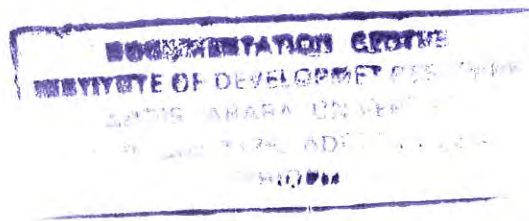


265-41
Addis Ababa University
School of Graduate Studies

GENDER POWER RELATIONS IN REPRODUCTIVE DECISION-MAKING:
THE CASE OF MIGRANT WEAVERS OF ADDIS ABABA



BY:
TEFERA DARGE

June 2009

The
T363
2009

137838

Addis Ababa University
School of Graduate Studies

**GENDER POWER RELATIONS IN REPRODUCTIVE DECISION-MAKING:
THE CASE OF MIGRANT WEAVERS OF ADDIS ABABA**

**BY:
TEFERA DARGE**

A THESIS SUBMITTED TO SCHOOL OF GRADUATE STUDIES OF ADDIS
ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN
POPULATION STUDIES

June 2009

The
T363
2009

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

***Gender Power Relations in Reproductive Decision-Making:
The Case of Migrant Weavers of Addis Ababa***

By
Tefera Darge Delbiso

**Institute of Population Studies
College of Development Studies**

Approved by the Examining Board

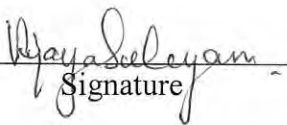
Dr. Eshetu Gurmu
Chairman, Department Graduate Committee


Signature

Dr. Samson Kassahun
Advisor


Signature

Dr. Vijaya Subramaniam
Examiner


Signature

Acknowledgment

I would like to thank my advisor Dr. Samson Kassahun for his comments and assistance from the beginning of the thesis work to the end. I would like also to extend my appreciation to Fitsum Abadi for providing me reading materials; Fikadu Nigusse and Mesay G/Mariam for their valuable comments and editing.

I would like to express my heartfelt thanks to all the staff members of Institute of Population Studies, Addis Ababa University for helped me to gain all rounded knowledge. I appreciate also the service that Addis Ababa University as a whole provided me for the research.

I must also express my gratitude to all weavers in Addis Ababa since the study would have been meaningless without their willingness and active participation. I also thank the enumerators for their efforts to gather the data.

Finally, I would like to thank all my family for their endless support they gave me throughout my life. I owe a debt of gratitude to all my friends who have contributed a lot to this thesis work in different ways.

Table of Contents	Page number
Acknowledgment	i
List of Tables.....	v
List of Figures	vi
List of Tables in Annexes.....	vii
List of Abbreviations.....	viii
Abstract.....	ix
Chapter One: Introduction.....	1
1.1 Background of the Study	1
1.2 Statement of the Problem	2
1.3 Literature Review	4
1.3.1 Theoretical Considerations	4
1.3.2 Empirical Findings.....	5
1.3.2.1 Socioeconomic and Cultural Variables Affecting Reproductive Decision-Making .	6
1.3.2.2 Demographic Variables Affecting Reproductive Decision-Making	9
1.4 Objectives	10
1.4.1 General Objective.....	10
1.4.2 Specific Objectives.....	10
1.5 Research Questions.....	10
1.6 Significance of the Study.....	11
1.7 Analytical Framework	11
1.8 Operational Definitions	13
1.9 Limitations of the Study	13

Chapter Two: Methods and Materials	14
2.1 Study Area	14
2.2 Study Population.....	14
2.3 Study Design.....	15
2.4 Sampling and Data Collection Methods.....	15
2.4.1 Sample Size Determination.....	15
2.4.2 Sampling Design	16
2.4.3 Methods of Data Collection	17
2.5 Data Analysis Methods.....	19
2.5.1 Model Specification	19
2.5.2 Model Diagnostic	20
2.6 Description of Variables.....	22
2.7 Ethical Considerations.....	23
Chapter Three: Background Characteristics of the Study Respondents.....	24
3.1 Demographic Characteristics.....	24
3.2 Socioeconomic and Cultural Characteristics.....	25
3.3 Family Planning Methods and Maternal Health Service Utilization.....	28
3.3.1 Knowledge and Practice of Contraceptive Methods	28
3.3.2 Maternal Health Service Utilization.....	32
Chapter Four: Contraceptive Use Decision-Making	35
4.1 Contraceptive Use Decision-Making by Selected Characteristics of the Respondents..	36
4.2 Determinants of Contraceptive Use Decision-Making.....	39
Chapter Five: Maternal Health Service Utilization Decision-Making	44
5.1 Maternal Health Service Utilization Decision-Making by Selected Characteristics of the Respondents.....	45
5.2 Determinants of Maternal Health Service Utilization Decision-Making	50

Chapter Six: Conclusions and Recommendations	57
6.1 Conclusions	57
6.2 Recommendations	60
References	62
Annexes	68
Annex A: Test of Model Assumptions	68
Annex B: Supportive Analysis	70
Annex C: Questionnaires (Data Collection Instruments)	72

List of Tables

Table 3.1: Percentage distribution of sample of weaver by selected demographic characteristics in Addis Ababa, 2009.....	25
Table 3.2: Percentage distribution of sample of weaver by selected socioeconomic and cultural characteristics in Addis Ababa, 2009.....	27
Table 4.1: Percentage distribution of sample of weaver by selected characteristics and contraceptive use decision-making in Addis Ababa, 2009.	38
Table 4.2 Multinomial logistic regression analysis result of contraceptive use decision-making of weavers in Addis Ababa, 2009.	43
Table 5.1: Percentage distribution of sample of weaver by selected demographic characteristics and maternal health service utilization decision-making in Addis Ababa, 2009.....	46
Table 5.2: Percentage distribution of sample of weaver by selected socioeconomic and cultural characteristics and maternal health service utilization decision-making in Addis Ababa, 2009.	49
Table 5.3 Multinomial logistic regression analysis result of maternal health service utilization decision-making of weavers in Addis Ababa, 2009.....	55

List of Figures

Figure 1.1: Analytical framework for the analysis of gender roles in reproductive decision-making. Adopted form Li (1999) with major modification.	12
Figure 2.1: Diagrammatic presentation of sampling procedure.....	17
Figure 3.1: Knowledge of contraceptive methods among sample of weavers in Addis Ababa, 2009.....	29
Figure 3.2: Practice of contraceptive methods among sample of weavers in Addis Ababa, 2009.....	30
Figure 3.3: Reasons for using contraceptive among sample of weavers in Addis Ababa, 2009.	31
Figure 3.4: Reasons for non use of contraceptive methods among sample of weavers in Addis Ababa, 2009.	32
Figure 3.5: Percentage of sample of women used antenatal care for the last pregnancy among weavers in Addis Ababa, 2009.....	33
Figure 3.6: Percentage of sample of women by person providing assistance during delivery for the last birth among weavers in Addis Ababa, 2009.....	34
Figure 4.1: Attitude and practice of contraceptive use decision-making among sample of weavers in Addis Ababa, 2009.....	36
Figure 5.1: Attitude and practice of maternal health service utilization decision-making among sample of weavers in Addis Ababa, 2009.....	44

List of Tables in Annexes

Table A.1.1: Contingency coefficient values for test of multicollinearity in the women sample..68

Table A.1.2: Contingency coefficient values for test of multicollinearity in the men sample.....68

Table A.2.1: Classification accuracy for all cases, and after omitting outliers and influential cases
for contraceptive use decision-making in the women sample.....69

Table A.2.2: Classification accuracy for all cases, and after omitting outliers and influential cases
for maternal health service utilization decision-making in the women sample.69

Table A.2.3: Classification accuracy for all cases, and after omitting outliers and influential cases
for maternal health service utilization decision-making in the men sample.69

Table B.1: Cross tabulation of women’s age and physical harassment or verbal abuse.....70

Table B.2: Cross tabulation of men’s average income and their educational status.70

Table B.3: Cross tabulation of men’s average income and their age.71

Table B.4: Cross tabulation of men’s educational status and their age.....71

List of Abbreviations

BCC:	Behavior Change Communication
CSA:	Central Statistics Agency
EDHS:	Ethiopian Demographic and Health Survey
FHI:	Family Health International
ICPD:	International Conference on Population and Development
IEC:	Information Education Communication
IIA:	Independence of Irrelevance Alternatives
ILO:	International Labor Organization
LAM:	Lactational amaneorehae
MDGs:	Millennium Development Goals
RRR:	Relative Risk Ratio
SNNPR:	Southern Nations, Nationality and People’s Regional State
SPSS:	Statistical Package for Social Sciences
UN:	United Nations
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children’s Fund
WHO:	World Health Organization

Abstract

Reproductive decision-making is strongly associated with gender power relations between couples. In many developing countries most of reproductive decisions are made by men although it is, as well, the concern of women. Hence, this study was undertaken with the objective of assessing the gender power relations in reproductive decision-making, particularly contraceptive use and maternal health service utilization decision-making of migrant weavers, who are living in Addis Ababa, from Gamo Gofa zone of SNNPR.

To attain the specified objectives, the study used both quantitative and qualitative data. The quantitative data was collected by using structured questionnaire from 317 married couples, whereas the qualitative data was collected from six women and three men key informants. Simple descriptive statistics and multinomial logistic regression analysis were used to determine factors that influence reproductive decision-making. The quantitative data was analyzed by using STATA and SPSS software packages, while the qualitative data was analyzed by using triangulation.

Accordingly, about 34% and 30% of women and 17.7% and 45.1% of men had women-centered and joint contraceptive use decision-making attitude, respectively. Besides, 22.1% and 32.6% of women; and 4.2% and 91.7% of men reported that they made the contraceptive use decision by their own and jointly with their spouses, respectively. On the other hand, the majority of respondents portrayed that they appreciate joint maternal health service utilization decision-making and practice it in their household. The multivariate analysis result revealed that women in the age group of 30 years and above; and literates made the reproductive decisions by their own or jointly with their husbands. Besides, working women have women-centered contraceptive use decision-making and joint or women-centered maternal health service utilization decision-making; women with fewer children made the contraceptive use decision alone or jointly with their husbands; women accessing media in regular basis made the contraceptive use decision by their own; and women who are not victim of violence participate in maternal health service utilization decision-making. Among men, being literate and having smaller number of children are each associated with joint or women-centered maternal health service utilization decision-making; 30+ years of age men and men who did not harass or abuse their wives made equal participation, with their wives, for maternal health service utilization decision-making; and men with regular access to media let their wives decide on maternal health service utilization.

In light of the above results, empowering the study population in general and women's of the study community in particular through education and employment opportunities will inspire egalitarian or women-centered reproductive decision-making pattern. This, in turn, helps couples to attain the highest standard of sexual and reproductive health.

Chapter One

Introduction

1.1 Background of the Study

Gender is defined as society's traditional expectations, explanations, justifications and perceptions of what men and women are, what they can and should be, and how they act, in different spheres of life. These traditional perceptions and prohibitions are characterized by inequality in the division of labor, power relations and allocation of status and privileges. Accordingly, men dominate the public domain, senior positions and collect most benefits, while women predominate in the domestic domain and lower rank although they carry the disproportionate share of burden and responsibilities in reproduction (UNFPA 2005). Hence, in most societies, women usually have less power compared to men in all spheres of life (Eguavoen, Odiagbe and Obetoh 2007).

Gender power relations are strongly associated with reproductive decision-making. In many developing countries most of decisions regarding sexual activity, fertility, and contraceptive use are made by men even if it is the concern of women as well (Oladeji 2008). The greater power of men over women across time, society and a wide range of settings offer the men greater access to, and control over, valued resources (Molm and Hedley 1992). The consequent gender based power inequalities hinder communication between partners about reproductive health decisions (Blanc 2001). Furthermore, it constrains women's and men's access to reproductive health services, prevent women's and men's attainment of sexual health and pleasure and this, in turn, contribute a lot to poor health outcomes (Speizer, Whittle and Carter 2005).

It is believed that eliminating gender inequality and achieving women's empowerment through addressing the lack of access to education, health services and productive opportunities of women are essential to achieve the Millennium Development Goals (MDGs). Accordingly, the International Conference on Population and Development (ICPD) held in Cairo in 1994 and The United Nations Fourth World Conference on Women held in Beijing in 1995, advocates equality between genders. Further, recommended women's empowerment with regard to social, political, economic and health status as a matter of human rights and fundamental prerequisite for

equality. It underlined women's equal participation in both productive and reproductive decision-making as a necessity for the well-being of the household. Without active participation of women and the incorporation of women's perspective at all levels of decision-making, the goals of equality, development and peace cannot be achieved (UN 1995 and 1994).

Ethiopia has wide regional and cultural diversity on the reproductive health of its people. The social context of reproductive health such as cultural, religious and socio-economic factors differentiates men's and women's roles within society. Most of these factors influence health risks indirectly by differentiating access to information, education and wealth and this, in turn, restricts the scope of reproductive decision-making power (WHO 1999).

1.2 Statement of the Problem

In Africa, husbands and fathers are much more likely to be decision-makers in family than women in childbearing ages. The patriarchal, hierarchical and polygynous organization of many African households, the young age at marriage for women, patrilocal residence after marriage, the large age difference between spouses, the unequal work burden between the sexes, the high bride price, and the low educational level of women tends to perpetuate the low status of women and make them voiceless and powerless in all spheres of life including sexuality and reproduction (Makinwa-Adebusoye 2001; Bosureup 1985). It is the man alone who decides whether or not family planning should be used to limit the number of children or space births. Consequently, women's needs and preferences are neglected, and their knowledge and experience are not used to help guide decisions in their family as well as in their community (Kuponiyi and Alade 2007; Arkutu 1995).

The situation is similar in Ethiopia, where women generally do not have equal right with their husband, to have access for resources such as property, credit and inheritance, to take decisions regarding their desire number of children, to use contraception and even to space or stop childbearing. Accordingly, they relay on the decisions of their husbands or other family members with regard to reproductive issues and others. According to Olokodana and Yeshe (1998), male dominance leads to the deprivation of females in making decisions about their own lives including reproductive decisions. The patriarchal system in Ethiopia which keeps women in subordinate position, through religion and culture as an excuse, brought about and maintained

disparities between male and female (Haregewoin and Emebet 2002). In general, in Ethiopia, women's decision-making abilities remain constrained and subjugated to the political, socio-economic and cultural dominance of men (WHO 1999).

Furthermore, the various socioeconomic, cultural and religious factors aggravate the subordination of women in Ethiopia. For example, in 2007/8 academic year, out of the total students enrolled in a preparatory class (11-12 grades) and postgraduate programme, only 32.5% and 24.2% respectively, were females. A similar disparity is observed in primary and secondary school as well (CSA 2008). A similar scenario is also observed in employment, where out of the working age population, about 74% of the females were unemployed compared to 26% of males in the year 2005 (CSA 2006). In 2004/5 about one third of employees in the civil service were women, and most of them are found in low-status and low-paying jobs. Regarding political participation, of the 530 active parliament seats, women represented only 22.1% (Emebet 2007). All the above evidence shows unequal gender relations in Ethiopia. As a result of their lower status in all spheres of life - at home, in education, in economic aspect - the level of women's decision-making autonomy is generally low in Ethiopia (Gebremariam 2007; Misrak 2007).

Weavers in Addis Ababa are selected for this study due to the following main reasons. The first reason is that women in the weaver's community are highly responsible for domestic or reproductive activities, such as childbearing and rearing, food preparation, care for the sick, elderly and spouse. Despite the domestic activities, they are fully participating in the income generating activities (outdoor activities) for the wellbeing of their families. For example, they collect firewood from the nearby forests for sale, they engage in the constructions as laborers to generate income, petty trading ('Gulit), and in other informal sector employments. With backdrops, the research tries to answer the following question: do women enjoy, in the study population, similar power and rights in making reproductive decisions as they take the lion share of production as well as reproduction activities in their households? Secondly, majority of weavers are migrants from Gamo Gofa zone of Southern, Nations, Nationality and People's Regional State (SNNPR) particularly from Dorze and Chenchas areas. As most part of Ethiopia, there is gender disparity in Gamo Gofa zone. Hence, the research tries to answer, if gender disparity in the zone reflected in Addis Ababa.

Understanding individuals, above all women's reproductive needs and identifying the key factors which influence reproductive negotiation process between husband and wife are necessary to formulate policies aimed at creating conducive environment to improve women's reproductive health, general well-being and their decision power (Li 1999). Furthermore, understanding the linkage between gender power relations and reproductive decision-making is among the key factors which can help to assess the extent of gender inequality. However, it has not been well assessed in Ethiopia. Thus, this study aims to fill the knowledge gap by using data collected from weavers in Addis Ababa who are from Gamo Gofa zone of SNNPR.

1.3 Literature Review

1.3.1 Theoretical Considerations

Range of theories has been developed to guide researches on the human fertility. Existing theories face difficulties in explaining the fertility pattern and complicated relations between human reproduction and related social, culture and economic dynamics. Consequently, theories like feminist theories, gender perspective and empirical studies are emerged to fill the gap in existing fertility theories. In most of analytical approaches to fertility- such as new household economics and women's status approach- women's own reproductive interest and their roles in reproductive decision-making remains ambiguous. Women either vanish in the homogenous household or are emphasized for their instrumental roles in reducing fertility (Li 1999).

For instance, in new household economics, families are seen as wholly cooperative, homogenous and super stable units with consensual reproductive preference; and the fertility decisions made by the altruistic household head are assumed to be optimal for both the families and individuals within it (Li 1999). Feminists criticize this altruistic household head assumption as it ignored gender inequality and hence women's position is not viewed as independent important issue. Therefore, it has patriarchal bias (Folbre 1983 and 1986b; Elson 1991; Mariamme A. and Julie 1993 as cited in Li 1999).

In women's status approach women have been emphasized mainly for their instrumental roles in reducing fertility level, but without their own interest and right in reproductive issues. This approach focuses on the empirical relations between women's education, labor force

participation and fertility. A study showed that women with higher educational level tends to have lower fertility level without questioning women's decision power and men's roles in reproductive decision (Zhu et.al 1991; Zheng and Chen 1995 as cited in Li). Here the intra-household determinant of fertility decision remains untouched. Therefore, this approach also lacks gender perspective.

In both new household economics and women's status approach, in general, the household arrangement for both production and reproduction are not necessarily formed by the consensus of all family members, and the final decision can be more favorable to one gender than the other (MacDonald 1993).

Consequently, the bargaining model of household decision-making was emerged. Unlike the new household economics and women's status approach, the bargaining model of household decision-making incorporates both cooperation and conflict of individual family members in to the economic models to take the intra-household relations. This model treats women as distinct agents with their own interest and decision power. In addition to economic variables, the bargaining approach allows the non-economic variables, such as cultural and social dimension, to enter the economic model of bargaining. The treat points of bargaining models allow for individuals to have divergent preferences, and hence opens up an analytical space for considering gender based interests and power relations as a dimension of household decision-making to provide new insights in to the reproductive decision making (Li 1999). Bargaining approach is useful in examining gender relations (Agrawal 1997) and best explains the intera-household decision-making process (Chapagain 2006). In this specific paper, the analytical frame work was constructed based on bargaining model.

1.3.2 Empirical Findings

According to Chapagain (2006), power relations between wives and husbands are determined by a combination of various factors of power including education, age, income or wealth, position in the family and society, sociopolitical participation, knowledge and exposure to information, gender roles, responsibilities and privileges and social norms and value systems. The power relations between spouses can affect their decision-making autonomy in the household. For example, a study conducted in Nigeria reported that male dominates the reproductive decision-

making in reproductive issues, such as family size, child spacing and sex composition of children (Kuponiyi and Alade 2007).

1.3.2.1 Socioeconomic and Cultural Variables Affecting Reproductive Decision-Making

Education

Education is a means which drives people towards economic, social and cultural development and hence one of the determining factor for reproductive decision-making. According to a study conducted in Honduras, those women who had primary level education or less believed that men alone should make decisions regarding family planning use or family size and they are living in a household in which man made family planning decisions. Similarly, men with least educational level, i.e., those who had primary school education or less, support and practice a male-centered decision-making in family planning use or family size (Speizer et.al 2005). Higher educational level for wives positively affects conjugal communication and simulates egalitarian decision-making process relating to family size and fertility control in the family (Chapagain 2006; Hossain 1998; Laban and Gwako 1997).

Women who are better educated than their husbands are more likely to obtain prenatal care, particularly during the first trimester. Because being better educated than one's husband enables a woman to exert power in family decision-making (Beegle, Frankenberg and Thomas 2001). Similarly, wives with secondary or higher levels of education have significantly higher participation in the decision-making to use antenatal care service than those with primary or lower level of education (Chapagain 2006). A study conducted by Gebremariam (2007) shows that high maternal and husband's education have a positive relationship to antenatal and delivery care utilization in Ethiopia and Eritrea. Bloom, Wypij and Gupta (2001) concluded that higher educational status for women is positively associated with the likelihood of using antenatal care and safe delivery.

Employment Status and Income

Unequal power relations between men and women are deeply rooted in the way work is divided in the society. Women's participation in the labor force is among the major factors which can have impact on their status and hence on their reproductive decision-making power. Many studies pointed out that there is positive relationship between income and decision-making over contraceptive use. For example, according to Chapagain (2006) and Hossain (1998), wives who had personal income or with higher income have more autonomy in decision-making and consequently are more likely to use family planning. In the contrary, women with low or medium socioeconomic status were more likely than their other counterparts in reporting that their husband alone decides on contraceptive use. Similarly, men having medium socioeconomic status had significantly higher odds of being the sole decision-maker on family planning use or family size than did men of high socioeconomic status (Speizer et. al 2005). A study conducted in Kenya showed that the participation of wives in income-generating activities has significantly improves their position in the family and their self-confidence. This intensifies communication between husbands and wife, thus making it an important factor in decision-making process with regard to family planning use and family size (Laban and Gwako 1997).

According to Gebremariam (2007) women's current work helps them to generate income and hence improve their decision-making power in the household, has a positive association with antenatal and delivery care utilization in Ethiopia. The distribution of economic power within a household significantly influences all dimensions of prenatal and delivery care utilization. Specifically, as the share of household assets owned by the wife increases so does the probability she will use prenatal care (Beegle et.al 2001). Likewise, women's employment increases control over income which, in turn, may increases power in making reproductive decision and their ability to pay for the maternal services they needed (Gill, Pande and Malhotra 2007). On the contrary, lack of access to and control over economic resources of women were some fundamental reasons for women's low participation in decision-making regarding maternal care utilization (Chapagain 2006). A study conducted in North India shows that women who were employed outside the home were less likely to use a trained attendant for delivery than women who did not work. However, higher economic status associated positively with the likelihood of using antenatal care and safe delivery (Bloom et.al 2001).

Religion

Religion is important factor in determining reproductive decision-making; since reproduction, sexual behavior and male-female interaction are influenced by normative attitudes like religion. A study conducted in Nigeria showed that majority of the respondents take their religious injections in to account while making decisions on reproductive issues, such as family planning use and family size (Kuponiyi and Alade 2007). Protestant women were more likely than other women to have male-centered decision-making attitude regarding family size or family planning use (Speizer et.al 2005). According to a study in Guatemala, evangelical women were more likely than their Catholic counterparts to report husband's dominance in household matters (Carter 2004) and this might also give the husband a privilege to make decisions regarding reproductive issues. However, a study conducted in North India showed that religion doesn't affect, significantly, the antenatal care utilization (Bloom et.al 2001).

Media exposure

Exposure to media will provide the respondents with new ideas and messages about the rights and reproductive issues. It has the power to make a substantial contribution to advance gender equality. Therefore, it is important element in affecting the reproductive decision-making. Those women with better access to mass media had a significant positive effect on their participation in contraceptive decision-making than those with no or less media access. The higher the access to mass media associated with the higher the women's participation in contraceptive use decision-making (Chapagain 2006). A study conducted in Southern India showed that women with medium to high degree of media exposure were more likely to have received antenatal care (Navaneetham and Dharmalingam 2000).

Physical Harassment or Verbal Abuse

The intimate partner's violence can lead to lack of control over health-seeking behavior, sexual decision-making and contraceptive use, which, in turn, can lead to adverse risks to women's sexual and reproductive health (Pallitto 2004). A study conducted by Chapagain (2006) discovered a strong negative association between the incidence of wife-battering (by the husbands) and wives' participation in contraceptive decision-making. Wives who had experienced verbal assault and those beaten by their husbands were less likely to participate in

antenatal care decision-making as compared to those who never-experienced verbal assault and never-beaten counterparts (Chapagain 2006). Similarly, Gebremariam (2007) concluded that those women who disagree with wife beating in Ethiopia has more likely in using antenatal care service. Moreover, wives experienced intimate violence likely to have poorer maternal health, because they are less likely to access antenatal, delivery and postnatal care (Gill et.al 2007).

1.3.2.2 Demographic Variables Affecting Reproductive Decision-Making

Age

Age is one of the determinant factors which can affect the reproductive decision-making. According to EDHS report, older women are more likely than younger women in making-decisions (CSA and ORC Macro 2006). A study conducted by Speizer et.al (2005) showed that women aged 40-49 were more likely than women in their 30's to have male-centered decision-making attitude with regard to family planning use or family size. On the other hand, a study conducted by Wyatt et.al (2000) showed that older women made the contraceptive decision alone. Blanc and Wolff (2001), in their study at Uganda, concluded that having older husband decrease the likelihood of discussion and use of condom as family planning. Regarding maternal health service utilization decision making, a study by Biratu and Lindstrom (2006) showed that the influence of husband's approval of prenatal care utilization declines with women's age due to the greater decision-making autonomy among older women compared to younger women. Conversely, a study in India showed that younger women are more likely than older women in using antenatal and safe delivery (Bloom et.al 2001).

Number of Living Children

Number of living children is relevant to examine the current fertility desire, reproductive decision-making and contraceptive outcome. Women's with no children would be the most likely to have male-centered decision-making attitude with regard to family planning use or family size, but as they have more children, and thus gain more control over household resources, their attitude towards supporting male-centered decision-making decreases (Speizer et.al 2005). A study conducted in Indonesia reported that women with two or fewer children have greater control of their reproductive lives than women with three or more children (Prasadja et. al 1997). Women having large number of living children use antenatal and delivery care

lower than those women with smaller number of living children because they have already experienced childbearing (Bloom et.al 2001).

1.4 Objectives

1.4.1 General Objective

The ultimate goal of this study is to assess the gender power relations in reproductive decision-making among weavers from Gamo Gofa zone of SNNPR and living in Addis Ababa and hence to recommend measures to be taken so as to improve their reproductive health and rights.

1.4.2 Specific Objectives

- i. To find out the contraceptive use decision-making of husband, wife and husband and wife together.
- ii. To find out the maternal health services (antenatal and delivery care) utilization decision-making of husband, wife and husband and wife together.
- iii. To identify determinants of contraceptive use decision-making.
- iv. To identify determinants of maternal health service (antenatal and delivery care) utilization decision-making.

1.5 Research Questions

In this research the following questions will be answered:

1. Who is responsible for contraceptive use decision-making in your household (husband, wife or husband and wife together)?
2. Who is responsible for the maternal health service utilization decision-making in your household (husband, wife or husband and wife together)?
3. What are the determinants of contraceptive use decision-making?
4. What are the determinants of maternal health service utilization decision-making?

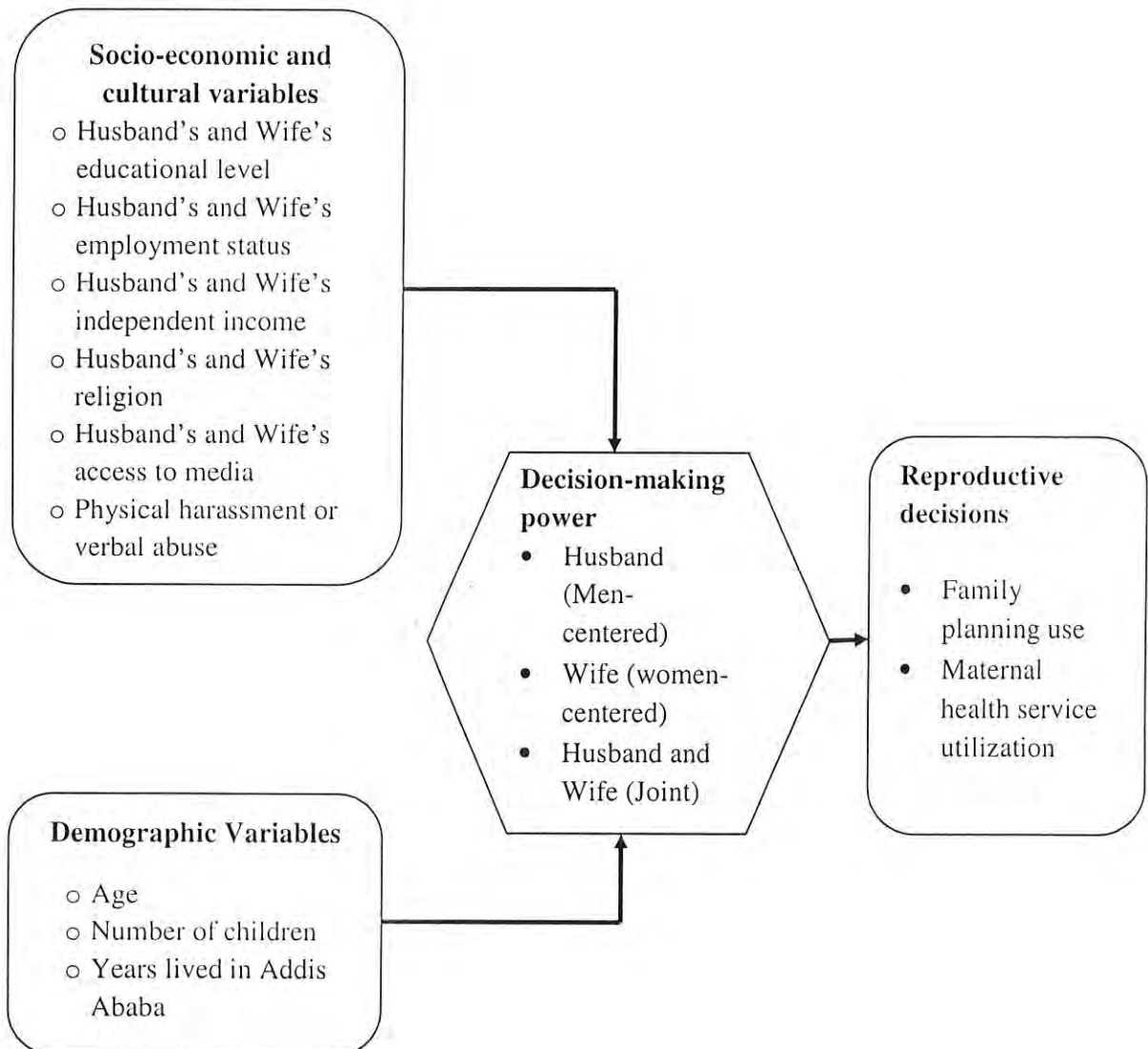
1.6 Significance of the Study

The finding of this study will enable the concerned stakeholders to comprehend the area which needs more attention in order to improve the reproductive health and rights of the study population. It can also be used as the spring board for further academic researches. Furthermore, the finding is useful for formulating effective policies and programs with regard to reproductive health and rights.

1.7 Analytical Framework

The analytical framework below, Figure 1.1, is constructed based on the bargaining model of household decision-making. It is developed to show how individual characteristics such as demographic, socio-economic and cultural variables affect the reproductive decision-making power of husband and wife. The demographic, socio-economic and cultural variables together determine the husband and wife's well-being and social norms of their gender responsibility and roles. The gender roles may not be the same among families because of the existence of differences in individual husband and wife's social characteristics. The family having better position in the determinant factors will have greater power in the household. The determinant factors together form the husband and wife's decision-making power. The final reproductive outcomes (use of family planning methods and maternal health service) are the result of negotiation between the husband and wife based on their reproductive decision-making power.

Figure 1.1: Analytical framework for the analysis of gender roles in reproductive decision-making. Adopted from Li (1999) with major modification.



1.8 Operational Definitions

Decision-making attitude – is opinions, out looks, position and intentions of the respondent towards the contraceptive and/or maternal health service utilization decision-making.

Decision-making practice – is process of carrying out the contraceptive and/or maternal health service utilization decision-making in the household.

1.9 Limitations of the Study

Extra-household environmental parameters, such as individual access to resource outside the household, the legal system for property settlements, the marriage market and marriage institute etc are believed to influence the reproductive decision-making process. However, in this study these parameters were not included.

In the study sample, small proportions of men respondents ever used contraceptive methods. Consequently, it was difficult to fit multinomial logistic regression model for the contraceptive use in the men sample due to the smaller sample size. Hence, this created difficulty to make comparison for men and women sample. Therefore, a model was fitted for the contraceptive use decision-making of women sample and for the men sample it was explained by using simple descriptive statistics.

Chapter Two

Methods and Materials

2.1 Study Area

The study area, Addis Ababa, is the capital city of Ethiopia, the seat of the African Union (AU) and the United Nations Economic Commission for Africa (UNECA). The city is divided into ten administrative sub-cities namely; Bole, Nifas Silk-Lafto, Kolfe-Keraniyo, Yeka, Akaki-Kaliti, Arada, Gulele, Addis Ketema, Kirkos and Lideta sub-city and 99 kebele administrations. According to the 2007 Housing and Population Census, the city has 2,738,248 population with 47.6% male and 52.4% female (CSA 2008).

Gulele sub-city, the study site, is one of the ten sub-cities in Addis Ababa. It is located in the northern part of Addis Ababa surrounded in the north by Oromiya region, in the south Arada sub-city, in the east Yeka sub-city and in the west by Kolfe-Keranio sub-city. The total population of the sub-city is 267,381 with 48.3% male and 51.7% female (CSA 2008). The sub-city is divided into ten kebeles.

The inhabitants of the sub-city come from different parts of the country and with different ethnic backgrounds. They are engaged in diverse economic activities. Of the economic activities, weaving business is the dominant one. About 20 percent of the total population of the sub-city was engaged in weaving business. However, they use traditional technologies which could not take the industry even one step ahead. Moreover, Gulele sub-city is one of the poverty stricken sections of the capital, Addis Ababa. Nearly half of the sub-city's population lives below the poverty line (Gulele sub-city strategic plan 2000-2003).

2.2 Study Population

The study population, weavers, are migrants from Gamo Gofa zone of Southern Nations, Nationality and People's Regional State (SNNPR) and living in Addis Ababa. Weaving encourages rural-urban migration since much of the demand for woven goods is concentrated in urban areas. According to the 2007 Population and Housing Census report, about 45,946 Gamo's are living in Addis Ababa. This accounts 1.68 percent of the Addis Ababa population (CSA

2008). Weaving is the means of livelihood for the majority of Gamo's in Addis Ababa. For generations, these weavers have been weaving 'netelas' and 'gabbies' on traditional looms using centuries old pattern and design. Traditionally, the men do the weaving and it is the sole source of income for this people.

According to the International Labor Organization (ILO) report, even if weaving is the most important source of employment for semi-illiterate and illiterate labor forces, the sub-sector is characterized by low and fluctuating income, little or no access to market, finance, information and technology. Due to these difficulties for survival, women's of this community are supposed to generate income in parallel to the unpaid domestic activities to fill the gap.

2.3 Study Design

The study is aimed at assessing the gender power relations in reproductive decision-making at the time of the study. Therefore, cross-sectional study design is appropriate for the study.

2.4 Sampling and Data Collection Methods

2.4.1 Sample Size Determination

According to Cochran (1977), the following formula is used to determine the minimum required sample size.

$$n_0 = Deff \left(\frac{z_{\alpha/2}}{e} \right)^2 pq$$

Where:

- n_0 is the minimum required sample size; $Deff$ is the design effect; e is the desired level of precision; α is level of significance; and
- p is estimated proportion of joint reproductive decision-making. Since there is no previous study conducted in related topic, it was difficult to get the estimate for the proportion p . Therefore, the value of 0.5 was used to obtain the maximum possible sample size.

According to the above formula, the minimum required sample size with 95% confidence level, 5% precision level, 1.5 *Deff* and 0.5 estimated proportion is $n_0 = 577$. To compensate for non-responses and to fit multivariate models 10% of the minimum required sample size was added and the final sample size becomes $n = 634$. This means that data from 317 couples were collected.

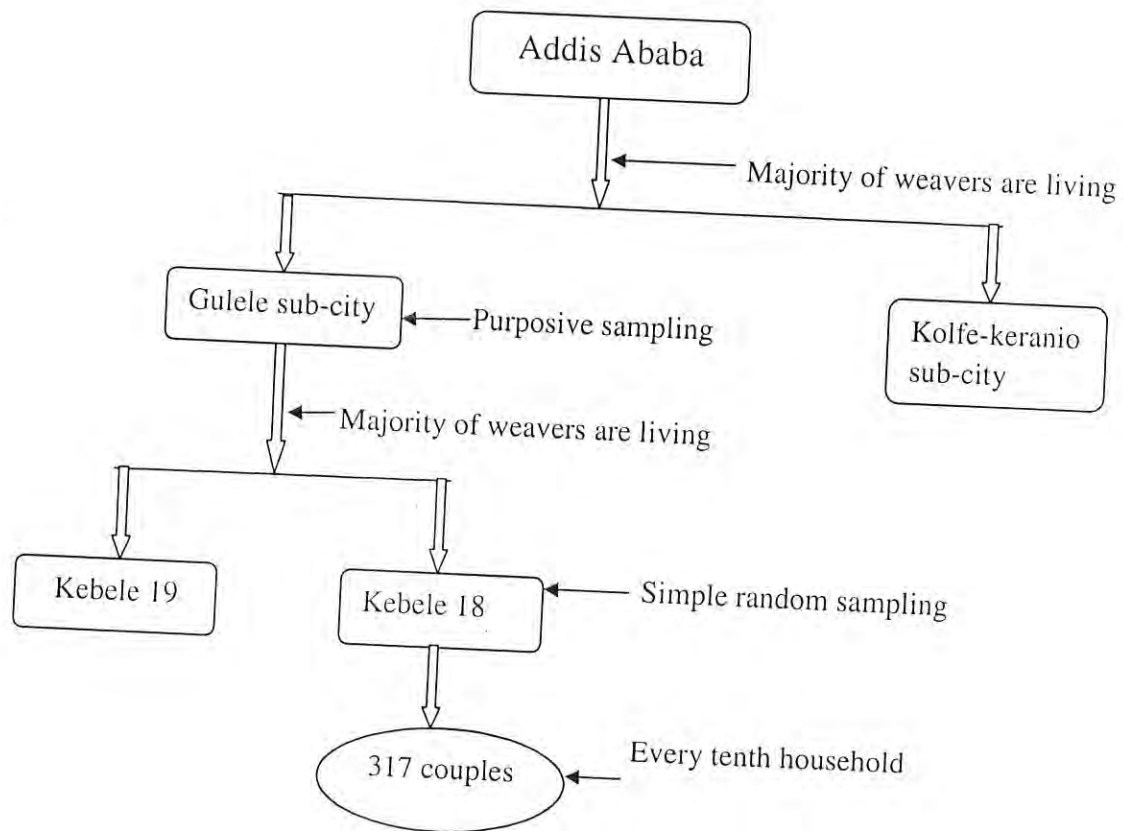
2.4.2 Sampling Design

After calculating the required sample size, double-stage cluster sampling and simple random sampling were used to select the study respondents. From the ten sub-cities of Addis Ababa, nearly all the weavers are found in two sub-cities namely Gulele sub-city and Kolfe-Keranion sub-city. Moreover, the majority are living in the Gulele sub-city. Therefore, Gulele sub-city was purposely selected for the study. Gulele sub-city is again composed of ten kebeles. Among the ten kebeles, weavers are concentrated in kebele 18 and 19. Using these two kebeles, two clusters were formed and one of the clusters was selected using simple random sampling. The selected cluster was kebele 18. According to information obtained from kebele administrators, more than eighty percent of the kebele residents are weavers. Since it was difficult to get the list of all residents in the kebele, every tenth household were selected for the study. Finally, from each household both wife and husband were interviewed. To remove spousal influence on answering questions, husband and wife were interviewed independently. The inclusion criteria for the study respondents were:

- The respondents should be migrant from Gamo-Gofa zone of SNNPR
- The respondent should be living with his/her spouse in Addis Ababa during the time of the survey
- The age limit for female respondents should be 15-49 years (reproductive age group) and for the men respondent it was (15-69) years.

When the selected tenth household did not satisfy the specified criteria, it was ignored and the next tenth household was chosen. Having these criteria, 634 individuals, i.e., 317 couples were selected for the study.

Figure 2.1 Diagrammatic presentation of sampling procedure



2.4.3 Methods of Data Collection

Data Collection Instruments

Both primary and secondary data were collected from the respective sources. To improve the quality and accuracy of information, both quantitative and qualitative data were collected.

The quantitative data were collected by using a well designed structured questionnaire (see Annex C). First the English version of the questionnaire was developed and then translated to Amharic so as to reduce mistakes which can arise when interviewers attempt to translate questions on the spot. The questionnaire was developed for men and women respondents

separately. In the men questionnaire, the female methods of contraceptives (in the practice part) and the maternal health service utilization were excluded.

Pretesting was conducted on a pilot survey of 20 individuals (10 women and 10 men respondents) in order to check the adequacy of the sampling procedure, to estimate the non response rate, to check the adequacy of the questionnaire, to check the codes chosen for pre-coded questions and to estimate the cost and duration of the data collection. Accordingly, the observed errors were corrected and improvements were made based on the result of the pretest. At the end, the finalized version of the questionnaire was developed and made ready for data collection.

The qualitative information, which used to support the quantitative findings, was collected by using key informant's interview (see Annex C). Six women and three men key informants, who are knowledgeable about the socio-cultural and economic context of their respective community, were interviewed to gather information on the reproductive decision-making attitude and practice. Moreover, the kebele health officer was interviewed for the methods of contraceptive which is most used by the community members and the associated reasons.

Recruitment and Training of Data Collectors

It is obvious that the quality of the survey is largely depends on the quality of the data collectors. For this specific study, the data collectors were recruited according to their educational level, the language they speak and their ability to create good rapport with the study population. Accordingly, six data collectors (three female and three male) with minimum educational level of 12th complete and speaks at least Amharic and Gamogna languages were recruited. They received a one day intensive training on the survey instruments and on how to approach the respondents to get the correct information. The supervision and training of the data collectors was made by the researcher. Finally, the data collection was started on February 09, 2009 and end on February 16, 2009.

2.5 Data Analysis Methods

To meet the objective of the research, both descriptive and inferential data analysis techniques were used. The descriptive analysis includes frequency tables, charts and cross tabulations whereas the inferential analysis includes chi-square tests of association and fitting a multinomial logistic regression model.

2.5.1 Model Specification

To answer the stated research questions, a probabilistic model was specified with decision-making pattern as a function of demographic, socioeconomic and cultural variables. The dependent variable, decision-making pattern, has three categories: 1) men-centered/husband-dominant decision-making; 2) women-centered/wife-dominant decision-making; and 3) joint decision-making.

Multinomial logistic regression is the extension of binary logistic regression and used to model relationships between a categorical dependent variable with more than two levels and a set of regressor variables. It provides more complete description of the variables being studied (Hosmer and Lemeshow 1989). Moreover, it provides the capacity not only to accommodate a variety of categorical dependent variables, but also to detect specific differences between categories within these variables.

Let Y_i be a random variable representing decision-making pattern of an individual. We assume that each respondent can have discrete, mutually exclusive choice of decision-making. The decision-making patterns are depends on socio-economic, demographic and cultural variables X . The multinomial logistic regression model for decision-making specifies the following relationships between the probability of choosing option Y_i and the set of explanatory variables x_i as:

$$\text{Pr ob}(Y_i = j) = \frac{e^{\beta_j x_i}}{\sum_{k=0}^j e^{\beta_k x_i}}, \quad j = 0, 1, \dots, J$$

Where: β_j is a vector of coefficients for category j and x_i is the vector of explanatory variables for observation i .

Estimating the above equation yields the J log-odds ratios:

$$\ln\left(\frac{P_{ij}}{P_{ik}}\right) = x_i' (\beta_j - \beta_h) = x_i' \beta_j, \quad \text{if } k = 0$$

The dependent variable is therefore the log of one alternative relative to the base alternative.

Moreover, the odds ratio, $\frac{P_j}{P_k}$, doesn't depend on the other choice alternative (Green 2003).

2.5.2 Model Diagnostic

Before running the multinomial logistic regression model, the categories were coded meaningfully, all relevant variables were included and all irrelevant variables were excluded. Moreover, the following assumptions were checked and addressed accordingly.

- **Multicollinearity:** is the existence of perfect or exact linear relationship among some or all explanatory variables of a regression model (Gujarati 1995). Multicollinearity leads to imprecise parameter estimation. To detect multicollinearity in qualitative (categorical) explanatory variables, one can compute Contingency Coefficient (C). It is given by:

$$C = \sqrt{\frac{\chi^2}{n + \chi^2}} \quad \text{Where: } C \text{ is contingency coefficient; } \chi^2 \text{ is a chi-square random}$$

variable; and n is the sample size.

If the contingency coefficient between pairs of explanatory variables is greater than 0.8, it is an indication of the existence of serious multicollinearity between the variables (Gujarati 1992). If multicollinearity exists, appropriate measures should be taken to address the problem. For example; omitting highly collinear variables, using prior information (Gujarati 1995) are some of suggested remedial to remove multicollinearity. However, in this specific study, even though there are significant correlations among some of the explanatory variables, none of the coefficients exceeds 0.8. Hence, it may be concluded that multicollinearity is not a serious problem in this case (see Annex A.1).

➤ **Outliers and Influential Values:** outliers and influential cases alter the estimated parameters in regression analysis (Long and Freese 2001; Gujarati 1995). For multinomial logistic regression, outliers and influential values are checked by running a binary logistic regression. Using binary logistic regression, the Cook's distance and standardized residuals are calculated and cases with Cook's distance greater than or equal to one or cases with absolute value of the standardized residual greater than or equal to three are considered as outliers or influential values. These cases are removed from the final model and the classification accuracy is compared with the classification accuracy of the initial model with all cases (including the outliers and influential cases). If the improvement is found to be more than 2%, the final model, that is, the model without the outliers and influential cases is used. But, if the improvement is below 2%, the first model with all the outliers and influential cases is used. However, in this paper the differences were found to be less than 2%. This indicates that even though there are outliers and influential cases, it do not alter the estimated parameters significantly. Therefore, the models with the outliers and influential cases were used (see Annex A.2).

➤ **The Independence of Irrelevant Alternatives (IIA):** Multinomial logit models assume that odds for each specific pair of outcomes do not depend on other outcomes available. That means, adding or deleting outcomes does not affect the odds among the remaining outcomes. There are two tests for the IIA assumption; Hausman test and Small-Hsiao test (Long and Freese 2001). However, both of the tests give inconsistent results and provide little guidance for violation of IIA assumption. Due to the practical limitations of these tests, multinomial models should only be used in case where the outcome categories can reasonably be assumed to be distinct and weighed independently in the eyes of each decision-maker (Long and Freese 2001). In this study it was tried to make the outcome categories distinct and independent so as to lessen the violation of IIA assumption.

The qualitative data obtained from the key informant's interview were analyzed by using triangulation (cross checking) method. Statistical software packages, STATA version 10 and SPSS version 15, were used to enter, organize, summarize and analyze the quantitative data.

2.6 Description of Variables

Dependent Variable

The dependent variables are the patterns of decision-making. It is categorized in to three as follows:

- Men-centered/husband-dominated decision-making: is characterized by response options that conform to traditional gender-role expectations. Here husband is generally the sole decision maker regarding family planning methods use and maternal health service utilization.
- Women-centered/wife-dominated decision-making: Here wife alone make the decision regarding family planning methods and maternal health service utilization.
- Joint decision-making: Both husband and wife makes the decisions regarding family planning methods and maternal health service utilization.

The responses to decision-making were coded as: 1=Men-centered decision-making, 2=Women-centered decision-making and 3=Joint decision-making.

Independent Variables

The reproductive decision-making can be affected by several demographic, socio-economic and cultural variables. The major explanatory variables are as follows.

Age: was categorized in to three; 15-24, 25-29 and 30+ years.

Educational level: categorized in to; Illiterate, Primary (1-8), and secondary and above (grade 9 and above). It was merged to illiterate and literate in the multivariate model.

Work status: categorized in to; generating their own income specified as “working” and do not generate their own income “not-working”.

Income: Have three categories; less than or equal to 300 Birr, 301-500 Birr and more than 500 Birr per month. This category was used only for men respondents.

Religion: the study respondents belong to two of the religions; orthodox and protestant.

Number of living children: was categorized to; No children, 1-2 children and 3 and above children (3+).

Exposure to media: the respondents were asked for exposure to electronic and printed medias- radio, television and newspaper. Respondents with almost every day access to the three medias were regarded as “Regular” and those with no access to all three medias were regarded as “No access” and the remaining combinations were regarded as “occasional”.

Physical harassment or verbal abuse: Have two categories; “Committed” and “Not committed”.

Years lived in Addis Ababa: categorized to; less than or equal to 10 years, 11-20 years and more than 20 years.

2.7 Ethical Considerations

The research permission was obtained for Institute of Population Studies, AAU. All the study participants were informed about the purpose of the study, their right to refuse and assured confidentiality. Informed verbal consent was obtained prior to the interview. The instruments and procedures were not causing any harm to the study subjects, the community, the data collectors and supervisors, which were involved in the survey.

Chapter Three

Background Characteristics of the Study Respondents

A total of six hundred thirty four respondents (three hundred seventeen couples) were participated in the study. This chapter describes the demographic, socioeconomic and cultural characteristics of the respondents. Besides, it portrays and discusses family planning methods and maternal health service utilization of the study respondents.

3.1 Demographic Characteristics

Of the 634 respondents, about 55% are under the age of 30 years and the remaining 45% are 30 and above years of age. The mean and median ages of the respondents are 30.42 and 28 years, respectively with standard deviation of 8.88 years. The mean and median ages of women are 27.3 and 26 respectively with standard deviation of 5.9 years and that of men are 33.5 and 30 with standard deviation of 10.1 years. On average husbands are six years older than their wives (see Table 3.1). This age difference between couples exacerbates gender-based power imbalance (Blanc 2001) and it is an indication of gender discrepancy in the study sample.

About 12% of the respondents do not have children while 46% of them have one or two children and the remaining 42% of them have three or more children. The average number of children an individual have is 2.88 (see Table 3.1).

About 34% of the respondents have been living in Addis Ababa for less than 11 years, 36% for between 11-20 years and 30% for above 20 years. Whereas, 49.2%, 30.3% and 20.5% of women respondents have been living for less than 11 years, 11-20 years and 20 plus years, respectively. Among the men respondents, 18.6%, 41.6% and 39.8% have been living in Addis Ababa for less than 11 years, 11-20 years and above 20 years, respectively (see Table 3.1). Since men dominate the weaving activity, husband migrates to urban areas first then his wife follows him. Consequently, most husbands lived longer years in Addis Ababa than their spouses.

Table 3.1: Percentage distribution of sample of weaver by selected demographic characteristics in Addis Ababa, 2009.

Characteristics	Women (n=317)		Men (n=317)		Total (n=634)	
	N	%	N	%	N	%
Age						
15-24	105	33.1	46	14.5	151	23.8
25-29	102	32.2	98	30.9	200	31.5
30+	110	34.7	173	54.6	283	44.6
Number of children						
0	38	12	35	11	73	11.5
1-2	150	47.3	142	44.8	292	46.1
3+	129	40.7	140	44.2	269	42.4
Years lived in Addis						
Below 11	156	49.2	59	18.6	215	33.9
11-20	96	30.3	132	41.6	228	36.0
Above 20	65	20.5	126	39.8	191	30.1

3.2 Socioeconomic and Cultural Characteristics

Regarding educational background, about 48% of the respondents are illiterate, 43% have primary and 9% have secondary and above level of education. About 66% of women are illiterate, 28.7% primary and 5.4% secondary and above. Similarly, of men respondents, about 30% are illiterate, 57.4% primary and 12.6% secondary and above. These figures are very low compared to the EDHS report. According to EDHS (2006), 17.6% of women in the age range of 15-49 years and 7.2% of men in the age range of 15-59 years were illiterate in Addis Ababa; compared to 66% and 30%, respectively in the study sample despite the increasing enrolment rate. Moreover, it is observed that there is discrepancy with regard to the educational attainment between men and women in the study sample. Women are underestimated than men, which might be ascribed to gender bias thinking of the society. In general, the overall educational attainment of the study respondents is low (see Table 3.2).

With regard to the religious affiliation, orthodox religion followers accounted about 71% and the remaining 29% were protestants. There are differences with regard to the religious affiliation

between the two sexes. Accordingly, about 68% of women are orthodox and 32% are protestant; whereas 74% of men are orthodox and 26% are protestant (see Table 3.2).

Apart from the household activities, about 57% of women respondents were engaged in income generating activities (informal sector) and the remaining 43% were not. Of the women engaged in income generating activities, about 47.4% were engaged in collecting firewood, 24.5% daily laborer, 15.8% petty trading ('Gulit') and the remaining 12.3% were engaged in other informal sectors. Almost all of them raise less than 300 Birr per month for their work. According to CSA (2006) labor force survey report, 22.6% of women in Addis Ababa were employed in the informal sector in the year 2005. The significant discrepancy between this study results compared to the CSA report might be attributed to the favorable working environment for women in the study area. On the other hand, all the men respondents were primarily engaged in weaving. Accordingly, 34% of them earned less than 300 Birr, 47.6% earned (301-500) Birr and the remaining 18.6% earned above 500 Birr per month. Side with their main activity of weaving, about 20% of them were engaged in extra jobs. Such as, 80.6% are working as a guard, 4.8% petty trading, 1.6% daily laborers and 12.9% in other informal employment sectors (see Table 3.2).

The exposure of respondents to media has indicated that 31.1% had no access, 44.8% had occasional access, and 24.1% had regular access to media. Yet, the study portrayed disparity regarding media consumption in men and women. Accordingly, 20.2%, 22.4% and 57.4% of women respondents had regular, occasional and no access to media, respectively, while 28.1%, 67.2% and 4.7% are the respective figures for men respondents with regular, occasional and no access to media. According to EDHS (2006), 29.2% of women and 21.4% of men in Addis Ababa had no access to media at least once a week compared to 57.4% of women and 4.7% of men respondents in the study sample. Furthermore, women are more disadvantaged than men and which has implication in the reproductive decision-making processes (see Table 3.2). The disparity concerning media consumption might attribute to the conducive working environment for men to access media especially the electronic media. However, the women respondents might not have better access and even if they have the access, language barriers together with their lower educational status, social status and restricted freedom of movement might have exacerbated the information transfer

Majority of surveyed women (69%) have claimed that their husbands committed physical harassment or verbal abuse while the remaining 31% reported that they have never been harassed or abused. Besides, survey result showed that 23.7% of men respondents have attested that they have committed physical harassment or verbal abuse on their wives while the remaining 76.3% have not harassed or abused despite the large figure obtained from the women respondents (see Table 3.2). Murphy and Ringheim (2001) clearly pointed out that violence against women is a product of gender subordination of women and men's control of decision-making in the family which is an indication of gender imbalance.

Table 3.2: Percentage distribution of sample of weaver by selected socioeconomic and cultural characteristics in Addis Ababa, 2009.

Characteristics	Women (n=317)		Men (n=317)		Total (n=634)	
	N	%	N	%	N	%
Educational level						
Illiterate	209	65.9	95	30	304	47.9
Primary	91	28.7	182	57.4	273	43.1
Secondary and above	17	5.4	40	12.6	57	9.0
Religion						
Orthodox	216	68.1	235	74.1	451	71.1
Protestant	101	31.9	82	25.9	183	28.9
Work status						
Working	181	57.1	317	100	498	78.5
Not working	136	42.9	0	0	136	21.5
Income						
<= 300 birr			107	33.8	107	33.8
301-500 birr			151	47.6	151	47.6
>=501			59	18.6	59	18.6
Media exposure						
Regular	64	20.2	89	28.1	153	24.1
Occasional	71	22.4	213	67.2	284	44.8
Never	182	57.4	15	4.7	197	31.1
Physical harassment/verbal abuse						
Committed	219	69.1	75	23.7	294	46.4
Not committed	98	30.9	242	76.3	340	53.6

3.3 Family Planning Methods and Maternal Health Service Utilization

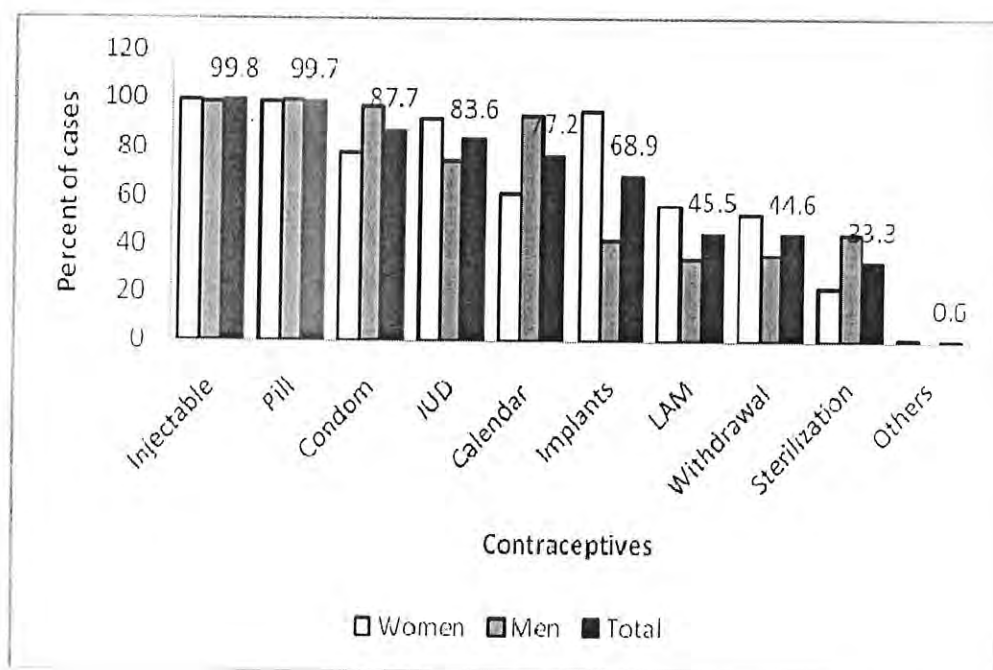
3.3.1 Knowledge and Practice of Contraceptive Methods

Knowledge of Contraceptive Methods

To get information on the knowledge of contraceptive methods, data collectors read the names of different contraceptive methods and asked the respondent's weather they heard the method or not. Accordingly, of 317 couples interviewed, 100% of women and 98.1% of men have heard about at least one method of contraceptive. This corroborates the national average that 88% of married women and 93% of married men know at least one contraceptive method (CSA and ORC Macro 2006). However, the slight discrepancy between this study and EDHS might be explained by the fact that this study is conducted in the urban area (the capital city) where there is a better information flow. The other reason might be attributed to the time difference between the EDHS and this study which is about 4-5 years gap. Unlike the EDHS, in this study women have better knowledge about contraceptive than their men counterparts. This might be due to the underlined age difference between women (15-49) years and men (15-69) in the study. Consequently, older men reported that they do not have any idea about contraceptives (see Figure 3.1).

Among different contraceptive methods, injectables, pill and condom are well known methods by the respondents with the respective percentages of 99.8, 99.7 and 87.7. On the other hand, sterilization, withdrawal, and LAM are the least known contraceptive methods with the respective percentages of 33.3, 44.6 and 45.5. All women respondents know injectables whereas only 24.4% of women respondents know sterilization. On the other hand, all men respondents know pill whereas Lactational amaneorehae (LAM) was the least known method by men respondents, which is known by only 34.4% of men respondents. There is a great variation in the knowledge of implants between men and women respondents. Accordingly, 95% of women respondents have heard about implants whereas only 42.2% of men respondents have heard about implant (see Figure 3.1).

Figure 3.1: Knowledge of contraceptive methods among sample of weavers in Addis Ababa, 2009.



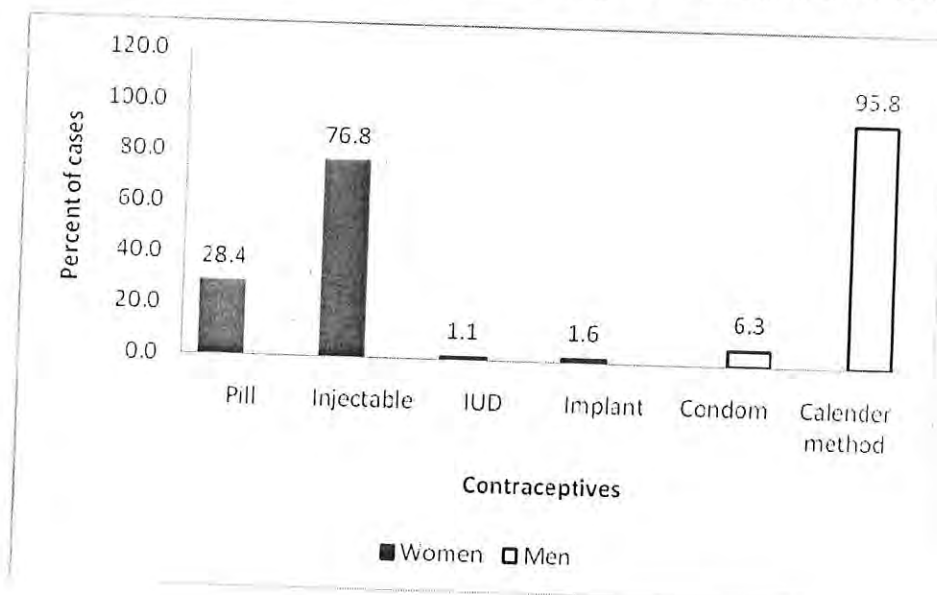
Practice of Contraceptive

Of the total respondents, 190 (60%) women and 48(15.1%) men have ever used contraceptive methods. This shows a huge gap compared to the national average of 24% of women and 19% of men had ever used contraceptive methods (CSA and ORC Macro 2006). This can be explained by the confinement of this study in urban area while the EDHS was inclusive of rural and urban. Furthermore, relatively small number of men contraceptive users in this study compared to the EDHS national average might be due to the increased percentage of women users and the perception of men's that contraception is women's business so that the women should use the methods. Of the women who had ever used contraceptives, about 76.8% have used injectables and 24.2% have used pill while smaller proportion, 1.6% and 1.1% of them have used long acting contraceptives such as IUCDs and implants respectively (see Figure 3.2). This finding is in agreement with EDHS (2006) that injectables are most used method by married women. Besides, the discussion that was held with kebele health officer justified the reason of using injectable contraceptives than others as follows:

“Majority of women have been using contraceptives without the knowledge of their husbands. As a result, they prefer to use injectables to other methods. Owing to the fact that injectable is simple to use, it takes only 3-5 minutes to take the injection and their husbands don’t know whether their wives are using a method or not.”

On the other hand, among men who have had experience of using contraceptive methods, about 96% of them have used traditional methods (calendar method) and 6.3% condoms (see Figure 3.2). Here, one can see a great discrepancy between knowledge and use of contraceptive method. This discrepancy might be attributed to one or many of the following: need of children, afraid of side effects, partner’s opposition to methods, lack of knowledge etc.

Figure 3.2: Practice of contraceptive methods among sample of weavers in Addis Ababa, 2009.

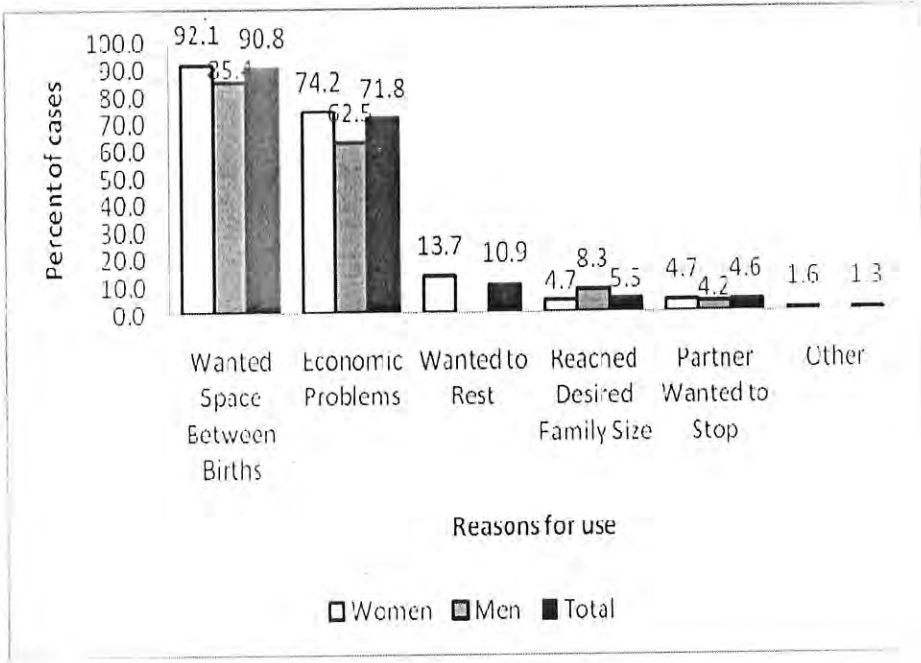


Reasons for Using Contraceptive Methods

Respondents were asked to tell the reason why they have been using the contraceptive methods. Accordingly, majority (90.8%) were revealed that they wanted to have space between births, 71.8% were due to economic problem which forced them to limit their family size, 5.5% were reached their desire family size and 4.6% were because of partners influence. Of the women

respondents, 13.7% were using contraceptives because they wanted to rest from having additional pregnancies and childbirth (see Figure 3.3).

Figure 3.3: Reasons for using contraceptive among sample of weavers in Addis Ababa, 2009.

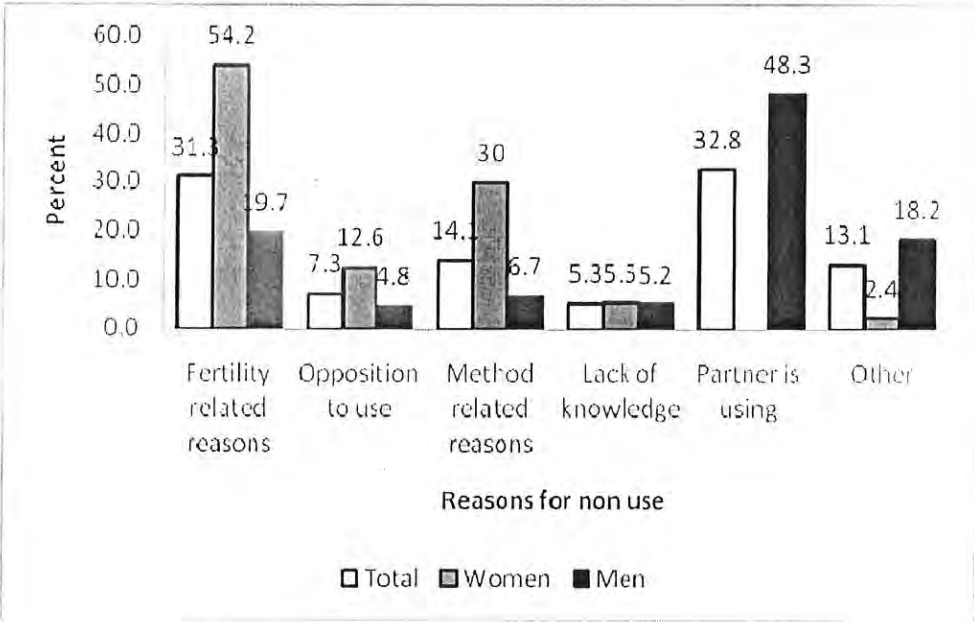


Reasons for Non Use of Contraceptives

Of the total respondents, 127 (40%) women and 269 (84.9%) men respondents have never used any contraceptive method. Questions were asked for their reason of not using contraceptives. The responses obtained were categorized in to the following: fertility related reasons which includes wants as many children as possible, can't get pregnant and infecund/subfecund; method related reasons which includes fear of side effects, health concerns and lack of access; opposition to use which includes respondent opposition, partners opposition and religious reasons; lack of knowledge which includes knows no methods and knows no source; partner is using the methods; and other reasons. Accordingly, majority (31.3%) of respondents demonstrated fertility related reasons, 14.1% method related reasons, 7.3% opposition to use, 5.3% lack of knowledge and 13.1% other reasons. Among women respondents majorities, 54.2%, 30% and 12.6%, respectively reported fertility related, method related and opposition to use. On the other hand majority of men respondents (48.3%) indicated that their partners were using the methods,

19.7% reported fertility related reasons and 18.2% told other reasons. Of those respondents reported fertility related reasons, the large share (23.2%) indicated that that they want children (see Figure 3.4).

Figure 3.4: Reasons for non use of contraceptive methods among sample of weavers in Addis Ababa, 2009.

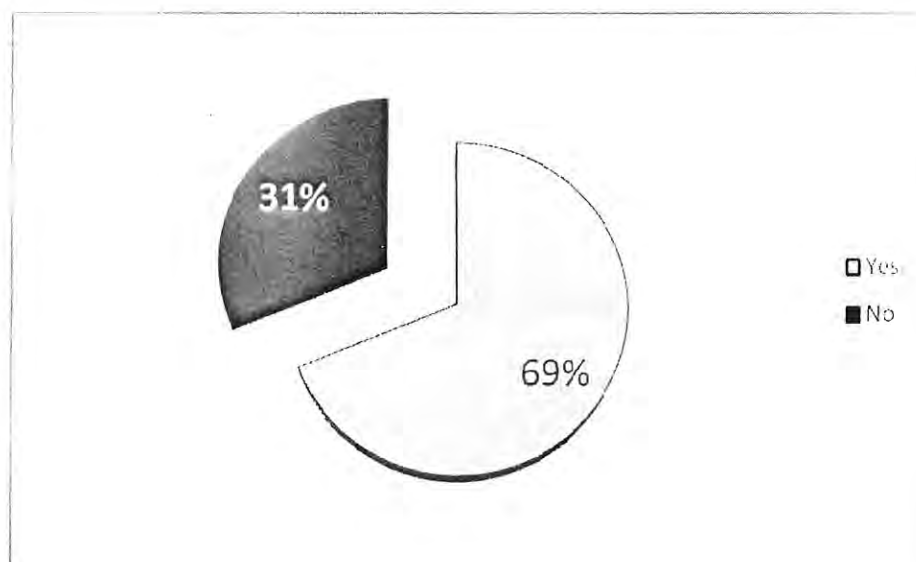


3.3.2 Maternal Health Service Utilization

Antenatal Care Utilization

Of 279 women who ever given birth, about 192 (69%) have obtained antenatal care from government health institutions (see Figure 3.5). Antenatal care utilizations are small compared to 88 percent of mothers in Addis Ababa obtained antenatal care from health professionals (CSA and ORC Macro 2006). Studies showed that mother’s education, income and exposure to media are some of conducive factors for antenatal care utilization (Navaneetham and Dharmalingam 2000). In line up with the above factors, the low level of antenatal care utilization in the study sample may be attributed to the prevailing low educational status, economic status, access to information and negotiation habit between couples which is resulted from gender inequality.

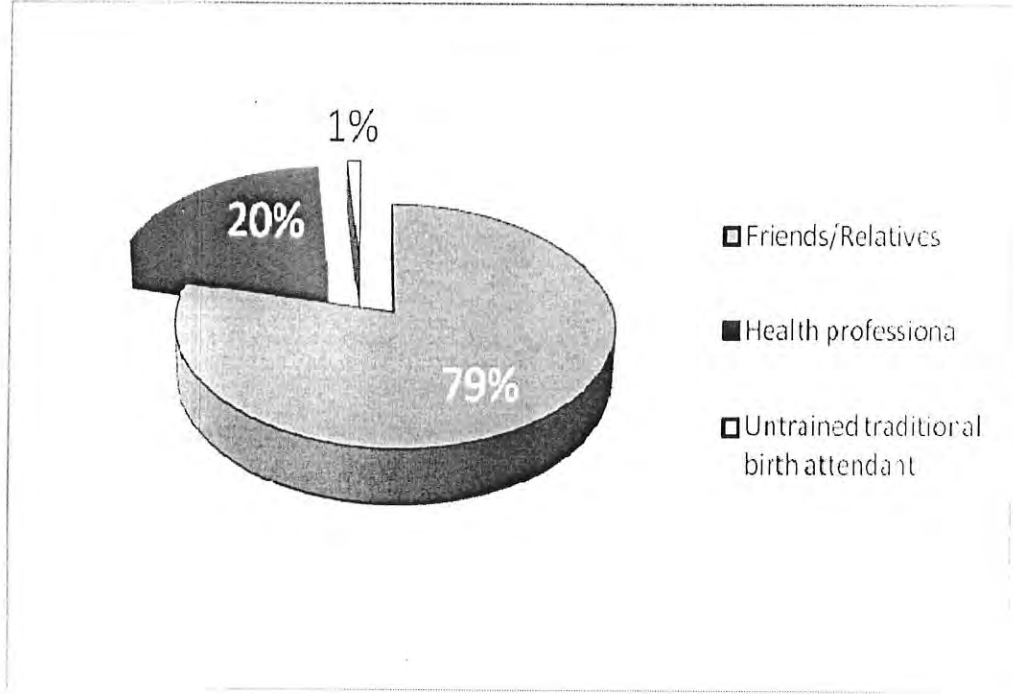
Figure 3.5: Percentage of sample of women used antenatal care for the last pregnancy among weavers in Addis Ababa, 2009.



Delivery Care Utilization

Most mothers (79%) in their last birth were assisted by friends or relatives and delivered at home. Whereas, about 20% were assisted by health professionals and very small proportions (1%) were assisted by untrained traditional birth attendants (see Figure 3.6). This figure shows a sharp contrast with the survey result of Addis Ababa. According to the EDHS (2006), about 79% of births were delivered in a health facility in Addis Ababa compared to only 20% of births in the study sample. The poor maternal health service utilization in the study respondents might be attributed to the low educational level, economic status, access to information and the socio-cultural setting of their birth place. Moreover, the poor maternal health service utilization reflects the persistent poverty and gender inequality (Family Care International 2007) and lack of decision-making power of women (Sundari 2004), which is observed from the sample data.

Figure 3.6: Percentage of sample of women by person providing assistance during delivery for the last birth among weavers in Addis Ababa, 2009.



Chapter Four

Contraceptive Use Decision-Making

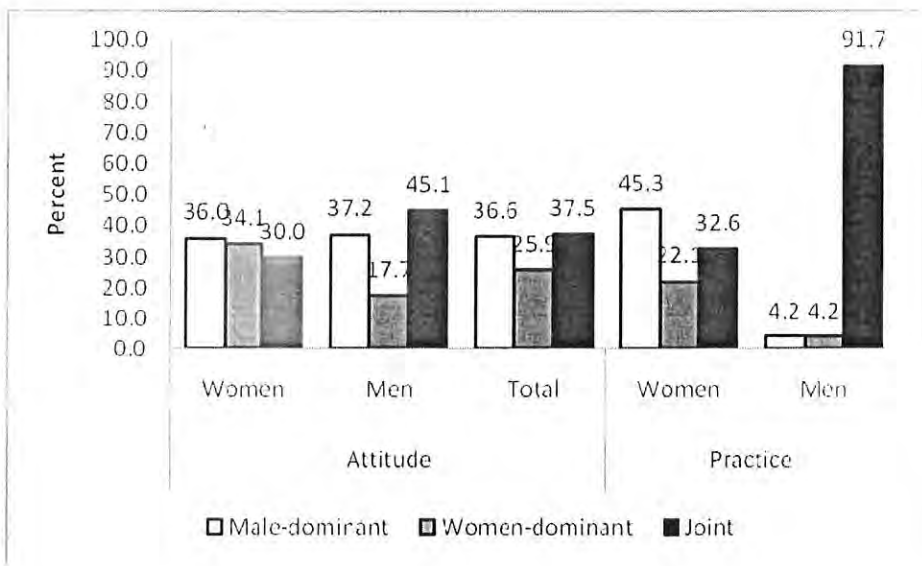
All sampled men and women were asked the attitude question: “who should make contraceptive use decision-making?” For the actual contraceptive use decision-making in their respective household, those individuals who ever used any of contraceptive methods, 190(60%) women and 48 (15.1%) men, were asked the question: “who actually make the contraceptive use decision-making in your household?”

Accordingly, 36% of women respondents perceived that men should dominate contraceptive use decision-making. While, the remaining 34% and 30% of women respondents reported that women-dominant and joint decision-making is vital, respectively. On the other hand, 45.1% of men respondents indicated that contraceptive decision-making should be made jointly; 37.2% of them reported that men should dominate contraceptive use decision-making and 17.7% of them claimed women-centered decision-making attitude is crucial (see Figure 4.1).

Of women who ever practiced contraceptive methods, 45.3% used it based on the consent of their husbands and 22.2% used it by their own decision. The remaining 32.2% of women made the contraceptive decision together with their spouses. However, 97.1% of men, who ever practiced contraceptives, made the decision together with their partners. Individual decision making was found to be negligible in the men respondents (see Figure 4.1).

It is thus, this result is the manifestation of most women in Africa due to their relegation position in the community. This finding is substantiated by the result obtained from Burkina Faso, Mali and Nigeria in which almost 75% of women respondents have indicated that husbands are sole decision-makers of women’s health care (UNICEF 2007). The low status of women in the study community might attribute to their limited decision-making power. However, this finding does not support the study result of Adair, Gultiano and Avila (1998) which underlined that even if family planning decision-making is a dynamic process, many women prefer to make joint decisions-with their spouses.

Figure 4.1: Attitude and practice of contraceptive use decision-making among sample of weavers in Addis Ababa, 2009.



4.1 Contraceptive Use Decision-Making by Selected Characteristics of the Respondents

In this part, men contraceptive users were small and almost all of them made the decision jointly with their partners, as a result, we will not consider them. Furthermore, only variables which showed significant association with contraceptive use decision-making in the Chi-square test are presented and discussed here (see Table 4.1 below).

Accordingly, majority of women in the age group of 15-24 (55.9%) and 30+ (43.3%) reported that their husbands dominate the contraceptive use decision-making. Slightly large portion (43.8%) of women in the age category (25-29) made the contraceptive use decision in collaboration with their husbands (see Table 4.1). This might be attributed to the lower bargaining power of women in the age category of 15-24; and the traditional belief of women in the age category of 30+ made them to locate the contraceptive use decision-making power to men in the study sample.

Furthermore, about 64% of illiterate women reported that their husbands made the decision to use contraceptive. However, about half of women with primary level education (50.8%) were living in the household where joint decision-making is practiced which is followed by 27.9% women-centered and 21.3% men-centered. Likewise, among women with secondary and above level of education, 53.3% and 46.7% respectively, made the contraceptive decision by their own and jointly with their husbands. This shows that, in the study sample, literate women made the contraceptive use decision alone or jointly with their husbands (see Table 4.1). This might be due to the fact that education helps women to know their rights and provide them the confidence to claim whenever their right is violated. Besides, more education a woman has, the more likely she is to participate in health related decision-making (Arkutu 1995).

Majority of orthodox (43.1%) and about half of protestant (50.9%) religion followers reported that contraceptive use decision-making is made by their husbands (see Table 4.1). This is an indication that more should be done in the religious institutions on fostering equal participation of couples in all decision-making in their household.

Besides, among women with regular media exposure, 46.2% and 38.5%, respectively made the contraceptive use decision together with their husbands and by their own. However, majority of women with no access (63%) and occasional access (39.5%) to media were living in a household where men-dominated the contraceptive use decision-making. When women's access to media improved, the practice of men-dominant contraceptive decision-making reduces and autonomy of women decision-making grows up (see Table 4.1). Media exposure facilitates the gradual initiation of spousal communication about family planning (Sharan and Valente 2002), which might help couples to make the contraceptive use decision together.

Moreover, of women who have been living in Addis for shorter (<11) years and medium (11-20) years, the larger portion (53.4% and 53.9%, respectively) were living in the household in which contraceptive use decision-making is dominated by the husbands. Of women who have been living for longer duration (>20 years), substantial portion (46.3%) made the contraceptive use decision together with their husbands (see Table 4.1). Longer stay in Addis for women might give them the opportunity to have better access to education, information and income. This, in

turn, facilitates their empowerment and participation in contraceptive use decision-making process in their household.

Table 4.1: Percentage distribution of sample of weaver by selected characteristics and contraceptive use decision-making in Addis Ababa, 2009.

Characteristics	Who usually make contraceptive use decision in your household								
	Women sample (n=190)					Men Sample (n=48)			
	Husband	Wife	Joint	Total	χ^2	Husband	Wife	Joint	Total
Age									
15-24	55.9	15.3	28.8	59	p<0.05	0.0	0.0	100	4
25-29	37.5	18.8	43.8	64		0.0	0.0	100	13
30+	43.3	31.3	25.4	67		6.5	6.5	87.1	31
Educational level									
Illiterate	64.0	14.9	21.1	114	p<0.01	0.0	0.0	100	6
Primary	21.3	27.9	50.8	61		7.1	0.0	92.9	28
Secondary and above	0.0	53.3	46.7	15		0.0	14.3	85.7	14
Religion									
Orthodox	43.0	19.0	38.0	137	p<0.05	6.3	0.0	93.8	32
Protestant	50.9	30.2	18.9	53		0.0	12.5	87.5	16
Media exposure									
Regular	15.4	38.5	46.2	52	p<0.01	0.0	0.0	100	19
Occasional	39.5	28.9	31.6	38		6.9	6.9	86.2	29
Never	63.0	11.0	26.0	100		0.0	0.0	0.0	0.0
Years lived in Addis									
Below 11	53.4	15.1	31.5	73	p<0.01	0.0	0.0	100	9
11-20	53.9	19.7	26.3	76		0.0	0.0	100	16
Above 20	14.6	39	46.3	41		8.7	8.7	82.6	23

NB: Since more than 20% of cells have values less than five, the chi-square test of association was not calculated for the men sample. In addition, only significant variables in the Chi-square test were reported in the table.

4.2 Determinants of Contraceptive Use Decision-Making

This section discusses about the major determinants of contraceptive use decision-making practice of women. Accordingly, age, education, number of children, work status and media exposure of women were found to be significant determinants of contraceptive use decision-making. The multinomial logistic regression results in Table 4.2 below shows the relative risk ratio (RRR) and its standard error for the determinants.

Age

Compared to women in the age category of 30+, women with age of 15-24 years are more likely (RRR=11) to live in where men dominated the contraceptive use decision-making relative to joint decision-making. Moreover, they are less likely (RRR=0.02) to practice the decision by their own compared with relying on their husbands decision. Similarly, women in the age group of 25-29 are less likely (RRR=0.22) to participate in contraceptive decision-making than those above 30 years old. Besides, their husbands dominate the contraceptive decision-making in their household (RRR=0.21). Hence, women in the age group of 15-29 are living in a household where the husband dominated the contraceptive use decision-making. The possible explanation for this result may be the low level of bargaining power of young women coupled with their low economic status and information exposure made them to live in the household where husband dominated the contraceptive use decision-making. Discussions with 22 years old key informant women also validate this finding as follows:

"As the husband is the head of the household, he has the right to make any decisions in the household including contraceptive use. ... He can have as many as possible numbers of children from me as far as he has the potential to raise them. Therefore, I do not refuse his idea as he provides our living expense."

On the contrary, for older women their life time experience might have given them the chance to develop asset, generate income and better exposure in the society. This, in turn, can give them a better freedom of movement, exposure to information, representation in the society, so that they could develop the decision-making power in the household. Furthermore, this result in line with the study conducted by Lapeyrouse (2002) that younger women have low bargaining power regarding contraceptive use.

Educational status

Literate women take the lion share of contraceptive use decision-making over their husbands than illiterate women (RRR=12). Moreover, they do not let their husbands make the decision alone rather they make active participation (RRR=0.06). Thus, it is possible to conclude that literate women made the contraceptive decision alone or together with their husbands. The higher the level of education for women, the more knowledge she acquires for the use of family planning methods (CSA and ORC Macro 2006), increase the desire to limit or space births and increase the use of and the intention to use contraceptives (Hogan, Betemariam and Assefa 1999). Furthermore, women's education provides them with more opportunity to participate in the process of modernization and enable them to bring about changes in the economic and social situation. These all benefits which could be obtained from education, in turn, help women to take large share of contraceptive use decision-making power in their household. A 10th grade completed key informant women further briefly substantiated the situation as follows:

"In our household, I together with my husband made the contraceptive use decision since it is our joint business. However, if my husband is reluctant to make the decision jointly, I make it by my own. Because I am in the first place to face problems related to child birth and care."

Moreover, this finding is in agreement with different research findings which concluded that education for women positively affects conjugal communication and facilitates egalitarian decision-making (Chapagain 2006; Hossain 1998; Laban and Gwako 1997). Hadi (2001) also pointed out that women's education positively affects their right to use contraception. Besides, Hogan et.al (1999) on their study in SNNPR concluded that literate women are more likely than illiterate women to discuss family planning with their husbands and also they might make the contraceptive use decision together.

Number of living children

The odds of having women-dominated contraceptive use decision-making practice in relation to men-dominated decision-making are 8.6 times higher for women having one or two children than women having three or more children. Moreover, it is 11 times higher for women with no children relative to three or more children. Furthermore, women having one or two children do not let the decision-making floor for their husbands only rather they make active participation (RRR=0.24). From this finding it is possible to conclude that having fewer children for women is attributed to have women-centered or joint contraceptive use decision-making. The possible explanation for this result is that having fewer children enables women to exercise more freedom within marriage. Women who delay or avoid births can bring about significant economic advantages over women with large number of children when terminating consensual union. Therefore, having fewer children can improve a woman's ability to end an unsatisfactory relationship (Dixon-Mueller 1993). In other words, having smaller family size improves women's self-confidence and allows her to exercise equal rights with in marriage. This finding is in line with a study result of Prasadja et.al (1997) which concluded that women with two or fewer children have greater control of their reproductive lives than women with three or more children.

Work Status

Compared to not-working women, working women (women generating their own income) are 4.2 times higher in making the contraceptive use decision by their own than relying on their husbands decision. Having own income for women increases their economic independence and challenges the traditional belief of men dominance in decision-making and hence improves their bargaining power within the household. Besides, women's ability to bargain in the household is usually augmented by the increase in her income (Sikod 2007). A 2nd grade completed key informant woman with an average monthly income of 250 Birr more clarified the situation as follows:

"In my household, I take the first place in making contraceptive use decisions. Because my husband wants more number of children...but bearing too many children will hinder me from participating in the income generating activities and also negatively affects my health."

This finding corroborates other study findings. Cash work and control over earnings for women improves women's autonomy and stimulates spousal communication about family planning and hence creates decision-making power about contraceptive use (Chapagain 2006; Hossain 1998; Laban and Gwako 1997; Gage 1995).

Exposure to media

Compared to women with occasional or no media access, women with regular access to media are more likely (RRR=3) to make the contraceptive use decision by their own than jointly with their husbands. Moreover, they are sole decision-makers of contraceptive use compared with their husbands (RRR=7.2). This means, more access to media for women made them to be sole decision-maker of contraceptive use in their household. Exposure to media, especially programs related to family planning, widens the scope of understanding issues related to contraceptive use and helps in realizations of its importance in achieving desired family size (CSA and ORC Macro 2006). Thus, better access to media for women might equip them with knowledge of contraceptive methods, its advantages in limiting family size, advantages of limited family size and the reproductive health rights. This might give them the motivation to make active participation in the contraceptive use decision-making process in their household.

Table 4.2: Multinomial logistic regression analysis result of contraceptive use decision-making of weavers in Addis Ababa, 2009.

Characteristics	Women sample					
	Wife Vs Both		Husband Vs Both		Wife Vs Husband	
	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR
Age						
15-24	0.74	0.24	0.82	11.00**	0.94	0.02**
25-29	0.60	0.22*	0.62	1.00	0.71	0.21*
30+ (ref)						
Educational status						
Illiterate (ref)						
Literate	0.56	0.76	0.59	0.06**	0.66	12.00**
Religion						
Orthodox (Ref)						
Protestant	0.56	4.6	0.54	2.22	0.55	2.00
Number of children						
0	0.96	5.50	1.00	0.49	1.00	11.00*
1-2	0.56	2.10	0.66	0.24*	0.74	8.60**
3+ (ref)						
Work status						
Working	0.55	1.90	0.47	0.45	0.60	4.20*
Not working (ref)						
Media exposure						
Regular	0.57	3.00*	0.62	0.41	0.63	7.20**
Occasional/Never (ref)						
Physical harassment/ verbal abuse						
Committed (ref)						
Not committed	0.48	1.00	0.45	0.73	0.51	1.37
Years lived in Addis						
Below 11 (ref)						
11-20	0.60	1.50	0.51	1.90	0.64	0.78
Above 20	0.70	1.90	0.79	0.55	0.84	3.40
LR chi2(22)	109.91					
Prob > chi2	0.0000					
Pseudo R2	0.2734					

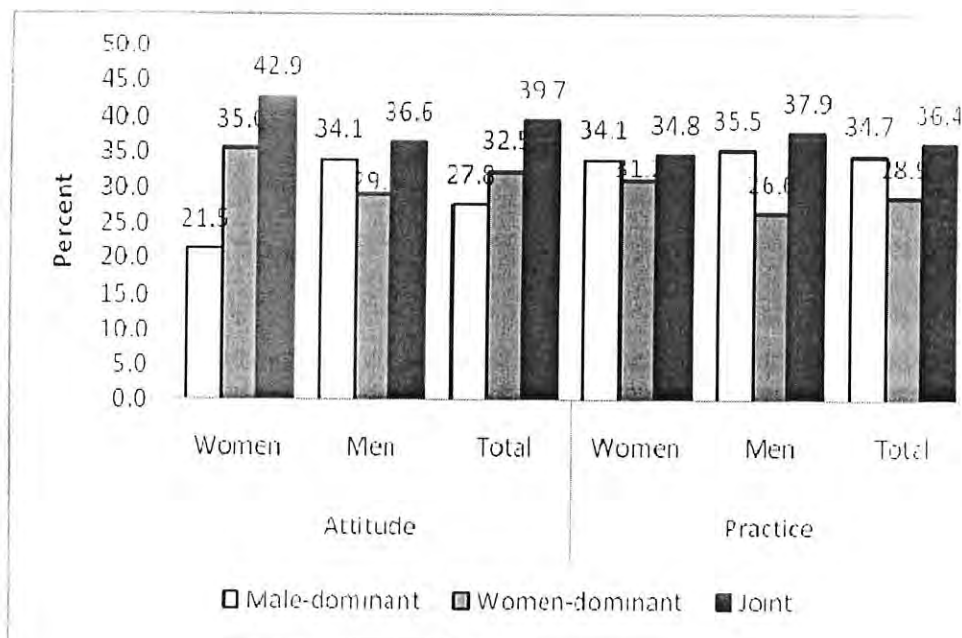
**Significant at 1%; *Significant at 5%; ref- indicates reference category; unmarked- indicates insignificant variables; RRR- relative risk ratio; Se(β)-standard error of the coefficient; the significant LR statistics (Prob>chi2=0.000) shows that all the regressors have significant impact on decision-making pattern.

Chapter Five

Maternal Health Service Utilization Decision-Making

All 634 respondents responded to the question: who should make the maternal health service utilization decision (the attitude question); and those having children (279 women and 282 men) responded to the question: who actually make the maternal health service utilization decisions in their household (practice question). Accordingly, majority of respondents (39.7%) perceived that both wife and husband should make decisions regarding maternal health service utilization (both antenatal and delivery care) followed by women-centered (32.5%) and men-centered (27.8%). In the actual decision-making, majority of respondents (36.4%) were living in a household in which joint decision-making is practiced. Following are men-dominated decision-making (34.7%) and women-dominated decision-making (28.9%). In both men and women sample respondents, joint decision-making attitude and practice regarding maternal health service utilization is supported (see Figure 5.1).

Figure 5.1: Attitude and practice of maternal health service utilization decision-making among sample of weavers in Addis Ababa, 2009.



5.1 *Maternal Health Service Utilization Decision-Making by Selected Characteristics of the Respondents*

The respondents having children were asked for the maternal health service utilization decision-making questions. Accordingly, 279 women and 282 men respondents were included. This section presents the bivariate analysis of maternal health service utilization decision-making by demographic, socioeconomic and cultural characteristics.

5.3.1 Demographic Characteristics

Both men's and women's age were significantly associated with maternal health service utilization decision-making. Among women in the age category of 15-24 years, majority (43%) reported that their husbands dominate the maternal health service utilization decision-making in their household. Similarly, overwhelming majority of men in the same age category 15-24 years (83.3%) attested that they dominate the maternal health service utilization decision-making. However, sizable portion of men and women in the age category of 24 years and above reported that they made the decision together with their partners (see Table 5.1). As age of the couples increase, they might have more children in their family, there might be better spousal communication and they may understand each other in a better way. Hence, they make all decisions together for the benefit of their family.

Besides, significant association was observed between years lived in Addis Ababa and maternal health service utilization decision-making of both men and women. Accordingly, of women who have been living in Addis for shorter duration (<11 years), nearly half (45.8%) of them indicated that their husbands made the maternal health service utilization decisions in their household. While, of those women who have been living in Addis for medium duration (11-20 years), 52.2% reported their equal decision-making authority; and 52.2% of women who have been living in Addis for longer (above 20 years) reported their sole maternal health service utilization decision-making power. On the other hand, 58.1% of men who have been living in Addis for shorter duration indicated their decision-making authority. Besides, of men respondents who have been living in Addis for medium and longer duration, majority (38.7% and 41.7%, respectively) indicated their inclination to joint decision-making pattern. In general, medium or longer stay in Addis Ababa is associated with egalitarian decision-making practice of maternal

health service utilization (see Table 5.1). This might be due to the socioeconomic and cultural differences between Addis Ababa and their birth place, which shapes them accordingly.

Table 5.1: Percentage distribution of sample of weaver by selected demographic characteristics and maternal health service utilization decision-making in Addis Ababa, 2009.

Characteristics	Who usually make maternal health service utilization decision									
	Women sample (n=279)					Men Sample (n=282)				
	Husband	Wife	Joint	Total	χ^2	Husband	Wife	Joint	Total	χ^2
Age										
15-24	43.0	32.9	24.1	79	p<0.05	83.3	5.6	11.1	36	p<0.01
25-29	38.9	24.4	36.7	90		30.8	26.9	42.3	78	
30+	23.6	35.5	40.9	110		27.4	31.0	41.7	168	
Number of children										
1-2	39.3	30.7	30.0	150	p>0.05	35.9	28.2	35.9	142	p>0.05
3+	27.9	31.8	40.3	129		35.0	25.0	40.0	140	
Years lived in Addis										
Below 11	45.8	25.2	29.0	131	p<0.01	58.1	16.3	25.6	43	p<0.05
11-20	24.4	23.3	52.2	90		31.9	29.4	38.7	119	
Above 20	22.4	56.9	20.7	58		30.8	27.5	41.7	120	

5.3.2 Socioeconomic and Cultural Characteristics

Educational level is significantly associated with maternal health service utilization decision-making of both men and women. Accordingly, 44.6% of illiterate women revealed that their husbands made the decision and 87.6% of illiterate men portrayed the fact that they made the decisions in their household. Sizable portion of literate women, 51.9% with primary and 83.3% with secondary and above educational level, discerned that they made the maternal health service utilization decision by their own. This is corroborated by 90.3% of secondary and above level educated husbands who empower their wives to make the maternal health service utilization decisions. Besides, 59.3% of husbands among those with primary level education appreciated joint decision-making with their wives (see Table 5.2). Hence, illiterate men and women rely on men-centered decision-making whereas literates rely on women-centered or joint maternal health service utilization decision-making. Educated individuals recognize the importance of health

care and know how to take care of themselves and their family. Therefore, they make the decisions on the benefit of their family.

The religious affiliation of men demonstrated significant association with maternal health service utilization decision-making. Accordingly, of protestant religion followers, majority (43.7%) let their wives decide on the maternal health service utilization, 35.2% made it jointly. On the other hand, among orthodox religion followers, slightly large portion (40.3%) takes the lion share of the decision-making followed by 38.9% joint decision-making pattern in their household (see Table 5.2).

There is significant association between women's work status and the maternal health service utilization decision-making pattern and also men's income and maternal health service utilization decision-making. Thus, most of women engaged in income generating activities (45.6%) made the decision together with their spouse followed by 29.4% by their own and 20% through their husbands. On the other hand, 46.2% of women with no income have unveiled that their husbands made the decision. While, most men who earn an average income of more than 500 Birr per month let their wives make the maternal health service utilization decisions (45.7%) or they made it jointly (43.5%). However, most of men respondents (42.5%) who earn an average income of 301-500 Birr reported that they made the maternal health service utilization decision alone, followed by 34.3% jointly and 23.1% let it for their wives. In the contrary, of those who earn less than 300 Birr 40.2% indicated joint decision-making, 37.3% take the upper hand of decision-making and 22.5% gave the decision-making power for their wives (see Table 5.2). In general, the majority of women with no income do not participate in the decision-making process whereas men who earn relatively higher income made the maternal health service utilization decision together with their wives or let it for their wives in the study sample. Unlike contraceptive methods, the cost of pregnancy-related problems is high. Hence, women who do not generate their own income find themselves unable to afford the payment. Consequently, they rely on the decision of their husbands for the service. On the other hand, the majority of men who earn relatively better income are literate (see Table B.2 in Annex). Hence, literate men open the maternal health service utilization decision-making floor for their wives. This could be the possible reasons why not-working women relies on their husbands for the maternal health

service utilization decision-making; and men earning relatively better income empower their wives to participate in maternal health service utilization decision-making.

Besides, media exposure was significantly associated with maternal health service utilization decision-making of both men and women. Accordingly, of women who have had regular and occasional access to media, 50.9% and 50% respectively, reported that they made the decision by their own. However, most women (45.1%), with no media access, portrayed that their husbands made the decision. Of men with regular access to media, significant number of them (53.5%) unveiled that maternal health service utilization decision-making was left for wives. On the contrary, 71.4% of men with no access to media, reported that they made the decision alone. Whereas, of men with occasional media exposure, 41.6% indicated that the decision about maternal health service utilization is their common business (see Table 5.2). This shows that better access to media creates women-centered or egalitarian decision-making practice about maternal health service utilization. Media exposure might facilitate spousal communication and leads to have appropriate decision-making concerning maternal health service utilization in the household.

Furthermore, physical harassment or verbal abuse was significantly associated with maternal health service utilization decision-making of women. Accordingly, of women who were victim of physical harassment or verbal abuse, slightly larger share (37%) reported that their husbands made the decisions. Yet, most women (47.1%) who were not subjected to physical harassment or verbal abuse by, their husbands, were living in the household where they participate in the decision-making process (see Table 5.2). Probably, those women who are victim of harassment or abuse might fear that raising the issue of maternal health service utilization will have violent consequences. This fear may cut off the spousal communication and discussions about health related issues in their family. Therefore, those women's decision-making on maternal health service utilization is shaped by fear of violence from their husbands. As a result, they rely on the decisions made by their husbands.

Table 5.2: Percentage distribution of sample of weaver by selected socioeconomic and cultural characteristics and maternal health service utilization decision-making in Addis Ababa, 2009.

Characteristics	Who usually make maternal health service utilization decision									
	Women sample (n=279)					Men Sample (n=282)				
	Husband	Wife	Joint	Total	χ^2	Husband	Wife	Joint	Total	χ^2
Educational level										
Illiterate	44.6	18.8	36.6	186	p<0.01	87.6	3.4	9	89	p<0.01
Primary	14.8	51.9	33.3	81		13.6	27.2	59.3	162	
Secondary and above	0.0	83.3	16.7	12		0.0	90.3	9.7	31	
Religion										
Orthodox	31.4	33.5	35.1	191	p>0.05	40.3	20.9	38.9	211	p<0.01
Protestant	39.8	26.1	34.1	88		21.1	43.7	35.2	71	
Work status										
Working	25.0	29.4	45.6	160	p<0.01					
Not working	46.2	33.6	20.2	119						
Income										
<= 300 birr						37.3	22.5	40.2	102	p<0.01
301-500 birr						42.5	23.1	34.3	134	
>=501						10.9	45.7	43.5	46	
Media exposure										
Regular	17.5	50.9	31.6	57	p<0.01	16.9	53.5	29.6	71	p<0.01
Occasional	19.0	50.0	31.0	58		39.6	18.8	41.6	197	
Never	45.1	17.7	37.2	164		71.4	0.0	28.6	14	
Physical harassment / verbal abuse										
Committed	37.0	33.9	29.2	192	p<0.05	44.9	30.6	24.5	49	p>0.05
Not committed	27.6	25.3	47.1	87		33.5	25.8	40.8	233	

5.2 Determinants of Maternal Health Service Utilization Decision-Making

Under this section major determinants of maternal health service utilization decision-making are discussed. Accordingly, age, educational status and physical harassment or verbal abuse of both men and women; number of children of men, work status of women, media exposure of men were found to be statistically significant determinants. The multinomial logistic regression results in Table 5.3 below shows the relative risk ratio (RRR) and its standard error for the determinants.

Age

Compared to women with age 30 years and above, women in the age group of 15-24 years are living in where the husband dominate the maternal health service utilization decision-making relative to joint decision-making (RRR=2.7). Moreover, they do not make the maternal health service utilization decision by their own rather their husband take the lion share in the household (RRR= 0.39). This means, women in the age group of 15-24 years are living in where men dominate the maternal health service utilization decision-making. This might be attributed to the low level of bargaining power of young women coupled with their lower socioeconomic status and information exposure degraded their participation in the maternal health service utilization decision-making. As women getting older, they might have more control over household resources, generate their own income, secure freedom of movement and might have better position in the society. These all give them the power to decide on their health matters. A discussion with 22 years old key informant women more substantiates the situation as follows:

"I need to pay some more amount of money for the maternal health service. But I don't have my own income to afford the payment.... Therefore I am supposed to get the money and permission to use the service from my husband."

Compared to men in the age category of 30+, men in the age of 15-24 years are more likely (RRR=8.9) to make the maternal health service utilization decision by their own rather than jointly with their wives. Moreover, they are less likely (RRR=0.006) to let their wives make the decisions. Thus, men in the age group of 15-24 years are sole decision-maker about maternal

health service utilization in their household. Among the possible reasons the low educational attainment (see Table B.3 in Annex) and income (see Table B.4 in Annex) of younger men might diverted their maternal health service utilization decision-making practice to be made by them. Moreover, the cost associated with pregnancy-related health care services is high. So, wives cannot afford the payment. As a result, men are supposed to cover the payment. Therefore, they take the lion share of maternal health service utilization decision-making process.

Educational status

Compared to illiterates, literate women are more likely (RRR=3) to make the maternal health service utilization decision by their own than jointly with their husbands. Moreover, they dominate the decision-making relative to their husbands (RRR=5.4). Besides, the odds of men-centered decision-making compared with joint decision-making are 0.21 times lower for literate women than illiterates. Hence, literate women made the maternal health service utilization decisions by their own or together with their husbands. This might be attributed to women's education, which provides them with more opportunity to participate in the process of modernization and enable them to bring about changes in the economic and social situation. This, in turn, improves their knowledge and practice of reproductive health rights and improves their decision-making power. Moreover, educated women may have higher status within their families and their higher status make them more effective at negotiating for their health care.

This result is in agreement with different research findings which concluded that education for women positively affects conjugal communication and facilitates egalitarian decision-making (Chapagain 2006; Hossain 1998; Laban and Gwako 1997). Furthermore, education affects women's situation through decision-making autonomy, control over resource, knowledge and exposure to modern world and husband wife closeness (Jejeebhoy 1992). Moreover, education improves women's ability to resist subjugation and to obtain greater power in decision-making (Hogan et.al 1999). The quantitative finding is further substantiated by a 10th grade completed key informant women as follows:

"Regarding maternal health service utilization.....the husbands might not feel the pain of maternal health problems. We are in the first place to feel the pain. Therefore, we need to tell them to have the health service so as to take care of our health. In my household,

most of the time, we made the decision together. Sometimes, I made the decision to take the maternal health service when I feel uncomfortable."

Literate husbands made their wives make maternal health service utilization decisions or made it jointly. Accordingly, literate husbands are less likely ($RRR=0.008$) to make the decisions alone relative to jointly with their wives than illiterates. Moreover, they are more likely ($RRR=7.6$) to let the decision-making autonomy for their wives than illiterate husbands. This situation is more clarified by a 10th grade completed key informant men as follows:

"As to maternal health service utilization decisions, I give the room to my wife. Because she knows her health problem, she knows the pain, she is in the first place to face the problem and its consequences. In case she needs my help I provide her with the necessary support."

Education improves conceptual reasoning and may lead to crucial transformations in aspirations and, eventually, to questioning traditional beliefs and authority structures (Martina and Juarez 1995). Furthermore, it provides people to obtain knowledge and change traditional value system and adopt modern way of living. Hence, literate husbands might practice modernity and make the reproductive decision-making floor open for their wives rather than sticking to traditional men dominance decision-making process.

Number of living children

Compared to men with three or more children, men who have one or two children are more likely ($RRR=4.6$) to have women-dominated maternal health service utilization decision-making than men-centered. Also they made the decision together with their wives than by their own ($RRR=0.12$). Hence, men who have had fewer children let the maternal health service utilization decision-making to be made by their wives or jointly with their wives. From several possible reasons, the women's freedom with in marriage is the most important one. Because, women with fewer children can have better economic advantages and which improves women's ability to end unsatisfactory relationship (marriage) (Dixon-Mueller 1993). Hence, to protect the dissolution of marriage and its related consequences, husbands with fewer children let their wives decide on maternal health service utilization or make it jointly. Secondly, having fewer children for men is

associated with being younger in age. Thus, younger generation's life style is more of modern than traditional. Consequently, they might give their wives the chance to participate in the maternal health service utilization decision-making process.

Work status

Compared with not-working women, women who have their own income (working women) are less likely ($RRR=0.23$) to live in where husbands dominated the maternal health service utilization decision-making relative to joint decision-making. Furthermore, women having their own income are more likely ($RRR=2.88$) to make decisions in their household than relying on their husbands decision. Therefore, women who generate their own income made the maternal health service utilization decision by their own or in joint with their husbands. Hence, women's work helps them to generate their own income and this, in turn, improves their socioeconomic status in the household and community. Consequently, their bargaining power within the household and community is improved and this intensifies their capacity to make their health service utilization decisions. Key informant women with an average monthly income of 250 Birr further consolidated the finding as follows:

"For the previous two years I didn't have my own income....at that time I needed the consent and money from my husband for my health care payment. But now I have my own income (from sells of firewood) and I get treatment as soon as I feel uncomfortable. Whenever I can't afford the fee, I ask my husband or take a loan from my friends."

This result is in line with the study finding by Hadi (2001) which concluded that women's participation in economic activities and their ability to contribute financially to the family can increase their role in household decision-making process. Furthermore, woman's employment outside home exposes her to the outside world, provides a sense of financial independence and increases her bargaining power and autonomy within the household and society (Chen 1995; Pruthi et al 1999; and Dixon-Mueller 1993 as cited in Yesudian 2004). In contrast, poor economic status of women curtailed them from making independent decisions (Chapagain 2006).

Exposure to media

Compared to men with occasional or no access to media, men with regular access to media are more likely (RRR=4.8) to have women-centered maternal health service utilization decision-making than joint decision-making. Having women-centered decision-making practice relative to men-centered are 5 times higher for husbands with regular exposure to media than those who have no or occasional exposure to media. Hence, men having regular access to media open the floor of maternal health service utilization decision-making process for their wives. The possible explanation is that having access to media will give full information about the reproductive health issues including reproductive rights, and this leads to have egalitarian or women-centered decision-making practice.

Physical harassment or verbal abuse

Compared to women who are victim of physical harassment or verbal abuse, women who are not a victim of physical harassment or verbal abuse are less likely (RRR=0.39) to make the maternal health service utilization decision by their own than jointly with their husbands. Likewise, husbands who did not harass or abuse their wives are less likely (RRR=0.37) to provide the maternal health service utilization decision-making power for their wives rather they participate in the decision-making process. It can be concluded that women who have not harassed or abused by their husbands; and men who have not harassed or abused their wives are more likely to make joint maternal health service utilization decisions in their household. From the bivariate finding, majority of women who were not experienced harassment or abuse were older (see Table B.1 in Annex). As have seen in the relation between women's age and maternal health service utilization (see Table 5.1), majority of older women made the decision jointly or by their own. With increasing age, violence lessens and decision-making power of women develops. Moreover, this finding corroborates the study result of Chapagain (2006) which concluded that women experienced violence from their husbands are less likely to participate in antenatal care utilization decision making. Furthermore, husbands who did not harass or abuse their wives might believe in spousal communication and share the decision-making power equally with their wives.

Table 5.3 Multinomial logistic regression analysis result of maternal health service utilization decision-making of weavers in Addis Ababa, 2009.

Characteristic	Women sample						Men Sample					
	Wife Vs Both		Husband Vs Both		Wife Vs Husband		Wife Vs Both		Husband Vs Both		Wife Vs Husband	
	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR
Age												
15-24	0.54	1.06	1.40	2.70*	0.20	0.39*	0.54	0.56	1.95	8.90**	0.007	0.006**
25-29	0.20	0.48	0.63	1.50	0.14	0.31	0.43	0.88	1.20	1.50	0.51	0.58
30+ (ref)												
Educational status												
Illiterate (ref)												
Literate	1.20	3.00**	0.10	0.21**	1.76	5.40**	1.20	1.60	0.005	0.008**	1.63	7.60**
Religion												
Orthodox (Ref)												
Protestant	0.30	0.82	0.37	1.07	0.30	0.76	1.00	2.73	0.63	1.10	1.47	2.44
Number of children												
1-2	0.34	0.84	0.44	1.10	0.35	0.80	0.63	1.47	0.10	0.12*	1.79	4.60**
3+ (ref)												
Work status												
Working	0.24	0.66	0.08	0.23**	1.06	2.88**						
Not working (ref)												

(Table 5.3, Continued)

Characteristic	Women sample						Men Sample					
	Wife Vs Both		Husband Vs Both		Wife Vs Husband		Wife Vs Both		Husband Vs Both		Wife Vs Husband	
	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR
Income												
<= 300 birr (ref)												
301-500 birr							0.48	1.25	0.68	1.42	0.48	0.88
>=501							0.91	1.89	0.27	0.30	6.00	6.30
Media exposure												
Regular	0.53	1.20	0.47	0.88	0.71	1.35	1.82	4.8**	0.31	0.47	1.72	5.00**
Occasional/Never (ref)												
Physical harassment/ verbal abuse												
Committed (ref)												
Not committed	0.14	0.39*	0.25	0.69	0.23	0.57	0.17	0.37*	0.25	0.42	0.56	0.89
Years lived in Addis												
Below 11 (ref)												
11-20	0.20	0.49	0.21	0.54	0.41	0.91	0.70	1.10	0.55	0.80	1.10	1.40
Above 20	0.80	1.50	0.71	1.28	0.62	1.20	0.52	0.74	1.30	1.55	0.44	0.48
LR chi2(22)	110.16						255.61					
Prob > chi2	0.000						0.000					
Pseudo R2	0.1799						0.4167					

** Significant at 1%; *Significant at 5%; ref- indicates reference category; unmarked- indicates insignificant variables; RRR- relative risk ration; Se(β)- standard error of the coefficient; the significant LR statistics (Prob>chi2=0.000) shows that all the regressors have significant impact on decision-making pattern.

Chapter Six

Conclusions and Recommendations

6.1 *Conclusions*

The study investigated the gender power relations in reproductive decision-making of migrant weavers, who are living in Addis Ababa, from Gamo Gofa zone of SNNPR. The objectives were assessing the reproductive decision-making pattern and identifying the determinant factors associated with reproductive decision-making in the study population. To meet the objectives, respondents were asked a series of questions related to reproductive decision-making. Finally, the decision-making patterns were analyzed by using both descriptive and inferential statistical methods. Moreover, qualitative information was gathered to substantiate the quantitative findings. The following are the major findings obtained from the study.

The study demonstrated the subordinate position of women in the weaver's community. The inequality between men and women in the study sample were observed in different aspects. Accordingly, wives were less educated, does not have their own income, have a lower exposure to information, are prone to physical harassment or verbal abuse and also younger in age compared to their husbands.

Furthermore, the maternal health service utilization of the study sample was very low (69% antenatal care coverage and 20% delivery care coverage) compared to the situation in Addis Ababa. Nonetheless, the knowledge of contraceptive use was found to be 100% for women and 98.1% for men while the practice was 60% for women and 15.1% for men in the study sample, which is better than the national average. .

Data gathered from the study respondents shows that majority of women respondents (36%) have the attitude of men-centered contraceptive decision-making. Furthermore, roughly half of the women (45.3%) use contraceptive according to their husband's decision. Of the men sample, 45.1% have joint decision-making attitude for contraceptive use. Moreover, among men who ever practiced contraceptives, overwhelming majority (97.1%) practiced in consensus with their

wives. Besides, the majority of men and women support joint maternal health service utilization decision-making and practice it in their households.

Age, education, number of children, work status and exposure to media are found to be significant determinants of contraceptive use decision-making of women. On the other hand, educational status, age and physical harassment or verbal abuse of both men and women; work status of women, number of children of men and media exposure of men are the demographic, socioeconomic and cultural determinants which affects the maternal health service utilization decision-making of the study population.

Accordingly, women in the age category of 15-29 years reported that their husbands take the upper hand of contraceptive use decision-making and those in the age group of 15-24 years reported the same for maternal health service utilization decision-making in their household. Moreover, 15-24 years old men confirmed their sole decision-making power of maternal health service utilization in their household.

Education is an essential tool for achieving the goals of equality (UN 1995). Moreover, schooling is the prerequisite for both male and female to enter into modern world living style (Pillai and Wang 1999) and it boosts personal and social-well being of an individual. Accordingly, literate women take the lion share or make active participation in reproductive decision-making process in their household. Besides, literate husbands let the maternal health service utilization decision-making power for their wives or made it jointly.

Smaller family size for women creates more time for community activities and work outside the home (FHI 1998), which helps them to have more autonomy in the household. Accordingly, women with smaller number of living children made the contraceptive use decision by their own or together with their husbands. Likewise, men having smaller number of children provide the maternal health service utilization decision-making power for their wives or made it jointly in their household.

Women's contribution in economic activities modifies the traditional gender relations within the household, creates opportunities for women to exercise some degree of autonomy and improve their participation in reproductive decision-making (Hadi 2001). Accordingly, working women

are more likely to have women-centered or joint maternal health service utilization decision-making. Furthermore, they are sole decision-maker of contraceptive use in their household.

Media is a medium through which an individual could obtain knowledge, awareness and information outside school curriculum (Yesudian 2004). Furthermore, information, education and communication are increasingly becoming important components of behavioral transformation of human population (Kwankye and Augustt 2006). Accordingly, regular access to media for men increases the odds to have women-centered maternal health service utilization decision-making. Similarly, women with regular access to media made the contraceptive use decision by their own.

Violence against women is the result of norms of men entitlement and ownership of women, male control of wealth in the family and male control of decision-making autonomy in the family (Blanc 2001; Heise 1998 and Levinson 1989 as cited in Murphy and Ringheim 2001). It is also the cause and consequence of women's low status (Haregewoin and Emebet 2002; Haji 2004). Besides, it endangers the psychological well being of the mother (Haji 2004), which directly affects the reproductive health behavior and decision-making capacity of the abused women (UNFPA 1998). Accordingly, women who have not physically harassed or verbally abused by their husbands are more likely to have joint maternal health service utilization decision-making in their household. On the other hand, men who did not harass or abuse their wives are more likely to have joint maternal health service utilization decision-making.

All the above findings clearly show that the intra-household gender power difference is one of the determinants for the reproductive decision-making process in the household.

6.2 Recommendations

The following measures are recommended based on the findings of the study:

- Women are underrepresented than their men counterparts in education, income, access to media and other. This shows the gender inequality in the study community, which negatively affects the reproductive decision-making power of women. It underscores the women's empowerment as one of the entry point for enabling them to make the reproductive decisions by their own or jointly with their husbands. Improving women's status and empowering them enhances their autonomy and participation in family decision-making including reproductive decisions (Eguavoen et.al 2007). Thus, the formulated policies like National Policy of Ethiopian Women, National Population Policy, The Ethiopian Education and Training Policy, Health Policy and other policies which advocate the women's empowerment should be implemented in well organized way.
- Efforts should be made to foster the elimination of gender imbalance and promote gender equality in the study communities, especially among those categories who have reported men-centered reproductive decision-making. Generally, more should be done on advocacy for reproductive rights, enhancing men's participation in reproductive health and preventing intra-household gender inequality. This will be achieved through Information Education communication (IEC) or Behavioral Change Communication (BCC).
- Education affects the reproductive decision-making pattern positively. Thus, empowering the study population in education, especially in the form of adult education will create more of egalitarian decision-making pattern.
- Fewer children in the household is associated with women-centered or joint reproductive decision-making. Having smaller family size is very important not only for shaping reproductive decision-making pattern of the household but also for socio-economic and health benefits of the family. Thus, this finding underlines the need of promoting smaller family size norms as a stepping stone for motivating egalitarian or women-centered reproductive decision-making process in the study population.

- Women's work is directly related to their reproductive decision-making power. This finding underscores the need of women's economic empowerment. To achieve this goal governmental and nongovernmental organizations should work hand-in-hand so as to create the income generating mechanism for women's in the study population. This goal would be achieved through the provision of credit services, skills training and the likes.
- Media exposure stimulates egalitarian or women dominance reproductive decision-making pattern in the household. Facilitating the mechanism through which the study population will reap information on reproductive health issues is vital. This might be achieved through provision of IEC/BCC for the study population through medias. Furthermore, efforts should be made to strengthen spousal communication and negotiation skills among couples through the provision of media access.
- Further studies should be conducted by including extra-household environmental parameters such as individual access to resource outside the household, marriage market, marriage institutions etc which might affect the reproductive decision-making pattern of couples.

References

- Adair, Linda, Socorro Gultiano and Josephine Avila. 1998. The Philippines: Childbearing, Women's Work and Household Decision-making in Cebu. Summary of Final Report Prepared for the Women's Studies Project: *Family Health International*.
- Agarwal, Bina. 1997. "'Bargaining' and gender relations: within and beyond the household." *FCND discussion paper NO. 27*. Food consumption and nutrition division, International food policy research institute, Washington DC, USA.
- Arkutu, A. Ananie. 1995. Healthy Women, Healthy Mothers: An information guide. 2nd edition, Family Care International: USA.
- Beegle, Kathleen, Elizabeth Frankenberg and Duncan Thomas. 2001. Bargaining Power within Couples and Use of Prenatal and Delivery Care in Indonesia. *California Center for Population Research*.
- Biratu, Belay T. and David P. Lindstrom. 2006. "The Influence of Husband's Approval on Women's Use of Prenatal Care: Result from Yirgalem and Jimma Towns, South West Ethiopia." *Ethiopian Journal of Health Development* 20(2).
- Blanc, Ann K., 2001. "The Effect of Power in Sexual Relationships on Sexual and Reproductive Health: An Examination of Evidence." *Studies in Family Planning* 32(3):189-213.
- Blanc, Ann Klimas and Brent Wolff, 2001. "Gender and Decision-Making over Condom Use in Two Districts in Uganda." *African Journal of Reproductive Health* 5(3):15-28.
- Boserup, E. 1985. "Economic and Demographic Inter-relationships in Sub-Saharan Africa." *Population and Development Review* 11(3):383-397.
- Bloom, Shelah S. David Wypij and Monica das Gupta. 2001. "Dimensions of Women's Autonomy and the Influence on Maternal Health Care Utilization in a North Indian City." *Demography* 38(1): 67-78.
- Carter, Marion W. 2004. "Gender and Community Context: An Analysis of Husbands' Household Authority in Rural Guatemala." *Sociological Forum* 19(4):633-652.
- Central Statistical Agency (CSA). 2008. Summary and Statistical Report of the 2007 Population and Housing Census: Population Size by Age and Sex. Addis Ababa: Central Statistical Agency.
- _____. 2008. Statistical Abstract. Addis Ababa: Central Statistical Agency.

- _____. 2006. Report on the 2005 National Labour Force Survey. Addis Ababa: Central Statistical Agency.
- Central Statistical Agency (CSA) and ORC Macro. 2006. Ethiopian Demographic and Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Agency and ORC Macro.
- Chapagain, Matrika. 2006. "Conjugal Power Relations and Couples' Participation in Reproductive Health Decision-Making: Exploring the Link in Nepal." *Gender, Technology and Development* 10(2):160-189.
- Cherinet, Haregewoin and Emebet Mulugeta. 2002. Country Gender Profile Ethiopia. Addis Ababa. Swedish International Development Cooperation Agency (Sida).
- Cochran, William G. 1977. Sampling Techniques. 3rd edition, John Wiley and Sons Inc.
- Dixon-Mueller, Ruth. 1993. Population Policy and Women's Right. Westport, Connecticut: Praeger.
- Eguavoen, Agatha N.T., Sims O. Odiagbe and Godfrey I. Obetoh. 2007. "The Status of Women, Sex Preference, Decision-Making and Fertility Control in Ekpoma Community of Nigeria." *Journal of Social Science* 15(1):43-49.
- Family Care International. 2007. Women Deliver for Development: Executive summary. Global Conference, ExCeL Center, London.
- Family Health International (FHI). 1998. Indonesia: Family Planning and Women's Empowerment in the Family. Research Triangle Park, North Carolina, FHI, Women's Study Project.
- Gage A. J. 1995. "Women's Socio-economic Position and Contraceptive Behavior in Togo." *Studies in Family Planning* 26(5):264-277.
- Gill, Kirrin, Rohini Pande and Anju Malhotra. 2007. Women Delivery for Development. www.thelancet.com.
- Green, William H. 2003. Econometric analysis. 5th edition, New York University, Pearson Education, Inc. Upper Saddle River, New Jersey.
- Gujarati, D.N. 1995. Basic Econometrics. 4th edition, New York: McGraw-Hill.
- _____. 1992. Essentials of Econometrics. Singapore: McGraw-Hill.

- Gulele Sub-City Administration. 2008. Gulele Sub-City Strategic Plan 2000-2003 E.C. Unpublished Amharic Version, Addis Ababa.
- Hadi, Abdullahel. 2001. "Effects of the Productive Role of Bangladesh Women on their Reproductive Decisions." *Asian-Pacific Population Journal* 16(4).
- Hogan, Dennis P., Betemariam Berhanu and Assefa Hailemariam. 1999. "Household Organization, Women's Autonomy and Contraceptive Behavior in Southern Ethiopia." *Studies in Family Planning* 30(4):302-314.
- Hosmer, David W. and Stanley Lemeshow. 1989. Applied Logistic Regression. 2nd edition, John Wiley and Sons Inc., New York.
- Hossain, Syeda Zakia. 1998. "Decision Making, Use of Contraception and Fertility in Bangladesh: a path analysis." *International Journal of Sociology and Social Policy* 18(7/8):27-55.
- ILO. 2005. Decent Work Country Programme for Ethiopia: A Case for the Cotton and Textile Sector ILO Intervention and Support." www.ilo.org
- Prasadja, Heru, Nancy Sunarno, E. Kristi Poerwandari et.al. 1997. In the Shadow of Men: Reproductive Decision-Making and Women's Psychological Well-Being in Indonesia. Centre for Societal Development Studies at Atma Jaya Catholic University, the Women's Studies Graduate Program at the University of Indonesia, and Family Health International.
- Jejeebhoy, Shireen. 1992. "Women's Education, Fertility and the Proximate Determinants of Fertility." Presented at the International Conference on Population and Development [ICPD], 1994, Expert Group Meeting on Population and Women, Gaborone, Botswana, June 22-26, 1992.
- Kedir, Haji. 2004. "Magnitude and Immediate Outcomes of Physical Partner Violence against Women in Kofele District, Arsi Zone, Oromial Region." Unpublished M.Sc. thesis presented to school of graduate studies of Addis Ababa University.
- Kuponiyi, F. A. and O. A. Alade. 2007. "Gender Dynamics and Reproduction Decision Making Among Rural Families in Orire Local Government Area of Oyo State, Nigeria." *Journal of social science* 15(2): 101-104.
- Kwankye, Stephen O. and Eric Augustt. 2006. "Media Exposure and Reproductive Health Behavior Among Young Females in Ghana." *African Population Studies* 22(2).

- Laban, Edwins and Moogi Gwako. 1997. "Conjugal Power in Rural Kenya Families: It's Influence on Women's Decision about Family Size and Family Planning Practice." *Sex Roles: A Journal of Research*.
- Lapeyrouse, Lisa M. 2002. Gender, Power and Culture: Reproductive Decision-Making among Mexican American Youth. Health Behavior and Health Education, University of Michigan, Michigan.
- Long, J. Scott and Jeremy Freese. 2001. Regression Models for Categorical Dependent Variables Using Stata. Stata Press, Texas, USA.
- MacDonald. 1993. "The Empirical Challenges of Feminist Economics: The Example of Economic Restructuring." In *Out of The Margin: Feminist Perspective in Economic Theory*, Conference Report, Amsterdam.
- Makinwa-Adebusoye, Paulina. 2001. Sociocultural Factors Affecting Fertility in Sub-Saharan Africa. Workshop on Prospect for Fertility Decline in High Fertility Countries. Population Division, Department of Economic and Social affairs, United Nation Secretariat, New York, 9-11 July 2001.
- Martin, Teresa C. and Fatima Juarez. 1995. "The Impact of Women's Education on Fertility in Latin America: Searching for Explanations." *International Family Planning Perspective* 21(2):52-57.
- Mohammed, Misrak. 2007. "Women's Role in Family Planning Decision Making: The Case of Jimma Town." Unpublished M.Sc. thesis presented to school of graduate studies of Addis Ababa University.
- Molm, Linda D. and Mark Hedley. 1992. "Gender, Power and Social Exchange." In: *Gender, Interaction and Inequality*, Cecilia L. Ridgeway, Springer-Verlag New York Inc.
- Mulugeta, Emebet. 2007. "Trajectory of the Institute of Gender Studies at Addis Ababa University, Ethiopia." *Feminist Africa issue 9*. (www.feministafrica.org)
- Murphy, Elaine and Karin Ringheim 2001. Reproductive Health, Gender and Human Rights: A Dialogue. Women's Reproductive Health Initiatives (WRHI), Path, Washington. DC.
- Navaneetham, K and Dharmalingam. 2000. "Utilization of Maternal Health Care Service in South India." A paper presented in Faculty Seminar at the Center for Development Studies, Thiruvananthapuram, Kerala.

- Oladeji, David. 2008. "Gender Roles and Norms Factors Influencing Reproductive Behavior among Couples in Ibadna, Nigeria." *Anthropologist* 10(2):133-138.
- Olokodana, Mobolaji and Yeshe Habtemariam. 1998. "Gender Equity, Equality and Empowerment of Women." In: Hand Book on Population and Family Life Education for Secondary School Teachers in Ethiopia, Markos Ezra and Seyoum Gebre Selassie, Addis Ababa.
- Pallitto, Christina C. 2004. "Domestic Violence and Maternal, Infant, and Reproductive Health: a critical Review of Literature." Submitted to the Pan American Health Organization, Washington, DC.
- Pillai, Vijayan K. and Guang-Zhen Wang. 1999. "Women's Reproductive Rights, Modernization, and Family Planning Programs in Developing Countries: A causal model." *International Journal of Comparative Sociology* 40: 270.
- Population Communication Services (PCS). 2003. The Gender Guide for Health Communication Programs. (www.jhuccp.org/pubs/cp/102/102.pdf)
- Sharan, Mona and Thomas W. Valente. 2002. "Spousal Communication and Family Planning Adoption: Effect of a Radio Drama Serial in Nepal." *International Family Planning Perspective* 28(1):16-25.
- Sikod, Fondo. 2007. "Gender Division of Labour and Women's Decision-Making Power in Rural Households in Cameroon." *African Development* 32(3):58-71.
- Spizer, Ilene S, Lisa Whittle and Marion Carter. 2005. "Gender Relations and Reproductive Decision Making in Honduras." *International Family Planning Perspective* 31(3):131-139.
- Sundari, Ravindran TK. 2004. "Zeroing in on Gender Discrimination." *Health Action* 17(7):4-7.
- UNFPA. 2005. Cultural Programming: Reproductive Health Challenges and Strategies in East and South-East Asia. UNFPA Country Technical Services Team for East and South-East Asia, Bangkok, Thailand.
- _____. 1998. Reproductive Health Effects of Gender-Based Violence: Policy and Programme Implications. UNFPA, New York.

- UNICEF. 2007. The State of the World's Children 2008. UNICEF, United Nations Plaza, New York, USA.
- United Nations. 1995. The United Nations Fourth World Conference on Women. Beijing, China - September 1995.
- _____. 1994. Report of the International Conference on Population and Development. Cairo, 5-13 September 1994.
- Woldemicael, Gebremariam. 2007. Do Women with Higher Autonomy Seek More Maternal and Child Health-Care? Evidence from Ethiopia and Eritrea. Stockholm Research Reports in Demography 2007:3.
- World Health Organization. 1999. An Assessment of Reproductive Health Needs in Ethiopia. World Health Organization, Geneva.
- Wyatt, G. E., Vargas Carmona J, Burns Loeb T. et.al. 2000. "Factors Affecting HIV Contraceptive Decision-Making Among Women." *Journal of Sex role* 42(7-8).
- Xu, Li. 1999. "Gender relations and reproductive decision-making in the context of rural china in the post-reform period." *Working Paper Series No. 284*.
- Yesudian, Princy P. 2004. "Impact of Women's Empowerment, Autonomy and Attitude on Maternal Health Care Utilization in India." Global Forum for Health Research, Forum 8, Mexico City, November 2004.

Annexes

Annex A: Test of Model Assumptions

Annex A.1: Test of Multicollinearity

Table A.1.1: Contingency coefficient values for test of multicollinearity in the women sample.

	Age	Education	Religion	Children	Work status	Media	Violence	Years lived in Addis
Age	1	0.152	0.055	0.524	0.132	0.026	0.183	0.32
Education		1	0.02	0.071	0.183	0.424	0.095	0.336
Religion			1	0.038	0.023	0.14	0.091	0.187
Children				1	0.031	0.032	0.17	0.35
Work status					1	0.195	0.056	0.257
Media						1	0.055	0.386
Violence							1	0.182
Years lived in Addis								1

Table A.1.2: Contingency coefficient values for test of multicollinearity in the men sample.

	Age	Education	Religion	Children	Income	Media	Violence	Years lived in Addis
Age	1	0.187	0.144	0.562	0.246	0.052	0.201	0.505
Education		1	0.223	0.115	0.204	0.205	0.008	0.217
Religion			1	0.049	0.072	0.032	0.058	0.054
Children				1	0.256	0.182	0.39	0.492
Income					1	0.288	0.055	0.174
Media						1	0.032	0.18
Violence							1	0.242
Years lived in Addis								1

Annex A.2: Test of Outliers and Influential Cases

Table A.2.1: Classification accuracy for all cases, and after omitting outliers and influential cases for contraceptive use decision-making in the women sample.

Classification accuracy with all cases					Classification accuracy after omitting outliers				
Observed	Predicted				Observed	Predicted			
	Wife	Husband	Both	Percent Correct		Wife	Husband	Both	Percent Correct
Wife	20	9	13	47.60%	Wife	22	7	11	55.00%
Husband	3	74	9	86.00%	Husband	4	72	9	84.70%
Both	6	17	39	62.90%	Both	7	13	40	66.70%
Overall Percentage	15.30%	52.60%	32.10%	70.40%	Overall Percentage	17.80%	49.70%	32.40%	72.20%

With all cases the classification accuracy rate was 70.4%. After omitting outliers and influential cases the accuracy rate improved to 72.2%. However, since the amount of the increase is less than 2% (i.e. 72.2%-70.4%=1.8%), the model with all cases was interpreted.

Table A.2.2: Classification accuracy for all cases, and after omitting outliers and influential cases for maternal health service utilization decision-making in the women sample.

Classification accuracy with all cases					Classification accuracy after omitting outliers				
Observed	Predicted				Observed	Predicted			
	Wife	Husband	Both	Percent Correct		Wife	Husband	Both	Percent Correct
Wife	50	14	23	57.50%	Wife	50	14	23	57.50%
Husband	14	63	18	66.30%	Husband	14	63	18	66.30%
Both	21	24	52	53.60%	Both	21	24	52	53.60%
Overall Percentage	30.50%	36.20%	33.30%	59.10%	Overall Percentage	30.50%	36.20%	33.30%	59.10%

The amount of increase in classification accuracy is 59.1%-59.1=0% which shows that there is no outliers and influential cases.

Table A.2.3: Classification accuracy for all cases, and after omitting outliers and influential cases for maternal health service utilization decision-making in the men sample.

Classification accuracy with all cases					Classification accuracy after omitting outliers				
Observed	Predicted				Observed	Predicted			
	Husband	Wife	Both	Percent Correct		Husband	Wife	Both	Percent Correct
Husband	88	1	11	88.00%	Husband	89	1	7	91.80%
Wife	4	39	32	52.00%	Wife	3	41	30	55.40%
Both	12	19	76	71.00%	Both	11	21	74	69.80%
Overall Percentage	36.90%	20.90%	42.20%	72.00%	Overall Percentage	37.20%	22.70%	40.10%	73.60%

The amount of increase in classification accuracy is 73.6%-72.0%=1.6% which is less than 2%. Therefore, the model with all cases was interpreted.

Annex B: Supportive Analysis

Table B.1: Cross tabulation of women’s age and physical harassment or verbal abuse.

Physical or verbal violence * Age of the respondent Crosstabulation						
			Age of the respondent			Total
			15-24	25-29	30+	
Physical or verbal violence	Committed	Count	79	77	63	219
		% within Physical or verbal violence	36.1%	35.2%	28.8%	100.0%
	Not committed/Negotiation	Count	26	25	47	98
		% within Physical or verbal violence	26.5%	25.5%	48.0%	100.0%
Total		Count	105	102	110	317
		% within Physical or verbal violence	33.1%	32.2%	34.7%	100.0%

Table B.2: Cross tabulation of men’s average income and their educational status.

			The educational attainment of respondents		Total
			Illiterate	Literate	
The average monthly income	<=300 birr	Count	35	72	107
		% within The average monthly income	32.7%	67.3%	100.0%
	301-500 birr	Count	54	97	151
		% within The average monthly income	35.8%	64.2%	100.0%
	>=501 birr	Count	6	53	59
		% within The average monthly income	10.2%	89.8%	100.0%
Total		Count	95	222	317
		% within The average monthly income	30.0%	70.0%	100.0%

Table B.3: Cross tabulation of men's average income and their age.

			The average monthly income			Total
			<=300 birr	301-500 birr	>=501 birr	
Age of the respondent	15-24	Count	19	25	2	46
		% within Age of the respondent	41.3%	54.3%	4.3%	100.0%
	25-29	Count	40	48	10	98
		% within Age of the respondent	40.8%	49.0%	10.2%	100.0%
	30+	Count	48	78	47	173
		% within Age of the respondent	27.7%	45.1%	27.2%	100.0%
Total	Count	107	151	59	317	
	% within Age of the respondent	33.8%	47.6%	18.6%	100.0%	

Table B.4: Cross tabulation of men's educational status and their age.

			The educational attainment of respondents		Total
			Illiterate	Literate	
Age of the respondent	15-24	Count	21	25	46
		% within Age of the respondent	45.7%	54.3%	100.0%
	25-29	Count	35	63	98
		% within Age of the respondent	35.7%	64.3%	100.0%
	30+	Count	39	134	173
		% within Age of the respondent	22.5%	77.5%	100.0%
Total	Count	95	222	317	
	% within Age of the respondent	30.0%	70.0%	100.0%	

Annex C: Questionnaires (Data Collection Instruments)

Hello, my name is _____. I am working as a data collector for the study with title “Gender Relations in Reproductive-Decision Making: The Case of Weavers in Addis Ababa.” The study is conducted by a postgraduate student of Addis Ababa University for the partial fulfillment of Master of Science Degree in Population Studies.,

The information you give through this questionnaire is used for the research purpose and it is confidential (not pass to the third party). Moreover, participation in this survey is voluntary and you can choose not to answer any individual questions or the whole questions. However, I hope that you will participate in the study since your cooperation is highly valuable for the success of the study. I appreciate your participation in this survey and I kindly request you to answer the questions accordingly. Thank You!

[Woman’s Questionnaire]

Section One: Questionnaire identification	
101 Kifle -Ketema _____	102 Kebele _____
103 Questionnaire Id _____	104 Data collectors Id _____
105 Date of interview ____/____/____	

Section Two: General information of Respondents		
201	Sex	1) Female 2) Male
202	How old are you?	
203	Place of birth	
204	How long have you been living continuously in Addis Ababa	
205	What is your religion?	1) Orthodox 2) Protestant 3) Other _____
206	Have you ever attended formal school?	1) Yes 2) No (Skip to Q208)
207	What is the highest grade you completed	
208	Can you read and understand a letter or newspaper?	1) Easily 2) With difficulty 3) Not at all (Skip to Q210)

209	How often do you read newspaper or magazine?	1) Almost every day (at least four times a week) 2) At least once a week 3) Less than once a week 4) Not at all
210	How often do you listen to radio?	1) Almost every day 2) At least once a week 3) Less than once a week 4) Not at all
211	How often do you watch television?	1) Almost every day 2) At least once a week 3) Less than once a week 4) Not at all
212	How long have you been with your partner since marriage?	
213	Sometimes when you and your partner have serious argument or misunderstanding, what measure or action do you take against your partner? <u>Multiple response is possible</u>	1) Keep quite 2) Cry 3) Quarrel or yell 4) Threaten to beat, slap, kick or physically harm 5) Actually beat, slap, kick or physically harm 6) Other _____
Section Three: Working status and income		
301	What is your occupation (kind of work you spend most of your time)?	1) Weaving 2) Collecting firewood for sale 3) Domestic activities like cooking food, child care, family care etc. 4) Facilitating materials for weaving 5) Other _____
302	How much do/did you usually earn per month from your occupation (on average)?	
303	Aside from your regular occupation, are you currently engaged in additional work?	1) Yes 2) No (Skip to Q306)
304	Aside from your regular occupation, on what kind of additional work do you engaged? <u>Multiple response is possible</u>	1) Daily laborer in construction, flower industries etc 2) Selling things ('Gulit') 3) Collecting firewood for sale 4) Guard 5) Other _____
305	How much do/did you usually earn per month from your extra work?	

306	How often do you share information with your partner about the money you earn?	1) Always 3) Never	2) Occasionally
307	How often does your partner share information with you about the money he/she earn?	1) Always 3) Never	2) Occasionally
308	What do you say about the money you bring into the household compared to your partner's?	1) More than him/her 3) Less than him/her 4) Partner doesn't bring money 5) I don't know 6) Other_____	2) About the same
309	Who decides how the money you earn will be used?	1) Respondent 4) Other_____	2) Partner 3) Jointly
310	Why the person in Q309 decides how the money you earn will be used?		

Section Four: Respondents family characteristics

401	Is your mother still alive?	1) Yes (if your answer is 2 or 3, Skip to Q404)	2) No 3) I don't know
402	Where does your mother live?	1) Same household 2) Same village or town	3) Elsewhere
403	How often do you see your mother?	1) Daily 3) At least once a month 5) Less than once a year	2) At least once a week 4) At least once a year 6) Never
404	Is your father still alive?	1) Yes (if your answer is 2 or 3, Skip to Q407)	2) No 3) I don't know
405	Where does your father live?	1) Same household 2) Same village or town	3) Elsewhere
406	How often do you see your father?	1) Daily 3) At least once a month 5) Less than once a year	2) At least once a week 4) At least once a year 6) Never
407	How many wives does/did your father have/had?		

Section Five: Contraceptive methods and its decision-making

501	Have you heard about any family planning method?	1) Yes 2) No (Skip to Q503)
502	Which way or method have you heard about? (read for the respondent and circle if he/she recognize it) <u>Multiple response is possible</u>	1) Pill 2) Injectables 3) IUCDs 4) Calendar methods 5) Condom 6) Sterilizations 7) Lactational amenorrhoea (LAM) method 8) Norplant/Implants 9) Withdrawal method 10) Other_____
503	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	1) Yes 2) No (Skip to Q506)
504	Which method(s) have ever used? <u>Multiple response is possible</u>	1) Pill 2) Injectables 3) IUCDs 4) Condom 5) Norplant/Implants 6) Female sterilizations 7) Lactational amenorrhoea (LAM) method 8) Calendar methods 9) Withdrawal method 10) Other_____
505	What was the main reason for using family planning methods? <u>Multiple response is possible</u>	1) Health problems 2) Reached desire family size 3) Economic problems 4) Previous delivery problems 5) Wanted to rest 6) Partner wanted to stop 7) Wanted to space between births 8) Other_____
506	What was the main reason for never using family planning methods? <u>Multiple response is possible</u>	1) Afraid of side effects 2) Religious reasons 3) Cost too much 4) Wants children 5) Can't get pregnant 6) Opposed methods 7) Partner opposed to methods 8) Difficult to get FP methods 9) Doesn't want to go to FP clinics 10) Other_____
507	Have you and your partner ever discussed doing something to delay or avoid a pregnancy?	1) Yes 2) No (Skip to Q509)
508	At the first time you discuss about FP, what was your partner's opinion?	1) Agreed 2) Refused 3) Indifferent

509	If you and your partner have different opinion on family planning methods, whose desire the final decision will be followed?	1) Respondents 2) Partner 3) Joint 4) Other_____
510	Why the decision is followed according to the desire of the person in Q509 ?	
511	Who do you think should decide if the couple should use family planning methods?	1) Husband 2) Wife 3) Jointly 4) Other_____
513	Who usually decides about using family planning method in your household?	1) Respondent 2) Partner 3) Jointly 4) Other_____
Section Six: Family size and decision-making about number of children		
601	Have you ever given birth?	1) Yes 2) No (Skip to Q604)
602	How many children do you have?	1) Number of boys_____ 2) Number of girls_____
603	How many of them are alive?	1) Number of boys_____ 2) Number of girls_____
604	How many children do you want to have in your lifetime?	1) Number of boys_____ 2) Number of girls_____
605	Have you talked with your partner about the total number of children you would like to have together?	1) Yes 2) No (Skip to Q607)
606	At the time you talked, what did your partner want?	1) More children than you 2) Fewer children than you 3) The same number as you
607	Have you ever discussed whether to stop having children with your partner?	1) Yes 2) No (Skip to Q611)
608	How many children had you given birth to when you first discuss to stop having children?	

609	At the time you first discuss this, did you want a/another child?	1) Yes 2) No
610	At the time you first discuss this, did your partner want a/another child?	1) Yes 2) No
611	If you and your partner have different opinion about the number of children you should have, whose desire the final decision will be followed?	1) Respondents 2) Partner 3) Jointly 4) Other_____
612	Why the desire of the person in Q611 should be followed?	
613	Who do you think should decide the number of children a couple should have?	1) Husband 2) Wife 3) Jointly 4) Other_____
615	Who usually decides about the number of children you will have in your family?	1) Respondent 2) Partner 3) Jointly 4) Other_____
Section Seven: Maternal health service utilization and decision-making		
701	When was your last pregnancy?	
702	Did you see anyone for antenatal care during your last pregnancy?	1) Yes 2) No (Skip to Q706)
703	Whom did you see?	1) Health professional 2) Community health agent 3) Trained traditional birth attendant 4) Untrained traditional birth attendant 5) Other_____
704	Where did you receive antenatal care for the last pregnancy?	1) At home 2) Public health center (hospital, health post etc) 3) Private health center 4) Other_____
705	How many times did you receive antenatal care for the last pregnancy?	
706	Who assisted you with the delivery of the last child?	1) Health professional 2) Community health agent 3) Trained traditional birth attendant

		4) Untrained traditional birth attendant 5) Friends/Relatives 5) Other_____
707	Where did you give birth to the last child?	1) At home 2) Public health center (hospital, health post etc) 3) Private health center 4) Other_____
708	Have you ever discussed about maternal health service utilization with your partner?	1) Yes 2) No (Skip to Q710)
709	At the first time you discuss about maternal health service utilization, what was your partner's opinion?	1) Agreed 2) Refused 3) Indifferent
710	If you and your partner have different opinion about maternal health service utilization, whose desire the final decision will be followed?	1) Respondents 2) Partner 3) Jointly 4) Other_____
711	Why the desire of the person in Q710 should be followed?	
712	Who do you think should decide if the wife should use maternal health services?	1) Husband 2) Wife 3) Jointly 4) Other_____
714	Who usually decides about use of maternal health service in your family?	1) Respondent 2) Partner 3) Jointly 4) Other_____

[Man's Questionnaire]

The following modifications were done on the man's questionnaire.

- **From Section Five: Question number 504, 505 and 506:** were modified accordingly as follows.

504	Which method(s) have ever used? <u>Multiple response is possible</u>	1) Condom 3) Withdrawal method 10) Other _____	2) Calendar methods 6) Male sterilizations
505	What was the main reason for using family planning methods? <u>Multiple response is possible</u>	1) Health problems 3) Economic problems 5) Wanted to space between births 6) Other _____	2) Reached desire family size 4) Partner wanted to stop
506	What was the main reason for never using family planning methods? <u>Multiple response is possible</u>	1) Afraid of side effects 3) Cost too much 5) Opposed methods 7) Difficult to get FP methods 8) Doesn't want to go to FP clinics 9) Other _____	2) Religious reasons 4) Wants children 6) Partner opposed to methods

- **From Section Seven:** Only question numbers 708-715 were included in the man's questionnaire.

The remaining questions are the same as the woman's questionnaire.

Questions asked for key informants

1. Who do you think should decide if the couple should use family planning methods? Why?
2. Who actually decides the use of family planning methods in your household? Why?
3. Who do you think should decide if a wife should use maternal health services? Why?
4. Who usually decides the maternal health service utilization in your household? Why?
5. Which family planning method is the most used method by the study community? Why? (question raised for kebele health officer)

Declaration

The thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have been duly acknowledged.

Tefera Darbe
Student

Signature

30/08/09
Date

I confirm that this thesis has been submitted with my approval as the supervisor of the same.

Samsen Kassaden
Advisor

Savouh
Signature

Date

Addis Ababa University
School of Graduate Studies

**GENDER POWER RELATIONS IN REPRODUCTIVE DECISION-MAKING:
THE CASE OF MIGRANT WEAVERS OF ADDIS ABABA**

BY:
TEFERA DARGE

June 2009