promotes the attainment by all peoples of the highest possible level of health and health care. WHO has designed a management guide titled Reproductive Health during Conflict and Displacement: a Guide for Programmed Managers (2000). The Guide provides tools to assess, plan, implement and evaluate reproductive health within the broader context of planning and reparation for conflict and emergencies. It includes guiding principles. The WHO Guide also endorses a core package of reproductive health care measures and provides details of the implementation and actual delivery of the package of services. This guide is an orientation, awareness-raising and training tool for health care providers.

Rights on the Protocol to the African Charter on Human and Peoples'

The Rights of Women in Africa Article 14 on Health and Reproductive Rights requires that governments respect and promote women's right to health. This includes control of their fertility, the right to decide, inclusive security, sustainable peace: a toolkit for advocacy and action whether and when to have children and, protection against sexually transmitted infection including HIV/AIDS as well as the right to information about their own and their partners' health. Within the EU there is the Communication from the Commission to the Council and the European Parliament: Health and Poverty Reduction in Developing Countries. The European Commission adopted its Health and Poverty Communication in March 2002. This commits the EU to protect the most vulnerable people from poverty through support for equal and fair health. The EU's development policy on sexual and reproductive health is based on the ICPD's Poi the EU policy also reflects the specific targets of the Millennium Development Goals (MDGs) that call for the empowerment of women and the reduction in maternal and child mortality. Bilateral agencies such as the Canadian International Development Agency (CIDA) support empowering girls and women through better access to education, more economic and political participation in their communities and health services geared toward reproductive health and fewer and safer pregnancies. Protecting women against violence is also becoming an increasingly important health and development issue.

The Swedish International Development Cooperation Agency (SIDA) has produced an Issue Paper on Health and Human Rights, which sets out SIDA's Department for Democracy and Social Development Health Division's policy on an individual's health. Additionally, USAID, one of the most influential funders of reproductive rights and services, has a Global Health programmed that includes a focus on, and funding for, child survival and maternal health, HIV/AIDS, factious diseases, family planning and reproductive health.

The rights of couples and individuals to decide freely and responsibly the number and spacing of their children, and to have the information and the means to do so; The right to attain the highest standard of sexual and reproductive health; the right to make decisions free of discrimination, coercion or violence The right to decide about marriage and no. of children, the right to well-being throughout life, for all matters relating to reproductive system The right to 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; The right to safe pregnancy and birth, the right to be free from sexual violence and assault; and the right to privacy in relation to Reproductive Health (UNFPA, 2004).

In Sub-Saharan Africa in particular, many societies are patriarchal, meaning that male dominance is a highly present characteristic in its culture. Because of this, women commonly have fewer agencies over their lives and in their relationships, and lower status in society (Jewkes, S, & Garcia M, 2002). Gender unequal norms thus translate into low education, low social and legal support for women, and lack of economic power)

In addition, ideologies in some societies of male sexual entitlement can promote the idea that men's sexual advances cannot be refused, and participating in sex is an obligation for a woman (WHO, 2010). This means that women are less protected from rape, feel they cannot speak up for themselves, or even consider it to be justified to be disciplined" by violent manners (Jewkes, S, & Garcia-Moreno, 2002; WHO, 2005). When sanctions for sexual violence are weak, this ideology might be reinforced at the community level (WHO, 2010). "

The Ethiopian demographic health survey (EDHS) asked women if they routinely participated in four types of decisions-deciding about women's own health care, making large household purchases, making household for daily needs, and visit to family or relatives. Nationwide about 4

in 10 women said that they participated in making all four types of decisions. Shared decision making is most common in Addis Ababa (81 percent) and Dire Dawa (59percent). Less than one-third of women participate in all four decisions in Somali (25 percent), Gambella (28 percent), and SNNP (29 percent). (EDHS, 2005)

The patriarchal, hierarchical and polygynous organization of many African households, the young age at marriage for women, patrilocal residence after marriage, the large age difference between spouses, the unequal work burden between the sexes, the high bride price, and the low educational level of women tends decisions regarding sexual activity, fertility, and contraceptive use are made by men (Oladeji,2008).

The situation is similar in Ethiopia, where women generally do not have equal rights with their husbands to access resources, to make decisions regarding their desired number of children, to use contraception and even to space or stop childbearing (Olokodana and Yeshi, 1998).As a result, women's DM abilities remain constrained and subjugated to the political, socio economic and cultural dominant of men (WHO, 1999).

The consequent gender based power inequalities hinder communication between partners about reproductive health decisions, constrains their access to reproductive health services, prevents them from attaining the highest level of sexual health and pleasure and this, in turn, contributes greatly to poor health outcomes (Blanc, 2001;Speizer,Whittle and Carter, 2005).

Understanding women's reproductive needs and identifying the key factors which influence reproductive negotiation processes between husband and wife are necessary to formulate policies aimed at creating a conducive environment to improve women's reproductive health, general well-being and their decision-making power Furthermore, realizing the linkage between gender power relations and reproductive DM is among the key factors which can help assess the extent of gender in equality.

Knowledge of family planning is a prerequisite to obtaining access to and using a suitable contraceptive method in a timely and effective manner. Information regarding knowledge of contraceptive methods by describing each method and asking female respondents if she had heard of it. Using this approach, 11 modern family planning methods: female and male sterilization, the pill, the IUD, inject able, implants, male and female condoms, lactation amenorrhea method (LAM), emergency contraception, and the standard day's method. Two traditional methods were also included in the survey: periodic abstinence (or rhythm) and withdrawal (EMDHS, 2014).

Respondents mentioned spontaneously shows the percentage of all women and currently married women, age 15-49, who know any contraceptive method, by specific type. Knowledge of at least one method of contraception is nearly universal among currently married women in Ethiopia. A currently married woman knows on average more than five methods of contraception. Women are much more familiar with modern contraceptive methods than with traditional methods. About nine in every ten currently married women have heard about the pill and inject able. LAM is the least known modern method. Only 2 percent of currently, (EMDHS, 2014). Family Planning is embedded in reproductive health reproductive health and aiming at increasing the capacity of couples and individuals in to making choice regarding their family size they wish and also the presence of the services where by people can easily access them. The principle of informed free choice is essential to the long-term success of family planning programmes. In every society, there are many social and economic incentives and disincentives that affect individual decisions about child bearing and family size.(Ibid).The concept of family planning therefore is linked to this research in the fact that, couples are expected to participate fully in the decision of how many children they may wish to have, when and how.

Though all couples are expected to have equal sexual rights, in most African societies and Ethiopia in particular and mostly in rural areas, it is common that both partners do not participate equally in issues related to sexuality. The fact that a woman is expected to have a shy behaviour; she is not expected to discuss issues of sexuality even with her husband. Issues of sexuality are regarded as a taboo and even a secret the only room for discussion is given to men. A woman who discusses sexual issues is regarded as a prostitute. It's from this view that, a woman who considers discussions around sexual issues as a taboo, will not be able to talk about family planning issues with her husband and therefore matters related to family planning will continue to be considered women issues. (EMDHS, 2014).

Family planning helps save women's and children's lives and preserves their health by preventing unwanted pregnancies, reducing women's exposure to the health risks of child birth and abortion and giving women who are often the sole caregivers, more time to care for their children and themselves. (Ibid).Therefore family planning issues shouldn't be regarded as women issue but rather a responsibility for both parents.

According to study done in India s gives the evidence that decision making power is low in the respondents with 48.2% of them having low level of power, while 27.6 have medium level and having high level of power of women do not have any autonomy as against 43.9% with low level, 25% with medium autonomy and 8.7% scoring above 7 (high level of autonomy). In the study population it was found that 273 of the respondents were using contraceptives. Women's autonomy, years of marriage and number of children were significant variables (S.R. Patrikar, 2014).

The study conducted in Malawi women's low status and the predominance of men's decision-making power at the household and community levels. Of particular note, women were least likely to have decision-making power regarding their own health care. Although none of the association with ever use of modern contraceptive methods, domestic decision-making areas had significant power and family planning decision-making power were significantly associated. Basic socio-demographic factors such as educational level, parity, and desired number of children had significant associations with ever use of modern contraceptive methods. Women's decision-making power was shaped by various socio-cultural factors including religion and tribe, education, cash employment, and marital structure, especially regarding men's perceptions toward women's low status, barriers to modern contraceptive use, couple's opinions on condom use, and recommendations toward current family planning services. (Rinko K, 2003).

In many developing countries most reproductive decisions are made by men although it is, as well, the concern of women. Accordingly, Gender power relations in reproductive decision-making: The case of Gamo migrants in Addis Ababa, Ethiopia 33% of women reported joint contraceptive use DM; 36% of women and 38% of men reported joint maternal health service utilization (MHSU) DM. Women who are older, literate, have fewer children, media access, have job, and not victims of harassment/abuse participate in reproductive DM, while men who are literate, have fewer children, media access, older, and did not harass/abuse their wives let wives participate in MHSU DM. Thus, empowering the study community in general and women in particular is recommended to improve their participation in reproductive DM. (Tefera D, 2013).

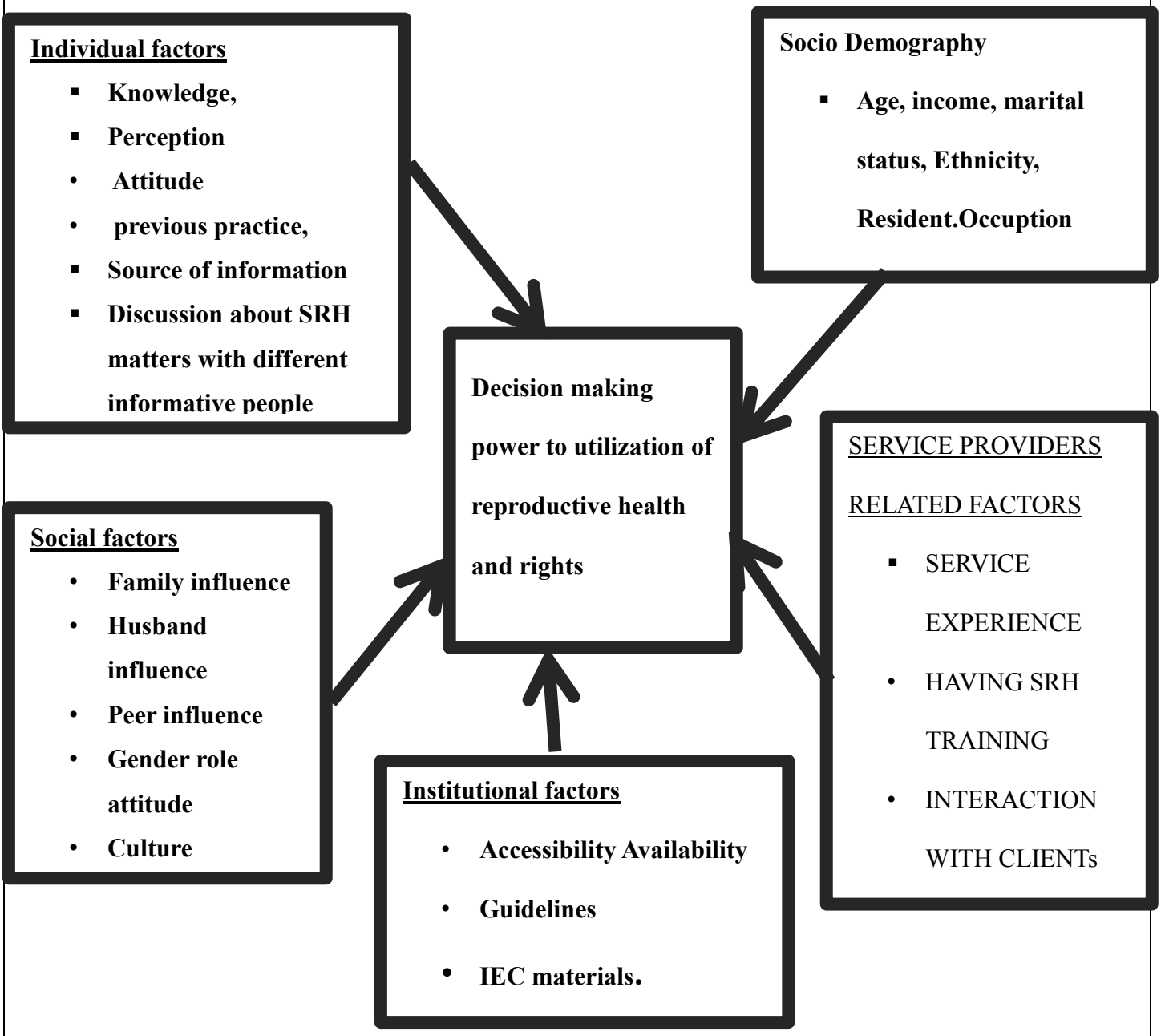

Fig 1. Conceptual frame work

Source: Adapted after reviewing different literatures.

Fig 1. Conceptual frame work of decision making power on sexual reproductive health Rights

3 Objectives of the Study

3.1 General Objective

- To determine decision making power and associated Factors to reproductive health and rights among women of reproductive age, Jimma town, Ethiopia.2016.

3.2 Specific Objectives

- To assess the knowledge level of reproductive age women in Jimma town on Reproductive Health and rights.
- To assess the extent of reproductive health and rights among reproductive age women in Jimma town.
- To assess women's decision making power on utilization of reproductive health and rights among reproductive age women.
- To identify and explore factors influencing utilization of reproductive health and rights among reproductive age women in jimma town.
- To assess health facilities and client provider interaction during service provision among reproductive age women.

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4 METHODLOGY OF THE STUDY

4.1 Study area and study period

Jimma town is located in Oromia National Regional State, in Ethiopia, Jimma town found at a distance 335 Km from Addis Ababa. Its astronomical location is 7º 4' North Latitude and 36º 5' East Longitude. Jimma town was founded in 1837. Jimma is one of the reform towns in the region and has a city administration, municipality and 19 kebele administrative.

According to the national population and housing census carried out in 2007, the population of the town was 120,960. Out of this 60,824 were male and 60,136 were female. Regarding age distribution 37,055 (31%) were within the age group of 0-15 years, 80,083 (66%) 16-60 years, and 3,822 (3%) 61 years and above. The population growth rates at medium 3.75%, while household size in the town was calculated to be 4. Regarding health services, in the town there are two government hospitals, four government health centers and 21 private and six government clinics. An institution based descriptive cross-sectional study supplemented with qualitative data was conducted from January to 2016- February, 2016 in Jimma town.

4.2. Study design

An institution based descriptive cross-sectional study was conducted in three selected health facilities which contains quantitative and qualitative methods supplemented and triangulated.

4.3Population

The target population were all women of reproductive age groups between 15 to 49 years (child bearing age) in Jimma town.

4.4.1 Source population

All women of reproductive age group (15-49 years old) women attended the sexual and reproductive health services in Family Guidance association of Ethiopia Jimma model clinic, Jimma Health center, Jimma higher two Health center.

4.4.2 Study population

All sampled women of reproductive age groups (15-49 years of age) women attended the sexual and reproductive health services in Family Guidance association of Ethiopia Jimma model clinic, Jimma Health center, Jimma higher two Health center during the study period .

4.5 *Inclusion and Exclusion criteria*

4.5.1. Inclusion criteria

All sampled women of reproductive age groups (15-49 years of age) attended the sexual and reproductive health services in Family Guidance association of Ethiopia Jimma model clinic, Jimma Health center, Jimma higher two Health center during the study period .

4.5.2. Exclusion criteria

Women who came to seek SRH services, who had mental problem and on labor pain was excluded from the study.

For qualitative study

Study participants for the qualitative study were SRH service providers and those responsible bodies who had full information and agents of sexual and reproductive services rights (gender clubs) working at the studied facilities, Female representatives, Youth representatives and Family health department of town health office, were included for in-depth interview total of 11 women's interviewed. Overt observation of health facility and client provider 3 facilities, 7 service providers and 15clients were observed.

4.6 Sample size determination.

4.6.1 Sample size for quantitative study

The sample size was calculated using a single population proportion formula considering sample size of shared decision making, p = 0.81(81% of SRH clients adopted SRH services is taken from a community based survey in Addis Ababa (EDHS, 2005) with 95% confidence interval, 5% margin of error & considering 10% non-response rate, Based on these assumptions, the sample size was calculated as follows: and the final sample size (n) was **260.**

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

$$n = \frac{(1.96)^2 x (0.57(1-0.5)}{d^2} = 260$$

Where: - n = Sample size

Assumption:

P = Decision making power (0.81)

D = Margin of sampling error tolerated- 5% (0.05)

Q= 1- p

($Z_{a/2}$)= Confidence level; taking 95% level of confidence interval.

4, 7 Sampling Techniques

For Quantitative study

For clients' perspective, the total sample size was proportionally allocated to the selected health facilities based on the number of patient flow month before starting of data collection to each health facilities. Finally, systematic sampling was used in each health facilities. (Figure 2).

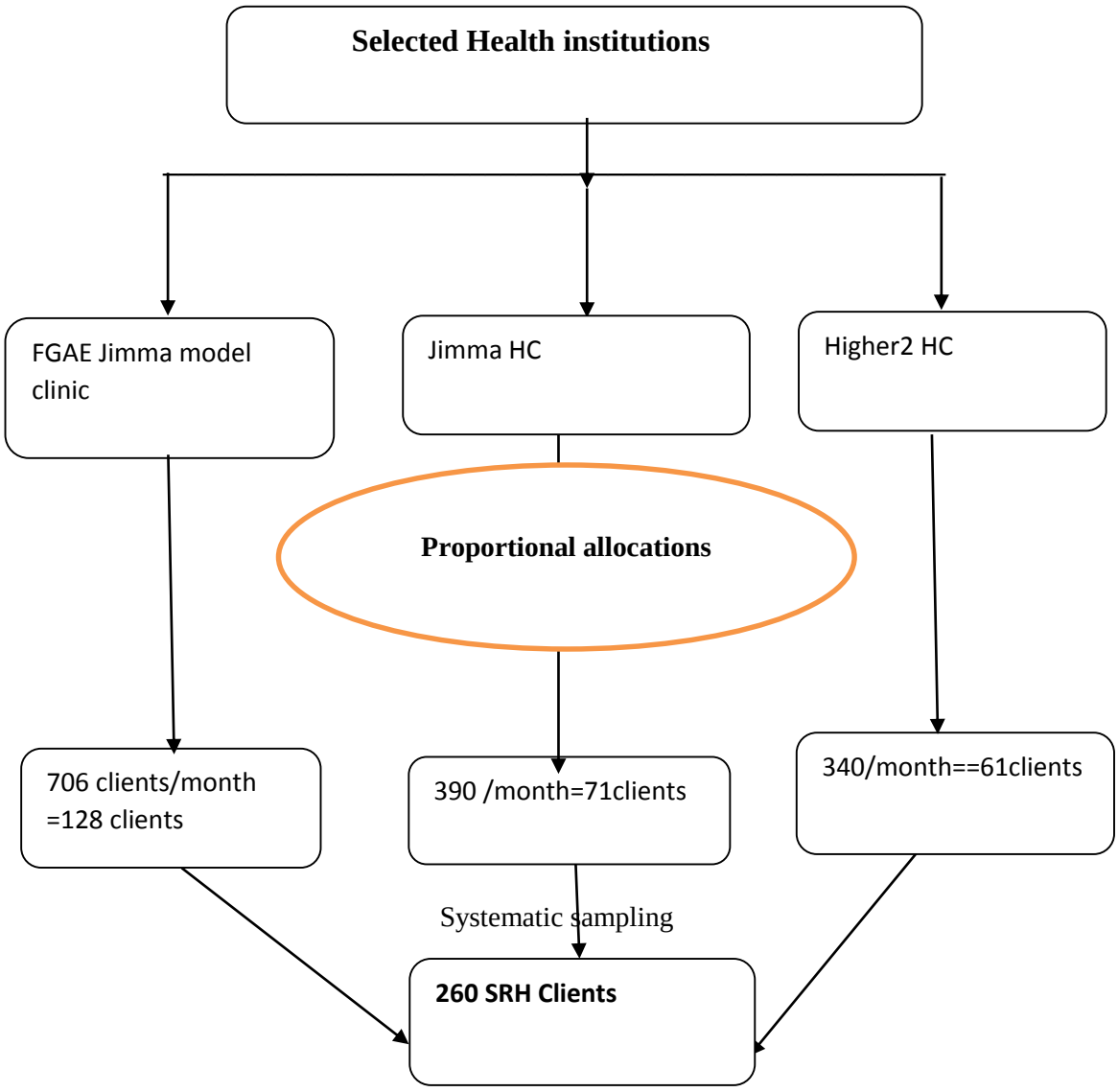

Figure.2 Diagrammatic presentation of sampling procedure

4.8. Data collection measurements and procedures

Three tools were used to collect relevant data for the study. The health facility assessment, availability of reproductive health commodities, staffing, supplies and materials availability check lists were adopted from literature review from .A structured questionnaire for reproductive decision making and in-depth interview guide others adopted from review of different literatures and pretested a month before the study was used for decision making power and utilization. (Annex I-111)

Data were collected from SRH services clients who attend health facilities between 1st January, 2016 and February 09, 2016. Data collectors and supervisors were trained for one day by the principal investigator on the study instruments, consent form, how to maintain confidentiality and data collection procedures. During each visit, clients were systematically chosen to participate in the study from the list of SRH services attending clients.

4.9 Data processing and analysis

Data were checked for completeness and a particular questionnaire with incomplete data were excluded Data were edited, cleaned, coded and entered in to SPSS version 20 for windows for cleaning and further data analysis. Qualitative data were coded and recoded and analyzed thematically. Logistic regressions were used to identify the predictor variables of decision making power. Variables that showed statistical significant association with p-value of less than 0.025 on binary logistic regression were entered into multiple logistic regressions. Then, variables which showed statistical significant associations with p-value less than 0.05 were considered as the final predictors of decision making power. Results from observation were counted down and summarized as thematic. Finally, results from quantitative was supported by a result found from qualitative research and triangulated with the quantitative one to get depth of the problem under study.

For the Qualitative study

An in-depth interview conducted with purposefully selected players of the health care system particularly the SRH service providers, Female representatives, Youth representatives and Family health department of town health office in Jimma town were conducted and guided by an in-depth interview checklist. A facility audit check list used and assessed the availability of essential

equipment and supplies required for reproductive health services and facility characteristics. A checklist guided observation was used to conducted and assess client-provider interaction and physical setting of the unit and availability of services, response from quantitative open ended questionnaires' were summarized..

4.10 Study variables

4. 10.1 Dependent variable

- Decision making power on utilization of reproductive health and rights.

4.10.2 Independent variables include,

- **Socio-demographic variables** (age, educational status, ethnicity, religion, marital status, occupation, parity, monthly income),
- **Individual factors** (Beliefs, Parity, Knowledge ,Source of information on service utilization)
- **Social factors** (patriarchal, hierarchical polygynous and patrilocal family, husband, peer influence)
- **Facility related factors (**equipment and supplies availability affordability accessibility, availability of trained personnel)
- **Service providers related factors (**professional background**,** training, service experience Knowledge, practice, client provider interaction)

4.11 Operational Definitions

Sexual reproductive health rights: when women's have the rights to information, access, choice, confidentiality, comfort,contiunity,and the right to safety,dignity,privacy and express their opinion during obtaining SRH services.(ICPD,1994)

Decision making power: when clients have made informed decisions about their own sexual health, using SRH services, free of coercion, discrimination and violence by maintaining reproductive rights. (ICPD, 1994).

Decision made by influence=no decision; made with partner=shared decision; Decision made without any influence=Autonomous decision.

If there is autonomous decision and shared decision there is decision, if with influence there is no decision. (EDHS, 2005).

Knowledge 0 – 7 marks= Poor Knowledge; 8 – 12 marks = Average Knowledge 13 – 16 marks = Good Knowledge. ((Abbey, 2002).

Client: a woman wants to health facilities to obtain SRH services.

Components of SRH: Quality FP counselling, IEC and services, ANC, safe delivery, PNC, Prevention and treatment of infertility, STIs, Cervical cancer screening.

Accessibility; when the distance from to health facility is 5 kilometers or one hour by walk it is accessible.(FMOH)

Patriarchal, when decision maker in the house is only men.

Polygynous when a male is more than one wife.

Patrilocal where the couples live with groom families,

Definition of Terms.

Right to information; all individuals in the community have a right to know about the benefits and availability of sexual and reproductive health services for themselves and their families.

Right to access; all individuals in the community have a right to obtain sexual and reproductive health services, without any discrimination.

Right of choice; Individuals and couples have the right to decide freely whether or not to control their fertility and which method to use.

Right to safety; Clients have a right to be protected from unwanted pregnancy, disease and sexual violence and, when receiving sexual and reproductive health services.

Right to privacy; Clients have a right to discuss their needs or concerns in a private environment.

Right to confidentiality; Clients should be assured that any information they provide or any details of the services received will not be communicated to third parties without their consent.

Right to dignity Clients have a right to be treated with empathy, courtesy, consideration, attentiveness and with full respect of their dignity regardless of their level of education, social status.

Right to comfort; Clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy and organization of service delivery facilities

Right of continuity; Clients have a right to receive sexual and reproductive health services and supplies, such as contraceptives, for as long as needed.

Right of opinion; Clients have the right to freely express their views on the services that they receive.

4.12 Data Quality assurances

Pre-test was conducted on 13 SRH clients (5% of the sample size) before the main study done in facility out of study facility in Jimma town, to identify future problems in the proposed study such as data collection tools and to check the performance of the data collectors and data that was collected in the pre-test was not be included in the analysis as part of the main study.

One day training was given for female nurse data collectors and supervisors on how to collect data. The data collection methods, tools and how to handle ethical issues was discussed with the data collectors.

Questionnaire was translated to respondent's convenient language during data collection. Regular supervision by the supervisor and the principal investigator was made to ensure that all necessary data were properly collected. Each day during data collection, filled questioners was cheeked for completeness and consistency.

4.13 Plan for dissemination and ensuring utilization of findings

Major findings of the study research will be presented and shared with /to Jimma University community and it will be disseminated to JU College of public health and medical science, department of Health Education and Behavioral Science, and the mother document will be provided to the responsible body of study participants.

Results will also be shared through international conferences and will be written up for publication in a peer-reviewed journal. Possible effort will be be made to publish at minimum two peer-reviewed publication which presents the pooled results of the primary and secondary outcomes.

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4.14 Ethical consideration

Ethical clearance was secured from the Ethical Clearance Board of Jimma University. Letter of support was obtained the study participant informed about the objectives and purposes of the study was introduced the true information and their contribution was critical to generate real and helpful information to themselves and the nation.

Written and verbal informed consent was sought from all respondents before start of each interview. After, Informed consent from each study participant was confirmed the purpose of the study was explained, including their rights to refuse participation at any point.

CHAPTER FIVE:

RESULTS

5.1.Socio-demographic characteristics

A total of 260 study participants were participated on the assessment of clients' perceived decision power on SRHS and their ability to practice their rights on SRHS.

Regarding the age distribution categories, majority 78(30.0%) of the respondents were between the age group of 25-29 years old in which the least age group were 27(10.4%) were 15-19 years and the mean age of study participants was 27.3 (SD at 6.11). Concerning the ethnic group status of the respondents, majority 129(49.6%) of them Oromo ethnic group which followed by Amhara accounts 72(27.7%). In terms of the average monthly income of the study participants, majority 69(26.5%) of them were had between the range of 1350-2100 Birr monthly income followed by those who had less than 400 Birr accounts 66(25.4%) .Concerning the religious status of the respondents, majority 111(42.7%) of them were Muslims and followed by Orthodox Christianity followers accounts 104(40.0%). In relation to Occupational status, majority of the respondents were Government employee accounts 71(27.3%) followed by Housewife which accounts 66(25.4%). Marital status of majority of respondents 188(72.3%) of them were currently married and the remained 72(27.7%) study participants were currently unmarried. Educational back ground of the study participants, majority of them were diploma and above. Majority of the respondent came from urban which accounts 92(35.4%). Majority of study participants 98(37.7%) of them have five children and 175(67.3%) intended to have more than five children. **(**Table 5.1.1)

Table 5.1. 1 Socio-demographic characteristics *females child bearing age (15-49) Jimma Town, Southwest Ethiopia,*

Variables	categories	frequency	Percentage
Age categories of respondents	15-19 years	27	10.4
	20-24 years	60	23.1
	25-29 years	78	30.0
	30-34 years	59	22.7
	> 35 years	36	13.8
Ethnic group categories	Oromo	129	49.6
	Amhara	72	27.7
	Tigre, Gurage, SNNP	59	22.7
Monthly income categories	less than 400 Birr	66	25.4
	400-1350 Birr	64	24.6
	1350-2100 Birr	69	26.5
	Greater than 2100 Birr	61	23.5
Religious status	Muslims	111	42.7
	Orthodox	104	40.0
	Catholic and protestant	45	17.3
Occupational status	Government employee	71	27.3
	Merchant	33	12.7
	NGO employee	25	9.60
	Housewife	66	25.4
	Private employee	29	11.2
	Students	36	13.8
Marital status categories	currently married	188	72.3
	Non-currently married	72	27.7
Educational status categories	Illiterates	24	9.20
	First cycle(1-4)	45	17.3
	Second cycle(5-8)	40	15.4
	2^0 and preparatory	59	22.7
	Diploma and above	92	35.4
Residency of respondents	Rural	62	23.8
	Urban	170	65.4
	Semi-Urban	26	10.0
Number of children	one child	34	13.1
	two child	41	15.8
	three children	56	21.5
	four children	31	11.9
	five children	98	37.7
Intention to have number of future children	1-2 children	38	14.6
	3-4 children	47	18.1
	>5 children	175	67.3

5.2 **Distribution of study participants characteristics by the decision power**

Regarding the age distribution categories, majority 78(30.0%) of the respondents were between the age group of 25-29 years old were in 24(25.5%)of them don't have decision power on SRHS. Concerning the ethnic group status of the respondents, majority 129(49.6%) of them Oromo ethnic group of this 53(56.4%) of them were not have decision power on SRHR&S. In relation to Occupational status, majority of the respondents 71(27.3%) were Government employee where in 57(34.3%) of them have decision power on SRHs.

Regarding to the marital status, majority 188(72.3%) of them were currently married and from this married individuals 64(68.1%) of them have not decision power on using the SRHR&S.

Majority respondents, came from urban170 (65.4%) and form this urban study participants 60(63.8%) of them have not decision power on using the SRHS and followed by those study participants who came from rural area accounts 62(63.8%) where in this group 43(25.9%) of the have decision power on utilizing SRHS services.

Regarding the Intention of study participants to have more than five children and from this group 68(72.3%) of them don't have a decision power on utilizing. Study participants who have accessibility to SRHS services accounts 202(81.1%) from this group of study participants, 59(66.3% of them don't have a decision power on utilizing the services.

Most of the respondents sources of information health professionals accounts 154(59.2%) from this, 77(81.9%) of them don't have decision power to SRHS services. Regarding the level of knowledge of study participants, majority 148(67.3%) of them had a good knowledge on the general SRHR&S services and from this group 31(40.3%) of them of them don't have a decision power on utilizing the services. services. Regarding the level of attitude of study participants, majority 160(61.5%) of them had a good attitude on the general SRHS services and from this group 65(69.1%) of them of them don't have a decision power on utilizing SRH rights.

The most extended rights to clients, majority 96(38.4%) of them raised right to information and the list was have right to privacy 18(7.2%). (Table.5.1.2.)

Table.5.1.2. frequency distribution study participants' characteristics with their outcome variable.

variables	categories	Right to decide to on SRHR&S		Total (%)
		Have decision power	Have no decision power	
Age categories of respondents	15-19 years	14(8.4%)	13(13.8%)	27(10.4%)
	20-24 years	42(25.3%)	18(19.1%)	60(23.1%)
	25-29 years	54(32.5%)	24(25.5%)	78(30.0%)
	30-34 years	36(21.7%)	23(24.5%)	59(22.7%)
	> 35 years	20(12.0%)	16(17.0%)	36(13.8%)
Marital status categories	currently married	124(74.7%)	64(68.1%)	188(72.3%)
	Non-currently married	42(25.3%)	30(31.9%)	72(27.7%)
Ethnic group categories	Oromo	76(45.8%)	53(56.4%)	129(49.6%)
	Amhara	56(33.7%)	16(17.0%)	72(27.7%)
	Tigre, Gurage, SNNP	34(20.5%)	25(26.6%)	59(22.7%)
Occupational status	Government employee	57(34.3%)	14(14.9%)	71(27.3%)
	Merchant	20(12.0%)	13(13.8%)	33(12.7%)
	NGO employee	20(12.0%)	5(5.3%)	25(9.6%)
	Housewife	33(19.9%)	33(35.1%)	66(25.4%)
	Private employ	3(1.8%)	0(0.0%)	3(1.2%)
	Private employee	19(11.4%)	14(14.9%)	33(12.7%)
	Students	14(8.4%)	15(16.0%)	29(11.2%)
Residency of respondents	Rural	43(25.9%)	19(20.2%)	62(23.8%)
	Urban	110(66.3%)	60(63.8%)	170(65.4%)
	Semi-Urban	13(7.8%)	15(16.0%)	28(10.8%)
Number of children	one child	31(18.7%)	3(3.2%)	34(13.1%)
	two child	35(21.1%)	6(6.4%)	41(15.8%)
	three children	35(21.1%)	21(22.3%)	56(21.5%)
	four children	15(9.0%)	16(17.0%)	31(11.9%)
	five children	50(30.1%)	48(51.1%)	98(37.7%)
Number of future children intended to have	1-2 children	33(19.9%)	5(5.3%)	38(14.6%)
	3-4 children	26(15.7%)	21(22.3%)	47(18.1%)
	>5 children	107(64.5%)	68(72.3%)	175(67.3%)
accessibility to SRSH services	Yes	143(89.4%)	59(66.3%0	202(81.1%)
	No	17(10.6%)	30(33.7%)	47(18.9%)
Source of information	Media(TV and radio)	89(53.6%)	17(18.1%)	106(40.8%)
	Health professionals	77(46.4%)	77(81.9%)	154(59.2%)
Right to decide to have sex	YES	114(71.7%)	23(26.4%)	137(55.7%)
	NO	45(28.3%)	64(73.6%)	109(44.3%)
Knowledge on SRHS	Good knowledge	117(81.8%)	31(40.3%)	148(67.3%)
	Poor knowledge	26(18.2%)	46(59.7%)	72(32.7%)
Attitude towards SRHS	Good attitude	95(57.2%)	65(69.1%)	160(61.5%)
	Poor attitude	71(42.8%)	29(30.9%)	100(38.5%)
Extended rights to clients	Right to access	36(22.6%)	21(23.1%)	57(22.8%)
	Right to choice	36(22.6%)	14(15.4%)	50(20.0%)
	right to information	55(34.6%)	41(45.1%)	96(38.4%)
	right confidentiality	10(6.3%)	10(11.0%)	20(8.0%)
	right to dignity	8(5.0%)	1(1.1%)	9(3.6%)
	right to privacy	14(8.8%)	4(4.4%)	18(7.2%)
Type of family planning	OCP	6(4.4%)	3(4.4%)	9(4.4%)
	DMPA	97(70.8%)	44(64.7%)	141(68.8%)
	IMPLANT	28(20.4%)	19(27.9%)	47(22.9%)
	IUCD	6(4.4%)	2(2.9%)	8(3.9%)
Ever used FP	YES	138(84.1%)	71(76.3%)	209(81.3%)
	NO	26(15.9%)	22(23.7%)	48(18.7%)

5.3 Multivariate analysis of independent characteristics of study participants with their decision power.

The probability of having decision power on those study participants whose age categories between 15-19 years old were found 75% times more likely in comparing to the age group categories of 20-24 years old (AOR=0.25, 95% CI = ((0.05-0.23)) *(P-value0.045). And the other age range groups were found statically insignificant with their ability to have decision power on the SRHS services

study participants who have only one child were found 86.9% times more likely to have a decision power on the SRHS services in comparing to the study participants who have three children (AOR=9.69, 95% CI = ((1.95-8.86)) *(P-value<0.040).and these who have four children were found 22.91 times more likely not have a decision power on the SRHS services in comparing to the study participants who have only one child (AOR=9.69, 95% CI = ((1.89-27.6)*(P-value<0.040). the inverse odds ratio shows that study participants who have more than only one child were found 6.3 times more likely to have a decision power on the SRHS services in comparing to those study participants who have five children (AOR=15.85, 95% CI = (1.43-17.6)*(P-value<0.024).

an inverse odds ratio indicates on study participants who have an intention to have future number of children, those study participants who intend to have one to two future children were found 8.86 times more likely to have a decision power on the SRHS services in comparing to those who intend to have more than five future children (AOR=11.28, 95% CI = (2.7-8.49)*(P-value<0.001).

Study participants who don't had access to SRHS services information were found 2.94 times more likely not to have a decision power in comparing to those who had an access to SRHS information services (AOR=2.94, 95% CI = ((1.90-8.74))*(P-value<0.044).

study participants whom their sources of information from health professionals were found 24.3 times more likely to have a decision power on the SRHS services in comparing from those study participants who used from media(TV/Radio) source of information (AOR=4.11, 95% CI = (1.63-10.34)*(P-value<0.003).

Those study participants who have a good knowledge level were found 32.2% times more likely to have a decision power in comparing to the study participants who poor knowledge level (AOR=4.22, 95% CI = (1.78-9.95)*(P-value<0.001).(Table 5.1.3.)

Table 5.1.3.**Multivariate analysis of independent characteristics of study participants with their ability of decision power.**

Variables	Categories	Right to decide to on SRHS		COR,95%CI	AOR,95%CI	P-Value
		Have decision power	Have not decision power			
Age categories of respondents	15-19 years	14(8.4%)	13(13.8%)	1	1	
	20-24 years	42(25.3%)	18(19.1%)	0.46(0.18-1.18)	0.25(0.05-0.23)	0.045
	25-29 years	54(32.5%)	24(25.5%)	0.48(0.20-1.17)		
	30-34 years	36(21.7%)	23(24.5%)	0.68(0.27-1.72)		
	> 35 years	20(12.0%)	16(17.0%)	0.86(0.32-2.34)		
Ethnic group categories	Oromo	76(45.8%)	53(56.4%)	1		
	Amhara	56(33.7%)	16(17.0%)	0.41(0.21-0.79)		
	Tiger, Gurage, SNNP	34(20.5%)	25(26.6%)	1.05(0.56-1.97)		
Occupational status	Government employee	57(34.3%)	14(14.9%)	1	1	
	Merchant	20(12.0%)	13(13.8%)	2.65(1.06-6.57)	2.65(1.06-6.57)	0.001
	NGO employee	20(12.0%)	5(5.3%)	1.02(0.32-3.18)		
	Housewife	33(19.9%)	33(35.1%)	4.07(1.91-8.68)	7.94(1.51-41.67)	0.014
	Private employee	19(11.4%)	14(14.9%)	4.36(1.71-11.1)	4.36(1.71-11.1)	0.0005
	Students	14(8.4%)	15(16.0%)	2.59(1.06-6.30)	2.59(1.06-6.30)	0.001
Residency of respondents	Rural	43(25.9%)	19(20.2%)	1		
	Urban	110(66.3%)	60(63.8%)	0.41(0.21-0.79)		
	Semi-Urban	13(7.8%)	15(16.0%)	1.05(0.56-1.97)		
Number of children	one child	31(18.7%)	3(3.2%)	1	1	
	two child	35(21.1%)	6(6.4%)	1.77(0.42-7.68)		
	three children	35(21.1%)	21(22.3%)	6.20(1.68-22.8)	9.69(1.95-8.86)	0.040
	four children	15(9.0%)	16(17.0%)	11.2(2.77-43.7)	22.91(1.89-27.6)	0.013
	five children	50(30.1%)	48(51.1%)	9.92(2.84-34.6)	15.85(1.43-17.6)	0.024
Number of future children	1-2 children	33(19.9%)	5(5.3%)	1	1	
	3-4 children	26(15.7%)	21(22.3%)	5.33(1.77-16.0)	5.33(1.77-16.0)	0.001
	>5 children	107(64.5%)	68(72.3%)	4.19(1.56-11.2)	11.28(2.7-8.49	0.001
accessibility to SRSH	Yes	143(89.4%)	59(66.3%0	1	1	
	No	17(10.6%)	30(33.7%)	4.27(2.19-8.34)	2.94(1.90-8.74)	0.044
Source of information	Media(TV and radio)	89(53.6%)	17(18.1%)	1	1	
	Health professionals	77(46.4%)	77(81.9%)	5.24(2.85-9.61)	4.11(1.63-10.34)	0.003
Knowledge on SRHR&S	Good knowledge	117(81.8%)	31(40.3%)	1	1	
	Poor knowledge	26(18.2%)	46(59.7%)	6.67(3.58-12.4)	4.22(1.78-9.95)	0.001
Attitude on SRHS	Good attitude	95(57.2%)	65(69.1%)	1		
	Poor attitude	71(42.8%)	29(30.9%)	0.59(0.35-1.02)		
Extended rights to clients	Right to access	36(22.6%)	21(23.1%)	1		
	Right to choice	36(22.6%)	14(15.4%)	0.66(0.29-1.51)		
	right to information	55(34.6%)	41(45.1%)	1.27(0.65-2.50)		
	right confidentiality	10(6.3%)	10(11.0%)	1.71(0.61-4.79)		
	right to dignity	8(5.0%)	1(1.1%)	0.21(0.03-1.83)		
	right to privacy	14(8.8%)	4(4.4%)	0.49(0.14-1.68)		
Ever used FP	YES	138(84.1%)	71(76.3%)	1		
	NO	26(15.9%)	22(23.7%)	1.64(0.87-3.12)		

5.2.2. Independent variable distribution characteristics by utilization of sexual and reproductive health services.

Cross tabulation of independent variables and dependents variables was made to identify the actual distribution of study participant's characteristics with their right utilization of sexual and reproductive health services and rights.

Regarding the age categories distribution of study participants majority 78(30.0%) of were between the age group of 25-29 years, out of this 62(33.0%) of them were utilized their rights of the SRH services and the remained 16(22.2%) were not utilized their rights. And the age group followed by 60(23.1%) were form the age group of 20-24 years old. And concerning the marital status majority 188(72.3%) of them were currently married in which from this 145(77.1%) of them were not utilized their rights and the remained 43(59.7%) were utilized their rights on SRH services. On point of the ethnical status of the study respondents majority 129 (49.6%) of them were Oromo ethnic group in which followed by Amhara ethnic group which accounts 72(27.7%). From the Oromo ethnic group, majority 94(50.0%) of them were utilized their rights and the remained 35(48.6%) Oromo ethnic group were not practiced their rights of sexual and reproductive health services and rights.

Regarding the residency status of study participants majority, 170(65.4%) of them were came from urban in which followed by study participants who came from rural areas. And majority 98(37.7%) of study participants have five children, form this group, majority of them 60(31.9%) were practiced their rights and the remained 38(52.8%) were not able to practice their right of sexual and reproductive health rights. And study participants, majority 175(67.3%) of them were intended more than five future number of children's. And majority 137(55.7%) of study participants have full rights of sexual related issues.

Table 5.1.4 **Independent variable distribution characteristics by utilization of sexual and reproductive health services.**

variables	Categories	SRHS utilization		Total(percentage)
		Utilized their rights	Not utilized their rights	
Age categories of respondents	15-19 years	21(11.2%)	6(8.3%)	27(10.4%)
	20-24 years	38(20.2%)	22(30.6%)	60(23.1%)
	25-29 years	62(33.0%)	16(22.2%)	78(30.0%)
	30-34 years	45(23.9%)	14(19.4%)	59(22.7%)
	> 35 years	22(11.7%)	14(19.4%)	36(13.8%)
Marital status	Currently married	145(77.1%)	43(59.7%)	188(72.3%)
	Currently not married	43(22.9%)	29(40.3%)	72(27.7%)
Ethnic group categories	Oromo	94(50.0%)	35(48.6%)	129(49.6%)
	Amhara	49(26.1%)	23(31.9%)	72(27.7%)
	Tigre, Gurage, SNNP	45(23.9%)	14(19.4%)	59(22.7%)
Occupational status	Government employee	53(28.2%)	18(25.0%)	71(27.3%)
	Merchant	29(15.4%)	4(5.6%)	33(12.7%)
	NGO employee	19(10.1%)	6(8.3%)	25(9.6%)
	Housewife	46(24.5%)	20(27.8%)	66(25.4%)
	Private employee	22(11.7%)	7(9.7%)	29(11.2%)
	Students	19(10.1%)	17(23.6%)	36(13.8%)
Residency of respondents	Rural	41(21.8%)	21(29.2%)	62(23.8%)
	Urban	131(69.7%)	39(54.2%)	170(65.4%)
	Semi-Urban	16(8.5%)	12(16.7%)	28(10.8%)
Number of children	one child	28(14.9%)	6(8.3%)	34(13.1%)
	two child	34(18.1%)	7(9.7%)	41(15.8%)
	three children	47(25.0%)	9(12.5%)	56(21.5%)
	four children	19(10.1%)	12(16.7%)	31(11.9%)
	five children	60(31.9%)	38(52.8%)	98(37.7%)
Number of future children intended to have	1-2 children	24(12.8%)	14(19.4%)	38(14.6%)
	3-4 children	30(16.0%)	17(23.6%)	47(18.1%)
	>5 children	134(71.3%)	41(56.9%)	175(67.3%)
accessibility to SRSH services	Yes	158(v0	44(63.8%)	202(81.1%0
	No	22(12.2%)	25(36.2%)	47(18.9%)
Source of information	Media(TV and radio)	84(44.7%)	22(30.6%)	106(40.8%)
	Health professionals	104(55.3%)	50(69.4%)	154(59.2%)
Right to decide to have sex	YES	98(56.0%)	39(54.9%)	137(55.7%)
	NO	77(44.0%)	32(45.1%)	109(44.3%)
Knowledge on SRHS	Good knowledge	105(67.3%)	43(67.2%)	148(67.3%)
	Poor knowledge	51(32.7%)	21(32.8%)	72(32.7%)
Attitude towards SRHS	Good attitude	116(61.7%)	44(61.1%)	160(61.5%)
	Poor attitude	72(38.3%)	28(38.9%)	100(38.5%)
Extended rights to clients	right to access	42(23.5%)	15(21.1%)	57(22.8%)
	right to choice	39(21.8%)	11(15.5%)	50(20.0%)
	right to information	64(35.8%)	32(45.1%)	96(38.4%)
	right confidentiality	14(7.8%)	6(8.5%)	20(8.0%)
	right to dignity	6(3.4%)	3(4.2%)	9(3.6%)
	right to privacy	14(7.8%)	4(5.6%)	18(7.2%)
Type of family planning	OCP	6(3.3%)	3(14.3%)	9(4.4%)
	DMPA	129(70.1%)	12(57.1%)	141(68.8%)
	IMPLANT	44(23.9%)	3(14.3%)	47(22.9%)
	IUCD	5(2.7%)	3(14.3%)	8(3.9%)

5.4 Multivariate analysis of independent characteristics of study participants with their Sexual and reproductive health services utilizations.

The probability of study participants to utilize sexual and reproductive health services, on the age range of 20-24 years old were found 5.54 times more likely not to utilize SRHS in comparing to the age range group of 15-19 years old (AOR=5.54, 95% CI = ((1.24-24.72)) *(P-value<0.025). And study participants whose age more than thirty were found 3.28 times more likely not to utilize SRHS in comparing to the age range group of 15-19 years old (AOR=3.28, 95% CI = (4.02-27.6)*(P-value<0.001).

Study participants who are currently not married were found 3.77 times more likely not to utilize SRHS in comparing to the age range group of 15-19 years old (AOR=3.77 , 95% CI = (1.24-11.42)*(P-value<0.019).

study participants on their intention to have future number of children, those study participants who intend to have more than five future children were found 0.27 times less likely to not utilize the SRHS services in comparing to those who intend to have one to two future children. (AOR=11.28, 95% CI = ((0.09-0.80))*(P-value<0.019).

Study participants who don't had access to SRHS services information were found 2.45 times more likely not to utilize SRHS services in comparing to those who had an access to SRHS information services (AOR=2.45, 95% CI = ((1.96-6.24), P-value<0.030).

Regarding sources of information, study participants whom their sources of information from media(TV/Radio) were found 1.98 times more likely to not to utilize SRHS services in comparing to those study participants whom their sources of information on SRHS from health professionals (AOR=1.98, 95% CI = ((1.92-4.26))*(P-value<0.045).

Regarding to the services Extended rights to clients, study participants who have right to information were found 2.77 times more likely to not to utilize SRHS services in comparing to those study participants who have an extended right to access to SRHS services, (AOR=2.77, 95% CI = ((1.06-7.28))*(P-value<0.038).

Table 5.1.5 .**Multivariate analysis of independent characteristics of study participants with their sexual and reproductive health services utilizations.**

Variables	Categories	Utilization of SRHS		COR,95%CI	AOR,95%CI	P-Value
		utilized	Not utilized			
Age categories of respondents	15-19 years	21(11.2%)	6(8.3%)	1	1	
	20-24 years	38(20.2%)	22(30.6%)	2.03(0.71-5.78)	5.54(1.24-24.72)	0.025
	25-29 years	62(33.0%)	16(22.2%)	0.90(0.31-2.61)		
	30-34 years	45(23.9%)	14(19.4%)	1.08(0.36-3.23)		
	> 35 years	22(11.7%)	14(19.4%)	2.23(0.72-6.80)	3.28(4.02-27.6)	0.001
Marital status	Currently married	145(77.1%)	43(59.7%)	1	1	
	Currently no married	43(22.9%)	29(40.3%)	2.27(1.27-4.06)	3.77(1.24-11.42)	0.019
Occupational status	Government employee	53(28.2%)	18(25.0%)	1		
	Merchant	29(15.4%)	4(5.6%)	0.40(0.12-1.31)		
	NGO employee	19(10.1%)	6(8.3%)	0.93(0.32-2.69)		
	Housewife	46(24.5%)	20(27.8%)	1.28(0.60-2.70)		
	Private employee	22(11.7%)	7(9.7%)	0.93(0.3-2.55)		
	Students	19(10.1%)	17(23.6%)	2.63(1.13-6.13)	2.63(1.13-6.13)	0.0001
Residency of respondents	Rural	41(21.8%)	21(29.2%)	1		
	Urban	131(69.7%)	39(54.2%)	0.58(0.30-1.09)		
	Semi-Urban	16(8.5%)	12(16.7%)	1.46(0.58-3.65)		
Number of children	one child	28(14.9%)	6(8.3%)	1		
	two child	34(18.1%)	7(9.7%)	0.96(0.28-3.18)		
	three children	47(25.0%)	9(12.5%)	0.89(0.28-2.77)		
	four children	19(10.1%)	12(16.7%)	2.94(0.94-9.21)		
	five children	60(31.9%)	38(52.8%)	2.95(1.11-7.80)	2.95(1.11-7.80)	0.005
Number of future children	1-2 children	24(12.8%)	14(19.4%)	1	1	
	3-4 children	30(16.0%)	17(23.6%)	0.97(0.40-2.36)		
	>5 children	134(71.3%)	41(56.9%)	0.52(0.24-1.10)	0.27(0.09-0.80)	0.019
accessibility to SRSH	Yes	158(v0	44(63.8%)	1	1	
	No	22(12.2%)	25(36.2%)	4.08(2.10-7.92	2.45(1.96-6.24)	0.030
Source of information	Media(TV and radio)	84(44.7%)	22(30.6%)	1	1	
	Health professionals	104(55.3%)	50(69.4%)	1.83(1.03-3.27)	1.98(1.92-4.26)	0.045
Extended rights to clients	right to access	42(23.5%)	15(21.1%)	1	1	
	right to choice	39(21.8%)	11(15.5%)	0.79(0.32-1.92)		
	right to information	64(35.8%)	32(45.1%)	1.40(0.67-2.89)	2.77(1.06-7.28)	0.038
	right confidentiality	14(7.8%)	6(8.5%)	1.20(0.39-3.69)		
	right to dignity	6(3.4%)	3(4.2%)	1.40(0.31-6.31)		
	right to privacy	14(7.8%)	4(5.6%)	0.80(0.22-2.81)		

CAPTER SIX

DISSCUSSION

According to the findings of this research there is a significant association between age categories of study participants and their decision power. That is those study participants whose age group 15-19 years old have 75% more decision power in comparing to the age group categories of 20-24 years old. This study was opposed by a research conducted by Abbey, (2002) in Nigeria, showed that majority of the study participants who have decision power were between ages 20-29 years and concluded by a descriptions, "This age group is crucial in the fight for reproductive rights". And it is supported by a research done in Gahanian (2014) by Eugene etal indicated that women's of age group from 35-49 years old were found 74.1% times more likely to have a decision on sexual related issues in comparing to the others. This might be due to the reason of both countries educational background and women's literacy level towards SRHS is different in which the Ethiopian literacy level is better than the Nigeria.

findings of this research showed that study participants who are currently married have 35.1% decision power in comparing to those who are currently non-married and this result supported by a research done by Tefera D, (2013) at Addis Ababa, Ethiopia, indicated that about 45% of women respondents reported that the decision was made by their husbands and this findings strengthen by a research conducted in Malawi Husbands had the predominant decision-making power in the household and reproductive issue which women were least likely to participate in decision-making power.(R. Kinoshita 2003) and this might be due to the reason of where the study participants are from the country of multi-cultural and social networks and strong religion aspects might drive to the strong basement of male dominancy.

The findings of this research showed that housewife in occupation were found 12.5% times more likely not have a decision power on the SRHRS services in comparing to the study participants who are government employee. And this result is confirmed by the qualitative research findings, SRH Service provider. *"…Yes, most women's in our community have no rights to decide by themselves and seek their partner's decision. Because they didn't know their rights as I told you above her husband are decision maker for her body, this is due to economic dependent." And it supported by a research done in Gahana (2014) by Eugene etl indicated that women's are more*

dependent of their partners on sexual and condom utilization issues. And this might be due to the reason of economic dependency which makes women's silent in decision making process.
Findings on residency showed that 63.8% of study participants from rural and 20.2% of study participants from urban have no decision making power. And this study supported by a research done by Bogale et.al (2011) revealed that (67.06%) study participants from rural and (45.83%) of urban and clearly showed that Reproductive decision making power is significantly associated with residence.

This study showed that there is a significant association between number of children and their decision power, which indicates, study participants who have only one child have a decision power in comparing to those who have three children and those study participants who have four children have not decision power than those who have only one. and this result is confirmed by an IDI participants, reported "*"…In our community having a number children has social value and using family planning is forbidden in some religions due to fear of this some women's can't deciding by themselves on the other hand most of the women's are economic dependent on men. They are waiting their partners' decision".*

This study result indicated that there is significant association between intention to have number of future children and their decision power on sexual and reproductive rights and services. In which those study participants who intend to have one to two future children have decision power in comparing those who intend to have more than five future children and this findings supported by a research done by Kinoshita (2003) in Malawi, indicated that The average preferred number of children was 4.45 children per woman, with a range of 0 to 12 children. 18% of women answered either "do not know" or "God decides" when asked about their fertility preferences. This might be due to the reason that Women's decision-making power was shaped by various socio-cultural factors including religion and, education, cash, employment, and marital structure. ***The result confirmed by a findings from one IDI participants and reported****"…Yes, because like having a number of children have a social value in the community, without spacing due to fear of partner, economic dependent, lack of knowledge and accessibility leads to non-decision making power on SRH services." In which this contemplation is supported by a statement wrote by RInko K. That pointed"* especially regarding men's perceptions toward women's low status, barriers to modern

contraceptive use, couple's opinions on condom use, and recommendations toward current family planning services. (Rinko K, 2003)."

Study participants who have accessibility to SRHS services accounts 202(81.1%) from this group of study participants, 59(66.3% of them don't have a decision power on and from the total 47(18.9%) of them don't have access and 30(33.7%) of them don't have decision power to SRHS services. accordingly, Study participants who don't had access to information were found 34.01% times more likely not to have a decision power in comparing to those who had information. This findings is supported by a report of Ethiopian Federal ministry of health on the importance of interpersonal communications" it is a research based consultative process of addressing knowledge, attitude and practices through identifying, analyzing and segmenting audience and participating in the programs and by providing them relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal communication channels" (FMOH).

Those study participants who have a good knowledge level were found 32.2% times more likely to have a decision power in comparing to the study participants who poor knowledge level. And this result is confirmed by the qualitative research findings from one IDI participant, reported "*"…Even if they have some knowledge on their rights they are economic dependent on men. So they are waiting their partners' decision not deciding by themselves".*

The right of the choice is more violated due to the following reasons by exploring open-ended question seven respondent explained their choice was not respected and they used implant contraceptive without their choice and during overt observation of client provider interaction the service provider pushing clients to long term F/P. I asked finally what is the reason she was pushing to long term, was government and donor interest, more plan than short terms, to achieve this plan they are violating clients reproductive choice.

LIMITATIONS

Assessment of SRH service providers through observation while they provide SRH service may change the actual behaviors and practices of service providers and the relationship between providers and clients, and the findings might be affected by social desirability.

The cross-sectional study design by itself might limit to know which variables comes first and un able to know the cause-effect relationship of characteristics. And the participatory observation, might introduce bias to the data collected by observation due to changing actual practice, in which service providers might realize and know as they are under observation.

This has been countered by assurances that the SRH service providers are often unaware of the true purpose of the study.

CHAPTER SEVEN

CONCLUSSION AND RECOMMENDATION

7.1 Conclusions

- According to this study there is high Male economic, dependency and culture are more factors for decision making power.
- Gender equitable attitude had significant statistical association with decision making on reproductive health and rights.
- Interventions in the area need to be promoted and consider empowering of women on reproductive decision making power and SRH utilization.
- The role of male partners on women reproductive decision making power SRH and utilization. decision making needs to be studied systematically from both partners perspective
- Women's have fair knowledge deficient in comparing to other studies but more have a problem on practicing their rights of SRHR and services.

7.2 Recommendation

From the findings the study recommends that women's empowerment through education and economic activities, as one of the entry points for enabling them to actively participate in the reproductive decision making process. Male involvement in SRH service provision. Strengthen partner communication and negotiation skills among couples to improve joint reproductive decision making patterns. More efforts should be made to foster the elimination of gender imbalance and promote gender equality in the study communities.

Reproductive health and rights information should be delivered through community based awareness creation and behavioral change interventions, using a variety of methods including printed materials, mass media, health displays, classes, workshops, and presentations to groups and individuals (through peer education).

Publication of cultural appropriate IEC materials related to reproductive health and rights. Community involvement especially kea informant groups during IEC session on reproductive health and rights

References

Adrio, K.L Lyra, s.medrado B.and Nascimento, P. (2002).Working with northeast Brazil: realising rights: transforming approaches to sexual and reproductive well-being Africa; Intra Health International, London, New York, PP 199-208.Africa.

Awid, (2004). Intersectionality: A tool for Gender and Economic Justice, Women's Rights and Economic Change No.9

Berer .M (1994) .Reproductive Health Matters: Motherhood, fatherhood and fertility: for women who do and women who don't have children. London EC 1M 3JB,

Blanc.K. (2001). Effects of power in sexual Relationships on sexual and reproductive health: An Examination of the evidence; studies in family planning, population council England.

Bogale et al. BMC Public Health, (2011). Married women's decision making power on modern contraceptive use in urban and rural southern Ethiopia.

Bui T, Thu H (2003). Male involvement in family planning in rural Vietnam: an application of the Trans theoretical Model. Oxford University Press 2003.All rights reserved.

Burke, J. (1988). Gender identity, Self-Esteem, and Physical and Sexual Abuse in Dating Relationships: American Sociological Association.

Cleaver, F. (2005). Masculinities matters: Men, Gender and Development. Zed Books London. New York.

Cook .J.R and Mahnoud F. (1996). Advancing Reproductive Rights beyond Cairo and

Beijing: International Family Planning perspectives, Vol.22, No.3

Cornwall. A. (2000). Missing men Reflections on Men, Masculinity and Gender in

CSA, 2005. Ethiopia Atlas of Key Demographic and Health Indictors

Diekman et al, (2004). Gender Gaps in Sociological attitudes: A sociological Analysis.Journal of personality and Social Psychology, Vol 87(6)

Eugene Kofuor. D, David D. (2014). Reproductive health decision making; Ghana.

GAD.IDS *Bulletin*, Vol 31: 27.

Elson D, (2003). Gender justice, Human Rights and Neo-liberal Economic Policies in M.Molyneux and S.Razavi, eds; Gender justice, Development and Rights, London: Oxford University Press, Chapter 3:96-114 ac 8587 words.

Esplen.E. (2006). Engaging men in Gender Equity: Positive strategies and Approaches: Overview and Annotated Bibiliography.N0 15.Bridge (Development-Gender).Institute of Development studies University of Sussex Bridgton BNI 9RE, UK

Ethiopian mini demographic health survey (2014).

Ethiopia Atlas of Key Demographic and Health Indictors

Eternberg.P.J, (2004). Evaluating men's involvement as a strategy in sexual and reproductive health promotion. Health Promotion International vol.19.No.3 Oxford University Press 2004.

Gender and Development in Brief, Bridge Bulletin Vol 37, No 5:2006: Institute of Development Studies, University of Sussex, Brighton BNI 9RE, UK

Greene, M., April (2000), changing women and avoiding men: Gender stereotypes and reproductive Health Programmes in Men Masculinities and development: Politics, policies and Practice. IDS Bulletin, Vol.31 (2):49-59.

Greene.E. et.al. (2006). Involving men in Reproductive Health: Contributions to development: A back ground paper to the report public choices, private decisions; Sexual and Reproductive health and Millennium Development Goals. New York UN Millennium Project

Guttmacher.A (2003). Executive Summary in their own Right: Addressing the sexual and reproductive Health Needs of men worldwide.PP.4-5.Full Report, PP.1-74. .

IPPF, 2009.SRH and Human Rights

Kabeer.N (1999). Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment. Development and Change Vol.30 (1999), 435-464.

Kahn.S.J (2009).An introduction to masculinities: The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, and UK

Lindsay, (2003). Men and Masculinities in Modern Africa: Social History of Africa Allen

Mathew .R and Marcia C.I, (2004). Men's influences on reproductive health: Medical anthropological perspective. Department of Anthropology, 1557 Pierce Drive. Emory University, Atlanta, GA 30322, USA.

Ministry of Health, (2006-2010). National Family Planning Policy and its five-year strategies; Rwanda.

Program of Action the International Conference on Population and Development Cairo, (1994).

UNHCR, (1999).”Reproductive Health in Refugee Situation.

Sen. G. (1994). The social control of reproduction Power and Decision: the feminist challenge to social policy. Harvard University press, Boston: 5-17.

Solo.J, (2008). How a taboo topic became priority number one: Intra health International.

S.R. Patrikar (2014).Women empowerment and use of contraception: Mumbai; India

Sternberg and Humbley.J (2004). Evaluating men’s involvement as a strategy in sexual and reproductive health promotion. Health promotion International, Oxford press; 19(3)

Tefera D, (2013).African Population Studies: Addis Ababa, Ethiopia, 2.

Tigabu K. Getu D, Zelalem B, (2014). : Modern contraceptive.

UNFPA State of world population, (2008).Reaching Common Grounds: Culture, Gender and human Rights

United Nations Population Information network (1994). A report of the International Conference on population and development .UN Population Division, Department of Economic and Social Affairs, with support from the United Population Fund (UNFPA).

USAID, 2001.Contraceptive Technology.

White .R.Naomi (1994). About Fathers: Masculinity and the social Construction of Fatherhood. Department of Anthropology and Sociology

Wondimu .A (2009). The involvement of men in family planning: an application of Tran's theoretical model in woloita soddo Town, south Ethiopia: Addis Ababa University of medicine school of public health.

QUESTIONNAIRES

ANNEXES I

QUESTIONNAIRES FOR CLIENT INTERVIEW

INTRODUCTION

Greetings!

My name is ---------- I am Master's Degree students from Jimma University. As part of our academic requirements,

The main objectives of this study is to assess reproductive decision making power on sexual and reproductive health rights and services among female clients of child bearing age , and factors associated with their decisions among women getting SRH service at health facilities in Jimma town.

INFORMED CONSENT FORM

As this study is directly related to decision making power on SRH services, you are one of the women who are selected to participate in this study; your selection for this questionnaire is merely by chance and not deliberately done. Your response will be kept confidential and there will be no ways of linking your individual responses to the final result of the study findings. While your participation in this study will be very important to identify the challenges of SRH services, there will be no harm to you at all. Therefore you are voluntarily and kindly requested to participate in this study and provide the information required.

I am going to ask some very personal questions and you have the right to refuse from participation. I would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study but also for producing relevant information which will be helpful in improving the provision of SRH services and decision making power.

Are you willing to participate in this study? Yes ---------- No ----------

Questionnaire code number_____

Part I Socio-demographic data related to females sexual and reproductive health rights, in Jimma town, 2016.

1. Age A; 15-24 B; 25-34 C; 35-44 D; 45-49

Others please specify_____

2, Ethnicity A. Oromo B. Amahara C.Gurage D .Tigre E .Others specify_____

3. Estimated monthly income (in Birr): _____

4. Religious status. A. Orthodox B. Catholic C. Muslim D. Protestant E Others, specify_____

5. Occupational status

A; Government employee B; Merchant C; Non-government employee

D; House wife E; unemployed F; student G; Private employee

6. What is your educational Level?

A; Illiterate B; 1st cycle (1-4) C; 2nd cycle (5-8) D; Secondary & prep (9-12)

E; Diploma & above

7. Marital status?

A; Single B; Married C; Separated D; Divorced E; Widowed

8, Respondents Place of residency?

A: Rural B: Urban C; Semi urban

9, where did you live?

A, Patrilocal B, with in your family C: Live separately from both,

Part II Questions related to respondents knowledge on females sexual and reproductive health rights, misconception, in Jimma town, 2016.

1. Have you ever heard about female sexual and reproductive health rights education?

A; Yes B; No

2. If yes what is your source of information?

A; Through TV\Radio programs B from health professionals

C; through peer friends D; through discussion with my spouse\friend

3. If answer for question 2: is A…which media is easily accessible for you?
   A. TV
   B. Radio
   C. Leaflets
   D. posters
4. During your consultation with health professionals are you provided with sufficient information regarding the choice that a woman has to make with respect to the following;
   A. Nature of the procedure, method, intervention and medication.
   B. Side effect, nature of the procedure, method, intervention and medication.
   C. Reasonable alternatives to proposed procedure, method, intervention and medication.
   D. Benefits and uncertainties related to each alternative.
5. Do you have the right to deciding whether or not to make sexual intercourse?

A; Yes B; No

6. Which of the following services do they render at SRH Services today?

1. F/P	5, HIV counseling and testing
2. ANC	6, STI screening and treatment
3. Immunization	7, prevention of reproductive cancer
4. Health education	8. Others (specify) _____

7. Is the SRH Service easily accessible to you?

1. Yes 2. No

8. What means of transport do you use when accessing SRH Services?
   1. Walk
   2. Public means
   3. Others (specify)
9. How many children do you have? _____
10. If you don't have, how many children do you plan to have? _____

11. Why do you desire the above specified size?

_____

_____

_____

12. Is the above viewpoint shared by your spouse?

A. yes B. No

13. If No, brief why?

_____

_____

_____

14. What do you intend to reach agreement with your spouse \friend on sexual and reproductive health rights;

A; Seek help his friends to get him convinced B; personally get him convinced

C; Ask him to learn from TV\Radio programs on family planning

D; God will help us. E Both A and C

15. Have you ever heard about female sexual and reproductive health rights?

A; Yes B; No

16. If yes mention them (don't read to the study participant and only when the participant mention circle or thick it);

A; Right to access B; Right to choice C; Right to information

D; Right to confidentiality E; Right to Dignity F; Right to privacy

G; Right to safety H; Right to continuity I; Right to comfort

H; Right to opinion J; Right to opinion K; Right to Choose their partner;

L; Have the Right to consensual marriage; M;The right to be free from discrimination/ gender inequality/ abuse/ violence

17. What are the key challenges to female sexual and reproductive health rights in your area or environment?_____

Part III Questions to assess Attitude of respondent's female sexual and reproductive health rights

	Characteristics	strongly Disagree	Disagree	undecided	Agree	strongly agree
1.	Female SRHR helps me to exercise my rights to promote my healthy life styles.	1	2	3	4	5
2.	SRHR doesn't help me to alleviate my health and health related maternal problems	1	2	3	4	5
3.	I am too young to contract any maternal problems	1	2	3	4	5
4.	The cost of female SRHR is expensive to utilize all.	1	2	3	4	5
5.	I don't use SRHR because I fear that the result would be shared with parents or partner (s) without my consent.	1	2	3	4	5
6.	I don't use SRHR because I fear of being labeled unhealthy and stigmatized by the community /my peer	1	2	3	4	5
7.	I am sure to use female SRHR in the future.	1	2	3	4	5
8.	If my partner doesn't want me to use my SRHR, I will not try to convince her/him.	1	2	3	4	5
9.	I have the information where to be used the female SRHR.	1	2	3	4	5
10.	Men and women should have equal rights in decision making	1	2	3	4	5
11.	A wife may seek for family planning services without her husband's knowledge or consent	1	2	3	4	5
12.	Single girls and ladies do not have Reproductive rights.	1	2	3	4	5

Part III Questions to assess respondents to female sexual and reproductive health rights utilization.

1. Which of the rights below are frequently extended to you?

   A; Right to access B; Right to choice C; Right to information

   D; Right to confidentiality E; Right to Dignity F; Right to privacy

2. Which one is not easily available to you?

   A; Right to access B; Right to choice C; Right to information

   D; Right to confidentiality E; Right to Dignity F; Right to privacy

3. Do you have the right to deciding whether or not, and. When to have children including the number of children and spacing of pregnancy? A; Yes B; No

4. If No, why? _____

5. Do you know modern F/P methods? A: Yes B.NO

If yes what type mention them

_____

_____

6. Have ever used family planning methods? A; Yes B; No

7. If yes what type mention them._____

8. Did you receive F/P by your choice? A: Yes B: No

10.If no why

_____

Thank you for your time and contribution!!!

ANNEXES II

SRH SERVICES OBSERVATION CHECKLIST

Observation ID number: _____ Health Facility Type: _____ Ownership _____Code Number _____ Date of Observation: Date_____

1. Provider providing MOST of the Counseling session:

1. Nurse 2. Nurse- Midwife 3. Health officer 4. Other _____

2. Sex of Provider: **1. Female 2. Male**

Reproductive health service.

1. Client status: 1. New 2. Revisit 3. Undetermined

1. Did the service provider	**Yes**	**No**	**Remark**
A. Ask open-ended questions?			
B. Encourage client to ask questions			
C. Treat client with respect			
D. See client in private			
E. Discuss a return visit			
F. Ask client her concerns with any method			
G. Use visual aids			
H. Use client record			
I. Assure client of confidentiality			

2. Good Client provider interaction markers (Mark all that done by the service provider satisfactory)	**" √ "**
a) Establish rapport:	
b) Assess the woman's needs:	
c) Explain human reproduction:	
d) Ask if the woman desires to delay or prevent future pregnancy:	
e) Assess the woman's individual situation:	
f) Explain well on service provided.	
g) Ensure that the woman understands about provided services.	

ANNEXES III

INTERVIEW GUIDE FOR SRH SERVICE PROVIDERS: AND INFLUENCIALS.

INTRODUCTION

Greetings!

My name is ---------- I am Master's Degree students from Jimma University. As part of my academic requirements,

The main objectives of this study is to assess the female decision making power on sexual and reproductive health rights and services among female clients of child bearing age , and factors associated with their decisions among women getting SRH service at health facilities in Jimma town.

INFORMED CONSENT FORM

As this study is directly related to decision making power on SRH services, you are one of the women who are selected to participate in this study; your selection for this questionnaire is merely by chance and not deliberately done. Your response will be kept confidential and there will be no ways of linking your individual responses to the final result of the study findings. While your participation in this study will be very important to identify the challenges of SRH services, there will be no harm to you at all. Therefore you are voluntarily and kindly requested to participate in this study and provide the information required.

I am going to ask some very personal questions and you have the right to refuse from participation. I would like to inform you that the responses that you provide to the questions are very essential, not only, for the successful accomplishment of the study but also for producing relevant information which will be helpful in improving the provision of SRH services and decision making power.

Are you willing to participate in this study? Yes ---------- No ----------

Questionnaire code number_____

IN-DEPTH INTERVIEW GUIDELINE: FOR SERVICE PROVIDERS AND INFLUENCIALS.

I: SOCIO-DEMOGRAPHIC

Zone _____Woreda _____Code_____,

Age _____, Ethnicity _____ Religious _____

Educational background_____, marital status _____ Occupation _____ Income Level_____ Parity _____ Position_____ Date of interview_____ **:**

In-depth interview guideline question

1. What do you understand by SRH rights?
   Probing can you mention them?
2. Which SRH rights are more experienced by women's?

   Probing why?

3. What do you understand by SRH Services?

   Probing can you mention them?
4. What factors are associated with female decision making power on SRH services?

   Probing why?

5. Do you think lack of decision making power on SRH services affect maternal health?

   If Yes how? _____

If no why? _____

6. What is your suggestion to improve decision making power on SRH service?

Started time_____ ending time_____