Addis Ababa University
Faculty of Medicine
Department of Community Health

ASSESSMENT OF THE ROLE OF CURRENTLY MARRIED MEN AGE 20-64 YEARS IN CONTRACEPTIVE USE AND FERTILITY PREFERENCE, IN HOSSANA, SNNPRG-ETHIOPIA.

BY
TSEDEKE TULORO (MD)

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I extend my appreciation to all participants including data collectors, supervisors and all men, religious leaders, Elders, Health providers and respondents of Hossana Town. I would also like to thank the Staff of the Computer lab of DCH for their valuable cooperation at any time.

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CBD – Community Based Distribution of family planning

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FGAE - Family Guidance Association of Ethiopia

FGD – Focus Group Discussion

IPPF - International Planned Parenthood Federation

IUCD - International Contraceptive Devices

KAP - Knowledge, Attitude and Practice

MOH - Ministry of Health

SNNPR- Southern Nation, Nationalities and Peoples Region

SPSS - Statistical Package for Social Science

UDAS - Urban Dwellers Associations.

EECMY – Ethiopia Evangelical Church of Mekane Yesus

SCS – South central Synod

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Abstract

This is a community based cross-sectional study conducted in Hossana Town southern Ethiopia n from December to January 2004; to assess the role of currently married men age 20-64 years in contraceptive use and fertility presences. A multistage sampling procedure was carried out to interview 776 men in study area. A pre-tested structured questionnaire complemented with focus group discussion was the main instrument used for data collection.

The study revealed that median age at marriage was found to be 25.9 years in the Study are. Average number of living children in the study area was found to be 3.84, while ideal number of children desired was 5.2 children per men. Ninety one point five percent of the study population has heard of contraception and 79.4% of the study population knew at least one method of contraception.

The contraceptive prevalence in Hossana Town was 47.6%. Among the non-users of family planning 13% of respondents mentioned desired to have more children, 8.4% mentioned that respondent opposed, followed by fear of side effects (5.4%), religious prohibition (4.5%) and known no methods was (2.7%). Fourteen point six percent of men in the study area was discontinued using family planning due to desire to have more children.

The most commonly mentioned reason for using contraception among current users was child-spacing by 30.7% and the second most commonly mentioned reason was child limiting by 17.5%. Thirty –seven point eight percent of men in the study area have never used family planning methods. Fifty-nine point four percent of men in the study area have mentioned intention to use family planning in the near future.

Knowledge about contraception, family size, discussion with wives about family planning and fertility in the family, attitudes of respondents and their partners were found to be determinates for contraception. Participating of men in family planning service delivery system, maximizing access to good quality services, improving the quality of family planning services, and making contraceptive method mix easier to obtain and use will help to meet need of many men.

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1. INTRODUCTION

Uncontrolled world population growth particularly in many developing countries has been a major challenge to the development plans (1). The recent demographic trends suggest that the world is experiencing rapid population change with subsequent doubling time (1,2). The 1998 United Nations projection portrays a future world population between 7.7 and 11.2 billion by the mid 21st century, an increase over the current total of 6 billion (3). The problem of the population is not simply a problem of number, but it is a human welfare and development problem (4). Then, with by the middle of this century at least two billon people will live in the countries where water shortage may constrain food production and economic development (4).

Most of the population growth is occurring in developing nations where fertility rates remain high. In Africa, the average growth rate during the last decade was 3.2 percent, the highest among third world regions (5). Sub-Saharan Africa in particular has experienced little change in its fertility rates. The majority of these countries have fertility rates of over 6.0, not with standing decrease in a few countries such as Kenya and Zimbabwe (6).

Further more, population growth decline would make a crucial difference in many developing countries. High population growth rate puts pressure on the already meager

resources and poses a serious challenge in the provision of food, housing, health and educational services and employment opportunity to the general population.

Family planning services have become the intervention of choice to slow this demographic explosion. It is believed that child spacing or the timing of every birth, including the first and the last, can improve the likelihood of survival and of good physical and emotional health for the entire family at all stages of life, the first associated with fetal death, birth defects, infant mortality, child morality and nutritional depletion for women and children can all be reduced through effective family planning (7).

Despite the awareness and knowledge about the demographic explosion and it is associated health hazards has raised a serious of question of why family planning programs were failed in many countries? Several reasons could be mentioned. Social, economic, cultural and psychological factors have been shown to influence a couple's decision to use or not to use contraception even in the availability of contraceptives (8). Communications between spouses, the effects of the attitude of significant others, and fear of side effects have also been known to be the main factors in influencing the use of modern contraceptives.

For many years, family planning program planners have focused their attention largely on women's attitudes and behaviors in matters concerning reproduction. The fact that women bear the physical and emotional strain of pregnancy and childbirth has meant that fertility and contraceptive prevalence rates are based solely on the female population.

Thus, the social roles of men who are dominant not only in decision making within the family but also at community leadership levels have been ignored (9).

Most family planning programs offer and promote certain contraceptive methods, such as pills and injectables to be used by women. However, the effectiveness and continuous use often remains unsuccessful owning to lack of approval from their partners/husbands (10). Most family planning programs give less attention to the understanding of men's role in the effective and consistent utilization of contraceptives. The methods that require male involvement such as condoms, periodic abstinence, withdrawal and vasectomy are less used (11,12).

Many studies have also suggested that family planning programs in many African societies have been unsuccessful since they failed to take into account the power relations between couples and the patriarchal nature of societies. African men are not only heads of the houses, but also are overall responsible for their families. Also men may have more influence on reproductive decisions since they typically control the family's assets (11,12).

Not surprisingly, African men generally desire larger families than do their wives. As Caldwell and Caldwell observed, African men want to have more children since they gain socially and economically from having a large number of children (12). Men are proud of the number of their children particularly sons because of the present and future

benefits derived from them. In the absence of social welfare and security programs, children constitute important source of old age support for their parents (13).

According to a study conducted to asses the perceptions of fertility regulation in a remote community, of southern Ethiopia, female respondents reported that because of the male dominance in the culture, women would be forced to bear large number of children (13). This is reported to be a major obstacle in the fertility regulation decisions by women.

Another study on the role of men in fertility and family planning program in semi-urban community, of Tigray Region, indicate that desire for more children among currently married or in union men, 80.9% wanted another child (14). Among currently married or in union women, 64.2% wanted another child, and 30% of men and 31% of women had discussion with regard to the current use of contraceptives (including: once or twice to more often). However, 36% of men and 37% of women reported that they had had no discussion concerning family planning with their partners in the previous one year (14).

In the study conducted in the North Gondar on the men's knowledge, attitude and practices of family planning, 30.6% them opposed the use of modern family planning method. Out of the 41% approving, the method 7.7% proposed that only men should use contraceptives, 41.7% said only women should use them, 32.3% said both should use them. Of all interviewed men, 50.1% objected to the use of contraceptives by nulliparas, where as 33.7% supported it (15). Ezech has shown that women's reproductive preference and behavior are strongly influenced by their husband's reproductive

motivation (11). Several studies have also shown that communication between partners about sexual matters is culturally unacceptable; the risk of unintended pregnancy and sexually transmitted disease is high (11).

Ethiopia is one of the populous countries in Africa. It stands third after Nigeria and Egypt (16). It has the highest annual population growth rate of 2.9%, high maternal mortality rate of 871/100,000 live births and high infant mortality rate of 97/1000 live births. The population increased over the last decade, from 42.6 million in 1984 to 53.5 million in 1994 (17). There was a slight decline in the population growth rates over the decade, from 3.1%in 1984 to 2.9% in 1994(17). In recognition of the need to address these issues, the government of Ethiopia adopted a population policy in 1993. The prime objective of the policy is to harmonize the rate of population growth with the socioeconomic development. The population policy also aims at reducing the total fertility rate from 7.7 children per women in 1995 to 4 children per women in 2015, and an increase in contraceptive prevalence rate from 4% in 1995 to 44% in 2015(17).

The international conference on population and development (ICPD) held in Cairo in 1994 secured international agreement conference on population and development approach that put people first and place women at the center of development efforts (18). The Cairo conference recognized that smaller families and slower population growth depend on free choice and conditions that encourage such a choice. This approach is surrounded in and defined by the principles of the international conference on population development (ICPD) program of action, which seeks to ensure on the basis of equality of

men and women, universal access to health care services including those related to reproductive health care which includes family planning and sexual health (18).

These were already guiding principles of the national population policy, adopted in Ethiopia, as part and the center of the new economic and social policies adopted by the Transitional Government of Ethiopia (18). The fact is no matter the program, no matter the country, religion, or economic status, control over one's fertility is a basic need as basic as food and housing. Any attempt to isolate family planning from development is not only outdated, but misguided (19).

According to the report of Ethiopian Demographic and Health Survey (DHS-2000), the total fertility rate is 5.9 children per women, where as the recent health and health related indicator of Ministry of Health (MOH) reported national Contraceptive Prevalence Rate (CPR) to be 8.1% (20). This is one of the lowest figures when compared with least developed countries (20). Some pocket cross- sectional studies and the first national Demographic Health Survey identified several reasons for low coverage of family planning service. Among the reasons for low prevalence of contraceptive use is the socio cultural aspect of the patriarchal society. Sociological factors (culture, religion, etc.) are in favor of Ethiopian men, as decision makers both at family and community levels. Traditionally, wives in most Ethiopian ethnic groups consider their husbands as overall heads. The husbands decide upon most things, and their wives are expected to abided by their spoken decisions or their perceived wishes (20). Thus, this male dominated family structure has great influence in matters of reproduction.

The Southern Nations, Nationalities and Peoples Region of Ethiopia (SNNPR) is characterized by high infant mortality rate of 102/1000 live birth, a high level of fertility rate of 6.8 children per women of reproductive age and low level of contraceptive use (21). Since April 1993, the new National population policy favoring fertility limitation was implemented. The SNNPR Government, many international and national none governmental organizations (NGOS) and numerous international organizations have prompted the delivery of family planning services. The regional government has been delivering such services mainly through maternal and child services as part of integrated program of health care services. The primary providers of family planning services have been the Family Guidance Association of Ethiopia (FGAE), an indigenous NGO's Associated with International Planned Parenthood Federation (IPPF) and EECMY-South Central Synoid Associated with the Pathfinder- Ethiopia. The NGOs also have been active in community-based systems for distributing contraceptive services (22).

2. LITERATURE REVIEW

The role of men in fertility and family planning in sub-Saharan Africa is becoming increasingly important in the context of raising contraceptive prevalence and reducing levels of fertility. Fertility studies in the recent past, however, have been dominated by findings almost exclusively from women (Mbizvo and Basset, 1995, Bankole, 1995 Adamchak and Adebayo, 1987, etc.) (23).

Regrettably, policies and programs based on such findings have not had the expected success in increasing contraceptive prevalence and simultaneously reducing overall fertility in sub-Saharan Africa. Men's involvement could assume an essentially prominent role in each couple's family planning effort. It is assumed in the African context that women do not have control over their own reproductive behavior. Most studies carried out in Ethiopia and other African countries (Geberkidan M., Shabbir I., Yemane B. and Mekonnen E. Isiugo - Abanihe, Mbizvo and Adamchak: 1991 etc) have all asserted the domineering position of men on reproductive health matters.

According to the result of these studies, men are dominant decision makers within the family. They gain socially and economically from having large numbers of children and their reproductive preferences and motivation influence their wives reproductive outcome. These assertions are corroborated by Fapohunda and Todaro (1988) when they concluded that men's negative attitude is a major reason why their wives fail to practice family planning even when the latter are motivated to do so (13,14,15,23).

The persistence of high fertility in Sub-Saharan Africa particularly has been the subject of considerable investigation during the past decade. Social forces sustaining high fertility

and impeding family planning programs are well understood. For instance, Ezeh observed that women's fertility preferences and behavior are strongly influenced by their husband's reproductive motivation. Also, in most developing countries, women carry the burden or responsibility of contraceptive use often with little or no support and sometimes with great resistance from their male partners. In spite of all these realizations, however, there is a paucity of demographic data on male knowledge, attitude and practice of contraception in Ethiopia. In other words, there is a need to know the reproductive intention and expectations of Ethiopian men more than ever before. Ignoring men in fertility research and programs undermines efforts both to change their attitudes on population matters and to motivate them, and through them, their wives, towards family planning (FP).

Here, issues such as the knowledge and practice of FP, men's approval of FP and other fertility issues deserve serious consideration. Again there is a need to investigate the gender power relations in reproductive health decision-making processes. For instance, who decides when or when not to have additional children? Who decides when to adopt family planning and which FP methods to use? All these questions are important for major channeling and direction of action programmes (13,14,15,23).

2.1 Characteristics of Husbands

In some settings, the difference in the ages of husband and wife is a determinant of whether the spouses have similar reproductive preferences. According to studies done in 18 developing countries, husbands are typically older than their wives, the median age difference ranges from 2.7 years in Brazil to 12.2 years in Senegal (24). Generally, the gap is widest in Sub-Saharan Africa.

Polygamy is evident in the 16 countries for which data are available on type of marriage. However, while polygamy is very common in sub-Saharan Africa its prevalence is negligible in other regions on average, 23% of husbands and 29% of wives are in polygamous union in sub-Saharan Africa, but wide variations exist within the region: polygamy is most prevalent in West African countries, which are predominantly Muslim. The relatively high prevalence of polygamy may account for the large age gap between spouses in these countries, since women in societies where polygamy is common tend to marry at younger ages than their counterparts in societies where the practice is less prevalent (24).

In every country, at least 80% of husbands are currently working. A substantial proportion of wives work, although wide variations exist between countries. More than 50% of wives are currently working in 10 countries, but in North Africa and Asia, the proportions are only 15-22% (24). The literacy level among men varies from 10% in Senegal to 77% in Zimbabwe. The proportion of wives who can read without difficulty ranges from 3% in Niger to 76% in Brazil (24).

The number of years of schooling that men and women receive remains very low in many developing countries. The proportion of husbands with seven or more years of schooling ranges from 5 % in Burkina Faso to 67% in Zimbabwe; it is greater than 20% in 12 countries (24). Wives tend to spend fewer years in school than their husbands in most of these countries: the proportion of wives with sever more years of education exceeds 20% in only six countries (24).

2.2 Reproductive Goals

Although conventional wisdom suggests that men desire more children than women in developing countries, data that permit empirical, cross-cultural studies to verify this claim have only recently become available. One commonly used measure of reproductive preference is the number of children that a respondent would like to have if he or she could choose. Husbands tend to seek a larger family than their wives in many countries, especially in sub-Saharan Africa (24). The proportion of couples in which the husband desires at least two children more than his wife ranges from 17% in Pakistan to 49% in Niger. By contrast the corresponding estimates for wives ranges from 11% in Bangladesh and Egypt to 23% in Malawi and Niger (24).

If we define agreement to mean that a husband and wife report either the same desired number of children or one child difference: - the proportion of couples in which spouses agree ranges from 27% in Niger to 70% in Bangladesh. Agreement is higher among couples in countries outside sub-Saharan Africa than in that region. While more than

60% of couples in the five North African, Asian and Latin American countries included here are in agreement, fewer than half agree in eight of the 13 sub-Saharan African countries, in five of eight countries, only 30-40% of husbands and wives desire the same number of children (24). On average, married men want a large number of children in of these countries.

The mean number of children desired by the husband ranges from 2.9 in Brazil to 11.5 in Niger, it exceeds five in 11 of the sub-Saharan African countries. The husband's desired family size tends to be higher in West Africa than East Africa. The wife's average preferred family size shows a similar range across countries and similar regional patterns. The difference in spouses' mean desired family size is substantial – one child or more – in seven sub-Saharan African countries, five of which are in West Africa (24)

According to a study done in Tigray Region the average desired ideal fertility (family size) was 4.9 children for men and 3.7 children for women. Ideal family size increased with age and number of living children for both groups (14). In a study done in urban Sudan in 1988, the mean ideal family size among husbands was 4.7 and among husbands with no education, the mean was slightly higher at 5.1. Desired family size was found to be highest among low income and high in come groups, and lowest among middle-income groups. The proportion of husbands who wanted more children than their wives did was higher than the proportion that wanted less than their wives did (25).

Reasons for wanting additional children were mainly related t o the happiness and strength associated with a large family, present and future economic benefits and parents old age security. A significant proportion, 13.5% of husbands, wanted more children for religious reasons. Husbands who did not want additional children (59.8 percent) tended to be concerned about the economic burden of a large family (25).

2.3 Fertility intention

Another prominent measure of reproductive preferences is whether or not the respondent intends to have another child. The proportion of couples in which both spouses agree on this measure (i.e. either both want more or both want no more) ranges from 74% in Kenya to 90% in Niger. Throughout sub-Saharan Africa, husbands and wives whose fertility intentions agree generally want more children. Of all couples in agreement, the proportion who want more children ranges from 53% in Kenya to 99% in Niger.

This supports the finding that a high proportion of both husbands and wives want a large family in sub-Saharan Africa. In the remaining four countries, the proportion that want to stop childbearing ranges from 51% in Morocco to 79% in Brazil (24). In a study done in the Northern part of Ethiopia (in Tigray Region), the proportion of husbands who wanted more children than their wives did was high (80.9%) (14) This regional differential is not surprising, since desired family size and actual fertility are lower and declining in most developing countries outside sub-Saharan Africa.

Among all couples experiencing disagreement, the proportion in which the wife wants no more children but the husband wants more is 60% or greater in 13 countries (24). Among couples in which both spouses want more children, the proportion who disagree as to the timing of the next birth range from 21% in Brazil to 40% in Burkina Faso and Uganda (24). This suggests that in the majority of couples, the spouses agree either to have another child soon or to wait. In six of the nine sub-Saharan African countries, for which data are available, husbands want the next child sooner than their wives. Therefore, at least in sub-Saharan Africa husbands not only want a larger family than their wives, but also want the next child sooner than their spouses (24). Although the causal path is unclear polygamy may be associated with men's reproductive preferences: men may either have more than one wife because they want many children or want many children because they have more than one wife (24)

The fertility preferences of wives in polygamous unions are less clear. Some differences exist in the desired family size of marital partners by type of union. In almost all countries for which we can classify couples by type of union, the proportion in which the husbands family- size preference exceeds the wives by two or more children is higher for polygamous than monogamous unions. In sub-Saharan Africa, the proportion ranges from 21% in Kenya and Zimbabwe to 48% in Niger among monogamous couples, and from 33% in Mali to 57% in Mali to among polygamous couples (24).

2.4 Contraceptive Knowledge and behavior

A substantial proportion of married men know of at least one method of family planning, but in some countries, only a small proportion of those who know of a method are practicing contraception. The proportion of husbands who know at least one modern method ranges from 57% in Burkina Faso to 100% in Brazil. In Zimbabwe nearly 79% of the men knew at least one method unprompted, with the pill (74.7%), condoms (37.6%), and injectables (19.8%) predominating (26). Reasons for using family planning methods: for spacing children nearly 53%, to limit the number of children 12%, to limit and space children 6.5% and health of wife 0.9% (26).

In Nigeria about 65% men and 54% of women knew of at least one contraceptive method: the condom being the most widely known method with 88.1% of men and 75.9% of women claiming knowledge of it respectively (23).This is followed by the pill with almost 74% of men and 70% of women claiming knowledge of it. The least known among the modern contraceptives is Norplant with only 6.7% men and 9.5 women having heard of it. Knowledge of traditional methods like abstinence and withdrawal were 68.2% and 71.4% for men respectively. The current prevalence contraceptive use is 32.3% among men (23).

In Ethiopia, according to DHS 2000, knowledge of FP was high among currently married men and women and almost similar of 85.3% (20). Among urban youth in Ethiopia, it was found that there was a large discrepancy between knowledge and the actual practice

of contraception. Only 15% of the males had used a condom (27). Among Ethiopian Domestic Distribution corporation employees 92% of them at least knew one method of FP (28). A t the time of study, current users rate was 39%, and the condom was used by 37.5% of the men only (28).

Among men in North Gondor zone (Ethiopia), nearly 62% of men knew about one or more FP methods: the known FP methods were pill (88.1%), condom (49.2%), rhythm (23.2%), injectables (23%), female sterilization 12%, and male sterilization (0.8%). The purpose of using contraceptives: child spacing (68.8%), child limiting (66.6%), maternal health (26.6%) (15). Knowledge about contraception varies among countries and even regions of one country. In many studies conducted so far associations between knowledge of and use of contraceptives have been reported differently (15).

Of all interviewed men 64.3% approved the use of modern FP methods and 30.6% opposed the use of modern FP methods (15). Out of,, the 535 approving, 41(7.7%) proposed that only men should use contraceptives, 223(41.7%) said only women should use them, 173 (32.3%) said either should use them. Regarding who should decide on method of the FP to be used: Both (husband and wife) 54.9%, husband only 25.2%, wife only 8.4%. Who should decide on the number of children to born in the family 47% reported both (husband and wife), 20% only husband, and 5.8 only wife. Out of the married men only 35.2% had discussed FP with their wives in the past one year (15).

Out of the total study population (47.2%) had heard about condoms, while (51.9%) had not. Attitudes towards condoms among those who knew about condoms: condoms prevent pregnancies 79.4% agreed and 20.1% disagreed, condoms prevent STDS, 83.2% agreed, and 16.3% disagreed condoms reduced male sexual pleasure 44.5% agreed and 49.9% disagreed. Out of the total of 832 men (10.6%) reported having ever used condoms in the past and only 3.5% are currently using condoms (15).

In Nigeria, about 63% of men and women would approve the use of FP (23). At least 50% of women and 38.1% of men indicated that they had talked about FP matters with their spouses on three or more occasions. More than 30% of the respondents had ever discussed FP matters with other persons aside from their spouses. Reproductive decision-making, both male and female respondents in the study area agreed with the statements that men should decide family size 47.6%, decide when to have sex (34.4%), decide what to do to unwanted pregnancy (57.3%) and when to take firm decision on FP (42.6%) respectively (23).

In Sudan among those who answered, 44.7% said that decision about whether to practice FP, should be made jointly by husband and wife. However, 34.1%said that FP decisions are the husband's responsibility and only 5.4% believed that is solely the wife's responsibility (25). In addition, 14.5% felt that decision should be made by neither the husband nor the wife, but by a medical professional, 54% of the men with no education and 43% of those with low income felt that FP decision should be the husband's alone. Almost all (97.30%) of the ever-married men said that the husband's permission was

absolutely necessary for the practice of FP. The ever-married respondents who had never practice FP were asked who made that decision. It was the husband's decision alone in 37% of all cases, and joint decision between husband and wife in 33.3% of the cases(25). A great proportion of the husbands with an elementary education or lower, compared to the more educated men, were responsible for making a deliberate decision not to practice FP.

Among men with a secondary education or higher, and among young men, the decision was made more often by the husband and wife together (25). Men who had had past experience with FP were asked why they stopped using of FP. Among them 33.6% were reported to have another child since they had been using contraceptives for child spacing. Another 23.6% stopped since they were dissatisfied with their contraceptive method. Due to side effects in 48.1% of the cases, because of the negative socio-cultural associations of contraception. In14.8%, in other 9.9% method was not effect, 7.4% since they decided that Islamic teachings disapprove of contraception, and 7.4% stopped because the cost of contraceptive was too high, 5% of men stopped because their wives had reached menopause (25). Current users were asked who made the decision to practice contraception in their families. In 13.9%, of the cases husbands made the decision, in 6.8% the wife did; and in 69.6% husband and wife made the decision jointly(25). The respondents were asked whom they would approach if they wanted information on FP, 47.7% said they would go to a private physician, and 7.9% said they would go to a family planning clinic. In addition, 15.1% said they would ask friends or family members, and 4.3% said they would ask at a pharmacy. A total of 912 (60.8%) of all respondents admitted that they are in need of in formation on FP.

Among these men, 20.4% were unable to specify exactly what kind of information they needed. Of those who knew what their needs were, 34.2% wanted general information and 31.2% wanted to know about the technology of FP methods. A large proportion (30.6%) of the men approved of tuba legation for their wives under certain conditions (22).

Tubal legation is considered acceptable when the wife's health in endangered by repeated childbirth and to a less degree, when the desired family size has been achieved and no more children are wanted. And also if the wife experiences side effects from the pill or if other contraceptive method's are not acceptable to the couple. Approval of sterilization for any reasons was reported by 17.7% of men with no education, compared to 33.8% approval among highly educated men. Very few of the men in this study approved of male sterilization as a method of family planning. Under no condition was vasectomy approved by more than 9% of the total population. Only 9% approved if the husband objected to condom use, and 7% if the couple were tired of using other methods (25).

Most men and women in all groups in Mali (87-96%) believe that women should not decide to use a birth spacing method on their own. Accordingly, 77% of men and 67% of women in Community Based Distribution (CBD) groups and 37% of women and 38 % of men in Non-Community Based Distribution (NCBD) groups reported to discus about FP with partners (29).

Husbands and wives of all ages differed in their statements about who acted as primary reproductive decision- maker within the South Indian family (30). When asked who decided to plan the family 51% of men reported mutual decision making with their wives and 38% of women reported the same. These discrepancies between spouse's answers about reproductive decisions have been explained as the men's attempt to provide a socially acceptable answer. The older generations of men effectively controlled contraceptive decisions. Several women acknowledge that although they had wanted more children, their husbands had vasectomies with out consulting or informing them (30). In 59% of the couples included in the Tanzanian Demographic and Health Survey, both spouses approved of the use of FP Methods (31) In Mali, men in CBD and NCBD groups, reported the ideal family size to be between seven and eight, where as the women reported wanting on average six children (29).

2.5 Fertility intentions and Contraceptive use

Use of modern methods in highest when both spouses want to stop childbearing and lowest when they want to have more children. Only in Malawi, are couples more likely to be using modern methods when the husband wants no more children and the wife wants more on the other hand use of modern contraceptives seems to be higher among couples in Egypt, Kenya Mali, Morocco, Pakistan and Uganda when the wife wants no more children and the husband wants more. In Bangladesh and Brazil, levels of use in the two groups of couples are very similar (24).

It is recognized that contraceptive use will be more effective in households were both partners reported a common understanding that they are using a method of contraception. However, the emphasis in this study is on male's current use of contraceptives since the primary focus is on male's reproductive behavior. Contraceptive use takes a value of one if a male partner reported use and zero if otherwise. For continuously measured independent variable a value less than implies a decline and a value grater than one, an increase in the like-hood of reporting current use of contraceptive as value of that variable increase. Education, age and joint decision on when to stop childbearing were found to have significant impact on contraceptive use.

The impact of education is particularly pronounced when none of the partners had below secondary school education (20). Generally, a substantial proportion of both male and female population know of at least one method of family planning, but in some countries, only a small proportion of those who know of a method are practicing contraception. In Nigeria among the study samples 32.3% of males were current users of contraceptives (23). In the study done in North Gondar, (Ethiopia) 10.6% of men reported having ever used condoms, and 3.5 percent and 0.4 percent of men are currently using condoms and rhythm method respectively, 51/832 (6.1%) are using one or more methods of FP, either themselves or their sexual partners are using it (15).

In the urban Sudan, only 18% men were reported about current use of contraception (25). Finding from the ZDHS indicate that contraceptive prevalence was 43%, and ZMFS found that nearly 81 percent of man had ever-used contraceptives (26). Contraceptive use

was reported by 32 males (7.7%) (32). Among the sexually active youths only (16.5%) were current users, using condom (protective contraceptive against STDs (27).

This study is therefore significant because for any population control activity to be effective there is a need to address the family life and sexual behavior of men. These are Very important since there are issues that have impact on fertility directly.

Indeed, the husband's participation and involvement in programs like family planning is indisputably very useful to its success. Hence men are the forgotten half of the family planning programs in this country. So far, only few studies have addressed this area of concern in order to improve the existing low perception and utilization of family planning services in this country.

To this effect, the present study, therefore aims to assess the role of men in fertility preference and contraceptive use among currently married men aged 20-64 years in Hosanna Town, SNNPRG. It is hoped that the result of this study will enable the planners and program managers to design appropriate interventions or strategies by filling the (untouched) gaps in the attempt to improve the family planning programs in the study area and other similar settings.

2. BJECTIVES OF THE STUDY

3.1 General Objective

To assess the role of men in fertility preference and contraceptive use among currently married men age 20-64 years, in Hossana Town, Southern Ethiopia.

3.2 Specific Objectives

1. To describe the contraceptive prevalence rate in the study area.
2. To describe attitudes of men towards fertility preference and modern contraceptive use in the study area.
3. To identify socio-demographic factors related to fertility preference and modern contraceptive practice among married men in the study area.
4. To describe the decision-making role of married men in fertility preference and utilization of modern contraceptive methods in the study area.

4. METHODS AND MATERIALS

4.1 Study design

This study used a community-based cross-sectional study employing both quantitative and qualitative data collection methods. Focus group discussion was a qualitative method used to complement the finding of the quantitative study.

4.2 Study area and source population

This study was conducted in Hossana Town, Hadiya Zone, one of the 13th zones in the Southern Nations Nationalities and People's Regional Government (SNNPRG). The zone is located in the northern part of the region, bordering in northeast with Slite Zone, the Gurage Zone in the north, the Yem Special Woreda in the west and in the Kambata Alaba Tambaro, Wolaita zones and Oromia region in the south and southwest. Hossana is the capital town of the zone, and is situated 230 Km. south of Addis Ababa and 275Km. north of Awassa (capital town of SNNPRG), connected with all weather roads.

According to the 1994 population and housing census, Hadiya Zone has a total population of 1,050,151 of which 521,807(49.7%) are males and 5 28,344(50.3%) are females. Male to female ratio is 1:1 and the Zone consists of seven woredas (33). The percentage distribution of Hadiya zone population by ethnic group and rural and urban residence indicated; Hadiya 95.7% rural 64.2% urban, Kembata 2.6% rural and 4.8% urban and Amhara, Gurage and Oromo 19.9%, 4.2% and 2.3% of urban residence respectively. Population by religious group protestant 56.5%Muslim 23.3 %, Orthodox 12%, Catholic 5.5% and others 2.7%.

There is one hospital, 14 health centers, 28 health stations (6 are NGOs), 19 health posts and one pharmacy in the Zone. With regard to the private sector 4 clinics, 3 pharmacies, 3 drug distribution stores, and 30 rural drug venders are available in the zone. The government health institutions provide service by assigning a total of 269 health professionals of various categories. According to the 1993E.C(2000/01) Zonal Health Department annual report the contraceptive prevalence rate was 2.8%, utilization of antenatal care and delivery services being 57.4% and 6.2% respectively (34).

The total population of Hossana Town is 31,701, of which 15,593 are males and 16,108 are females, with male to female ratio of about 1:1. Women of reproductive age group(15-49 years) in the town number 7,853 with total housing units of 5,873 according to the 1994 Census (33). Hossana town is structured in such a way that it has three kifleketma (newly formed district level local administrative unit) with a total of 15 urban dwellers associations or Kebeles (the smallest urban administrative sub-unit) and each kifleketma consisting of five kebeles. In the Town there is one hospital, one health center and one clinic, all run by the government. In the private sector there are 4 clinics (of which two are higher clinics), three pharmacies, three drug distribution stores, and 5 drug venders (34).

4.3 Study population

The study population comprises of those currently married men age 20-64 years residing in Hossana Town, who were selected from source population by using systematic sampling techniques and quality the designated inclusion criteria for the study.

4.4 Sample size determination

The formula used for calculating the sample is

$$n = \frac{(Z\alpha_2)^2 P(1-P}{d^2}$$

Where:

n= The desired sample size

P= Proportion of men who approve contraceptive use =64.3%(15).

$Z\alpha/2$ = Critical value at 95% confidence level of certainty (1.96)

d= the margin error between the sample and the population =5%

Using EPI INFO version 6.04 to calculate the sample size for the single population proportion, the desired sample size was 352.6. Considering a design effect of 2 for multistage sampling techniques and a non-response rate of 10% the total sample size used for the study was 776 married man.

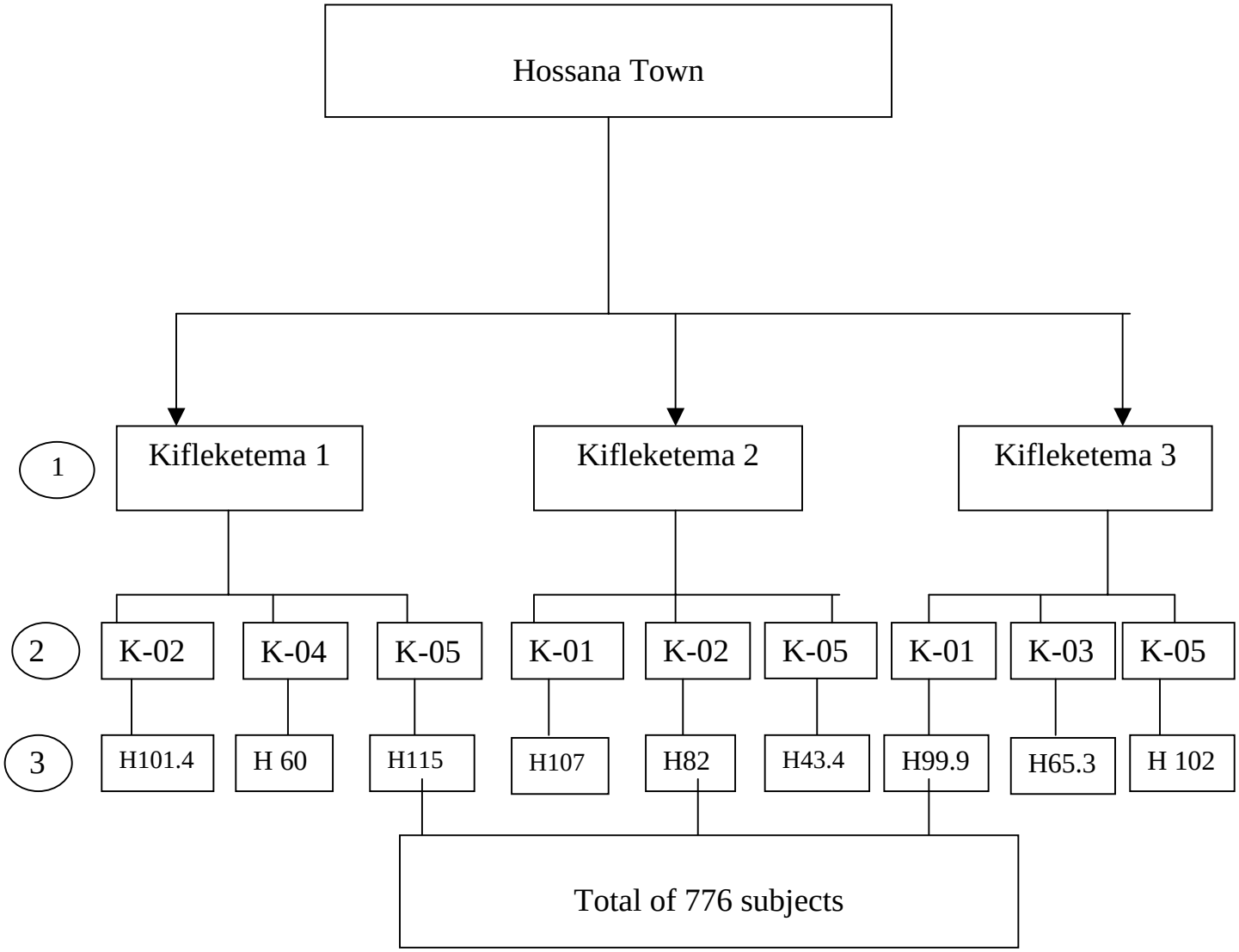
4.5 Sampling procedure

To accommodate major ethnic groups the town was divided into three strata using the new administrative unit, kifleketma. In Hossana Town, there are three kifleketmas and fifteen kebeles, each kifleketma consisting of five kebeles and all were included in the study. Of those, a total of nine kebeles, three kebeles from each kifleketma were selected, using simple random sampling method (Fig. 1).

The sampling fraction from each of the selected kebeles was determined proportional to the size of the total population of each kebele. Then systematic sampling method was employed to select the households from each kebele, where the sampling interval were the total number of households in each kebele divided by the corresponding number of households to be interviewed in each kebele. The first household to be interviewed was determined from the kebele house number register using simple random sampling method. The next household was identified systematically (H/h^{th}) by going in a clockwise direction.

If more than one eligible respondent was found in the selected household, only one respondent was chosen by lottery method (simple random sampling). In cases where no eligible was identified in the selected household, the interviewer went to the next household in the clockwise direction until he got eligible men.

SAMPLING PROCEDURE



Key:

*= **Kifleketema: - Adminstrative unit***

= Kx, y, z: Selected Kebeles

= HH: selected household

1. ***Kifleketema or total Kebeles***
2. ***Randomly selected Kebeles***
3. ***Systematically selected households***

Fig. 1 SCHEMATIC REPRESENTATION OF THE SAMPLING PROCIDURE

Eligibility criteria

The study was utilized samples of currently married men who were living in the study area.

Inclusion criteria

- Married men age 20-64 years,
- Married men regularly living in the study area for at least 6 months

Exclusion criteria

- Non-irregular residents of the study area
- Those husbands whose age was less than 20 years and greater than 64 years

The rationale for the 6 months cut off is that non-marital, short-term relationships less likely to initiate the long-term issues for negotiation concerning family formation and family planning.

4.6 Tools For Data Collection

I. Structured Questionnaire (Quantitative part of the study)

The data for the quantitative section was collected using a structured questionnaire prepared by addressing all-important variables. These questionnaires were adopted from different literatures developed for similar purpose by different authors. It was reviewed to suit the local condition and translated to Amharic language and then back to English to

ensure its consistency. The survey questionnaire was pre-tested and the necessary modifications and correction were made to standardize and ensure its validity. Using the questionnaire, currently married men from the selected households were interviewed by trained 12th complete data collectors with possible experience in data collection. The data collectors speak both Amharic and the local language. The interview was made by house-to-house visit in the presence of strong supervision.

II. Sampling technique and data collection for qualitative study

The qualitative data collection method was utilized in order to generate information from health service providers, in the study area, currently married men, religious leaders and elders residing in the study town using focus group discussion(FGD) in order to supplement the result of the quantitative data that could not be quantified.

The FGD was conducted in the following manner:

- From currently married men two groups were selected
- From health service providers one group was selected.
- From religious leaders and community leaders (elders) two groups were selected.

Discussion was made with five focus groups and each group consisted of 7-10 participants who were selected from the respective communities and facilities, using non-probability sampling method.

A semi-structured interview guide was used to facilitate the focus group discussion. A checklist was prepared to guide the discussion in such a way to generate relevant information. FGD was held in a quiet and comfortable place, and it took one and half-hours with each group. The principal investigator was the moderator and one temporary employed note taker, took short notes of the discussion. A tape recorder was used to record the discussion.

4.7 Data Quality Assurance

To maintain the quality of data

- Questionnaires were prepared first in English then translated to Amharic and then back to English in order to maintain its consistency.
- The selection of data collectors was based on the ability to speak the local language, having similar experience and male data collectors were selected.
- Provision of training for data collectors and supervisors for five days about the objectives and process of the data collection. Mean while any doubts in the questionnaire was clarified. Finally, pre-testing was conducted in a community similar to the study population, but out of the selected kebeles and care was taken not to include those who already participated in the pre-testing of the questionnaire.

4.8 Study variables

Dependent –Variables

1) Actual practice of contraception measured by current use of contraceptive methods
2) Fertility preference:
    1) The actual- ideal number of children
    2) The desire for additional children:
        - Wanting more children
        - Wanting no more children

Independent Variables

The following variables were considered as determinant of fertility preference and practice of contraceptive methods of the married men:

A. Husband and wife communication on FP and fertility,
B. Socio economic variables
    - Education
    - Occupation/ employment
    - Income (Monthly)
C. Demographic variables, age, religion ethnicity, and number of living children.
D. Reproductive History: discussion the number of children, decision when to have another child

E. Knowledge of FP method –men who are aware of at least one Method of contraceptive.

F. FP Attitude of men:- indicating approval or disapproval of couples using contraceptive methods and attitudes toward family size.

Operational definitions

- Current contraceptive users - are men who are using contraception's or wife has been using contraceptives for at least the last three months.
- Ever- contraceptive users - are men or partners who have used a contraceptive at some time in the past, but have discontinued before the time of the survey.
- Non-users - are men or partners who have never used contraception till the day of the survey.
- Knowledge of contraception methods: men who are aware of at least one method of contraceptive.
- Discussion between spouses (inter-spousal communication) about family planning refers to conversation between spouses regarding whether or not either one uses a method of FP, in a given (specified) period of time.
- Attitude of currently married men towards contraceptive use measured:- for non – users measuring desire to know more and want to use., for users-desire to know more and continue to use.
- Male involvement – practice of family planning methods and (full) participation in family planning provisions services and programs. The methods that require male involvement such as:- - Condom use

- Periodic abstinence
- Withdrawal
- Vasectomy
- STD prevention

4.9 Data analysis

Data were entered, cleaned and analyzed using EPI-INFO version 6.04 and SPSS 10 statistical packages. Frequencies, proportions and measures of dispersions were employed to describe socio-demographic and other related variables.

Chi-square test used to check the significant differences of some categorical variables.

The degree of association between dependent and independent variables measured using odds ratio with 95% confidence interval. Bi-variate and multivariate logistic regression was carried out to control for the effects of confounding variables.

Ethical clearance

Ethical clearance was obtained from the Department of Community Health and Faculty of Medicine, Addis Ababa University. Written consent was secured from SNNPRG Health Bureau, Hadiya Zonal Health Desk and other relevant authorities. All the study participants' were informed about the purpose of study, their right to refuse, and assured confidentiality. Their informed verbal consent was obtained prior to the interview. The benefit of this study was explained accordingly.

Dissemination of Research finding

The Study was done for the partial fulfillment of the Degree of Masters of Public Health, at the Department of Community Health, Faculty of Medicine, and Addis Ababa University. The result of the study will be reported to MOH, RHB and the potential organization who financed the study. The finding of the study will be published in different journals.

5. RESULTS

5.1 Socio-demographic characteristics of respondents.

Overall, among 776 currently married men regularly residing in Hossana Town 773(99.6%) responded to the questionnaire. Three currently married men refused to be interviewed. Selected socio-demographic variables of the study subjects are presented in Table l. The mean age of the study subjects was 39.8 years, 19.1% were aged 20-30 years, 40.8%, 31-40 Years, 26.5%, 41-50 years and,13.6%, 51 years or above. The Hadiya ethnic group comprised more than half of the study subjects (60.8), followed by Amhara (15.7%), Kambata (9.3%), Gurage (6.0%), Silt (5.0%) and Oromo (2.3%).

The majority of the study subjects were protestant by religion (53.2%) followed by Orthodox (35.4%), Muslim (8.7%), and Catholic (2.7%) (Table 1). Among all men involved in the study, 6.0% were illiterate, (16.6%) can read and write (did not have a formal education), 18.4%, attended elementary school, 26.3% attended junior high school, 25.7% had secondary school and only 7.1% had higher education. The average number of currently living children per men was 3.84, about 3% of them did not have living children, 32.5% having one to two children, 30.9% having three to four children, 33.5% having five or more children. Forty-one, point three percent of the study subjects were employed in government and non-government organizations, 35.7% reported that they were self employed, 13.2% unemployed during the interview, and 9.8 % were farmers.

Among currently married men, 98.3% were reported monogamous marriage, and only 1.6% reported polygamous. Fifty- two point four of the respondents reported that their monthly income was less than 250 birr, and 47.6% earned more than 251 birr. Among the study subjects 57.2% reported having radio, 18.1% reported having both radio and TV and 24.7% reported none of them. It was found that, 51.5% of the study subjects said that man has the greatest influence in the family decision -making, 47.5% said both (husband and wife) and only point six percent said woman alone made decision.

Table 1: Socio-economic and demographic characteristics of currently married men aged 20 –64 years.

Hossana Town , SNNPRG Ethiopia2004. (n=773)

Variables	Respondent	
	Frequency	%
Age/Year	n=773	
20-30	148	19.1
31-40	315	40.8
41-50	205	26.5
51-64	105	13.6
Mean ± SD	39.8 ±9.42	
Ethnicity		
Hadiya	477	60.8
Amhara	121	15.7
Kembata	72	9.3
Gurage	46	6.0
Silte	39	5.0
Oromo	18	2.3
Religion	n=773	
Protestant	411	53.2
Orthodox	274	35.4
Catholic	21	2.7
Muslim	67	8.7
Educational status	n=773	
Illiterate	46	6.0
Read and write (1-6)	128	16.6
Junior high School (7-10)	142	18.4
Secondary high school (11-12)	199	25.7
Higher education	55	7.1
Occupational	n=773	
Unemployed	102	13.2
Farmer	76	9.8
Employed	319	41.3
Private	276	35.7
Current living children	n=773	
0	24	3.1
1-2	251	32.5

3-4	239	30.9
≥ 5	259	33.5
Marital status	n=773	
Monogamous	760	98.3
Polygamous	13	1.7
Monthly income	n=773	
≤ 250 birr	405	52.4
≥ 251 birr	368	47.6
Possession of radio & TV	n=773	
Radio only	442	57.2
Radio TV	140	18.1
None	191	24.7
Family decision-making	n=773	
My self	398	51.5
My wife	8	0.6
Both of us	367	47.5

5.2 Reproductive and family planning characteristics of the study of subjects.

The question to investigate the age at first marriage revealed that only 6.1% of the respondents married below the age of 20 years, while 34.7% married at age between 20 and 24 years, 38.8%, between age 25 and 29 years, 14.5% between age 30 and 34 years, and 6% married at 35 years and above (Table 2). The medium age at marriage was 25.9 years. Among the study population, 47.2% were reported that they lived together with their wives one to ten years, 29.4% reported eleven to twenty years, 16.4%,.from 21 to 30 years and 7% reported 31 years or above.

The average desired number of children was found to be 5.2. About 8 % of the men desired to have one to two children, 40.1% desired three to four children and 52.0% five or more children.

While concerning the sex composition (preference), 56.41% of the study men preferred to have one to two boys, 20.8% preferred three to four boys 13.1% preferred five and above five boys. On the other hand 65.0 % of the study subjects were preferred one to two girls, 20.7% preferred three to four girls, two point five percent preferred five and above five. Of the study subjects, 566 (73.2% discussed with their wives the number of children they need to have and 207 (26.8%) did not.

Out of the study population, 459 (60.3%) desired to have more children and 290 (39.7%) would like to have no more children.

With regard to the timing of next birth, 16.6 % of the respondents would like to have the next child within less than two years, 22.6% would like to have next child in two to three years, 10.9 % would like to have the next child three to four years, and 12.3% would like to have the next child after four years. Sixty–six point five percent of husbands thought that their wives/ partners wanted the same number of children, eight percent wanted more children, 11.6% wanted fewer children and 13.8% did not know the preference of their wives.

Table 2: Reproductive characteristics of currently married men age 20-64 years in Hossana Town, SNNPRG-Ethiopia 2004.

Variables	Respondent	
	No.	%
Age at first marriage	n=773	
15-19	47	6.1
20-24	268	34.7
25-29	300	38.8
30-34	112	14.5
≥35	46	6.0
Mean		
Actual number of children	n=749	
1-2	251	32.5
3-4	239	30.9
>5	259	33.5
Means ± SD	3.84 ±2.46	
Desired number of children	n=773	
1-2	61	7.9
3-4	310	40.1
>5	402	52.0
Mean ± SD	5.2 ± 2.23	

Sex preference		
Boys	n=698	
1-2	436	56.4
3-4	161	20.8
≥ 5	101	13.1
Mean ± SD	2.91 ±1.39	
Girls	n=686	
1-2	507	65.6
3-4	160	20.7
>5	19	2.5
Mean ± SD	2.28±1.12	
Discussed the number of children	n=773	
Yes	566	73.2
No	207	26.5
Desire to have more children	n=773	
Yes	476	60.3
No	297	39.7
Waiting before t he birth of nest child	n=482	
<2 years	128	16.6
2 to 3 years	175	22.6
3 to 4 years	84	10.9
> 4 years	95	12.3
Wife agreement to the number of children	n=773	
The same number	514	66.5
More children	62	8.0
Fewer children	90	11.6
Do not know	**107**	13.8

5.3 Knowledge of contraception

All study subjects were asked whether they had heard of family planning. About 92% of them reported that they knew about or had heard of family planning, and 79.4% of them reported, as they were familiar with at least one of the contraceptive methods. Tables 3 present the percentage of respondents who knew the specific family planning methods. The most commonly reported method of family planning was the pill followed by injectables, condom, and Norplant. IUD, Rhythm, Female Sterilization and withdrawal

were mentioned less frequently. The least known reported methods were male sterilization and spermicidal.

The respondents were asked whether the use of condom could prevent pregnancy or not, and 61.1% of them respondent “Yes”, 19.8% said “No”, four point eight percent had no opinion, and 14.4% did not know. All men in the study sample were asked their sources of information about family planning. Fifty- six point seven percent said health institution, 49.4% reported radio, 34.2% reported TV, 28.7% reported, 9.3% reported friends and three point eight percent reported CHA’S. The knowledge of sterilization was asked, and 47.9% of the respondent, replied yes, 49.7% said not know it, and two point five percent said no opinion.

Table 3: Knowledge of currently married men age 20-64 years about modern contraception and fertility intention Hossana, SNNPR Ethiopia 2004.

Variables	Respondent	
	No.	%
Ever heard of contraception	n=773	
Yes	707	92
No	66	8.5
Know at least one method of FP	N=706	
Yes	644	79.4
No	62	8.8

Men specific knowledge of MCM		
Pill	614	79.4
Injectables	605	78.5
Condom	507	65.6
Norplant	325	42.0
IUD	236	30.5
Rhythm	219	28.3
Female sterilization	198	25.6
Withdrawal	132	17.1
Male sterilization	122	15.8
Spermicidal	73	9.4
Using condom can prevent pregnancy	n=625	
Yes	472	61.1
No	153	19.1
Source of information about MCM		
Health institution	438	56.7
Radio	382	49.4
TV	264	34.2
Newspaper	222	28.7
Friends	72	9.3
CHA's	28	3.8
Neighbors	12	1.6
TBA's	4	0.5
Wife	2	0.3
Knowledge of sterilization	n=773	
Yes	370	47.9
No	384	49.7
No opinion	19	2.5

5.4 Attitudes toward family planning

About 89% of the study men approved the use of modern contraceptives, and more than half of them (62.0%) believed that their wives approved modern contraception too. Only three point four percent were reported that their wives disapproved use of Modern

Contraceptive Methods (MCM), while 34.7% said that they did not know about their wives attitude towards MCM (Table 4). Sixty-six point one percent of the respondents reported that they discussed about family planning with their wives during the last one year. Of those who discussed about family planning, about 50.8% reported that they had frequent discussions, with their wives and nine point two percent and six point one percent reported that they had discussion with their wives twice or once, respectively.

Four hundred fifty-nine (59.4%) of the respondents intended to use contraception in the future, and 267 (34.5%) did not, while 84.3% of respondent desired to know more about contraception methods. A total of 642(83.1) of the study subjects admitted that they were in need of information on family planning. About 81% of the respondents, reported joint decision (husband and wife) on family planning methods to be used, 14.4% reported that the husband alone should take the decision, only two point six percent reported that their wives alone take the decision and two point two percents did not have response.

About 54% of the respondents reported joint decision-making on when to have another child, 63.4% on whether to stop having children, and 62. 2% on what to do to stop child bearing. Twenty four percent of the respondents reported that the husband should decide when to have another child, 20.6% on whether to stop having children, and 25.6% on what to do to stop child- bearing. Only two point one percent of them reported that their wives alone took the decision when to have another child, one point nine percent on whether to stop having children, and four percent on what to do to stop childbearing. About nineteen percent of the respondents reported “God Knows ” on when to have

another child, 13.8% on whether to stop having children and seven point six percent on what to do to stop childbearing (Table 2).

Among the study subjects 83.6% were agreed that too large a family size strains the family's economic situation, nine point two percent reported disagreement and seven point two percent were neutral. Seventy six point five percent of the respondents, reported disagreement in that a large family makes a happy home, 15.8% reported agreement and seven point eight reported neutral. Fifty-five point six percent of the study population reported disagreement on that, family planning practice will cause a loss of confidence between a husband and a wife, 26.5% reported agreement and 17.9% reported neutral.

All men in the study sample were asked that contraceptive use might cause infertility in women, 22% agreed, 47.2% disagreed and 30.8% reported neutral. About 87% of the respondents were reported that agreement on that, men should share the responsibility for family planning, six point five disagreed and six point nine were, neural. Seventy-nine point two percent of the study subject reported that, the use of modern contraceptive methods is not against their religious belief and 20.8% reported it is against their religious belief.

Table 4: Attitudes of currently married men age 20-64 years towards contraception and fertility preference Hossana, SNNPRG Ethiopia2004.

Variables	Respondent	
	No.	%

Respondent approve disapprove using MCM	n=766	
Approve	687	88.9
Disapprove	79	10.2
Wife attitude towards contraceptive methods	n=773	
Approve disapprove	479	62.0
Disapprove	26	3.4
Do not know	268	34.7
Discussed about MCM with wife	n=773	
Yes	511	66.1
No	238	30.8
No opinion	24	3.1
Number of times discussed	n=512	
More often	393	50.8
Once	48	6.2
Twice	71	9.2
FP information and services should be made available to men	n=773	
Yes	642	83.1
No	59	7.6
Neutral	72	9.2
Desire to know more about contraception	n=773	
Yes	652	84.3
No	121	15.7
Intention to use contraception	n=739	
Yes	459	59.4
No	280	36.3

Table 5:. Attitude among currently married men age 20-64 years to statements towards decision- making role of men in fertility and contraception Hossana, SNNPRG- Ethiopia 2004

Variables	Respondent	
	No.	%
Decision when to have another child	n=773	
Husband only	183	24
My wife only	16	2.1
Both of us	414	54
God knows	144	18.6
No decision	16	2.1
Decision whether to stop childbearing	N=733	
Husband only	159	20.6
Wife only	17	2.2
Both of us	490	63.4
God knows	107	13.8
Decision what to do to stop childbearing	n=773	
Husband only	198	25.6
Wife only	31	4.0
Both of us	479	62.2
God knows	65	8.2
Decision on the method of FP to be used	n=773	
My self	111	14.4
My wife	20	2.6
Both of us	625	80.9
No response	17	2.2

Table 6: Attitudes among currently married men age 20-64 years to statements to wards fertility and contraception. Hossana, SNNPRG- Ethiopia, 2004

Variables	Respondent	
	Frequency	%
Condom use reduces men sexual pleasure	n= 773	
Yes	114	14.7
No	306	39.6
No opinion	98	12.7
Nor response	255	33.0
Approve/Disapprove male sterilization	n= 773	
Approve	207	26.8
Disapprove	298	38.6
Un decided	72	9.3
Do not know	196	25.4
Too large a family size strains family 's economic situation	n=773	
Agree	646	83.3
Disagree	71	9.2
Neutral	56	7.2
A large family makes a happy home	n=773	
Agree	122	15.8
Disagree	591	76.5
Neutral	60	7.8
Too many children are often harmful to the health of the mother	n=773	
Agree	619	80.1
Disagree	87	11.3
Neutral	67	8.7
FP practice will cause loss of confidence between a husband and a wife	n=773	
Agree	205	26.5
Disagree	430	55.6
Neutral	138	17.9
Contraceptive use may cause in-fertility in a woman	n=773	
Agree	170	22.0

Disagree	365	47.2
Neutral	238	30.8
Men should share the responsibility for FP	n=773	
Agree	670	86.7
Disagree	50	6.5
Neutral	53	6.9

5.5 Use of contraceptives

Current contraceptive use was reported by 368 (47.6%) study subjects , 14.6% were ever-users, and 37.8% were non-users. Eighty point nine percent of the contraceptive users reported joint decision (husband and wife) to use contraception; however the respondent (husband) decision alone was reported by 14.4% and the wife/ partners decision alone was reported by only two point four percent.

In order to assess the knowledge of family planning methods respondents were asked, "Why are you and your partners using contraception"? 237(30.7%) of respondents reported that they were using it for birth spacing and 133 (17.2%) reported that they were using it for birth limiting. About 79.9% of respondents indicated that the responsibility for practicing some contraceptive methods should be the responsibility of both (husband and wife), however 12.8% said that it should be the husband's responsibility, and only three point six percent said that it should be the responsibility of wife.

5.5.1 Types of currently used contraceptive methods and reasons

Injectables (Depo-Provera) were the most commonly used method, by 30.1%. The second most commonly used method was oral contraceptive, (14.4%), followed by condom and rhythm, three point six percent and three point two percent respectively. The least used methods were Norplant, postpartum abstinence, IUD, spermicidal and female sterilization at 2.8, 1.3, 1.0, 0.6 and 0.1 percent respectively (Table 5). The most commonly reason for using contraception among currently users was child spacing (30.7%). The second most commonly mentioned reason was child limiting (17.5%).

5.5.2 Reasons for non-use of contraception

The rate of non-use of contraceptive methods among respondents was 37.8%. Various reasons were given during the interview for not using contraception. About 13% of respondents mentioned, the desire to have more children, eight point four percent mentioned that respondent was opposed followed by fear of side effect (5.4%). Religious prohibition (4.5%) did not know a methods (2.7%) health concern (2.2%) and fear of infertility (1.8%) and the others reasons constituted small proportions.

5.5.3 Reasons for stopping the practice of FP.

Among those in the study sample who had ever-practiced family planning 113 men had practiced in the post (14.6%). Men who had had past experience with family planning were asked why they stopped use? Among respondents eight point three percent stopped to have another child, they had been using contraceptives for child spicing only and not for stopping child bearing. Those who stopped practicing contraception, even though they

did not want another child did so mainly because of side effects in (3.2%) of the cases, low risk of pregnancy in (1.4%) of the cases and medical problem in (1.3%) of the cases.

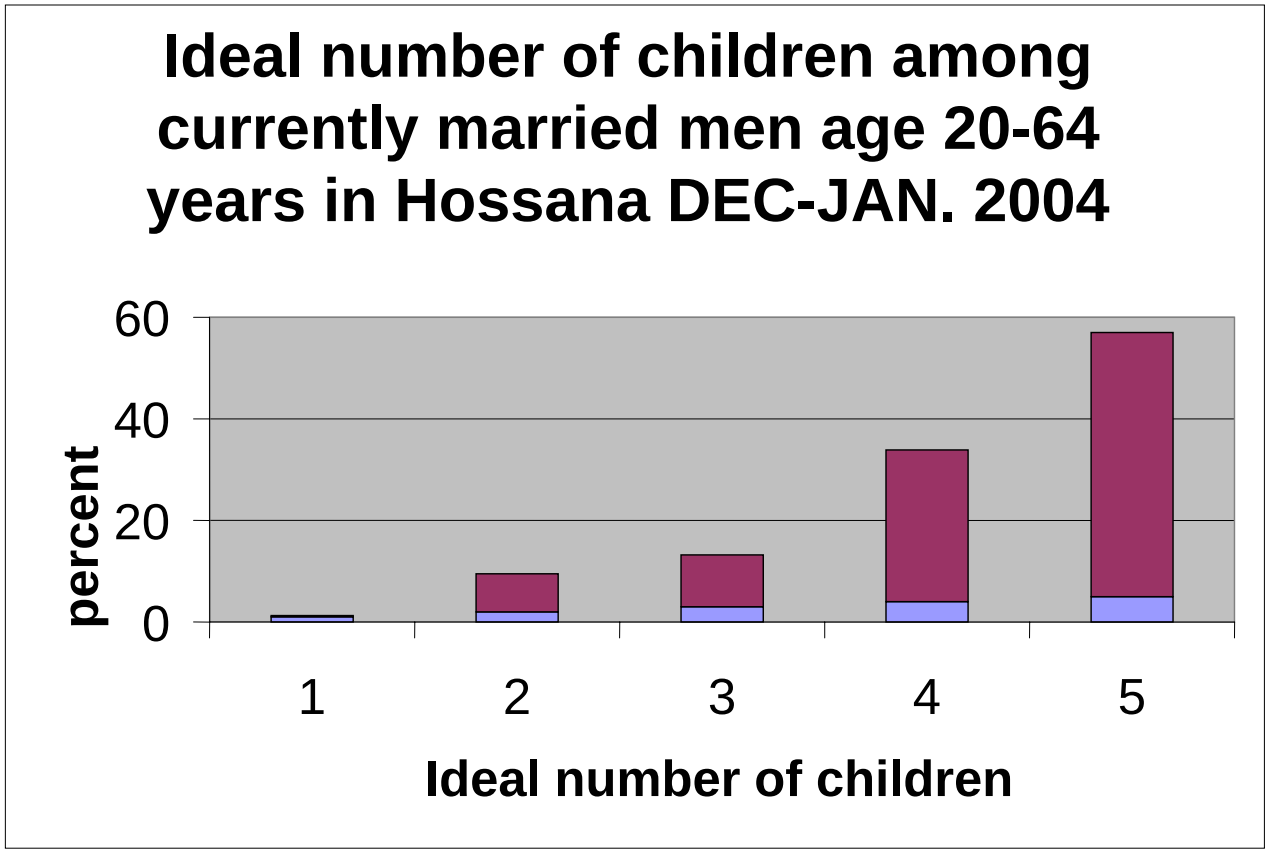
5.5.4 Type of contraception preferred for future use.

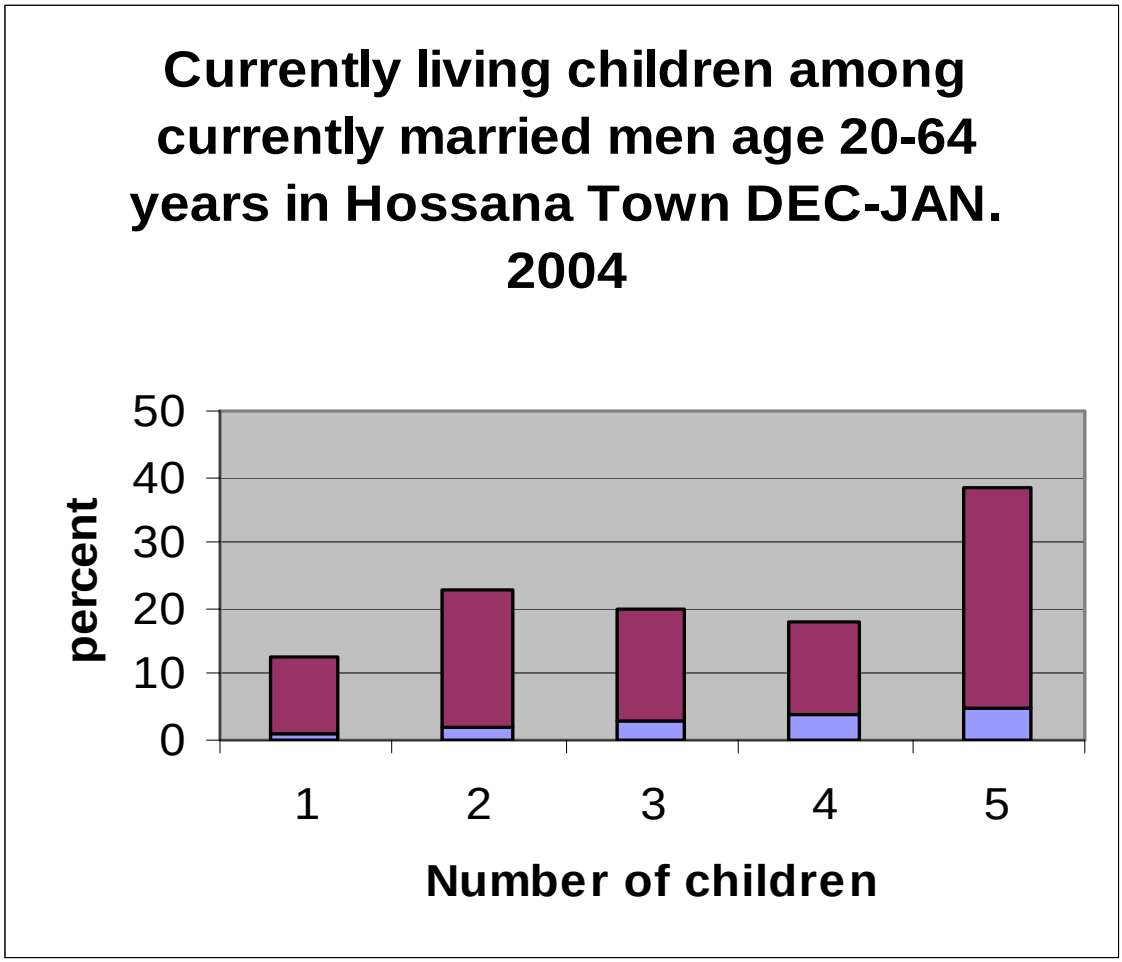
The most commonly mentioned contraceptive method was indictable (39.9%) and pill (12.2%) followed by Norplant (6.7%), condom (5.2%) IUD (0.5%), Female sterilization (0.10%) (Table 5).

Table 7.: Practicing contraception and reason for use and non-use among currently married men age 20-64 years; Hossana, SNNPRG Ethiopia, 2004

Variables	Respondent	
	No.	%
Type contraceptive users	n=773	47.6
Current user	368	14.6
Ever user	113	37.8
Non user	292	
Reason for contraception (current users)	n=372	
To space birth	237	30.7
To limit child	135	17.5
Types of contraception currently using	n=443	
Injectables	233	30.1
Pill	111	14.4
Condom	28	3.6

Rhythm period	25	3.
Norplant	22	2.8
Postpartum Abstinence	10	1.3
IUD	8	1.0
Spermicidal	5	0.6
Female sterilization	1	0.1
Reason for not using contraceptive (non-user)	n=253	
Desire to have more children	90	12.7
Respondent opposed	65	8.4
Fear of side effect	42	5.4
Religious prohibition	35	4.5
Knows no methods	21	2.7
Health concern	17	2.2
Wife opposed	6	0.6
Relative opposed	2	0.3
Known no source	2	0.3
Reason for discontinuation every user	n=110	
Desire to have more children	64	8.3
Fear of side effect	25	3.2
Medical problem	11	1.4
Little perceivably risk of pregnancy	10	1.3
Type of contraception preferred for future use	n= 663	
Injectables	307	39.9
Pill	94	12.2
Norplant	52	6.7
Condom	40	5.2
Rhythm period	37	4.8
Postpartum Abstinence	12	1.6
IUD	4	0.5
Female sterilization	3	0.4
Spermicidal	3	0.4
Male sterilization	1	0.1


Ideal number of children among currently married men age 20-64 years in Hossana DEC-JAN. 2004
60
40
20
0
percent
1
2
3
4
5
Ideal number of children


Currently living children among currently married men age 20-64 years in Hossana Town DEC-JAN. 2004
50
40
30
20
10
0
percent
1
2
3
4
5
Number of children

Logistic regression analysis

Because of the influence of extreme cases upon the average, we decided to classify many of the variables in to the categories. Then cross tabulation was done to determine whether any association existed. Later a chi-square statistic, odds ration and their 95% confidence intervals were calculated to assess the strength of the association between the variables. To see the relative effect of independent variables on the dependent variables, logistic regression analysis was carried out using SPSS version 10. This was done to control for the effects of possible confounding factors upon current practice of MCM, ideal number of children desired and desire for additional children.

Current practice of MCM Table(8,9)

The result of analysis of independent variables in relation to the current practice of MCM showed that men in the age, group of 20-40 years are 1.76 times more likely to practice contraception when compared to men within age group of 41 years or older. This was statistically significant. According to the result of this study, the difference between the

religious groups and current modern contraceptive use was found to be statistically significant (P<0.05). A strong relationship existed between use of modern contraception and education. Being literate is 3.74 times more likely to practice modern contraception when compared to that of illiterates (OR 3.74, 95% CI 1.5-9.06).

According to the finding of this study, men with currently living children three or less children are less likely to practice modern contraception when compared to those men with four or more children. While also those men with ideal number of children three or less than three are less likely to practice MC than men with more than three ideal numbers of children (OR 0.53,95% CI-0.35-0.87). In this study it was revealed that men who wanting for additional children are less likely to practice modern contraception when compared to those who wanted no more children (OR=.54, 95% CI-.35-.84).

In the present study revealed that, being employed is 2.06 times more likely to practice MC. Men with possession of radio and TV are 2.68 times more likely to practice modern contraception than men without radio or TV. Statistically significant association was observed between use of MC and Attitude of respondent to ward modern contraception. Those with positive attitudes are 14.11 times more likely to practice modern contraception (OR=14.11, 95% Cl = 5.91-33.71). Among men who had discussed with their wives about the number of children to have in the Family are 5.64 times more likely to practice MC than those without discussion (OR=5.64, 95% Cl –3.69-8.60).

A strong association was found between communication about family planning methods and current practice of modern contraception. Those with inter-spousal communication are 17.27 times more likely to practice family planning methods when compared to those who did not reported the communication (OR= 17.27, 95% Cl, 10.72-27.82), while those who reported joint decision- making on when to have another child and those who reported husband's alone decision-making were 1.49and 2.88 times more likely to practice modern contraception (OR= 1.49, 95% Cl- 2.79-7.23) and OR=2.88, 95% Cl- 1.70- 4.88) respectively. Again statistically significant association was found between husband and wife joint decision and husband alone decision-making on what to do to stop childbearing and current use of modern contraception. Those who reported joint decision and husband alone decision–making were 5.71 and 2.17 times more likely to practice modern contraceptive methods (OR= 5.71, 95% Cl- 2.94- 111.08 and OR= 2.17, 95% Cl- 1.07 –4.37).

Table 8: Practice of modern contraceptive methods among currently married men age 20-64 years in relation to selected explanatory variables in Hossana, SNNPRG-Ethiopia 2004

Variables	Practice (n=660)		Crude OR 95%CI	Adj. OR95% CI
	Yes	No		
Age (Years)	n(%)	n(%)		
20-40	255(61.9)	157(38.1)	1.94(1.41-2.67)	1.76(1.20 –2.58)*
≥ 41	113(45.6)	135(54.4)	1.00	
Religion				
Protestant	220(65.3)	117(34.7)	3.11(1.77-5.46)*	2.49(1.38-4.51)*
Orthodox	113(45.9)	133(54.1)	1.404(.79-2.50)	1.52(.820-2.78)
Catholic	12(75.0)	4.25.0)	4.95(1.43-17.15)*	5.32(1.49-18.97)*
Muslim	23(37.7)	38(62.3)	1.00	
Education				
Illiterate	7(15.9)	37(84.1)	1.00	
Literate	361(55.8)	255(41.4)	7.48(3.28 -17.05)*	3.74(1.54 -9.06)*
Currently living children				
≤ 3	224(60.7)	145(39.3)	.63(.47-.87)*	.87(.60-.26)
≥ 4	144(49.5)	147(50.5)	1.00	
Occupation				
Unemployment	49(53.3)	43(46.7)	1.10(.68-1.79)	1.18(.71-1.95)
Farmer	14(18.4)	62(81.6)	.22(.15-.41)	.301(.16-.59)*
Employed	187 (71.9%)	73(28.1)	2.48(1.70-3.60)*	2.07(1.29-3.28)*
Private	118(50.9)	114(49.1)	1.00	

Possession of Radio				
Radio only	229(62.1)	140(37.9)	3.30(2.26 -4.89)*	2.45(1.63 -3.68)*
Radio and TV	81(69.8)	35(30.2)	4.67(2.81 - 7.75)*	2.68(1.51-4.76)*
None	58(33.1)	117(66.9)	1.00	
Ideal number of children desired				
≤ 3	93(72.1)	36(27.9)	3.42(.27-.63)*	.53(.35-.87)*
≥ 4	275(51.8)	256(48.2)	1.00	
Discussed number of children				
Yes	.327(69.0)	147(31.0)	7.87(5.29-11.71)*	5.64(3.70 - 8.60)*
No	41(22.0)	145(78.0)	1.00	
Wanting for more children				
Yes	.223(54.4)	187(45.6)	.86(.70-1.86)	.54(.35-.84)*
No	145(58.0)	105(42.0)	1.00	
Approve/Disapprove couples using FP				
Approve	.362(63.0)	213(37.0)	20.39(8.72 - 47.70)*	14.11(5.91-33.71)*
Disapprove	3(12.0)	22(88.0)	1.00	
Discuss about FP with Wife				
Yes	.329(77.4)	96(22.6)	21.61(13.74 -33.99)*	17.27(10.72-27.82)*
No	29(13.7)	183(86.3)	1.00	
Deciding when to have another child				
Husband only	.85(51.8)	79(48.2)	2.69(1.64-4.40)*	2.879(1.698-4.88)*
My wife only	8(61.5)	5(38.5)	4.00(1.24-13.05)*	3.076(.891-10.62)
Both of us	236(68.2)	110(31.8)	5.36(3.43-8.394)*	1.487(2.787-7.23)
No decision	3(37.3)	8(72.7)	.94(.24 -3.73)	1.28(.288-5.66)
God Knows	36(28.6)	90(71.4)	1.00	

Table 9: Practice of modern contraceptive methods among currently married men age 20-64 years in relation to selected explanatory variables in Hossana, SNNPRG-Ethiopia 2004

Variables	Practice n (660)		Crude OR 95%CI	Adj. OR95% CI
	Yes	No		
Deciding what to do to stop childbearing				

Husband only	70(39.3)	108(60.7)	2.13(1.09 -4.16)*	2.167(1.07-4.37)*
My wife only	15(53.6)	13(46.4)	3.79(1.46 -9.84)*	2.53 (.93 - 6.91)
Both of us	269(68.3)	125(31.7)	7.07(3.75 -13.34)*	5.70(2.94 -111.08)*
God Knows	14(23.3)	46(76.7)	1.00	

Fertility preference

The trends in fertility preferences reveal increases in the desired to limit childbearing some of them substantially, in all regions. A strong individual level relationship between fertility preferences and contraceptive behavior is well documented. Our analysis departs from most recent research in making use of two fertility preference measures: the desire for another birth and the difference between the number of living children and the ideal number of children.

Ideal number of children desired

The Result of this study of independent variables in relation to the ideal number of children desired showed that men within the age group of 20-40 years are 3.15 times more likely to prefer ideal number of children two or less than two when compared to men age group 41 years or older (OR= 3.15, 95%. CI 1.63- 6.10). Men with current living children of three or less than three are 8.40 times more likely to prefer the ideal number of children two or less than two when compared to those men who have currently living children of four or more than for children (OR= 8.40, 95% CI-3.74-18.85).

Men who reported having discussion with their wives, about the number of children to have in the family are 4.27 times more likely to prefer the ideal number of children two or less than two, when compared to those men who did not reported discussion with their wives about the number of children to have in the family. This was statistically significant. Significant association was found between men's fertility preference and

their attitude on whether a large family makes a happy home, those who reported disagreement are 4:39 times more likely to prefer ideal number of children two or less than two when compared to those men who reported agreement. This was statistically significant. And also there was association between men's fertility preference and their attitude towards too many children often harmful to the health of the mother. Those who reported disagreement are 0.12 times less likely to prefer ideal number of children, two or less than two, when compared to those who reported agreement (OR= 0.12, 95% CI, 0.02-0.93).

Wanting for more children

The result of analysis of independent variables in relation of wanting for more children showed that, men in the age group of 20-40 years are 2.72 times more likely to want more children than men in41 years or older. This was statistically significant. Men with educational level of illiterates are 3.96 times more likely to want for more children when compared to men with educational level literate. This was statistically significant. The present study reveal that being a farmer is 5.73 times more to want for additional children when compare to private sector employee's.

According the result of this study, men with family monthly income of more than 251 birr are 1.70 times more likely to want for more children, when compared to men with family monthly income of less than 250 birr (OR 1.70, 95% CI, 1.13-2.55). This was statically significant. Men with currently living children of three or less than three are

12.74 times more likely to want for more children when compared to men with currently living children of four or more than four (OR 12.74 95% CI, 8.83-18.40). A significant association was found between men's fertility preference and their attitude on whether too large a family size will strains the family's economic situation. Some 164(39.4%) of the men were disagreed that it did not strains the family's economic situation(OR 4.03,95% CI 1.99-8.14). Men who were reported disagreement on whether a large family makes a happy home are less likely to want for more children when compared to men who reported agreement. This was statically significant.

According the result of these study men who were reported husbands alone decision-making on when to have another child are 1.73 times more likely to want for additional children compared to men who reported God knows. Men who reported, that expected time before birth of the next child less than two years are 3.41 times more likely to want for more children compared to men who reported four or more years. This was statistically significant (OR=3.41, 95% CI, 1.036-11.24).

Table 10: Ideal desired number of children among currently married men age 20-64 years in relation to selected explanatory variables in Hossana, SMMPRG- Ethiopia 2004

Variables	Ideal desired number of children (n= 773)		Crude OR 95%CI	Adj. OR95% CI
	Yes	No		
Age (year)	n(%)	n(%)		
20-40	49(10.6)	44(89.4)	2.94(1.54-5.62)	3.15(1.63-6.10)*
≥ 41	12(3.9)	298(96.1)	1.00	
Currently living children				
≤ 3	54(13.3)	353(86.7)	7.83(3.52-17.44)	8.40(3.74-18.85)*
≥ **4**	7(1.9)	359(98.1)		
Discussed number of children with wife				
Yes	56(9.9)	510(90.1)	4.39(1.73-11.12)	4.27(1.59-11.43)*
No	5(2.4)	200(97.6)	1.00	
A large family makes a happy home				
Agree	3(2.5)	119(97.5)	1.00	
Disagree	55(9.3)	536(90.7)	4.07(1.25-13.22)	4.39(1.29-14.89)*
Neutral	3(5.0)	57(95.0)	2.09(.41-10.66)	1.94(.37-10.17)
Too many children often harmful the health of the mother				
Agree	59(9.5)	560(90.5)		
Disagree	1(1.1)	86(98.9)	.110(.02-81)	0.12(0.02-0.93)*
Neutral	1(1.5)	66(98.5)	.14(.02-1.06)	0.17(0.02-1.30)

Table 11. Wanting for more children. Among currently married men age 20-64 years in relation to selected explanatory variables in Hossana, SNNPRG –Ethiopia 2004.

Variables	Wanting for more children (n= 773)		Crude OR 95%CI	Adj. OR95% CI
	Yes	No		
Age (year)				
20-40	.349(77.9)	99(22.1)	5.89(4.29-8.09)*	2.72(1.88-3.94)*
≥ 41	110(36.5)	191(63.5)	1.00	
Education				
Illiterate	32(71.1)	13(28.9)	1.54(.81-2.94)	3.99 (1.84 - 8.62)*
Literate	427(60.7)	277(39.3)	1.00	
Occupation				
Unemployment	72(71.3)	29(28.7)	1.66(1.02 - 2.71)*	1.02 (.58 - 1.76)
Farmer	62(86.1)	10(13.9)	3.36(1.77 - 6.39)*	5.73 (2.68 -12.22)*
Employed	163(52.9)	145(47.1)	.77(.57-1.07)	.93(.56 - 1.54)
Private	162(60.4)	106(39.4)	1.00	
Family monthly income in birr				
≤ 250 birr	.275(69.4)	121(30.6)	1.00	
≥ 251 birr	184(52.1)	169(47.9)	2.05(1.53 -2.75)*	1.70(1.13-2.55) *
Current living children				
≤ 3	.224(60.7)	145(39.3)	11.26 (7.96 - 15.94)*	12.74 (8.83 -18.40)*
≥ 4	144(49.5)	147(50.5)	1.00	
A large family makes a happy home				
Agree	93(80.9)	22(19.1)	1.00	
Disagree	323(56.2)	252(43.8)	.374(.24-.59)*	.278(162-.48)*

Neutral	43(72.9)	16(27.1)	.75(.37-1.52)	.578(.247-1.34)
Too large family size strains the family's economic situation				
Agree	139(69.2)	62(30.8)	1.00	
Disagree	252(60.6)	164(39.4)	2.53 (1.42-4.51)*	4.03 (1.99-8.14)*
Neutral	68(51.5)	64(48.5)	1.69(.94-3.05)	2.62(1.27-5.39)*
Who decide when to have another child				
Husband only	.99(55.0)	81(45.0)	1.95(1.23-3.09)	1.73(1.036-2.90)*
My wife only	7(43.8)	9(56.3)	3.02(1.06-8.63)	2.05(.63-6.74)
Both of us	.247(60.7)	160(39.3)	1.53(1.01 - 2.29)	1.50 (.94 -2.40)
No decision	6(40.0)	9(60.0)	3.02(1.06-8.63)	1.94(.56-6.68)
God knows	100(76.3)	31(23.7)	1.00	
Expected time before birth of next child				
< 2 years	109(87.2)	16(12.8)	2.76(.98-7.96)	3.41(1.04-11.24)*
2 to 3 years	167(96.5)	6(3.5)	.639(.19 - 2.15)	.77(.21-2.86)
3 to 4 years	81(96.4)	3(3.6)	.67(.15-2.88)	.75(.16-3.65)
≥ 4 years	90(94.7)	5(5.3)	1.00	

Qualitative Study

Focus Group discussion (FGD)

The qualitative study was carried out through focus group discussions. Based on the checklist that was developed to guide the discussions, relevant information was obtained. The participants freely and actively expressed their ideas about family planning and

fertility issues. Almost all of the participants clearly understood the general concept of family planning.

The focus group discussions revealed that participants understood the use of family planning methods well. The most mentioned reason was birth spacing and STI prevention followed by pregnancy prevention and birth limiting. The discussion also revealed that most of the discussants had heard of family planning but they had limited knowledge about specific modern contraception. This might hinder some of the beneficiaries to have a range of choice of contraceptive methods and use. For instance, the participants were asked to enumerate the contraceptive methods that they knew, and the frequently mentioned ones were injectables followed by pills, condoms Norplant and Rhythm methods, while vasectomy and tubal ligation were least mentioned by participants. Overall older people and religious leaders were less familiar with specific methods. Older people and religious groups knowledge on contraceptive methods compared to younger groups was not strong as expected.

They were also asked to enumerate the contraceptive methods that only men can use. The most mentioned one was condoms followed by Rhythm methods but few of the discussants claimed that there was an injectables for men and they debated for a long time in order to persuade other discussants. Most of the participants, except few, expressed that they had had discussions about modern contraceptive use and the number of children to have with their wives, but concerning decision making for practicing modern contraception and about the number of children to have in the families, it still

needed the full approval of the husband, even-though they said that, in some educated families there was joint decision making in MCM use and the number of children to have. More than half of participants mentioned positive attitudes towards modern contraception, but a few participants expressed negative attitude and rumors in the community, that MCM use can cause infertility and condom use can case HIV/AIDS, hyper pigmentation of women's faces and softening of the uterus. The role of men in contraceptive use and fertility intention was discussed, and all participants mentioned that men should use male methods and should fully support his wife to practice the FP when she wanted to use it and also expressed, that he (the husband) was responsible to provide necessary supplies to her. Almost all the participants mentioned that they were in need of family planning information.

The optimal family size and reasons for couples to want more children were discussed and most said 4-6 children and very few mentioned two children, however, it was also said that it depended on the situation of the family. It was mentioned that the ideal number of children desired could be achieved by discussing among the couple and utilizing modern contraceptive methods. The reasons, why couples more children were discussed, and cultural obligations, religious focus and economic benefit were the main reasons followed by family economic situation. Problems raised regarding large family size were poor maternal and child health, maternal and child death, poor economic condition (children can not go to school, shortage of food- malnutrition) streetism, lack of job and shortage of land to plough, therefore it was mentioned that there is no need of large family size.

The main sources of information for family planning methods were health workers (health institutions), followed by mass media, and community based reproductive health workers. These days men are using contraception, but still there are people who do not use due to lack of knowledge and method mix. The health education rendered by health service providers is not on regular basis.

The advantages of having children and disadvantages of having too large a family were discussed and many said that having children was important for the social security of families and economic benefit, followed by bearing family name. Concerning disadvantages for men, economical problem, un-affordability to provide necessary things (for the family), alcoholism and loss of family love and relations. For women too large a family is harmful to the health of women, and even, may cause death. There were a few men who said that it was up to "God" to determine the number of children. All these factors affect the utilization of family planning services and fertility regulation.

Family planning issues was discussed openly in protestant churches. Orthodox and catholic churches do not publicize then openly but nor do they oppose using family planning services. It was mentioned by one of the health workers that clients who use IUD family planning method are expected to remove it, if they want to get in patient health services in catholic owned health institutions.

Attitudes and opinions of the community towards the family planning service providers depended on the quality of the service they obtained and the availability of their choice (method mix). If the clients did not get their choice of method, if they were not treated well and if they had to wait a long time to get the service their attitude is not positive to wards that health provider. In general it was said that the attitude was positive. Men as well as their wives were positive towards contraception and support its utilization, but still there are a few men who do not support using contraception and desire as many children as women can bear and say that children are asset and it is up to God to determine the number of children. There are also a few men who consider that family planning is only for women and it is not men's concern. This idea is reflected by all FGD groups except health service providers.

The community was very aware of family planning use, and said that the chief reasons was for avoidance of unwanted pregnancy, birth spacing, child limiting and STI prevention through using FP services. But there was people who lacked awareness and did not use the family planning service. The most mentioned reason not using family planning was wanting more children and lack of awareness followed by fear of side effects and lack of method mix (choice).

The major obstacles to alleviate problems regarding family planning services and fertility health intentions mentioned were low awareness since the education rendered by health workers was not on a regular basis, mostly the health education is given to the clients in the health institutions. It was said by health workers that the health education given at

outreach sites was weak; the family planning service integration at outreach level with other maternal and child health services is not strong.

The contraceptive method mix was not always stable, the methods that have acceptance by the clients are sometimes out of the stock, while methods not preferred by the clients are in excess, for instance injectables Norplant was not available on demand basis, while pill was getting expired, sometimes there were no syringes and needles and male methods like condoms were in excess and less used, these factors hinder the utilization of the services. The family planning services rendered in government health institutions were free of charge but the clients were supposed to wait a long time. The health workers in governmental institutions get fed up due to client over loads and treated clients poorly. Besides that there was male influence in reproduction as well as, in over all family and family asset decisions, including modern contraception with strong intention to wanting for more children. In general these were some of the factors that hinder the utilization of family planning services in the study area.

6. DISCUSSION

This study has attempted to assess the role of men in fertility preference and modem contraceptive use in Hossana, SNNPRG. A strong effort was made to ensure that a representative sample of eligible men living in urban Hossana were included in this study. No attempt was made, however, to represent the rural area of Hossana. Therefore, the survey results are not applicable to the rural areas of the zone.

The modern contraceptive methods especially male methods, like condom and vasectomy are poorly practiced in the study area and the main reasons mentioned by non-users in the study area for not practicing modern contraceptive methods were desire for more children, fear of side effect and religious taboos. More of the couples used contraceptive methods for birth spacing than for stopping having children in the study area and the family decision making role is mostly influenced by husband (51.8%). This can be explained by less access to information, education communication and family planning services in the study area.

Men in the study area are striving for larger family sizes. Men's desire for more children was high at all age levels and number of living children. The desire for more children by men is, however, prominent at later ages, particularly at or above the age of 34 years. According to the present study, a great proportion (60.3%) of the study men, who already had 4-6 children, sought more children. This is in line with other studies (14, 24, 27, 36). The ideal and expected family size preference in this study also revealed a higher preference for large family size by study men, due to religious and cultural taboos. This also can be explained that in study area men want to have more children because culturally they consider children as asset and they think they gain, socially and economically from having a large number of children.

The ideal number of children is also still high (average of 5.2). During the focus group discussion the ideal number of children was mentioned to be 4-6 children per man,

which, while it is in agreement with many African studies, underlines the importance of influencing attitudes on family size, as well as making modern contraception more available. It is in line with other studies (15, 24,28,36,37). The median number of living children per man was 3.84. This is a little higher than the other study (20).

In this study, it was revealed that there was a difference between the actual and ideal number of children, which indicates, the desired fertility is yet to be attained. Ideal family size indicates the socially acceptable reproductive behavior for couples in a society. Ideal family size desire increased with age and increasing number of living children for men in the sample. In fact desire for large family size (ideal number of children) is lower in the young age group. This would indicate the changing reproductive norms and accords with growing awareness of smaller family size and demand for family planning among the young couples.

A comparative study in Zaire showed similar findings in that men were found to have greater desire for more children than women (38). Results are also in agreement with the previous findings by Caldwell and Caldwell, that African men want to have more children because they think they gain socially and economically from having a large number of children (12).

The educational level they achieved moreover influenced the desire for more children by study subjects. Desire for more children decreased with better education. The finding is in agreement with findings from the different DHS and FP surveys carried out in sub-

Saharan African countries. An education-fertility hypothesis suggests that higher education is consistently associated with reduced fertility levels (39, 40, 41). In general societies in the study area are male dominated. Most ethnic groups in the study area are characterized by a strong patriarchal tradition.

This is in fact true for the majority of Ethiopian families. This gives men the power and confidence to dominate their families and societies on social and cultural matters including sexuality and reproduction. Traditional cultures and religions participate by emphasizing the decision-making roles of men in their families even where women have an important economic role in the family.

Moreover, this study demonstrated the influence of partners' attitudes and discussion between couples on matters like fertility. A husband's approval of family planning promotes family planning method use. Of interest is the rate (88.9% of positive attitude towards modern contraceptive (MC) seen in this study population. This high rate should be interpreted with some caution. In this study the contraceptive prevalence rate was found to be 47.6% in Hossana Town, which is higher, comparing with national urban CPR (42) and also higher than other urban CPR in the country (43,44,45). This might be due to increased awareness and knowledge of the Community about contraception, increased access of family planning services through CBD (community based distribution of contraception) agent, increased non-governmental and private organizations and religious organizations participation in the education and provision of family planning services.

A lot of factors may influence the attitude and the actual use of contraceptives by the men. In the current study, certain factors are considered as major contributors for positive /negative attitude toward MC the actual use of it by the study subjects.

Finding from the world fertility survey (WFS) conform that education has a powerful effect on contraceptive use. In general, higher education leads to higher use of contraception, even in those countries, where the percentage of couples currently practicing contraception is lowest (46). Although there may be methodological difference, our findings agree with many of the data collected (47).

There was strong statistically significant association between literacy and use of contraceptives (OR = 3.74,95% CI, 1.54-9.06). The attitude of the men towards contraceptive is also associated with their level of education. Thus a favorable attitude towards MC and the actual use may be largely dependant on attained educational level. However the present study clearly showed that more of the couples use contractive methods for birth spacing than for stopping having more children.

One of the major contributes to use or not use contraceptive in other studies was religion. Among the reasons given in a Nigerian study, 19.6% of non-users said that contraceptive was sinful (48). In our cases, 4.5% among non-users expressed the religious prohibition. This was supported by young group focus group discussant who said that in some churches religious leaders are teaching against use of condom. In this study it was found

that Muslims seemed to be more resistant to use contraceptive than Christians. There is a statistically significant association between the individual supportive attitude towards and the actual practice by men (OR- 14.11, 5.91-33.71). The majorities of the users have a supportive attitude towards the use of but do not use it. This result indicates that improving the attitudes of the individuals may have a significant effect on the use of it by the couple. The majority of the men who are using contraceptive in this study have said that the attitude of their spouse/ partners towards contraceptive was supportive. This finding suggests that involvement of both husband and wife can have important role for the success of a family planning programme.

Discussion between a couple on matters like fertility is also strongly associated with current use of contraceptives ($P < 0.05$ OR 5.64), hence, partners approval of family planning and the extent and frequency of discussion among couples concerning fertility and family planning appear to be important determinants and predictor variables of current use of family planning methods. A similar association was observed by study carried out in Ghana, (43) that greater approval and more frequent discussion among couples enhanced contraceptive use by women in the Ghanaian families as well.

Though more fertility research on the underlying factors determining men's fertility preference, behavior and intention, is necessary, study findings bear some policy implications for future design and formulation of family planning programs. Current family planning programs not only should focus on women but also should specifically target men. Men should be encouraged to apply their decision-making power to

influence their wives in the promotion of family planning use and hence to make the right decision for the better health of their family. Family planning method use by men can be improved by mobilizing men to deliver services to other men.

Men who are convinced and satisfied users can serve as peer motivators to reinforce use of family planning methods by other men. Moreover, involving men along with women in encouraging communication and joint decision-making on issues like family size and reproduction can help exercise their responsibility and address their concerns towards family planning within their family.

Men that are aware of the harmful effects of early child bearing and closely spaced pregnancies, by virtue of their respected social decision making power, can be motivated to play important role in their families and their communities. Indeed, to set and endorse policies and legislation on marriage age and the right of access to safe and legal abortion in the country, program planners need to encourage and utilize the socially respected decision- making power of men. The need for men's involvement in family planning cannot therefore be over emphasized.

7. STRENGTH OF THE STUDY

- In this study quantitative and qualitative methods were used. These methods improve the research out comes as qualitative study complement or strengthen the quantitative assessment.
- The study subjects were selected using random sampling techniques, which helps to avoid selection bias.
- Data Collectors were trained thoroughly on interpersonal communication. Adoption to the local language, norms and traditions during training and field pretest may also have given strength to the assessment tool.

- Using logistic regression to control the possible confounding factors in order to assess the relative effect of independent variables could as well he stated as an additional strength.

Limitation of the study

- Cross-sectional study design used in the present study could show the exposure and out come at the same point in time, but we cant not formulate the cause and effect relationship. The other limitation is that the study was carried out only in urban setting and it lacks information about rural situation and unmarried men are not included in the study population, which might affect in the out come of the study.

8. CONCLUSION

1) Modern contraceptive methods especially male methods, like condom and vasectomy are poorly practiced.
2) The main reasons mentioned by non-users in study area for not practicing MCM, were desire for more children and fear of side effects.
3) More of the couples used contraceptive methods for birth spacing than for stopping having children.

4) The family decision-making role is mostly influenced by the husband (51.8%)
5) 60.3% of the study subjects wanted more children
6) The mean number of living children was found to be 3.84 children per men, while the mean desired numbers of children were 5.2.
7) Most of the respondents were found to have a favorable attitude towards male contraceptive methods.
8) More than 73.2% and 66.1% of the study men mentioned that they had frequent discussion with their wives about number of children to have and family planning methods respectively, within the last one year.
9) The majority of the study subjects believed in joint decision making on family planning. The findings obtained in this study suggest that adoption of family planning is positively associated with the attitude of individual supportive spousal attitude and more inter-spousal communication on family planning. Similar to numerous studies in family planning, our study has shown that literacy is highly associated with contraceptive use.

9. RECOMMENDATION

1) Family planning should be improved by mobilizing men to deliver services to other men, and use those men who are convinced and satisfied users of FP as peer motivators to reinforce use of FP methods by men.
2) Maximizing access to good quality services. Improving the quality of FP services for men and making contraceptives mix easier to obtain and use by men.

3) The programs should advocate the minimal risk or side effects associated with contraceptive methods compared to health and socio economic problems and maternal heath incurred by having too many children.
4) Modify traditional social norms among men, by using broad education programs, like mass media, community meetings, and professional associations, out-reach workers, and other communication channels.
5) Population information and awareness programs should be targeted at men, with the aim of influencing their attitudes about reproductive matters and motivate them, and thereby their wives, to produce fewer children.
6) Focus on men as well as women. Encouraging communication b/n couples and involving men more in FP, and increasing men's commitment and joint responsibility in all areas of sexual and reproductive health by sensitizing men to gender issues in ensuring women's equality.

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Annex II Consent Form

Department of Community Heath, Faculty of Medicine Addis Ababa University.

Survey questionnaire on the role of men in fertility preference and contraceptive use among currently married men in Hossana Town, SNNPRG.

Client interview Greeting

My name is _____. I am working in a research team (project), which is conducted by the Addis Ababa University in collaboration with the Ministry of Health. We are interviewing currently married men to know their role in fertility preference and modern contraceptive use and the general knowledge, practice and attitude towards family planning. I am going to ask you some questions that are not difficult to answer. Your name will not be written in this form and will never be used in connection with any of the information you tell me. You don't have to answer any question that you don't want to answer and you may end this interview at any time you want to. However, your honest answer to these questions will help as in identifying the role of currently married men in fertility preference and contraceptive use and will enable us to design appropriate interventions or strategies. We would appreciate your help in responding to our questions. The interview will take about 30 minutes.

001 Questionnaire Number _____

002 Identification number of interviewer_____

003 Study Site: Kebele _____

Household number _____

004 Are you willing to participate in the study?

1. Yes _____
2. No _____

- Signature of the interviewer certifying that the informed consent has been verbally obtained

Name _____ Signature _____

005 Time table of visiting /revisiting

	Visit 1	Visit 2	Visit 3
Date			
Result			

1. Completed 2. Partially responded 3.Respondent not available 4. Refused 5 other, specify ___

. Part I: - Socio-Demographic Characteristics of the Respondents if it is more than one answer circle each number.

No	***Questions***	Responses	***Code***	***Skip***
101	Respondents age	_____years		

102	What is your ethnicity?	1. Hadiya 2. Amhara 3. Kambata 4. Gurage 5. Silte 6.Oromo 7. Other, specify_____		
103	What is your religion?	1. Protestant 2. Orthodox 3. Catholic 4.muslim 5. Traditional 6. Other, specify		
104	Education status of respondent	1 Illiterate (can't read and write) 2 Can read and write (no formal grade) 3 Elementary school (1-6) 4 Junior high school (7-10) 5 Preparatory school (10-12) 6 Higher education		
105	What is your main occupation?	1 Jobless 2 Farmer 3Government employee 4 Mass org. employee 5 Self employee 6 student 7 Daily laborer 8 Merchant 9 Pension 10NGOs employee 11 other, specify_____		
106	Marital status	____1 Monogamous marriage ____2 Polygamous marriage ____ 3 Living with the woman		

107	How many years have you and your wife lived together after marriage?	1 If less than 6 months stop interview 2 Number of Years _____ 3 Number of months _____	⟶	STOP
108	At what age were you married	Age in years_____		

Part II: - Economic Status

No	***Questions***	***Responses***	***Code***	***Skip***
201	Do you have radio / TV in your house?	1 Radio only 2 TV only 3 Both Radio and TV 4 None		
202	What is your monthly income in Birr?	1 _____Birr per month (estimate of the Respondent 2 No response 3. No any income (Zero)		
203	(For farmer only) How many cattle dose your family own?	1 None 2. One 3 Two 3 Three 4 Four or more		
204	Who has the greatest influence in the family decision-making?	1My self 2 My wife 3 Both of us 4 My parents 5 My wife's parents 6 Other, specify_____		

Part III:- Reproductive History of Respondent

No	***Questions***	***Responses***	***Code***	***Skip***
301	How many living children do you	1 Not applicable		

	have now?	Enter number _____M _____F		
302	What would be the number of children you desire in your family?	1Enter No._____ 2 _____M ____F 3 No response		
303	How many of these children would you like to be boys /girls and for how many would it not matter?	1 Boys _____ 2 Girls _____ 3 It is not a problem 4 God knows 5 Other, specify _____		
304	Have you ever discussed the number of children you really want to have with your wife?	1 Yes 2 No		
305	Who has the greatest influence in deciding the number of children to have?	1 Not applicable 2 Husband 3 Wife 4 Both 5 Kin 6 God 7 Others, specify _____		
306	If you have already two or more children, would you like to have any more?	1 Not applicable _____ 2 yes → 308 3 No 4 Up to god		
307	If you preferred to have another child, how long would you like to wait before the birth of another child?	1_____months if less than 2 years 2 2 to 3 years 3 3 to 4 years 4 More than 4 years 5 Do not want to wait 6 Do not know		
308	Do you think your wife/partner wants the same number of children that you want, or does she want	1 Same number 2 More children 3 Fewer children		

	more or fewer than you want?	4 Don't know		
309	Who takes decision on when to have another child?	1 Husband only 2 My wife only 3 both of us 4 No decision 5 God knows 6 Other specify_____		
310	Who takes decision on whether to stop childbearing?	1 Husband only 2 My wife only 3 both of us 4 No decision 5 God knows 6 Other specify_____		
311	Who takes decision on what to do to stop childbearing?	1 Husband only 2 My wife only 3 both of us 4 No decision 5 God knows 6 Other specify_____		

Part IV :- Knowledge about modern contraception

No	***Questions***	***Responses***	***Code***	***Skip***
401	Have you ever heard of FP methods?	1 Yes 2 No →		404
402	Do you know any way or methods that women and men can use to delay or avoid pregnancy?	1 Yes 2 No →		404
403	Which of the following contraceptive methods	1. Pill		

	do you know about? (Read and circle all mentioned)	2IUD 3 Injectables 4 Implants (Norplant) 5 Condom 6 Spermicidal 7 Male sterilization 8 Female sterilization 9 Rhythm/periodic abstinence 10 withdrawal 11 Other, specify_____		
404	What do you think is the best way that, for married men and women in the reproductive age to limit family size, prevent unwanted or mistimed pregnancy?	1 Use modern contraceptive 2 Use natural methods (periodic abstinence, withdrawal, 3 Do not know 4 Other specify _____		
405	What are the most important benefits of having children?	1 Povide support for parents in old age 2 Are a source of fulfillment joy and pride 3 provide help to parents 4 Bear family name 5 Are source of companionship 6 No response 7 other Scpecify_____		
406	Do you think that, using condoms can prevent pregnancy?	1 Yes 2 No 3 No opinion 4 Don't know		
407	Do you know what sterilization is? (vasectomy/ tubal ligation)	1 Yes 2 No 3 No opinion		→ 412
408	Do you think that vasectomy reduces sexual potency?	1 Yes 2 No 3 No opinion 4 Don't know		
409	Where is the main place that you and your wife/partners are able to get modern contraceptives from?	1 Hospital 2 Health Center 3 Health station 4 Community Health Post 5 FGAE clinic 6 Private clinic		

		7 Pharmacy/drug vender 8 Shop 9 Do not know 10 other, specify_____		
410	Have you ever got information about modern contraception?	1 Yes 2 No →		415
411	Source of information about modern contraception (FP)	1 Health institution 2 CHA'S 3 TBA'S 4 Friends 5 Mass media (Radio) 6 TV 7 Newspaper 8 Wife/husband 9 Neighbors 10 Others, specify_____		
412	From whom would you like to get information about modern contraceptives?	1 Health professional 2 CHAS 3 TBAS 4 Friends 5 Wife/partner 6 Neighbors 7 Radio 8 TV 9 Newspaper 10 Other specify _____		

Part V: - Attitudes towards contraception methods (10)

No	*Questions*	*Responses*	*Code*	*Skip*
501	Would you like to know more about contraception methods?	1 Yes 2 No 3 No response		
502	Do you yourself approve or disapprove of couples using methods of FP?	1 Approve → 2 Disapprove 3 Do not know 4 Other specify _____		504

503	If you disapprove why?	1 Respondent refusal 2 Wife/ partner refused 3 Family disapproval 4 Religious prohibition 5 culture do not allow 6 Desire to have more children 7 Fear of side effect 8 Medical problem 9 Other, specify_____		
504	What is your wife /partner attitude towards contraceptive methods	1 approve 2 Disapprove 3 Do not know		
505	Have you discussed about modern contraception with your wife/partner within the last one-year?	1 Yes 2 No 3 Do not know		507
506	If the answer is yes, how many times have you discussed within the last one-year?	1 Once 2 Twice 3 More often 4 Never 5 I can't remember		
507	Did you ever discussed with any other person about contraceptive aside from spouse?	1 Yes 2 No 3 No response 4 I don't remember		
508	Do you believe that FP information and services should be made available to men?	1 Yes 2 No 3 Neutral		
509	Do you think that only men should decide on family size?	1 Yes 2 No 3 No opinion 4 No reponse		
510	Do you think that only man should decide when to have sex?	1 Yes 2 No		

		3 No opinion 4 No reponse		
511	Who decide on the method of FP to be used?	1 My self 2 My wife 3 both of us 4 No response 5 Don't know		
512	Do you feel that using condoms reduces men sexual pleasure?	1 Yes 2 No 3 No opinion 4 Don't know		
513	Do you approve or disapprove men sterilization (vasectomy)?	1 Approve → 2 Disapprove 3 Undecided 4 Don't know		515
514	If you disapprove, what are the reasons?	1 _____ 2 _____ 3 _____ 4 _____		
515	Do you feel that too large a family size strains the family's economic situation?	1 Strongly aqgrre 2 Agree 3 Strongly disagree 4 Disagree 5 Neutral		
516	Do you imagine that a large family makes a happy home?	1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree 5 Neutral		
517	Do you feel that too many children are often harmful to the health of the mother?	1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree 5 Neutral		
518	Do you expect that FP practice will	1 Strongly agree		

	cause a loss of confidence between a wife and a husband?	2 Agree 3 Disagree 4 Strongly disagree 5 Neutral		
519	Do you think that contraceptive use may cause infertility in a woman?	1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree 5 Neutral		
520	Do you accept that men should share the responsibility for FP?	1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree 5 Neutral		

Part VI:-Practice of modern contraception

No	***Questions***	***Responses***	***Code***	***Skip***
601	Please tell me to which group do you and your wife belongs with regard to modern contraceptive use?	1 Current user____ → 606 2 Ever user_____ 3 Non user ____ → 610 4 Other, specify_____		
602	How many living children did you have at time when you stop using? (For ever- users)	Enter the number of children _____		
603	What was the method you used then?	Enter the methods _____ _____ _____ _____ _____ _____		
604	What was the main reason that you stopped using contraceptive	1 Fear of side effect 2 Fear of infertility		

	methods?	3 Desire to have more children 4 Medical problem 5 Preferred method is not available 6 Little perceived risk of pregnancy 7 Unacceptable in my culture 8 Religious prohibition 9 Rumors 10 Other, specify _____		
605	Who talked about these rumors?	1 Current users 2 Previous users/defaulters 3 Nonusers 4 do not know 5 Other, specify _____		
606	If you are currently using the contraceptive method for what purpose?	1 Birth spacing 2 Limiting birth 3 do not know 4 Other, Specify _____		
607	What modern or traditional contraceptive method do you use? (Circle only in the number against the method that he/she urrently uses)	1 Pill 2 IUD 3 injectables 4 implants (Norplant) 5 condom 6 spermicidal; 7Female sterilization 8 male sterilization 9 Rhythm period 10 Post partum abstinence 11 Other, specify_____		
608	Who usually in the family make the	1 Respondent		

	decision whether to practice FP or not?	2 Wife 3 Both 4 Our friends 5 Our parents 6 Other sepcify,_____		
610	If you were not using any contraceptive method to delay or avoid pregnancy would you tell me the main reason?	1 Respondent opposed 2 Wives opposed 3 Relative opposed 4 Knows no methods 5 knows no source 6 Health concern 7 Fear of side effects 8 lack of access or too far 9 To much cost 10 to have more children 11 In convenient to use 12 Religious prohibition 13 Cultural problem 14 Fear of infertility		
611	Do you intend to use any method with your wife to delay or avoid pregnancy at any time in the future?	1 Yes 2 No 3 Not decided 4 do not know		413
612	If yes which method would you prefer to use with your wife?	1 Pill 2 IUD 3 injectables 4 implants (Norplant) 5condom 6 spermicidal; 7Female sterilization 8 male sterilization 9 Rhythm period 10 Post partum abstinence		

		11 Other, specify_____		
613	Who do you think should take the responsibility for practicing some contraceptive methods?	1 My self 2 My ife 3 Both of us 4 No Opionion 5 Other, specify_____		

006- Date of interview in Ethiopian calendar _____/_____/_____(dd/ mm /yy)_____/hrs.

007 – Checked by supervisor

Signature _____ DD _____ MM_____ YY_____

Annex III

Table 1: Summary of focus group discussion married men age 20-40 years and 41-64 years plus male religious leaders and community elders. Hossana Town, SNNPRG. Ethiopia,

	Variables	Responses variables	Married marriage 20-40 year	Married men age 41-64 years.	Elders religious leaders
	FP and its use	-Child spacing - Pregnancy preventing - Child limiting - STI prevention	~~IIII~~ ~~IIII~~ ~~IIII~~ ~~IIII~~	~~IIII~~ ~~IIII~~ ~~IIII~~ llll	lll ~~IIII~~ ~~IIII~~ ll
	Specific FP methods knowledge	-Injectables -Pill -Condom -Norplant -Rhythm -Sterilization	~~IIII~~ ~~IIII~~ ~~IIII~~ ~~IIII~~ lll llll	~~IIII~~ ~~IIII~~ llll ll ~~IIII~~ llll	ll ~~IIII~~ l ~~IIII~~ l
	FP methods only men can use	-Condom - Rhythm -Injectables	~~IIII~~ lll ll	~~IIII~~ ~~IIII~~	l ~~IIII~~
	FP discussion	-Discussed -Not discussed	~~IIII~~	lll ll	l llll
	Decision on FP use	-Husband - Wife - Both	ll llll ~~IIII~~	llll ll lll	llll l ll
	Male attitude of FP	- Positive	~~IIII~~	~~IIII~~	ll

		- Negative			llll
	FP rumors in the community	- Cause infertility - Condom causes HIV/AIDS -Hyper pigmentation of uterus	- llll lll llll	ll llll l	llll
	Role of men in FP use and fertility	- Use male method - Provide methods to his wife - Support her willing	lll lll lll	lll lll llll	 ll
	Ideal family size	- 6 - 4 - 2 - Depend on economy	ll lll lll	lll lll lll	lll lll ll
	Why couples want more children	-Cultural obligation -Religious pressure - Having wealth -Not having income	lll ll lll ll	lll lll lll l	lll lll l l
	Discussed number of children	- Discussed Not discussed	lll	lll llll	 lll
	Variables	Responses variables	Married men age 20-40 year	Married men age 41-60 years.	Elders religious leaders
	Advantage of having children	- Social security - Economic benefit - Bear family name - Old age support	ll l lll l	llll lll lll lll	llll lll lll llll
	Disadvantage of having too large family	-For men –economic un-affordability - Loss of family love - Loss of family relation For women - Health problem - May be death	lll lll lll llll	lll l ll lll ll	ll l l
	Problem of service delivery -	- Scarcity - Lack of method mix	lll lll	ll lll	l -
	Religious prohibition in contraceptive use	- Yes - No	llll		
	FP information and service for men	- Yes - No - No opinion	lll	lll	ll
	Source of information for FP	- Health institution	lll lll	lll llll	

		- Mass media - CBRH workers	~~llll~~	llll	~~llll~~
	Obstacles to alleviate low CPR and high fertility	- Awareness creation - Resource allocation - Trained man power	~~llll~~ ~~llll~~ ~~llll~~	llll ~~llll~~ ~~llll~~	llll ll l

Table 2 : Summary of focus group discussion with government health service provider

	Variables	Response variables	Government health provider
	FP services provided in GaH H. institution	- Affordable - Available - Regular - Not regular - Method mix - Acceptable	~~llll~~ lll l ~~llll~~ l l
	Potential client	- Men - Women	 ~~llll~~
	Public opinion and attitude towards H.S providers	-Positive - Negative	~~llll~~
	Role of mass media about FP	- Important - No use	~~llll~~
	Knowledge of public about FP and its use	- Yes - No	~~llll~~

		- For spacing - STI/HIV prevention - Prevention pregnancy -Child limiting	~~IIII~~ ~~IIII~~ ~~IIII~~ ~~IIII~~
	Attitude of men towards MCM and Ferility	- Positive - Negative	~~IIII~~
	Reason for less or not using FP	-	
	Perceived Technical capability of H.S providers	- - Need on job training - Basic training is not enough --Need for upgrading training	~~IIII~~ lll ~~IIII~~
	Major obstacles	- Lack of trained man power - Lack of resource - Lack of method mix - Law awareness	~~IIII~~ llll llll ~~IIII~~

Annex IV

CURRICULAM VITAE

Name Tsedeke Tuloro
Place of birth Hadiya zone, SNNPRG
Profession Medical doctor

Year of birth July 1961
Nationality Ethiopian
Address Addis Ababa
P.O. Box 9086
Tele Mobile 251-64-13-58
251-06-55-06-15
Email Tsedeke 2004@yahoo.com
Hossana –SNNPRG
Ethiopia

1. EDUCATION:

a) MPH in reproductive health Addis Ababa University 2002/2004

b) Degree programme in former USSR VINNITSA Medical institute from 1981-88,
c) Secondary in Wachamo comprehensive secondary School 1973-78,
d) Elementary in Hadiya Mission School 1968-72

2. TRANING

a) Child survival project, experience-sharing workshop organized by world-vision Ethiopia and World Vision Kenya in Kenya 2001
b) The integrated health facility assessment training and implementation organized by Save the Children USA and World Vision-Ethiopia and Oromia health bureau 1998,
c) The course on management of finance, integrated rural development, policy, project and development planning organized by federal government and SNNPGR 1997 in Awassa
d) The course on managing successful training programs organized by USAID/ESHE/ project in Cairo 1996
e) The course on malaria and other major tropical diseases and planning there control organized by WHO and MOH in Nazareth
f) Accelerated district health management, course in Ras Imiru training center in 1990

3. WORK EXPERIENCE

a) District health manager and representative of MOH in Kelafo Awraja, 1990-1992 Autonomous Ogaden Adminstrative region
b) Head of health education programs and infectious diseases control in former Ogaden autonomous
regional health department, 1992-1993
c) Head of diseases prevention and control department, region five-health bureau,
June 1993-1995.
d) Head, Hadiya Zone health department, 1995-2001.
e) Programmes Coordinator for global fund in Addis Ababa HAPCO.

4. OTHER COMMUNITY AND NGO SERVICE EXPERIENCE

a) Collaborative work with World Vision international Ethiopia, Shonkola child Survival project, Hadiya Zone, SNNPRG.
b) Project advisory committee member, EECMY-SCS and Pathfinder International community based reproductive health project in Hadia Zone, SNNPRG,
c) Chairperson, Ethiopia Red Cross Society, Hadiya coordinating office.

5. LANGUAGE

- Hadiygna written-spoken
- Amharic written-spoken

- English written-spoken
- Russian written-spoken

6. **SPECIAL SKILL**

a) Computer skill
b) 3rd class driving license

7. REFERENCES

1. Dr. Tesfaye Bulto ESHE/JSI/ USAID Addis Ababa office coordinator Tele 251-1- 52-28-82 Addis Ababa

2.. Solomon Demamu ESHE/JSI/USAID
Awassa Regional office coordinator Tele. 251-6-20-44-52

3. Dr. Sheferaw T/Mariam Head of Southern Region Heath Bureau
Tele. 251.06-20-05-95 Awassa

Annex V

DECLARATION

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

Name Tsedeke Tuloro (MD)

Signature _____

Place Addis Ababa, Ethiopia

Date of submission April 29, 2004

This thesis has been submitted for examination with our approval as University Advisors.

Dr. Ahmed Ali _____

Advisor Signature

Dr. Gail Davey _____

Advisor Signature