ADDI SABEBA UNIVERSITY

COLLEGE OF HEATH SCIENCE

SCHOOL OF PUBLIC HEATH

ASSESSMENT OF MEN'S INVOLVEMENT IN LONG ACTING AND PERMANENT CONTRACEPTIVE USE AMONG CURRENTLY MARRIED MEN AGED 20-64 YEARS, IN MIZAN-AMAN DISTRICT, SOUTH WESTERN ETHIOPIA

BY

KEBADNEW MULATU (B.Sc.)

ADVISOR: WUBEGZIER MEKONNEN (PhD)

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BY: KEBADNEW MULATU (B. Sc.)

Approved by examining board

Dr. Wubegzier Mekonnen _____

Advisor

Dr. Mulugeta Betre _____

Internal examiner

Dr. Demeke Desta _____

External examiner

June, 2014

Addis Ababa, Ethiopia

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Acronyms

CPR	Contraceptive Prevalence Rate
CI	Confidence Interval
EDHS	Ethiopian Demographic and Health Survey
FGDs	Focused Group Discussions
FP	Family Planning
HH	Household
IRB	Institutional Review Board
IUD	Intra Uterine Device
LAPM	Long Acting and Permanent Contraceptives Methods
MPH	Master of Public Health
MDG	Millennium development goal
RH	Reproductive health
SD	standard Deviation
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
TFR	Total Fertility Rate
TL	Tubal Ligation
WHO	World Health Organization

Abstract

Introduction: Though women bear the physical, psychological and emotional strain of pregnancy and childbirth, it could not mean that fertility and contraception are based exclusively on the female population. Thus, the social roles of men who are dominant not only in decision making within the family, but also at community leadership levels have been overlooked. Most family planning programs give less attention to the understanding of men's role in the effective and steadfast utilization of contraceptives.

Objective: the main aim was to assess the role of men in long acting and permanent contraceptive use among currently married men aged 20-64 in Mizan-Aman District, South Western Ethiopia.

Methods: Community-based cross-sectional study was conducted. A mixed method of quantitative and qualitative research was used. A total of 554 study participants were recruited for the study. The investigator prepared, pre-tested and structured questionnaire was used to collect data. Odds ratio along with 95% Confidence interval in Multivariate Binary Logistic regression was used to assess the strength and significance of the association. Thematic analysis has also been adapted for analyzing the qualitative data.

Results: A total of 521 men were included in the analysis. Only 11.5% the respondent's wives used LAPMs though no study participant used any of these methods. Discussions between couples about LAPMs in the last 12 months (AOR=4: 95% CI.1.9-8.2) and on the number of children they want to have (AOR=3.1: 95% CI.1-9.2), going to health facilities with wives to discuss about FP with health providers (AOR=2.7: 95% CI. 1.3-5.6), and supporting the use LAPMS (AOR=4.5: 95% CI. 1.6-12.5) were significantly and strongly associated with utilization of LAPMs compared to their respective counterparts.

Conclusions and recommendation: Discussion between couples on the use of LAPMs and on the number of children they should have; and men's approval of LAPMs' utilization were factors that influencing utilization of LAPMs in the town.

Health extension workers should enhance discussion between couples. Town level health programmers should advocate discussion between couples and men's awareness on LAPMs. Further research, including both men and women is recommended in the Town and beyond.

INTRODUCTION

1.1 Back ground

World Population has grown by 1.2 percent per year between 2000 and 2010. Countries in Sub-Saharan Africa have documented the fastest average growth rate of 2.5 percent per year(1). The Projections issued by the United Nations suggest that World population by 2050 could reach 8.9 billion, but it could be as high as 10.6 billion or as low as 7.4 billion (2). Uncontrolled population growth has been associated with high maternal, infant and child mortality rates. Fetal deaths, low birth weight and related problems are also associated with unregulated fertility (3).

Most of the population growth happened in developing nations where fertility rates remained high (3.2%). Sub-Saharan Africa, in particular, has experienced little change in its fertility rates. The majority of these countries have fertility rates of over 5 children per woman. The sub-region's high fertility combined with declining mortality resulted in rapid population growth of 2.5 % per annum. According to the UN projections, the sub-Saharan population grows from 0.86 billion in 2010 to 1.96 billion in 2050 (4).

Ethiopia is the 2nd populous countries in Africa. It has the highest annual population growth rate of 2.6 %, high maternal mortality ratio of 676 maternal deaths per 100,000 live births and high infant mortality of 59/1000. The population increased over the previous decade from 53.5 million in 1994 to 73.9 million 2007 (5-6) and it was 86 million in 2012 (7) .

According to authors of the Ethiopian population policy, "Population growth in Ethiopia has exceeded the carrying capacity of the economy. Based on the calculation of the 2007 census data, 25 million people can be considered as overpopulation"(7). In recognition of the need to address these issues, the government of Ethiopia has adopted a population policy in 1993. The aim of the policy is to bring into line the rate of population growth with the socioeconomic development, by reducing the total fertility rate from 7.7 children per women in 1995 to 4 children per women in 2015, and increasing the contraceptive prevalence rate from 4% in 1995 to 44% in 2015(3, 6). However, the total fertility rate (TFR) Ethiopia is still 4.8 (6). There was a slight decline in the population growth rates over the decade, from 2.9% in 1994 to 2.6% in 2007(5-6). If these high population growth rates continued, it will pose a serious challenge in the provision of food, housing, health and educational services and employment opportunity to the

general population. So using contraceptive has been widely accepted, low cost ,and effective strategy to achieve MDGs (8). It is central to efforts to reduce poverty, promote economic growth, increase female productivity and improve child survival and maternal health. It can help to ensure healthiest timing and spacing of pregnancy. As fertility falls, so do infant, child, and maternal mortality(9). Women can decrease the time they could spend on giving birth and caring for young children and increase their enrolment in productivity and education to enhance their social status and decision making power (10). Waiting at least two years from the previous birth to attempt another pregnancy allows parents to devote more time to each child in the early years, lessening pressures on the family's finances and giving parents more time for income-generating activities(9).If the unmet need for spacing and limiting births addressed, in each country in sub-Saharan Africa millions of dollars could be saved (19).

Among modern FP methods, "Long-acting and permanent methods are by far the most effective (99% or more) methods of modern contraception available, and are very safe and convenient. They are all clinical based methods and hence must be provided in health facilities by trained doctors, nurses, and/or midwives. Only one action by a client and provider results in years of protection against unwanted pregnancy. Contraceptive methods that categorized as long-acting and/or permanent are: intrauterine devices (IUDs or IUCDs), implants, female sterilization, and male vasectomy. IUDs and implants are long-acting temporary methods; when they are removed, coming back to fertility is immediate. Copper-containing IUDs are effective for up to 12 years and Implants last between 3–5 years. Female sterilization and vasectomy, on the other hand, are permanent methods(11).

The Southern Nations, Nationalities and Peoples Region of Ethiopia (SNNPR) is characterized by high infant mortality rate of 78/1000 live birth, a high level of fertility rate of 4.9 children per women of reproductive age and low level of contraceptive use. That is Modern CPR was 24.7%, among these long acting and permanent contraceptive accounts only 0.5% female sterilization, 0.3% IUCD and 2.9% implant(6) .

1.2 Statement of the problems

Even if, the awareness and knowledge about the demographic explosion and its association with health hazards has risen, family planning use were not as anticipated in many countries(12). Different studies suggested that family planning programs particularly LAPMs in most African societies have not been successful since they failed to take into account the role of men in contraceptive use. For the reason that, men play an influential role in most household decision-making in many countries of sub-Saharan Africa and generally oppose their partners' contraceptive usage (13).

In Africa, men generally desire larger families than their wives do. Gender norm, the culture specific societal messages that state appropriate or expected behavior for females and males often bound women's ability to negotiate in contraceptive use and actively participate in efforts to improve their livelihoods(14).

Early marriage, repeated pregnancies and childbirth restrict women from education, employment and productivity resulting in poor status of women in the community which resulted in poor living standard. This intern results in lower decision making in the family and the society at large. Hence, they cannot decide on family planning that helps women to track their education for better employment opportunities, payment and to be influential decisions makers(15). Men played role not only to encourage their spouse to use contraceptive, but also they are involved in the use of contraceptive methods (16.3% and 4.9% of male were users of condoms and vasectomy respectively)(16).

Globally modern CPR was 57% in 2012.While in Africa , in Asia , and in Latin America and the Caribbean CPR were 24%, 62%, and 67% respectively in 2012 (17). Whereas in Ethiopia, current contraceptive prevalence rate and the unmet need for family planning were 28.6% and 25% respectively in EDHS of 2011(6). According to PMA 2020 findings in 2014 ,CPR was 33.3%,while the unmet need was 18.8% (18).

Though LAPMs of contraception is safe and convenient, their utilization is low. Studies in SSA between 2003 and 2005 showed that in each of the nine countries including Ethiopia, fewer than 7 percent of the women were using LAPMs (19-20). In a country like Ethiopia with high fertility rate and unmet need of contraceptives , shifting towards LAPMs is an important strategy to ensure continuity of services(21-22). However it is still low, utilization of female sterilization,

IUCD and implant were 0.5%, 0.3% and 2.9% respectively (6). And according to PMA2020 findings , the prevalence of female sterilization, IUCD and implant were 15.9% , 1.9%, and 0.4% in that orders(18). Another study conducted in Mekele town showed that the prevalence of long acting and permanent contraceptive methods use was 12.3%. This is the lowest figures when compared with least developed countries. Social, economical, cultural, fear of methods' side effects, misconception, husband's opposition, religious prohibition, lack of knowledge, and communications between spouses were some factors that influenced utilization of LAPMs (23-26). Some expressed that if they use LAPMs, a layer of fat may build up around the devices which make them hard or impossible to remove. A study reported that some respondent perceived that IUCD use for long period of time would accumulate fat around women's uterus which makes it difficult to remove when they want, and Others believed that woman using IUD or implant could not be involved in energy demanding works, so they felt as this method is unsuitable particularly for rural farming women(23).

1.3. Rational of the study

For many years, family planning program planners focused their attention largely on women. Though women bear the physical, psychological and emotional strain of pregnancy and childbirth, it could not mean that fertility and contraception did not solely refer the female population. Thus, the social, cultural and economic roles of men who are dominant not only in decision making within the family but also at community leadership levels have been overlooked. Most family planning programs gave less attention to the understanding of men's role in the effective and steadfast utilization of contraceptives. Likewise the methods that require male involvement such as condoms and vasectomy were less used (13, 25).According to EDHS2005, Male contributed only 1.1% from 13.9% of CPR (22)

Men were usually proud of the number of their children, particularly sons, in anticipation of the present and future paybacks derived from them. for the reason that they thought children were important source of old age support for their parents in the absence of social welfare and security programs(27). So, females would be forced to bear large number of children because of the male dominance in the culture which hinders fertility regulation (27). In Ethiopian traditions, wives in most ethnic groups consider their husbands as overall heads. This is due to sociological factors such as religion, culture, etc that favored Ethiopian men, as decision makers both at family and community levels (21). Husbands decide on most issues and their wives are expected to be abided by their decisions or their perceived wishes. Thus, this male dominated family structure would have significant contribution in matters of reproduction. And has great influence on a couple's family planning decisions and use. Ethiopia has made several important international commitments to improve the sexual and reproductive health and rights of its entire people (MDG). And LAPMs use may play critical role in meeting these international goals(20). There is no any prior research done in the study area that described the role of men in LAPMs use. So this study made out the role of male in LAPMs use and it also assessed the magnitude of LAPMs use and its' associated factors in the study area that are important to fill gaps for program and policy makers.

2. LITERATURE REVIEW

2.1 Knowledge of Long Acting and Permanent Contraceptive Methods

Many clients in SSA lack information about LAPMs even in countries where knowledge about FP is high. Only few people have knowledge of IUD and vasectomy compared with other methods(28). The study in Nigeria on Gender issues in contraceptive use among educated women in Edo state, showed that the knowledge for female sterilization, male sterilization, and IUCD were 68%, 2.9%, and 44% respectively(29). A base line survey study done in Zimbabwe showed that the knowledge of men on any long term and permanent method were 86.6%, and 80.2% respectively. While the knowledge of IUCD, implant, Tubal ligation, and Vasectomy were 62.8%, 5.9%, 79.7%, and 59% receptively(30).

According to Ethiopian 2011 DHS, 98% of all men and 97.2% of women have heard of at least one method of contraception. However, the knowledge of LAPMs is low. For instance the level of awareness on female sterilization, IUCD, and implant among married women were 39.8%, 26.4%, and 69.2% respectively while it was 46.8%, 27.5%, and 63.5% among married males in the same order respectively(6). Another study conducted in Mekele among married women also showed that 63.9% of married women heard about LAPMs as a whole, out of which, 80.7%, 55.3% and 39.8% were aware of implants, IUCD and female sterilization, respectively. However, only 15.6% of the married women heard about vasectomy. Only 23.8% of study participants were able to name more than two LAPMs. Besides, only 44.1% of them were able to tell more than one advantage of LAPMs (25). A study done in Wolita zone in Southern Nations and Nationalities region among short term users indicated that female sterilization, male sterilization, IUCD, and implant were known by 28.2%, 9%, 54%, and 87.8% of respondents respectively(31). However, another study done in Debremarkos town also showed that 81.5% of respondents mentioned at least one methods of LAPMs (32).

2.2 Attitude, Myths and misconceptions towards LAPMs

Myths and misconceptions with regards to LAPMs have also been widespread. Some feared that if they use LAPMs fat may build up around the devices which make them hard to remove which is particularly mentioned in relation to IUCD when they use it for long period of time. Similarly some believed that a woman with an IUD or implant could not easily engage in energy demanding works, so they felt as this method is unsuitable particularly for rural farming women

(23, 31-32). Others believed if a woman used such methods for a long time she may not give birth to a child and could also be exposed to develop cancer. Another commonly held view was that couples should not use family planning methods early in their childbearing years, because they would be in fertile. And some men feared that women become promiscuous when they practiced family planning. Another more common misconception was that the IUD may become dislocated and get lost in a woman's abdominal cavity, thereby causing complications and it may require major surgery to remove it(33). A study showed that the belief of most men was that contraception is a woman's business and therefore men need not be involved, and some societies also belief that family planning is largely a woman's business with the men playing a peripheral role(8).

Another study showed that 53.6% of married women had negative attitude towards LAPMs and 15.5% and 26.8% of married women perceived that implant causes irregular bleeding and severe pain during insertion and removal. On the other hand, 29.7% of married women have a belief that IUCD causes shame while it is inserted to cervix by health professional and 19.6% felt that it prevents from doing normal activities (25). Similarly, a study conducted in Wolita zone among married women showed that 52.6% of the participants had negative attitude towards LAPMs. Among those, 33.3 % of them perceived as implant moved to other parts the body and cause severe pain(31) . A study conducted in Tanzania showed that rumors for vasectomy included equating vasectomy with castration, believed as it causes cancer, sperm would be accumulated in the body leading to bad outcome, and fears that vasectomy causes weight gain and physical weakness inhibit the use of vasectomy(34) . A study done in Debremarkos indicated that the respondents perceived as vasectomy causes impotence(32).

2.3 Use of Long Acting and Permanent Contraceptive Methods

Globally modern CPR increased, from 54% in 1990 to 57% in 2012. In Africa it went from 23% to 24%, in Asia it has remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67% (17).

The modern contraceptive methods for men are limited to male condoms and sterilization (vasectomy) and the use of contraception by men makes up a relatively small subset of the above prevalence rates(17). That is 16.3% and 4.9% of males were users of condoms and vasectomy respectively)(16). However, 222 million women globally have unmeet need. And in Africa, 53% of women of reproductive age have an unmet need for modern contraception while in Asia, and the Caribbean regions, the unmet need are 21% and 22%, respectively (17). Data from Demographic and Health Surveys conducted in sub-Saharan Africa between 2003 and 2005 showed that more than 20 percent of women in nine of the 11 countries surveyed want to limit childbearing. But, in each of the nine countries, less than 7 percent of the women are using LAPMs(20).A baseline survey that was conducted in Zimbabwe, showed that the utilization log term and permanent methods by married men was very low. In that IUD and tubal ligation were used by 2% and 0.9% of them, where as no one was used either implant or vasectomy(34).

In Ethiopia utilization of contraceptive methods is very low though it increased from 15.2% in 2005 to 28.6 % in 2011, while the unmeet need is 25% in 2011 (6). Though Ethiopian adopts different policy including the population policy, which was promulgated in 1993, with the objective of reducing the total fertility rate, as well as raising the contraceptive prevalence rate to a national coverage of 44% by the year 2015 and its National Reproductive Health Strategy from 2006 – 2015, that stated the need to increase contraceptive prevalence to 60% by the year 2010 and increase couples' approval of FP to 75% by 2015, still the unmeet need is high(3, 35). The prevalence of long acting and permanent contraceptive methods was, however low with the prevalence of IUD being only 0.3%; implant 3.4% and female sterilization 0.5%(6). According to PMA202,the prevalence of LAPMs were, implant 15.9%, IUCD 1.9%,and female sterilization 0.4%(18). Study conducted in Mekele also showed a LAPMs prevalence of only 12.3%. The majority of women (87%) used implants followed by IUCD users which were only 13%. However, no woman used female sterilization in this study(25). Another study done in Debremarkos Town in 2012 among married women also showed that the prevalence of LAPMs use was 19.5%, of those 83.2% was implant user ,while the rest IUCD users (32). Similarly, the

study done in Goba Town in Bale Zone and Wolita Zone showed the utilization rates of LAPMs were 8.7% and 12.2% respectively (31, 36)

2.4 Factors affecting the use of long acting and permanent contraceptive methods

Different studies showed that factors including socio-demographic, fear of side-effects, cultural or religious opposition, poor quality and availability of services, misconception, and husband opposition could act as barriers to use LAMPs (25, 31-34, 37,38). Socio-demographic factors including age and religion affected the use of contraception. A study showed that age group 30-34 was **2.**6 times more likely to use contraception than those in the age group of 15-19 years (24). The study done in Nigeria showed that Muslims were less likely to use contraceptive methods than their Christian counter parts(29).

Educational status was also one of the factors affecting the use of FP. Twenty-two percent of women with no education report current use of any method, compared with 68 percent of women with more than secondary education(6). Another Study also showed that women with elementary school and more than elementary school education had 3 and 6 times more likely to use respectively than among couples where the wives were illiterate(26). Similarly, Husband's education had positive effect on couple's contraception use. Husband's with elementary school (5.4) and more than elementary school education (13.9) times a higher effect than couples where the husbands were illiterate (26). Couples with employed husbands were more likely to use contraception than those whose husbands were not employed (26, 31-32, 38). The study showed that Husband and wife knowledge on family planning have statistically significant positive association with couples contraception use. That is The Odds of contraception use was 2.4 times higher among women who had better knowledge on family planning than the counter parts (26). Another study also showed that couples with the husbands' positive attitude (approval) of LAPMs were more likely to use than the counter parts (26, 32).

Lack of availability and access of commodities contributed to low use of LAPMs. Distance to clinics, and Shortage of trained providers also inhibited use of LAPMS (11). Women's participation in decision-making, number of children they already had, desired no of children also affected the use of LAPMS (24, 32, 39).

2.5 The role of men in the use of long acting and permanent contraceptive methods

Most decisions which affect family and political life were made by men. Men hold positions of leadership and influence household decisions. Therefore, their involvement in family planning matters would accelerate the understanding and practice of family planning(8).

Men also played an influential role in most household decision-making in many countries in sub-Saharan Africa and generally opposed their partners' contraceptive use. Women's young age at marriage, age difference between husband and wife, polygamous family structure, and culture are factors that make male dominance in decision-making among couples and affects women's decision-making power in contraceptive use. In societies where gender stratification is commonly observed, decisions on limiting fertility is made by the husband or his parents(13, 40).

The use of FP look like for females only(6, 15). Because , from 13.9% CPR ,male contributed only 1.1%(22). The study conducted in a rural community of western Ethiopia showed that only about 4.9% of the men ever used any contraceptive methods. Of which 47% and 42% used condom and periodic abstinence respectively(24). Factors such as culture, education and employment status, and others affected male involvement in contraceptive use. In most cultures, reproductive activities were considered to be roles of women, whereas productive and community activities are heavily dominated by men (41).

In summary, LAPMs use and role of men in LAPMs use was determined by several factors as discussed in the literature. Some of these factors have direct influence on contraceptive use. However, it may not be possible for one factor to entirely determine contraceptive use, but rather, these factors are interrelated. Also role of men in use of LAPMs is influenced by some of these factors, like socio demographic, fertility preference, exposure to family planning messages, health care system and networking among women of reproductive age. This interrelationship is showed in the conceptual framework depicted in Annex 1.

3. OBJECTIVE

3.1 General Objective

To assess the role of men in long acting and permanent contraceptive use among currently married men aged 20 -64 years, in Mizan-Aman District, South Western Ethiopia.

3.2. Specific Objectives

1. To assess the knowledge and attitudes of men towards long acting and permanent contraceptive methods in the study area
2. To measure the prevalence of long acting and permanent contraceptive methods among men or their spouses in the study area.
3. To identify factors associated with the use of LAPMs among men or their spouses in the study area.
4. To explore myths, misconceptions and opinions towards LAPMs in the study area.

4. METHODS AND MATERIALS

4.1 Study design

A community-based cross-sectional study was conducted by employing both quantitative and qualitative data collection methods. In-depth interview was a qualitative method used to complement the finding of the quantitative study.

4.2 Study area

The study was conducted in Mizan -Aman District, Bench Maji Zone, one of the 13 zones in the Southern Nations Nationalities and People's Regional Government (SNNPRG). The District is located in the western part of the region, bordering with Semen Bench District in the North and North West, Shay Bench in the East and South East, and Guraferda in South East. Mizan -Aman is the capital town of the zone, and is situated 561 Km far from Addis Ababa. The total population of Mizan-Aman district is 34,080, of which 18,138 are males. Women of reproductive age group (15-49 years) in the town were 7,853 residing 9,145 housing units according to the 2007 Census. The District is structured in such a way that it has two kifleketma (administrative unit) with a total of 5 Kebeles (the smallest administrative sub-unit). There is one general hospital, one health center and 5 health posts all run by the government. In the private sector there are 9 clinics (of which 5 are medium clinics), three drug distribution stores, and 5 drug venders. District department annual report of 2005 showed the contraceptive acceptance rate was 53% utilization of antenatal care and delivery services being 57.4% and 14.7% respectively. The study was conducted starting from data collection through final dissemination between Novembers 2013 to June 2014.

4.3 Study and source population

4.3.1 Source population

The Source population was all men in the age group 20-64 in the study area.

4.3.2 Study population

The study population was comprises of those currently married men aged 20-64 years residing in Mizan-Aman Town/District who were selected by systematic random sample method(SRS).

4.4 Sample size determination

The sample size was determined by using formula for single population proportion. By taking the proportion for the knowledge, attitude and practice from previous studies, sample size was calculated for each of them, and then the largest calculated sample size was taken for this study. That is

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

Where:

n= the desired sample size

P= Proportion of men approving (positive attitude) LAMPS =67.6 %, knowledge= 87% and for practice= 8.72 %, the study done in Goba Town in 2012 (36).

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

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

EPI INFO version 7 was used to calculate the sample size for the single population proportion. Then sample size of attitude (336) was considered to be a desired sample size. Considering a design affect of 1.5 and 10% a non-response rate. The total sample size recruited for the study was 554 married men.

Table 1: Assumptions for the calculation of the sample size for this study, 2014

No	Type	Prevalence	Calculated sample size
1	Knowledge about LAPMs	87%	307
3	Attitude towards LAPMs	67.6 %,	336
3	Practice of LAPMs	8.72	122

CI=95%, Zα/2=1.96, Margin of error=5%

For qualitative studies, 8 key informants were included in the interview. The sample size was determined based on the saturation of ideas. Two Health Extension Workers, one program officers, 3 currently married men, and 2 women were involved.

4.5 Sampling procedure

In the Town/district, there are two kifleketma with 5 Kebeles from which a total of 3 Kebeles was selected randomly. The sample size was proportionally allocated to each selected three Kebele using sampling proportion to size technique. The sampling fraction of each Kebele was determined by proportional to the size of the total household in each Kebele (which was taken from respective Kebele). Systematic sampling method was employed to select the households from each Kebele. The selected kebele were properly zoned form their bordering kebele. And the sampling interval was determined by dividing the total number of households in each Kebele to the corresponding sampling fraction (proportional sample) in each Kebele. After that the first household was selected from the house of respective Kebele using the lottery method and the next household was identified systematically by using the sampling interval of respective Kebele. When more than one eligible respondent were found in the selected household, only one respondent was chosen by lottery method. In cases where eligible was not found in the selected household, the interviewer went to the next household until he got eligible men.

Snow ball sampling procedure was employed for qualitative part to identify informed key informant interviewees from HEWs, program officers, and currently married men and women.

Table 2: shows sampling procedure using probability proportion to size for the selected Kebele, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014

Selected Kebele	No. of HHs	Relative frequency	Proportional sample	K value
Komta	1388	0.28	155	9
Addis ketma	1137	0.23	127	9
Slam ber	2382	0.49	272	8.8
Total	4, 907	1.00	554	8.9

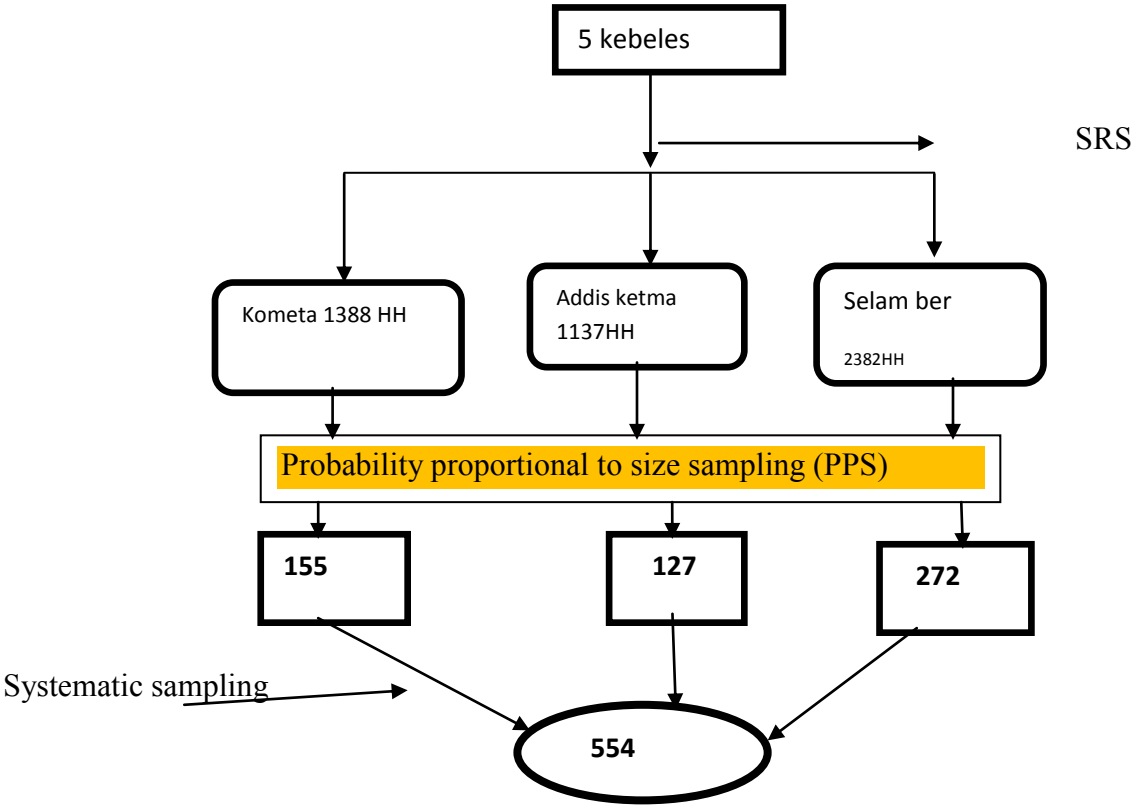

Figure 1: Schematic presentation of the sampling procedure

4.6 Inclusion and exclusion criteria

Inclusion criteria: Married men age 20-64 years who were regularly living in the study area for at least 6 months. In qualitative part: Individual who was regularly living in the study area for at least 1 year, and age 20 and above were included.

Exclusion criteria: Men who were not be found during data collection time and those seriously sick (unable to respond) and those who could not speak and/or hear.

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

4.7 Tools for Data Collection

I. Structured Questionnaire. The data for quantitative section was collected by using a structured questionnaire. The questionnaire was adapted from different literatures, including Ethiopian Demographic and Health Survey. It was first developed in English and translated to Amharic language and then back to English to ensure its consistency. The survey questionnaire was pre-tested and the necessary modifications and correction took place to ensure its validity. Using the

questionnaire, currently married men from the selected households were interviewed by trained 12th grade complete data collectors who could speak both Amharic and the local language. The interview was done by house-to-house visits in the presence of strong supervision.

For qualitative part semi-structured interview guide was prepared by reading different literature in such a way that it enabled to explore myths, misconceptions, barriers and attitudes. An in-depth interview was conducted among currently married men, HEWs, and program officers in a quiet and comfortable place till information was saturated. The principal investigator was the moderator assisted by a note taker. The tape recorder was used to record the interview.

4.8 Data Quality Assurance

To maintain the quality of data, questionnaires were prepared first in English then translated to Amharic and again back translated to English in order to maintain its consistency. Training was given for five data collectors and two supervisors for 2 days about the objectives, principles and procedures of the data collection. And any doubts in any question in the questionnaire were clarified by discussing each of them one by one. Pre-testing was done on 26 individuals in a community similar to the study population, but out of the selected kebele. Supervision was conducted by the Principal Investigator and supervisors. The data collectors were observed by supervisors how they administered the questions to the respondents/interview and checked some households to make sure that they were from the residence of the eligible men. The Principal investigator and Supervisors randomly revisited 5 % of respondents; to check whether some households were left out without visit or not and important and sensitive issue were correctly filled or not by the data collectors. Each data collector checked the questionnaire from each study participant for completeness on a daily basis. The Supervisor and Principal Investigator reviewed each questionnaire daily and checked for completeness. The replacement was made for those households where respondents were not found in three subsequent visits.

For qualitative data: To ensure the quality, data were recorded with a tape recorder to capture all the information by the principal investigators and note was taken by another person. Transcripts from audio tapes and notes from recorders/facilitators were compared. The transcription of the study was done on the date of interview.

4.8 variables

Dependent Variable

Knowledge and attitude towards use of LAPMs among married men and current use of LAPMs among men or their spouse were the dependant variables

Independent Variables

1. Demographic variables: age, religion, ethnicity, and number of living Children.
2. Socioeconomic variables: - Education - Occupation/ employment - Income (Monthly)
3. Reproductive History: age at first marriage, age at first child bearing, number of children, discussion on the number of children, decision when to have another child, communication on FP.

4.9. Operational definitions

♦ **Current contraceptive users** - are men or their spouse who are using contraception during the survey.

♦ **Ever users of LAPMs** - are men whom themselves or their partners used IUCD, implant, vasectomy or tuba ligation any time in their marital life.

♦ **Current LAPMs users** - are men or their spouse who are using LAPMs during the survey.

♦ **Non-users** - are men or partners who have never used contraception till the day of the survey.

♦ **Knowledge**

Very good Knowledge: Those who scored above 67% of Knowledge question on LAPMs.
Moderate Knowledge: Those who scored 33-67% of Knowledge question on LAPMs.
Low knowledge: Those who scored below 33% of Knowledge question on LAPMs.
Depending of the frequency of respondents on each of the knowledge categories tercile of the median score was used to divide them into three knowledge groups.

Attitude

Positive attitude: Those who scored above 67% on attitude questions of LAPMS
Indifferent way: those who scored from 33 -67% on attitude questions of LAPMS

Negative attitude: Those who scored below 33% on attitude questions of LAPMS

Role of Male: The one who have knowledge and positive attitude towards LAPMs and support/encourage his wife or others to use LAPMs and /or to use of the methods by themselves (vasectomy).

4.10 Data entry, cleaning and analysis

For quantitative section: Each questionnaire was given a unique code by the Principal Investigator. The principal investigator prepared the template and entered data using an Epi-info version 3.5.1. Then, the entered data were cleaned for anomalies prior to data analysis. Frequency distributions and cross tabulations were used to check for missed values and outliers during analysis. Any errors were corrected after revision of the original data using the code numbers of the questionnaires. Data were cleaned for inconsistencies and missing values and analyzed using SPSS version 21 statistical software. Frequencies and Proportions were computed for a description of the study population in relation to socio-demographic and other relevant variables (age, marital status, no children). Significance of association between different covariates and the main outcome variable of interest was checked by chi-square test for categorical variables. Strength and significance of statistical associations were determined using crude and adjusted odds ratios with 95% confidence intervals in Logistic Regression. To assess the association between the different predictor variables of LAPMs utilization with the dependant variable, first bi-variate relationships between each independent variable and outcome was investigated using a binary logistic regression model. Those independent variables that were significant with p-value less than 0.05 at the bi-variate level were included in a multivariate logistic regression model for each dependent variable to control for potential confounding variables. The analysis gave in standardized partial regression coefficients that estimated the direct effect of predictor variable on the dependent variable controlling for the effects of all other independent variables in the equation. The results were presented in the form of tables, figures and summary statistics.

Qualitative data analysis

The qualitative data that were obtained from participants‟ conversations was audio-taped, transcribed, translated and coded with Open Code version 3.6. Inductive content analysis was used. First the qualitative data were transcribed in Amharic language which was then translated to English language using Word format. The MS Word document was exported to Open Code software. The data was exhaustively coded. The qualitative data codes were categorized and then grouped in theme as per the objective of the study. Certain verbatim, which describe various concepts in relation to myths and misconception, were also quoted to reflect the perception of individual discussants.

4.11. Ethical clearance

Ethical clearance was obtained from a Research Ethics committee of the School of Public Health, College of Health Science of AAU, Bench-Maji Zonal Health office and respective Kebele authorities. Prior to data collection, individual informed verbal consent was obtained from the study participants. Each respondent was informed about the objective of the study, procedures of selection and assurance of confidentiality and their names were registered to minimize social desirability bias and enhance anonymity. Individuals were free to withdraw from the interview at any time. Permission to audio-record for the interview was also obtained. Participants were not faced any harm and received any monetary incentive for participating and it was solely voluntary based.

4.12. Dissemination of Research finding

The Study was done for the partial fulfillment of the Degree of Masters of Public Health, at the School of Public Health, Addis Ababa University. The result of the study will first be reported to school of public health of AAU and Mizan-Aman District and Bench-Maji zone. It will also be sent for publication in peer reviewed journal and presentations should be made in scientific conferences.

5. RESULTS

5. 1. Socio-demographic characteristics of the respondents

A total of 521 married men were interviewed in this study making a response rate of 94.1 %. The majority of the respondents were in the age group of 20-30 years (34.5%) making the mean age and standard deviation [SD]) 36.9 (± 9.3) years. In their ethnicity, 194 (37.2%) were bench followed by Amahara 110 (21.1%) (Table 3). Out of the total respondents, 232 (44.5%) were Orthodox Christianity followers followed by Protestant Christianity followers of 157 (30.1%) (Figure 2).

The majority, 437(84%) of men were residents of urban Mizan-Aman, while the rest were rural residents. Regarding to the respondents' educational status 461 (88.5%) of study participants, and 398 (76.4%) of their wives were able to read and write. Of those, 139(30.2%) of respondents and 121(30.4%) of their wives were attained secondary school (figure 3). Two hundred (38.4%) of the respondents were government employee (figure 3), while 258 (49.5%) of the respondents' wives were house wives (Table 3).

One hundred ninety two (36.9%) of respondents' household earned a monthly income of 2500 ETB or more, while163 (31.3%) of the respondents' household got a monthly income which was less than 12000ETB, with mean and SD, 2150.5 ±1410.9. Over 494(94.8%) of respondents were involved in monogamous marriage, but twenty seven (5.2%) reported being involved in polygamous marital union. Regarding to the means of communication, more than half 266(51.1%) of respondents had both radio and TV, while, 227(43.5%) of the respondents had either radio or TV, and the rest 28(5.4%) of respondents had none of them (Table 3).

Table 3: Socio -demographic characteristics of the study participants, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014 (n = 521)

Variable		Frequency	**Percent (%)**
Age of respondents:	20-30	178	34.2
	31-40	169	32.4
	41-50	122	23.4
	51-64	52	10
Ethnicity :	Bench	194	37.2
	Amahara	110	21.1
	Kefa	94	18.0
	Oromo	52	10.0
	Tegri	41	7.9
	Others**	30	5.8
Wives occupation:	House wife	258	49.5
	government employee	119	22.8
	Private employee and others*	52	10.0
	Student	92	17.7
Marital union:	Polygamous	27	5
	Monogamous	494	95
Household size:	2-3	176	33.8
	4-5	190	36.5
	≥6	155	28.8
House hold monthly income:	≤1199	163	31.3
	1200-2499	166	31.9
	2500	192	36.9
	With Mean &SD	2150.5 ±1410.9	
Possession of means of communication			
	Radio only	109	20.9
	TV only	118	22.6
	Both radio &TV	266	51.1
	I have no	28	5.4

Others* merchant and daily laborer, others**, Siltae, Gurage, and Wolita

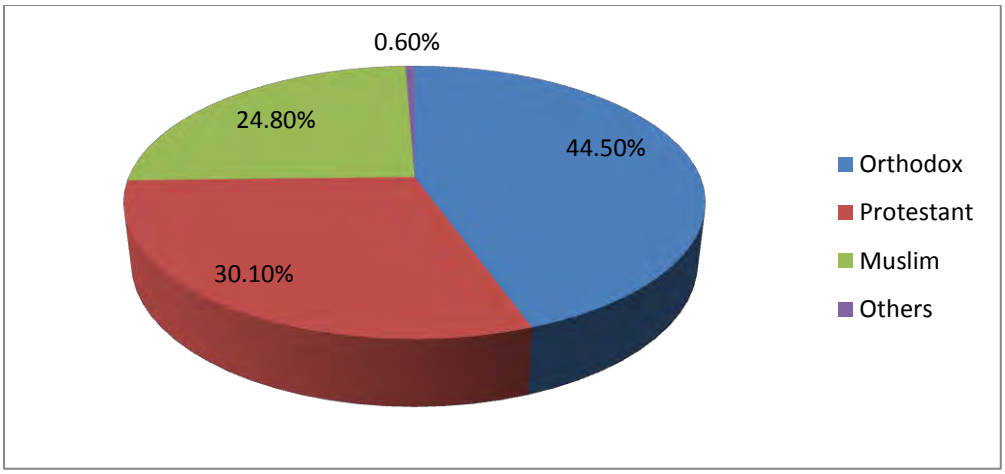

Figure 2: Religions of the study participants, Mizan-Aman town/district, SNNPR, Ethiopia, 2014(n=521)

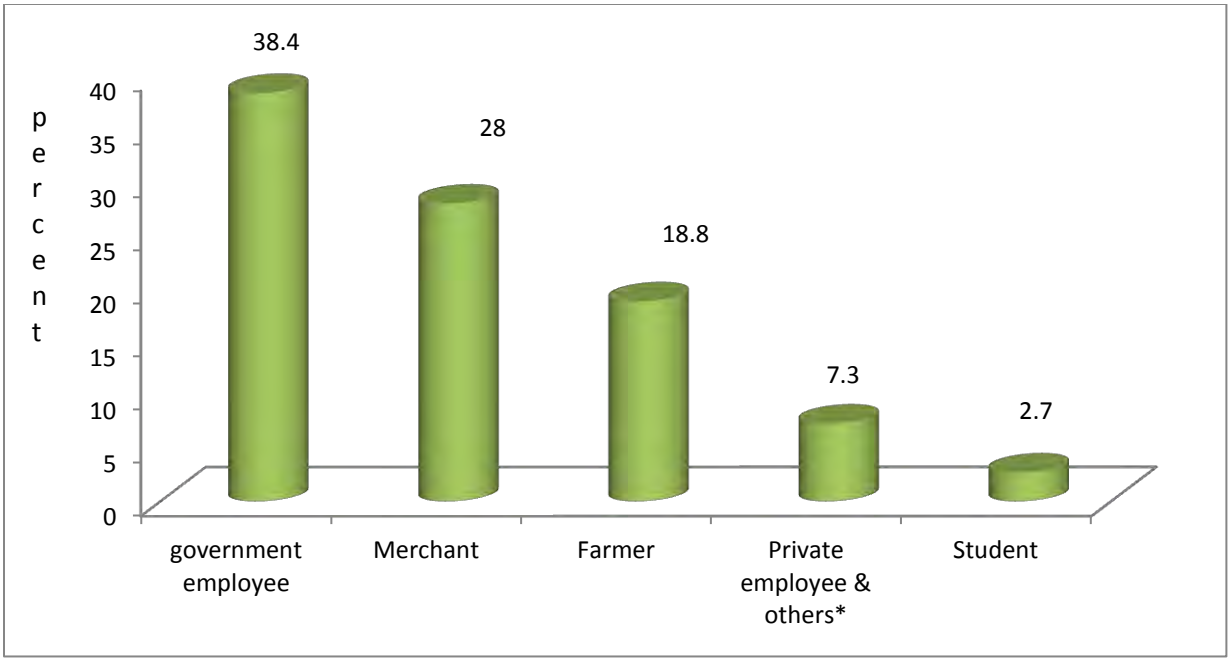

Figure 3: Occupation of the study participants, Mizan-Aman town/district, SNNPR, Ethiopia, 2014(n=521)

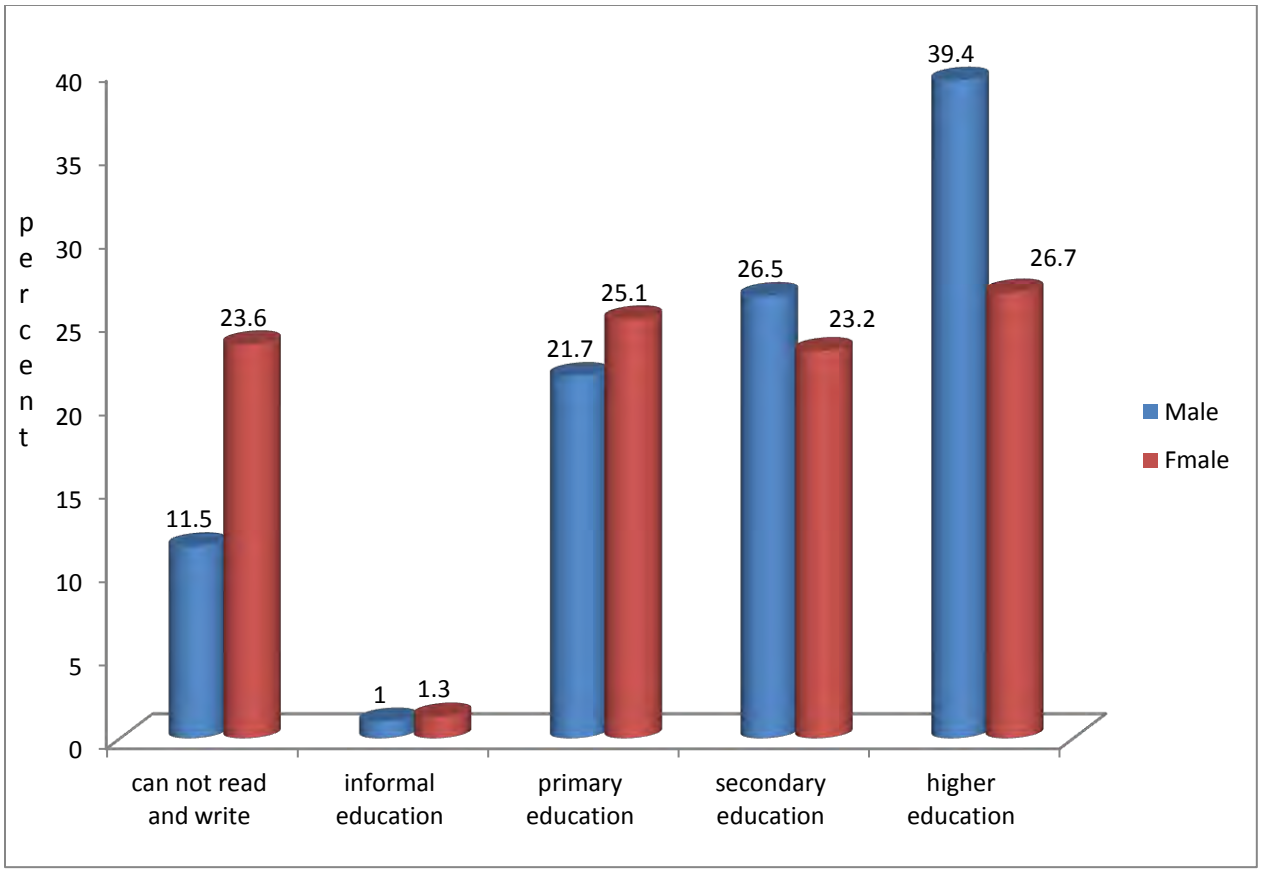

Figure 4: Educational status of the study subjects and their wives, in Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=521)

5. 2. Reproductive characteristics of respondents

Among the study population, 248 (47.8%) married at the age of 20-24 with the mean and SD 22.86±3.7. Of those the majority345 (66.2%) got married before ten years, while the rest within ten years. The Majority 449 (86.2%) were to be the father of the child (had child). Of those who had a child, nearly half 230(51%) were to be the father of their first child at the age 25 and above, while only 3% were below the age of 19 years. The average number of total and currently living children was 3.5 and 3.1 per man respectively, while the average desired number of children was 4.4 per man (Table.4).

Twenty seven percent of the respondents preferred to have the next child within 2 years, while, 41%, and 32% of the respondents wished to have their next child between 2 and 3 years and after 3 years respectively. Only Twenty two percent of respondents had (1-2) no of children that were not alive. More than half 311(59.7%) of the study subjects wished to have another more children, from those, the majority189 (60.8%) wished to have 1-2 no of children, While122 (39.2%) of the respondents wished to have more than five children (Table.4).

Sixty two percent of the study participants had discussed with their wives on the number of children that they want to have, while the rest did not discus. Regarding to wives' desired no of children, nearly three quarter 231(71.1%) of them wanted the same no of children with their partners, while 62(19%), and 28(8.6%) need less and more children than their partners respectively. Fifty seven point two percent of study participants made the decision jointly (either) to have more children or to stop , whereas, 36.5 % left the issue to God /Allah (figure 5).

Table 4: Reproductive characteristics of the study subjects, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=521)

Variable		Frequency	Percent (%)
Age at the first marriage:	≤19	91	17.5
	20-24	249	47.8
	25-29	156	29.9
	≥30	25	4.8
Age at the first child(N=449):	≤19	16	3.6
	20-24	203	45.2
	≥25	230	51.2
No of total born children (N=449) :	0	72	13.8
	1-2	192	36.9
	3-4	142	27.3
	≥5	115	22.1
No of currently living children(n=449 :	<2	201	44.8
	3-4	160	35.6
	≥5	88	19.6
No of children not alive (n=449) :	0	339	75.5
	1	69	15.4
	≥2	41	9.1
Wanting more children :	Yes	311	59.7
	No	182	34.9
	I do not know	28	5.4
How many children do you want?(n=311):	1-2	189	60.8
	≥3	122	39.2
The respondents Desired no of children:	1-2	93	17.9
	3-4	252	48.4
	≥5	176	33.8
Discussion with wife on the No of children to have :	No	197	37.8
	Yes	324	62.2
Wives desired no of children(n=324):	the same	231	71.3
	Less children	62	19.1
	More children	31	9.5

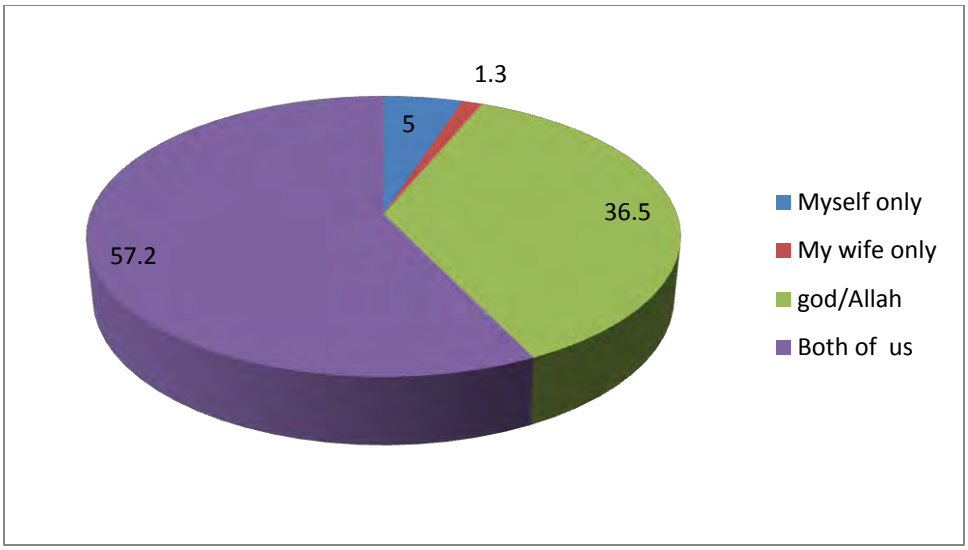

Figure 5: The decision making power of couples on either to have or stop child bearing in the study area, SNNPR, Ethiopia, 2014(n=521)

5.3. Knowledge of study participants on Long Acting and Permanent Contraceptive Methods.

All study participants were asked whether they had ever heard about modern family planning or not and in particular for LAPMs. Most 508 (97.5%) of them reported that they heard about modern family planning, while only 394(78%) of them had ever heard about LAPMs. Table 5 revealed the percentage of respondents who knew the specific LAPMs methods.

The most commonly known modern family planning method reported by study participants was Pills 508 (97.5%), followed by injectables 506 (97%), male condom 381 (73.1%), Norplant 381 (73.1%), and IUD 362 (69.5%). But Female condom 212 (40.7%), Female Sterilization156 (30%), and male sterilization 149 (29%) were mentioned less frequently (figure 6). At the same time, as in LAPMs, implants 388 (98.5%) and IUCD 349 (88.6%) were mentioned mostly, while male sterilization147 (37.3%) was the least known reported methods (Table.5).

Respondents were also asked whether pregnancy is possible or not after female sterilization, and more than half 217 (55.1%) of them responded that pregnancy cannot happen after sterilization while the rest of them177 (44.9%) mentioned that pregnancy is possible. They were also asked the advantage of LAPMS, and 370 (94%), 309 (78.4%), and 216(54.4%) of respondents said spacing of child birth, limiting the number of children to be born and reducing maternal and child death respectively as uses of long acting and permanent contraceptive methods (Table.5).

Among those who had ever heard about LAPMs, the majority 344 (93.1%) of them had heard messages of LAPMs in the last 12 months through the mass media. Regarding to the source of information about LAPMs, eighty seven percent got from health institution, while only 30 (7.6%) got information form NGO (Table.5).

Table 5: Knowledge of the study subjects on modern FP, particularly on LAPMs, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=521)

Variable		Frequency	Percent (%)
Ever heard about modern FP:	No	13	2.5
	Yes	508	97.5
Ever heard about LAPMs (n=508):	No	114	22.4
	Yes	394	77.6
Heard message on LAPMs through mass media about (n=394):	No	27	6.9
	Yes	367	93.1
Knowledge of the respondents about LAPMs.			
Low		211	40.5
Moderate		138	26.5
High		172	33
The Awareness of the respondents on specific LAPMs n=394			
IUCD		349	88.9
Implant		388	98.5
Female sterilization		148	37.6
Male sterilization		147	37.3
Purpose of LAPMs(n=394)			
Prevent unwanted pregnancy		350	88.8
Reduce Maternal and Child death		216	54.8
For limiting		309	78.4
For spacing		370	94
Source of information for LAPMs (n=394)			
Health institutions		344	87.5
Family members		71	18
Friends		126	32
Media		292	73.9
NGO		30	7.6
0thers**		20	5.1

Others** school,

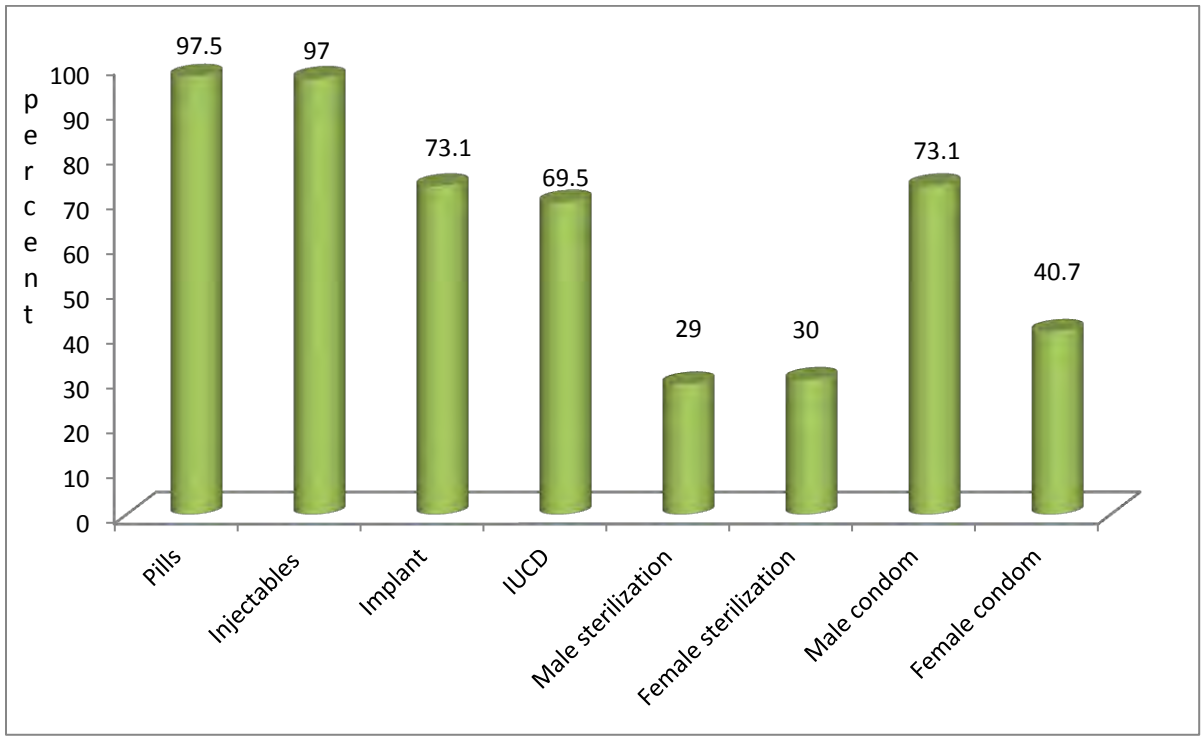

Figure 6: The awareness of respondents on specific modern FP, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=521)

5.4. Attitudes of the respondents toward Long Acting and Permanent Contraceptive Methods

From study participants more than half 281 (54%) of men approved the use of long acting and permanent contraceptive methods. Among those who did not support the use of LAPMs, 118 (49.2%) mentioned religious prohibition, whereas, 66 (27.5%), 55 (22.9%), 25 (10.4%), and 22 (9.2%) reiterated the need for more child, because fear of side effect, they did not accept, health problems, and culture respectively as reasons not to support the use of LAPMs (Table.5).

More than half 345 (66.2%) of the study subjects disagreed to discus about LAPMs with their wife /partner, while 69 (13.2%), 31 (6%), 69 (13.2%), and 7 (1.3%) were strongly disagreed, not sure, agreed and strongly agreed respectively to discuss about the use of LAPMs with their spouses. The respondents were also asked about their agreement, whether male sterilization could cause sexual impairment /impotence. And more than half 307 (59.2%) were not sure, whereas 15 (2.1%), 120 (23%), 69 (13.3%), and 10 (1.9%) were strongly disagreed, disagreed, agreed, and strongly agreed respectively. Regarding to attitude category, 179 (34.4%) had unfavorable attitude, while 130 (25%) had favorable attitude and the rest 212 (40.7%) were indifferent (Table.6).

Table 6: Attitude of the study subjects towards LAPMs, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=521)

Variable	Frequency	Percent
Support the use of LAPMs		
No	240	46.1
Yes	281	53.9
Wife's approval of the use of LAPMs		
Yes	318	61
No	132	25.3
I do not know	71	13.6
Information about LAPMs should be available for males		
strongly disagree	2	.4
Disagree	16	3.1
not sure	18	3.5
Agree	312	59.9
strongly agree	173	33.2
Discussion with wife about LAPMs is not good		
strongly agree	7	1.3
Agree	69	13.2
not sure	31	6.0
Disagree	345	66.2
strongly disagree	69	13.2
Male sterilization is not acceptable		
Strongly agree	20	3.8
Agree	95	18.2
Not sure	145	27.8
Disagree	239	45.9
Strongly disagree	22	4.2
IUCD averts daily work		
Strongly agree	5	1.0
Agree	67	12.9

Not sure	212	40.7
Disagree	212	40.7
Strongly disagree	25	4.8
Long acting contraceptive cause infertility		
Strongly agree	4	0.8
Agree	109	20.9
Not sure	219	42.0
Disagree	167	32.1
Strongly disagree	22	4.2
Male have to share LAPMs use		
Strongly disagree	16	3.1
Disagree	132	25.3
Not sure	76	14.6
Agree	249	47.8
Strongly agree	48	9.2
Male sterilization causes impotence		
Strongly agree	10	1.9
Agree	69	13.2
Not sure	307	58.9
Disagree	120	23.0
Strongly disagree	15	2.9
Only Male should decide on FP		
Strongly agree	7	1.3
Agree	50	9.6
Not sure	90	17.3
Disagree	286	54.9
Strongly disagree	88	16.9
Attitude towards LAPMs		
Unfavorable	179	34.4
Indifferent	212	40.7
Favorable	130	25

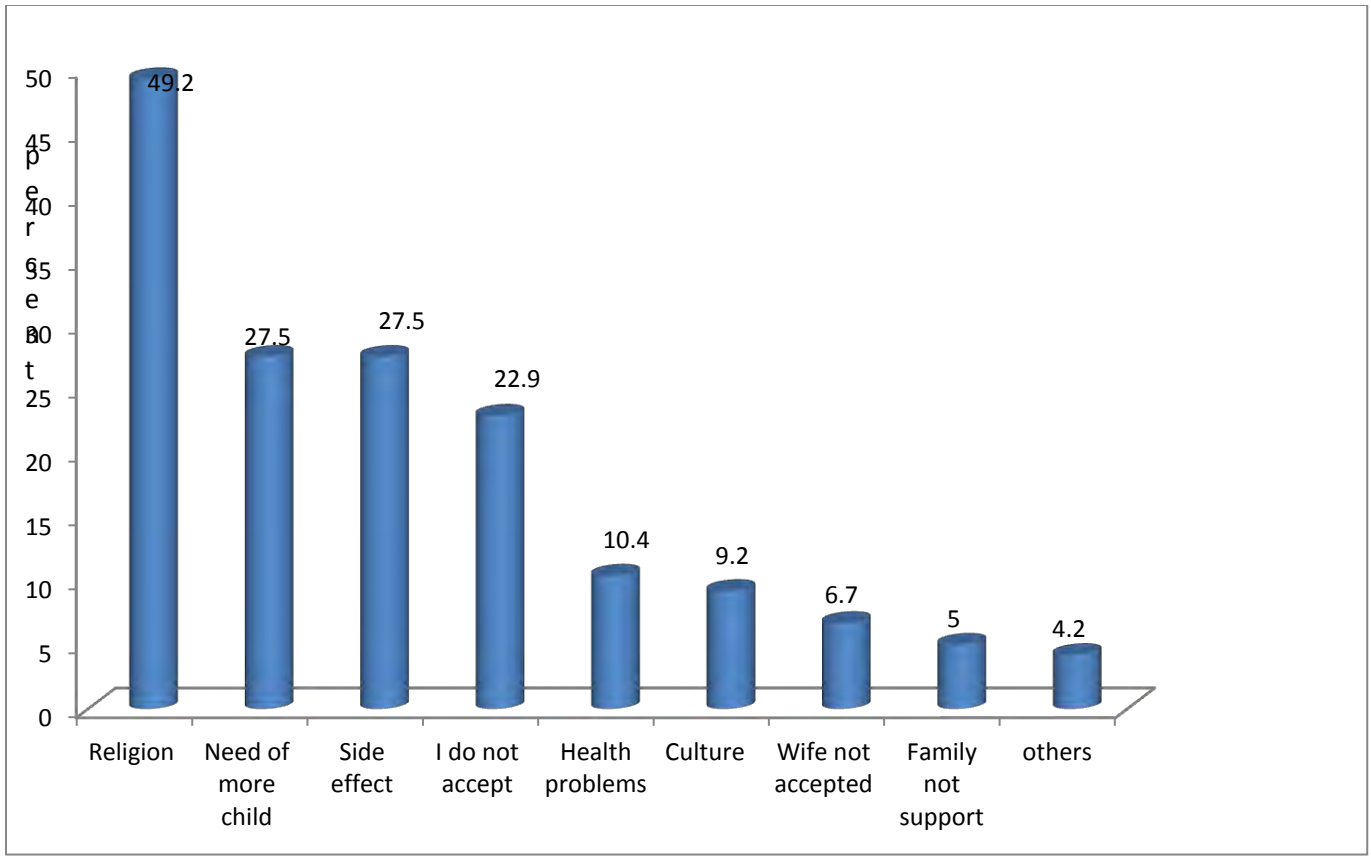

Figure 7: The reason of those who do not support the use of LAPMs, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=240)

5.5. Current use of Long Acting and Permanent Contraceptive Methods by respondents or their spouses

LAPMs were used by 60 (11.5%) of study participants' wives, while 75 (14.4%) of the respondents' wives has been ever-users, and the rest were non-users. Currently, the most commonly used methods by the respondent's wives was implant by 51 (85%), while IUCD by 9(15%) of the respondents, but there is no anyone who underwent either female or male sterilization in the study area (Table 7).

About 171 (32.8%) of the respondents reported as, they discussed (communicated) about LAPMS with their wife in the last 12 months, whereas 28 (5.8%) did not remember whether they discussed or not and the rest did not discuss at all. Of those who had discussed, more than half 128 (64.3%) had discussed many times, while 38 (19%) of them did not remember how many times they discussed (table 7). Of those respondents whose wives had currently used LAPMs, The majority43 (71.5%) of them reported as the choice was done by both, while 10 (16.7 %) and 7(11.8%) was by the wives and the respondent lonely respectively (Table 7).

Regarding to the decision on current use of LAPMs, 50 (83.3%) of respondents made the decision jointly, while eight point three percent of the respondents made a decision by themselves only. The majority 59 (98.3%) of the respondents reported that their wives got the service from public health facility free of charge. Regarding to the role of males in LAPMs utilization, the majority367 (70.4%), of the respondents indicated that the role of the male should be to know the advantages of LAPMs and tell their wives and discussion with the wife about utilization of LAPMs. Whereas, 90 (17.3%) of study subject indicated as they had to use the methods by themselves (Table 8).

The study subjects were asked whether they want to use LAPMs in the future and176 (33%) of them wanted to use LAPMs in the future and the rest do not want. For the majority142(80.7%)of the respondents, implants was the preferred types of LAPMs to be used by their wives in the future , Followed by IUCD (17.6%), but only three study participants wanted female sterilization to be used by their wives (Table 8).

Table 7: Current use of LAPMs among married men aged 20-64 years or their spouse, in Mizan-Aman town/district, SNNPR, Ethiopia, 2014(n=521)

Variable	Frequency	Percent
Ever user: No	446	85.6
Yes	75	14.4
Types of LAPMS that were used by ever users n=75		
Implant	65	86.7
IUCD	10	13.3
Currently are you using or stopped? (n=75)		
Stopped	15	20
Using	60	80
Types of LAPMs that are Currently used n=60		
Implant	51	85
IUCD	9	15
Whose choice is the current LAPM n=60		
My wife	10	16.7
Myself	7	11.7
Both of us	43	71.7
Who made the decision on LAPMS that your wives used currently? (n=60		
My wife	5	8.3
Myself	5	8.3
Both of us	50	83.3
Discussions about LAPMs in the last 12 months with their wives. No	322	61.8
I do not remember	28	5.4
Yes	171	32.8
Number of discussion with their wives (n=171)		
Once	11	5.5
Twice	22	11.1
many times	128	64.3
I do not remember	38	19.1
Whose idea was accepted during discussion n=171		
Mine	75	37.7
my wife/partner	80	40.2
Both of us	44	22.1
Going to health facility with their wives to discus about FP with heath providers. No	363	69.7
Yes	158	30.3

Table 8: Intention to use LAPMs in the future, and Responsibility of male in LAPMs utilization among married men aged 20-64, in Mizan-Aman town/district, SNNPR, Ethiopia ,2014(n=521)

Variable	Frequency	Percent
Reasons for not going to health facility with their wife to discus about FP with heath providers (n=363)		
Female task	139	38.3
Providers not allowed	16	4.4
Culture	97	26.7
Religion	39	9.4
Since I am busy	67	12.7
Intention to use LAPMs in the future		
No	345	66.2
Yes	176	33.8
Type of LAPMs that would be preferred for future use (n=176)		
Implant	142	80.7
IUCD	31	17.6
Female sterilization	3	2.3
Responsibility of male in LAPMs utilization		
Support wife to use	282	54
Use the methods by themselves	90	17.3
Allocate budget for it	124	23.8
Support in chore so as female use LAPMs	185	35.5
Discussion with wife about utilization	358	68.7
Know the advantages and tell the partner/wife	367	70.4
Have no role	47	9.2

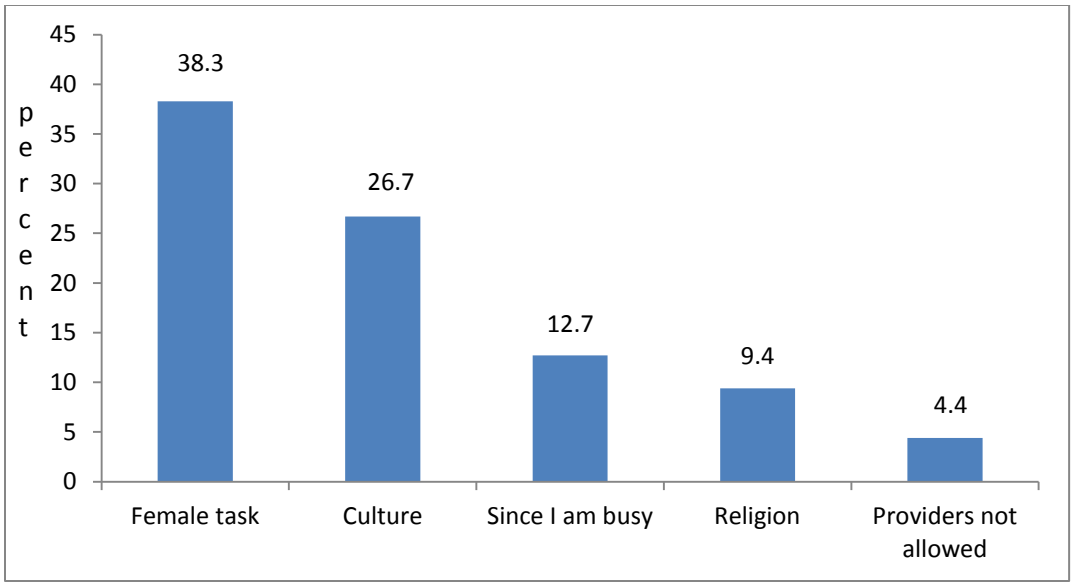

Figure 8: Reason for those who did not go to health facility with their wives to discuss about FP with health providers in Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=363)

5.6. Reasons for non-users, discontinuation among previous users, and not using LAPMs in the future

Among respondents, the majority 446 (85.6%) of their wives was non-users of LAPMs. Various reasons were given during the interview for not using LAPMs. Of those, religion, desire to have more children, fear of side effects, and respondents' opposition were the most important reason that accounts 179 (40%), 172 (38.6%), 149 (33.4%), and59 (13.2%) respectively (figure.5). Among the respondent's wives who had ever-used LAPMs, fifteen had stopped using LAPMs. The men were asked why their wives stopped using LAPMs. And the majority (10) of them reported as their wives had stopped because they want to have more another children. While others three and one were due to a medical problem and fear of infertility in that order (Table.8).

The majority 345 (66.2%) of study participants did not want to use LAPMs in future. The respondents revealed that fear of infertility187 (54%), fear of side effect 75 (21.7%), and religion 155 (44.8 %) were their main reason (Table.8).

Table 9: Reasons for discontinuation among previous users and not using LAPMs in the future, in Mizan-Aman town/district, SNNPR, Ethiopia, 2014 (n=521).

Variable	Frequency	Percents
Reasons for discontinuation among previous users(n=15)		
Need more child	10	66.7
Heath problems	3	20
Religion	1	6.7
Others	3	20
Reason for not using LAPMs in the future (N=345)		
Fear of s/e	75	21.7
Fear of infertility	187	54
Need of more child	56	16.2
Culture	35	10
Religion	155	44.8

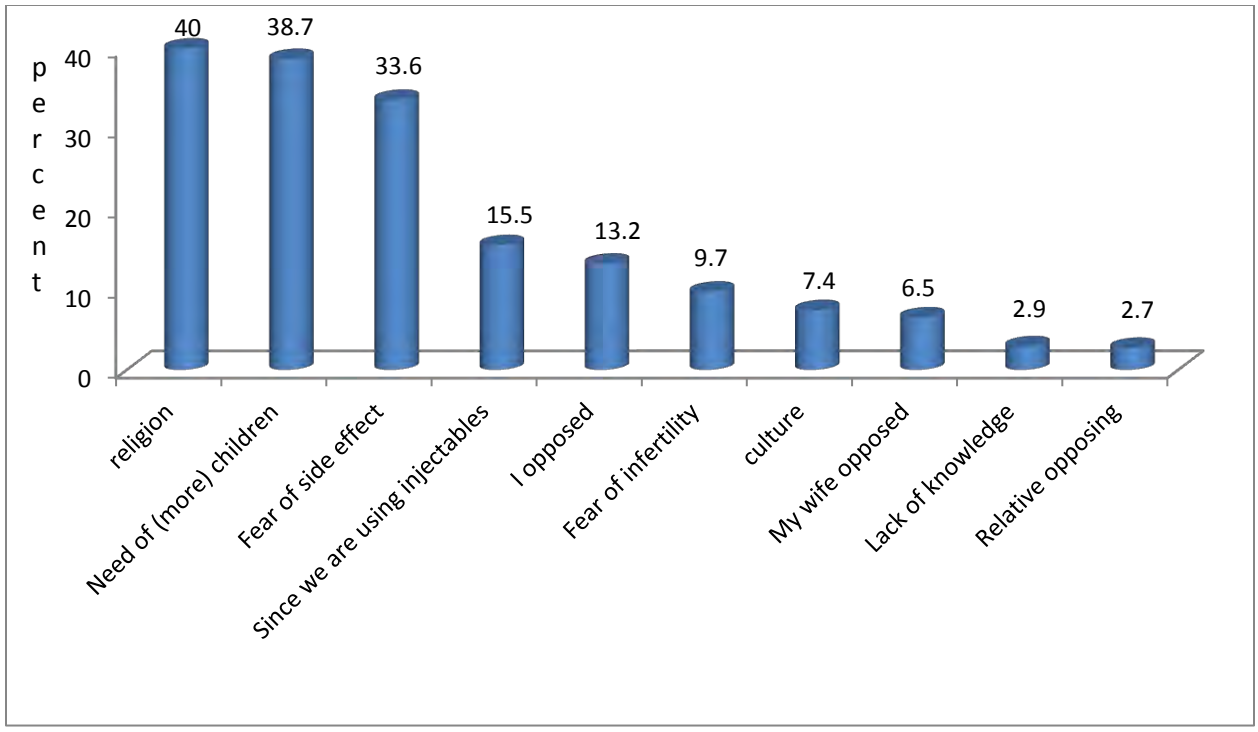

Figure 9 : Reason for non users of the study participants, in Mizan-Aman town/district, Ethiopia, SNNPR, 2014(n=446)

5.7. Factors associated with the current utilization of Long Acting and Permanent Contraceptive Methods among married men or their spouses

The result of binary logistic regression analysis on the association between independent variables and the current utilization of LAPMs showed that men whose age groups 20- 30 and 31-40 years were COR=2.2 (95% CI: 1.1- 4.5) and COR=1.7 (95% CI: 2.8-3.5) times respectively more likely to use LAPMs compared to those who were in the age group of 41 years and older (Table 10).

This study also revealed that a strong association existed between the use of LAPMs and education status of wives. Men whose wives attained primary, secondary, and higher level of education were (COR =3.3 (95% CI: 1.3-8.5, COR=3: (95% CI: 1.1-7.9) and COR=2.9: (95% CI: 1.1-7.6) times respectively more likely to use LAPMs compared to wives who could not read and write. Besides, there was also a statistically significant association between wives occupation and current utilization of LAPMs. Men whose wives were governmentally employed, private employee, and students were (COR=2.1: (95% CI: 1.1-4.2), COR= 3 (95% CI: 1.3-6.9) and COR=2.3 (95% CI: 1.1-4.7) times respectively more likely to use LAPMs compared to those who were house wives (Table 10).

Men who had ever heard about LAPMs were (COR=4.1 (95% CI: 1.5-11.6) times more likely to use LAPMs than those who had not ever heard. Similarly, those men who heard media messages on LAPMs in the last 12 months were (COR= 5.3 (95% CI: 2.1-13.4) times more likely to use LAPMs compared with those who were not exposed to messages about LAPMs (Table 10).

This study also showed that men who supported the use of LAPMs were (COR=11.4 (95% CI: 4.5 - 29) times more likely to use LAPMs compared to those who did not support the use of LAPMs. It also revealed that the attitude towards LAPMs and the knowledge about LAPMs of men had significant association with wives current utilization of LAPMs. That is Men who had favorable attitudes towards LAPMs were (COR= 4.8 (95% CI. 2.3-10) times more likely to use LAPMs than those who had an unfavorable attitude (Table 10).

Similarly, men who had high and moderate knowledge of LAPMs were (COR=9.4 (95% CI: 3.1-28.8) and COR=5.4 (95% CI: 1.8-16.4) times respectively more likely to use LAPMs compared to those who had low knowledge of LAPMs.

Men whose desired number of children were less than two and 3-4 were (COR=3.1 (95% CI: 1.4 – 7) and COR=2.3 (95% CI: 1.1 - 4.6) times respectively more likely to use LAPMs compared to those who desired five or more children. And those men who wished to have the next children in the coming three or more years were (COR=2.1(95% CI: 1 -4.2) times more likely to use LAPMs than those who wished to have it within two years. Men who had discussed with their wives on the no of children they want to have, were (COR=6.4 (95% CI: 2.7 -15.1) times more likely than those who did not discuss (Table 10).

A strong association was also found between discussion about LAPMs in the past 12 months and current utilization of LAPMs. Those who had discussed with their wives about LAPMs in the past 12 months were (COR= 8.8 (95% CI: 4.7 -16.6) times more likely to use LAPMs than those who did not have such a discussion. Moreover, those who reported joint decision- making to have another child or to stop childbearing were (COR= 4.4 (95% CI: 2 -9.5) times more likely to use LAPMs compared to those who said God/Allah knows. In addition to this, men who went with their wives to health facilities to discuss about LAPMs with health providers were (COR= 6.9 (95% CI: 3.8 -12.5) times more likely to use LAPMs compared to those who did not accompany their wives to health facilities (Table 10).

After controlling most demographic, social, economic and reproductive health characteristics of married men through the use of multivariate Binary Logistic Regression analysis, this study showed that discussion with wives on the number of children they want to have and about LAPMs in the last12 months, going to health facilities with wives to discuss about FP with health provider, and supporting the use LAPMS were found to be strongly and significantly associated with LAPMs utilization as shown on Table 10 below.

Discussion with wives about LAPMs in the last12 months was significantly associated with utilization of LAMS. Married men who had discussed with their wives about LAPMs in the last 12 months were (AOR=4 (95% CI: 1.9-8.2) times more likely to use LAPMs compared with those who had no discussion with their wives. Similarly, those who had discussed with their wives on the number of children they want to have been (AOR=3.1, 95% CI.1-9.2) times more likely to use LAPMs than those who did not discuss (Table 10).

Married men who accompanied their wives to a health facility to discuss about FP with health provider were (AOR=2.7 (95% CI: 1.3-5.6) times more likely to use LAPMs compared to those who did not do it. Besides, married men who supported the use LAPMS were (AOR=4.5 (95% CI: 1.6-12.5) times more likely to use LAPMs than those who did not support (Table 10).

Table 10: Factors associated with the current utilization of LAPMs among married men or their spouses, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014(n=521).

Variable	Utilization of LAPM		COR(95%CI)	AOR(95%CI)
	no	Yes		
Age group of the respondent				
20-30	151	27	2.21 (1.10-4.45)*	0.63(0.26-1.54)
31-40	149	20	1.66 (2.80-3.46)*	0.96(0.39-2.38)
>41	161	13	1.00	1.00
Wives educational status				
No education	117	6	1.00	1.00
Primary school	118	20	3.31(1.28-8.52)*	1.21 (0.56-4.56)
Secondary school	105	16	2.97 (1.11 -7.87)*	2.32(0.78-6.91)
Higher education	121	18	2.90(1.11-7.56)*	1.82(0.73-4.56)
The respondents desired no of children				
1-2	77	16	3.12(1.38-7.03)*	4.13(0.86-19.87)
3-4	219	33	2.26(1.11 -4.61)*	1.11(0.42-2.98)
≥5	165	11	1.00	1.00
Wives occupation				
House wife	239	19	1.00	1.00
Government employee	102	17	2.10 (1.05-4.20)*	1.60(0.56-4.55)
Private employee	42	10	3.00 (1.30-6.90)*	2.32(0.80-6.91)
Student &Others	78	14	2.26(1.08-4.71)*	1.82(0.73-4.56)
Discussion with wife/ wives on the no of children to have				
No	191	6	1.00	1.00
Yes	270	54	6.37 (2.69-15.10)*	3.05(1.01-9.18)*
Ever heard about LAPMs				
No	99	5	1.00	1.00
Yes	338	55	4.10(1.45-11.59)*	0.32 (0.02-4.28)
Exposed to message through the mass media about LAPMs in the last 12 moth				
No	149	5	1.00	1.00
Yes	312	55	5.23(2.06-13.40)*	2.57(0.26-25.43)
Supporting the use of LAPMs				
No	235	5	1.00	1.00
Yes	226	55	11.44(4.50-29.09)*	4.46(1.59-12.49)*

Knowledge about LAPMs				
low knowledge	201	10	1.00	1.00
moderate knowledge	121	17	9.41(3.08-28.78)*	1.96 (0.62-6.20)
High knowledge	139	33	5.42(1.79-16.41)*	2.18 (0.72-6.66)
Attitude towards LAPMs				
Unfavorable attitude	170	9	1.00	1.00
Indifferent way	190	22	2.82 (1.25-6.37)	1.25 (0.46-3.37)
Favorable attitude	101	29	4.77 (2.28-10.00)*	1.53(0.58-4.01)
Communication with wife/wives about LAPMs in the last12 month				
No	336	14	1.00	1.00
Yes	125	46	8.83(4.69-16.63)*	3.96(1.90-8.23)*
Going to health facility with wife/wives to discuss about FP with health provider				
No	345	18	1.00	1.00
Yes	116	42	6.94 (3.84-12.53)*	2.71(1.32-5.55)*
Who made decision either to stop/to have more children				
Either husband/wife only	29	4	3.14(0.90-11.09)	4.13(0.86-19.87)
Both(husband and wife)	250	48	4.37(2.02-9.46)*	1.12 (0.42-2.98)
God /Allah	182	8	1.00	1.00
Birth orders				
<2years	128	13	1.00	1.00
2-3 years	195	18	0.91(0.43-1.92)	0.60 (0.23-1.55)
Above three years	138	29	2.01(1.03-4.15)*	0.81 (0.32-2.06)

* Indicates the significance of association

6. Myths, Misconceptions and Opinions of Men towards LAPMs through a Qualitative Study

After the audio records were transcribed into Amharic and translated into English using MS Word Software, it was imported into Open Code software for coding and categorization. Different codes were given line by line for each statement, then categories were developed according to the content of the in depth interview. Main categories of the in depth interview were, knowledge and perception on LAPMs, reasons for not using LAPMs, Myths and misconception towards LAPMS, the role of men in LAPMs utilization and Quality of service and related problems. Many codes were grouped into each category by making the categories flexible.

Table 11: The theme, categories, and codes as identified from qualitative data, Mizan-Aman Town/District, SNNPR, Ethiopia, 2014

Theme	**Factors associated to low utilization of LAPMs**				
Category	Knowledge and perception on LAPMs	Reason for not using lAPMs	Myths and misconception towards LAPMs	The role of men in LAPMs utilization	Quality of service and related problems
Code	knowledge gap low awareness important misperception negative attitude	knowledge gap low awareness misconception culture fear sin	Fear Sin knowledge gap low awareness misconception	Support Share Influential Use the methods	No problem It is good Lack of follow up No education

6.1. Knowledge and perception on LAPMs

Concerning the knowledge of LAPMs, almost all the respondents knew about LAPMs with their advantage, however, considerable misinformation about specific methods persists. Some participants were not aware of male sterilization. The informants explained there were huge gap in the awareness of the community towards LAPMs. Informants elucidated that lack of awareness and knowledge gap are the key barriers for utilization of LAPMs. Among the informants a woman aged 35yearsold described as,

> "*Majority of the society did not know about LAPMs. The only known method is injectables and pills. The awareness is somewhat low towards LAPMs, so health professional has to do more to change the awareness and the attitude of the society".*

In relation to their thoughts (perception) linked to the utilization of LAPMs, participants believed that it is very essential to balance their household size with their economy and decide on the number of their children they wanted to have. Another 45 years old male participant said that,

> *"LAPMs are very important since it enabled us to balance household size with our economic capacity. If one has many children, he /she cannot send all children to school, buy appropriate clothing, and even cannot feed them properly. So they will be the burden of the family, community and for the country at large. So, using LAPMs is very mandatory"*

6.2. Reason for not using LAPMs

The participants were informed about the impact of high population growth, and what is the impact of fast population growth. However, the utilization of LAPMs in the community was low because of different factors. As the informants elucidated, culture, religion, knowledge gap and low awareness on LAPMs, and misconception towards LAPMs were the commonest reasons. Religious beliefs and faiths are powerful influences on individuals and communities and can affect behaviors, including health practices. 35 years old female participants elucidated as,

> "*Stopping of child bearing by using FP is considered as sin. Some said that it is the same as killing of a person. But this is not good, in my opinion if we do not feed, dress, and educate them properly, it is better to have few children."*

Similarly 31 years old male participants described as,

> *"In our community the usual understanding is, when the child is born it is not born only with mouse but also with foot and hand, so he can do and live by his own and when we got old he/she may help us. If you have only one child he/she may pass away so it is better to have more children."*

Another factor that hinders the use of LAPMs is culture. Most participants indicated that, as it needs more efforts to be changed, and the community must be educated just to bring on the truck. *Forty seven years old male participants elucidated as,*

> "*In our community, one male can marry up to seven wives. This is an accepted norm for the rich in the area. One is said to be a rich man, when he had more than two wives and many children. Those thoughts hinder the society from utilization of FP. So education is important to change the society's attitude".*

But in the contrary, program officers described as,

> "*In the previous time there was cultural and religious thoughts that are against LAPMs use. The society had been proud by their high number of children. Even when they are talking with their friends they said I have this much number of children, and some considers their children as an asset. But now the community changes their thoughts, because of community education. They are in good truck. Now in my onion there are no either cultural or religious problems."*

6.3. Service quality and related problems

The study revealed several issues with availability and quality of services. In general, providers understood clients' expectations about quality, but admitted that it was sometimes difficult for them to meet these expectations. In reality, client's desire for a specific service might not be provided. The client was offered the methods of FP based on their choice. There were no problems with supplies and equipment; often the methods were supplied by Non-Governmental Organizations. But the HEWS complained of high workload due to an insufficient number of trained providers. This problem also leads to increased waiting time for clients. There was controversy regarding perceived service related problems in the community.

A thirty three years old male informant explained as,

"There is no any problem related to service provision by professionals. The problem is mainly due to our cultural barrier and other problems. Even if people wanted to use they should like to use it secretly because they fear the rumors from society."

On the contrary 45 year male informants described as,

> *"There is no follow up. There is no anyone who gives house to house education. So there is huge gap related to awareness creation and mobilization,"*

6.4. Myths and misconception towards LAPMs

Myths and misconceptions are also widespread on LAPMs in the community. Some expressed their fear that if they use LAPMs, it may migrate to the brain, and make them crazy, and then finally it will kill them. Similarly, few others believed that a woman with an IUCD or implant could not easily engage in energy demanding works, so they felt as this method is inappropriate for rural women and those who are in hard work. Others believed that a woman used such methods for a long time may not give birth to a child and finally she may develop cancer.

The other misconception is that couples should not use family planning methods early in their childbearing years, because they would be infertile. Another common misconception was that the IUD pierces the wall of the uterus and get lost in a woman's abdominal cavity, thereby causing life threatening condition. Similarly, others perceived that LAPMs had psychological, mental, and physical impact on the child who will be born after its use. They believed that the child who is born after an extended use of LAPMs would be physically inactive and mentally retarded. A forty five years old male participant revealed that:

> "Some said that, the *method is not good and correct because it has psychological, mental, and physical impacts on children born after utilization. There are also some who said children become mentally retarded. On the other hand on female IUCD may cause cancer, Diabetes Mellitus, and hypertension"*

Similarly anther 45 years old male participants said that,

"IUCD may reduce sexual pleasure, it does not feel good. It also causes cancer, conflicts between husband and wife, and prevents users from doing their routine work. Implant also prevents one from doing hard work, since it makes the hands of users very weak. "

6.5. The role of men in LAPMS utilization

The participants described as most of the decisions which affect family life were made by men. Except those who are in higher education status who made the decision jointly by discussion, men hold positions of leadership and influence in household decisions. They explained the fact that such norms are related to past trends, culture, and knowledge gap between husbands and wives. The informants said, men mostly spent their time outside, that made them to be exposed to different information. In addition to that, they are more likely to be educated than women. This and other factors made them household decision makers. All participants confirmed that male involvement in the utilization of LAPMs is very crucial. Some said that, their role is not only to support the wives to use, but also they have to use the methods by themselves. 36 years old male informants who is a teacher described as,

"Since they are family leaders, they have to play a great role. Men have the power to influence and persuade their wives. So for me, it is good to change the attitude of male, because they can easily change the attitude of their wives or even they can use the method by themselves. But if we try to change the attitude of female only, we cannot be successful. And there must be alternative methods, for male also, as that of females."

Similarly, 26 years female participants illustrated as,

"*Decisions are mostly done by men. But there are some who are discussing with their wives. Women lack information because they mostly stay at home and they are not educated equally as men. If men said" if I can feed, educate and dress them, I can born what I want, it is not female's business."*"

7. Discussion

The results of the study revealed that the proportion of men who had ever heard about LAPMs was 394 (78%) and the proportions of respondents who had low, moderate, and high knowledge was 40.5%, 26.5%, and 33% respectively. In Ethiopian demographic and health survey of 2011 the level of awareness for female sterilization, male sterilization, IUCD, and implant was 46.8%, 17.6%, 27.5 %, and 63.5% respectively. This indicates as there is an improvement in the level of awareness which may be explained by advancement of information, education and communication to the community by media and HEW. It also revealed that 25%, and 34.4% of men had favorable and unfavorable attitudes correspondingly. And 281(54%) of men were approved the use of LAPMs. This is a good progress when it is seen with our national reproductive health strategy (2006 - 2015) that affirmed increase contraceptive prevalence to 60 percent by the year 2010 and couples' approval of FP to 75 percent by 2015. This may be due to that the government has given due attention and change of communities' awareness and perception through mass media advertisement. This may be also the contribution of HEW.

The results of the study also revealed that the proportion of men whose wives currently using LAPMs was 11.5 % in the Town/District. This result is in line with that of a study done in Mekele Town and Wolita zone , which were 12.3% and 12.2% respectively (25, 31). However, it was higher than the study done in Goba Town in Bale Zone which was 8.7% (36) And EDHS result of 2011 which was 4.2 %(6). The qualitative result also underpins this result, one participants elucidated as," in the previous time there were cultural and religious thoughts that are against use of LAPMs. And the individual was being proud by their high number of children. And even some considers their children as an asset. But now the community has changed their thoughts, because of community education". This may be explained by the increment of advertisement through mass media, and community mobilization by government and nongovernmental organization. The population pressure due to the high economic recession may be also one factor that may force individual to use LAPMs. And the contribution of HEW might not been forgotten.

The utilization rate for each method was 85%, and 15% for implant and IUCD respectively in this study. This is also in line with the study done in Mekele Town and Goba Town (25, 36). However, there were no anyone who used vasectomy (male sterilization) among the respondents

and tubal ligation (female sterilization) among the respondents' wives. The qualitative result complemented this findings, one informant described the context as follows, "We heard about male and female sterilization, but there was no one who used it in our community, because we heard that such methods bring about total infertility. So, these methods are not good." This may be explained by perceived side effects, low awareness, and misconceptions of both the study subjects and their wives. The non reversibility of the method might be also another thing, which makes them to be frustrated.

The study has also revealed that there was a statistically significant association between supporting LAPMs and its utilization in the study area. Men who supported the use of LAPMs were more likely to use LAPMS compared to their counterparts. This finding is in agreement with previous studies conducted in other areas of the country (26-27, 34, 38, 42) and elsewhere (34, 43-45). The qualitative result augmented this finding. One of the participants described that," since men are heads of the family, they can influence and persuade their wives. Hence, the attitude of male towards use of LAPMS has to be changed, because they can easily change the attitude of their wives or even they can use the method by themselves." Lack of support from the husband not only hinders contraceptive use, but could also lead to premature termination of use of LAPMs. And respondents who approved use of family planning methods are more likely to ensure that their favorable attitude is translated into high use of LAPMs.

Those who had discussed their wives about LAPMs in the last 12 months were more likely to use LAPMs than those who did not have such a discussion. The finding is in line with another study done in Jima Town(26), and Wollegazone(24) and outside of the country(30, 44, 46-47) . However, this could be tricky to justify because cross-sectional surveys cannot grant the direction of causation between communication and contraception use. In many cases, it is unclear whether communication, infarct, predicts contraception use, or the use of contraception generates communication between couples.

Similarly, men who had discussed with wives on the number of children they wanted to have were also more likely to use LAPMs than those who did not have the discussion. This finding is in agreement with studies done in other areas of the country (24, 38) and outside the country (30, 46-47). This may be explained by the fact that partners who discussed with wives on the number of children that they wanted to have may have an opportunity to discuss about LAPMs. Partners

may know how to express their desires and feelings without any fears, and easily make out his/her spouse's attitudes and beliefs regarding LAPMs. The partner may think the other is not opposed to use, hence, he/she may not hesitate to discuss about it for fear of angering or annoying their spouse.

Men who had gone to a health facility with their wives to discus about FP with health providers were also more likely to use LAPMs when compared to those who had not gone. These findings are in line with the study conducted in Nigeria, which documented that when the husband went to the health facility with his wife, his resistance to contraception was more likely to be broken and the couple was likely to adopt a method(43). This is may be due to that those who had misconception and confusion towards LAPMs, and fear the perceived side effect of LAPMs would be clear for them when they are discussing with health providers. In addition, those who are going to health facility to discus about FP with health providers are those who may have intention to use.

The qualitative results of this study showed that most of the decisions were made by men this is in line with the study done in other parts of the country and elsewhere (14, 24, 38, 48). This indicates that men are more likely than their wives to influence household decision than their wives. Hence, this makes clear that males' involvement in the utilization of LAPMs have a paramount role in decision making, supporting and encouraging their wives to use LAPMs. Involving men in encouraging communication and joint decision-making on issues like family size and LAPMs use can help them to exercise their responsibility and take in hand their concerns towards LAPMs within their family and outside their family. Men who are aware of the benefits of LAPMs use can be motivated to play a key role in their families and their communities. This is supported by the study done in Cairo which stated that men had the authority for contraception decision-making. In reaction to men's opposition to contraceptive use, women were observed to use covertly. And finally resulted with divorce as potential consequences of covert use when it was exposed(48). This confirm that involving men can lead to better outcomes including those specific to LAPMs knowledge, intra-spousal communication, and LAPMs use and its sustainability .

8. Strengths and Limitations of the study

Strengths

- Combining quantitative and qualitative methods.
- Inclusion of study participants from rural and urban part of the District
- Use of standardized Questionnaires

Limitations

- The study design was cross-sectional, which implies that the direction of causal relationships cannot always be determined. I.e. temporal relations could not be assessed.
- Since this study included only men, the Practice of their spouses might be different from what is measured by this study.
- Perceived social-desirability of responses rather than actual knowledge or practices could be response biases.

9. Conclusions and recommendations

Conclusions

- Awareness and support towards the use of LAPMs were 78% and 54% respectively.
- Utilization of LAPMs in the study area was small. That is only (11.5%) of the respondents reported.
- Discussion with the partners on the number of children they want to have, and communication with the wives about LAPMs in the last 12 months were the most important Factors that were influencing utilization of LAPMs in the study area.
- Respondents' approval of LAPMs' utilization and accompanying spouses to a health facility to discuss about FP methods with health providers were also the other most important factors that were influencing utilization of LAPMs in the town.
- Even if men did not use vasectomy, in cases of decision making, supporting and encouraging of their wives to use LAPMs, they played a valuable role.
- IUCD may migrate to the brain, and make them crazy, then finally it will kill, IUCD or implant prevents from doing routine /daily work, and LAPMs had psychological, mental, and physical impact on the child who will be born after utilization were commonly observed misconception in the study area.

Recommendations

- Health professionals, including HEWs should continuously facilitate discussions between couples on the use of LAPMs and the number of children, couples should have to increase the uptake of LAPMs in the area.
- Besides, men should be encouraged to accompany their wives in FP, ANC and PNC services to initiate discussion by health care providers on the use of LAPMs.
- The media should promote on the use of LAPMs to increase the attitude and involvement of males in the use of such methods.
- Consistent awareness creations should be provided by health service providers and the media to mitigate some of the myths and misconceptions related to LAPMs.
- Researchers should include both females and males to replicate this study.

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ANNEX

1. Conceptual frame work of utilization of Long acting and permanent contraceptive.

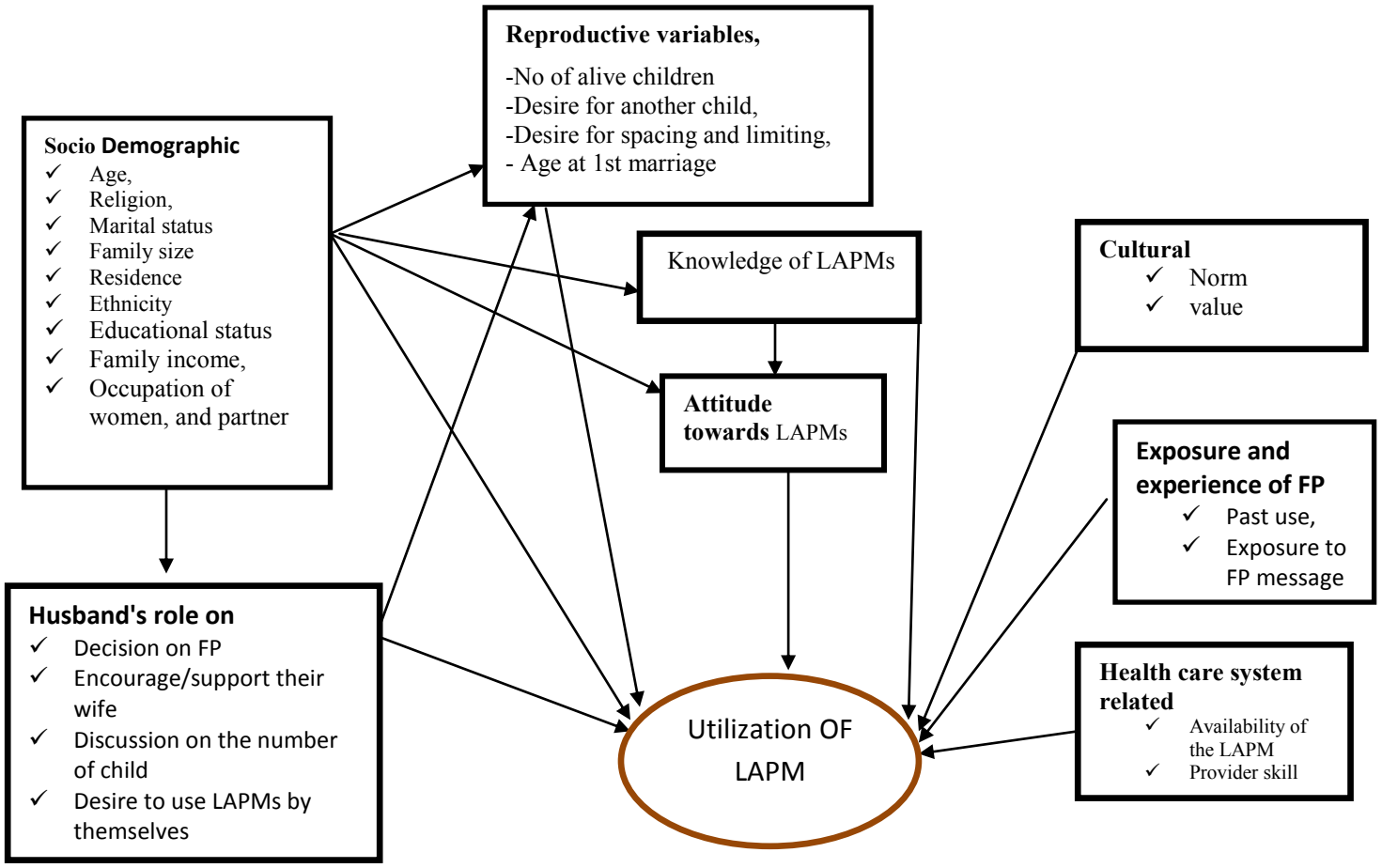

Fig. 1: Conceptual framework of utilization of LAPMs

Map of Bench- Maji Zone

2: QUESTIONNAIRES

English version Questionnaire

Addis Ababa University College of Health Science, School of Public Health

I. Information sheet

Greeting: Good morning/afternoon

My name is _____. I am working as data collector in a survey conducted for the partial fulfillment of Masters Degree in Public Health in Addis Ababa University. The purpose of the study is to explore the role of currently married men aged 20-64years in the use of long acting and permanent contraceptive men, in Mizan_ Aman District, South Western Ethiopia. I would like to ask few questions which would take 30 munities about knowledge, attitude and use of long term and permanent contraceptives among currently married men. Only code number will identify participant and no names will be used. Your response will be kept confidential and participating has no any risk for and the interview will be conducted in private to make safe. Your participation in this study is completely on voluntary basis; you have the right to participate, or not to participate or refuse at any time during the interview. You don't have to answer any questions that you don't want to answer. There will be no way of linking your individual responses to the final results of the study findings. However, Your genuine response that you are going to give is very important to identify the role of men in long term and permanent family planning methods use, and design programs of family planning service in this district and in general to our country . We would very much appreciate your participation in this survey by genuinely responding to the interviews.

II. Informed consent

I have read this form or it has been read to me in the language I comprehend and understand all conditions stated above. Therefore I can decide whether participate or not in this study.

Would you be willing to participate?

Yes ☐ No ☐

Signature_____

Name of Principal investigator: Kebadnew Mulatu

Address: Tell: 0924491976; Email: kebadmulatu@gmail.com

Name of institution: Addis Ababa university college of Health Science IRB

Address: Addis Ababa, Ethiopia

Tell No: 251-011-553873

Signature of the interviewer certifying that the informed consent has been accepted by the participant ---------- Date----------

Date of interview in Ethiopian Calendar ----------/----------/-------

Result of interview: 1. Completed 2. Respondent not available

3. Refused. 4. Partially completed

Checked by Supervisor, name---------- Signature ----------Date----------

1. Socio demographic

No	Question	Response	Skip
101	Questionnaire code		
102	Kebele		
103	How old were you at your last birthday?	Age in completed years----------	
104	What is your usual place of residence?	1.Urban 2.Rural	
105	What is your Religion?	1. Orthodox 2. Muslim 3. Protestant 4. Others	
106	What is your Ethnicity?	1. Bench 2. Kefa 3. Amahara 4. Oromo 5. Tigre 6. Others	
107	Can you read and write simple sentences in any language you speak?	Yes . . . . . 1 No. 0	If no go to

			no.109
108	What is the highest attained level of Education?	----------Grade Non-formal=00	
109	Can your wife read and write simple sentences in any language you speak?	Yes . . . . . 1 No. 0	If no go to no.111
110	What is your wife's highest attained level of Education?	----------Grade Non-formal=00	
111	What is your main Occupation?	1. Farmer 2. Merchant 3. Governmental employee 4. Private employee 5. Daily labourer 6. .Others (specify	
112	What is your wife's main occupation	1. House wife 2. Government employee 3. Private employee 4. Daily labourers 5. Farmer 6. Student 7. Other specify---------	
113	How long have you lived in this kebele?	Year____ month_____	
114	What was your age when you got married for the first time?	_____	
115	How long is it since you got married (in Years)?	1. Number of Years _____ 2. Number of months _____	
116	What is the size of usual member of your household?	_____	
117	How many wives do you have currently?		

Part II: - Economic Status

No	Questions	Responses	Skip

201	Do you have radio / TV in Your house?	1 Radio only 2 TV only 3 Both Radio and TV 4 None	
202	What is the total monthly income of your household? (From all sources and all members. Please ask income in kind and cash. If in kind use the current market price to convert it to cash income)	Enter the No. in birr_____	
203	For farmer only, how many cattle dose your family have?	1. Cattle ------- 2. Sheep ------- 3. Goat ------- 4. others------	

Part III: - Reproductive History of Respondent

No	Questions	Responses	Skip
301	Do you have children?	1. Yes 2. No →	To 306
302	At what age did you have your first child?	_____	
303	How many children ever born to you?	Enter number-----	
304	How many living children do you have now?	Enter number _____	
305	Do you want more children?	1. Yes 2. No → 99. I don't know	T0308
306	If your answer for Q 305 yes, How many more children do you want?	Enter No----------	
307	If your answer for 306 is yes, How many children do want?	Enter number ------	
308	If you are return to back, How many children do you want to have?	----------	
309	Have you ever discussed the number of children you really want to have with your wife?	1. Yes → 2. No	

310	If your answer for q309 is yes, Do your wife/partner wants the same number of children that you want, or does she want more or fewer than you want?	1. Same number 2. More children 3. Fewer children 4. Don't know	To 312
311	Between two consecutive children , how many years of intervals do you think is good?(how long they should be spaced) _____year/s	1. ------	
312	Who takes decision on when to have another child or to stop childbearing?	1 myself only 2 My wife only 3 both of us 4 my parents 5 God/Allah knows 6 Others pacify_____	

Part IV: - Knowledge about LAPMs

No	Questions	Response	Skip
401	Have you ever heard about modern family planning methods?	Yes No	
402	If your answer for q 401 is yes, which type of modern family planning method you know?	1. Pills 2. Injectables 3. Norplant 4. IUD 5. Female sterilization 6. Male sterilization 7. Condom 8. Others(specify) ---------- 9. I don't know	
403	Do you know about Long Acting and Permanent Methods (methods used for many years or	1.Yes 0.No)	If no go to

	permanently just after having it once)		501
404	If yes to Q 403, what is the purpose of using LAPMs? (Tick all mentioned) ***(Multiple answers are possible)***	A. Helps for prevention of unwanted Pregnancies B. Prevention of possible maternal and child death and ill health. C. Limiting family size D. Child spacing E. Others----------	
405	If yes to Q403 which LAPMs do you know? ***(Multiple answers are possible)***	A. IUCD B. Implant C. Vasectomy D. Tubal Legation E. other	
406	What is your source of information? ***(Multiple answers are possible)***	A. Health institution B. Family C. Friend D. Mass media (TV, Radio, etc.) E.NGO F. Others----------	
407	Have you ever exposure through media to LAPMs message within the last 12 months	1. Yes 2. No →	To409
408	If your answer is yes to Q-407, what was the type of media (thick all mentioned)	1. Television 2. Radio 3. Print media_____	

	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid Pregnancy. Have you ever heard of (METHOD)?		
409	Female sterilization PROBE: Women can have an operation to avoid having any more children	1 . . . . Yes 0. . . . . No	
410	Male sterilization PROBE: Men can have an operation to avoid having any more children.	1. . . . . Yes 0. . . . . .No	
411	IUD PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse.	1. . . . . .Yes 0……. No	
412	Implants (Implanon /Jadelle/ Norplant) PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	1…….Yes 0…….No	
413	IUCD can prevent pregnancies for more than 10 years	1……..Yes 0……No	
414	After female sterilization pregnancy is not possible	1……..Yes 0……..No	
415	IUCD is not appropriate for female at high risk of getting STIs	1…….. . Yes 0……No	

Part IV: Attitude towards LAPMs

No	Questions	Responses	Skip
501	do you approve or disapprove of using	1. Approve 2. Disapprove	→ To 503

	LAPMs?	3. Do not know 4. Other specify _____	
502	If you disapprove why?	1. Need to increase clan size 2. Children are assets for the family 3. Children protect from the attacks of other families 4. Religious prohibition 5. Culture do not allow 6. Desire to have more children 7. Fear of side effect 8. Medical problem 9. Other, specify_____	
503	Does your wife support/aprove the use LAPMs?	1. Yes 2. No 3. I don't know	
Please Mention your agreement or disagreement in the following questions			
504	For me, information and services about LAPMs should be made available to men.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
505	For me, discussing about LAPMs contraceptive methods with my wife or friend is not necessary.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
506	For me, operation for female sterilization and/or male sterilization is unacceptable.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
507	Using Intra uterine contraceptive device restrict normal routine activities.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
508	Using Long acting methods cause infertility in women.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree	

		5. Strongly disagree	
509	For me, men should share the responsibility for using LAPMs?	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
510	For me, male sterilization causes impotence.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	
511	Men should decide on FP use.	1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly disagree	

Part VI:-Practice of LAPMs

601	Have you ever used LAPMs	1.....Yes 0.....N0 →	610
602	What was the LAPM you /your wife's' used? (ever users)	Enter the methods _____ _____ _____ _____	
603	Did you/your spouse stop using LAPMs now?	1. using → 2. Stopped	To605
604	If your answer for q 603 is no, What was the main reason to stop using contraceptive?	1. Due to side effect of the method 2. Fear of infertility 3. Desire to have more children 4. Medical problem 5. Preferred method is not available 6. Unacceptable in my culture 7. Religious prohibition 8. Other, specify _____	
605	Which LAPMs do you or your spouse use? (Circle only in the number against the method that he/she currently uses)	1. IUD 2. implants (Norplant) 3. Female sterilization 4. male sterilization 5. Other, specify_____	
606	Whose choice is the method that you or your spouse currently using?	1. My choice 2. My wife's/wives' choice	

		3. Both of us 4. Other's choice	
607	From where did you/your partner get the service?	1. Public health facility 2. private health facility 3. others specify--	
608	Did you /your partner get the service free from any fee or with fee?	1. Free from fee 2. With ------birr 3. I don't know	
609	Who decide on LAPMs to be used?	1. My self 2. My wife 3. both of us 4. No response 5. Don't know	
610	If your spouse were not using any LAPMs to delay or avoid pregnancy would you tell me the main reason?	1. Respondent opposed 2. Wives opposed 3. Relative opposed 4. Knows no methods 5. knows no source 6. Health concern 7. Fear of side effects 8. lack of access or too far 9. Too much cost 10. to have more children 11. Religious prohibition 12. Cultural problem 13. Fear of infertility 14. Others ------	
611	Have you discussed about LAPMs with your wife/partner in the last 12 months?	1. Yes 2. No ——————————→ 3. Do not know	614
612	If the answer is yes for q 611, how many times have you discussed within the last one-year?	1. Once 2. Twice 3. More often 4. We did not discuss 5. I can't remember	
613	Whose preference was accepted during discussion on use of family planning method?	1. My choice 2. Partner's choice 3. both of us 4. Other's choice	

614	Did you go to health facility with your wife to discuss about FP with the health provider?	1. Yes ——→ 0. No	616
615	If not, why do you think you did not go to? ***(Multiple response is possible)***	1. It is female task 2. Provider did not allow for male 3. Since I am not using 4. I Don't know 5. Other(specify)_____	
616	Do you /your spouse want to use LAPMs in the future?	1. Yes 2. no ——→	618
617	If yes which method would you prefer to use with your wife?	1. IUD 2. implants (Norplant) 3. Female sterilization 4. male sterilization 5. others ----------	
618	If your answer for q 613 is no, why?	1. Fear of side effect of the method 2. Fear of infertility 3. Desire to have more children 4. Preferred method is not available 5. Unacceptable in our culture 6. Religious prohibition 7. Other, specify _____	
619	What do you think would be the role of men in the use of LAPMs in this community? (Multiple Answers Possible)	**1.** Encourage their wives to use it **2.** Use the methods themselves **3.** Allocate necessary cost for it **4.** Help wives in domestic chores so that they can use LAPMs **5.** Discuss with their wives about the use of LAPMs **6.** Assess the benefits of such methods and inform wives **7.** Others (specify) 8. They do not have any role	

Thank you

IV. Guide line for in depth interview

How are you? My name is _____

I am a post graduate student in public health in Addis Ababa University and doing a research in SNNPR, Mizan- Aman district for master's degree in public health supervised by SPH/AAU instructors. I am studying the role of men in long acting and permanent contraceptives use among currently married men aged 20-64years, in Mizan_ Aman District, South Western Ethiopia .The information obtained from you and others respondents is very much useful to improve the quality and accessibility of contraceptives especially long acting (implant, and IUCD) and permanent (voluntary male and female sterilization) in this area and the whole our country.

In the interview we do not need to write your name. Your answers will be kept confidential. The interview shall be conducted in private situation. If you decide that you do not want to participate in the study, we can stop at any time you feel so. We appreciate if you try to answer all the questions. If you agree to be interviewed, we will go 35-40 minutes for me to complete the questionnaires. If you have any questions about the study you can ask.

Thank you. Next I will read a consent, which assures your interest to participate.

CONSENT FORM

The researcher explained the aim of the study clearly that I can decide once I understand the objective of the study. I decided:

1. **Agree to participate** 2. **Not agree to participate (**stop here the interview**)**

Signature of Person administering consent_____ Date_____

Respondent Signature _____ date _____ code number_____

Age ----------Occupation----------

Thank you

Interview guide for the clients

1. How do you perceive the population growth in your community?
2. What mechanisms should be put in place to control the fast growing population in this community?
3. How do you see the use of family planning methods?
4. What do you /the community knows about long acting and permanent

   IUCD
   Implant
   Male and female sterilization
5. Why don't you/the community use long acting (IUCD, Implant) and permanent (male and female sterilization)?
6. What are the cultural barriers to use LAPMs in this community?
7. What are religion related barriers to use of LAPM in this community
8. What are service related barriers to use of LAPM in this community?
9. Are there any barriers to deliver LAPM in regarding supplies, equipment and trained staff and access in your health center?
10. Who should decide about family size? Why?
11. What is your and communities attitude concerning the use of male sterilization?
12. What myths and misconception in your area preventing either women or men from using LAPMs?
13. What do you think would be the role of men in the use of LAPMs?
14. Is there any additional idea that you want to add on LAPMs and related issues?

በሚዛን-አማን ከተማ የቋሚ ና የረጅ ም ጊዜ የ ቤተሰብ ምጣኔ አገልግሎት ላይ ያለዉን የወዶቸን ሚና ስለተያያዙ ሁኔታዎች ለማጥናት የተዘጋጀ መጠይቅ

<u>ፍቃድ የመጠየቂያ ቅፅ</u>

<u>ዉድ ተሳታፊ</u>: ጤና ይስጥልኝ! እኔ _____ ስሆን በአዲስ አበባ ዩኒቨርስቲ፣ ጤና ሳይንስ ኮሌጅ ፣ በሕብረተሰብ ጤና ሳይንስ ት/ትቤት ለድህረ ምረቃ ማሟያ ጥናት በሚዛን-አማን ከተማ/ወረዳ በቋሚ ና በረጅም ጊዜ የ ቤተሰብ ምጣኔ አገልግሎት ላይ ስላለዉ የወዶቸ ሚና ላይ በመረጃ ሰብሳቢነት በማገልገል ላይ እገኛለሁ።

በጥናቱ ለመሳተፍ ፍቃደኛ ከሆኑ ስምዎት በዚህ ቅፅ የማይሞላ ሲሆን፣ ከጥናቱ ግኝት ጋር በተየያዘ መልኩም ስምአይጠቀሰም። በመጠየቁ ጊዜ ለመመለስ የማይፈልጉትን ጥያቄ ያለመመለስ መብትዎም የተጠበቀ ሲሆን፣ መጠየቁንም በፈለጉት ጊዜ ማቋረጥ ይችላሉ። ሆኖም የሚሠጡት ትክክለኛ ምላሽ በሚዛን-አማን ከተማ/ወረዳ የቋሚ ና የረጅም ጊዜ የቤተሰብ ምጣኔ አገልግሎት ላይ ስላለዉ የወንዶቸ ሚና ጋር ስለተያያዙ ሁኔታዎች ለማወቅና ችግሮችን ለመፍታት በእጅጉ ይረዳል። ቃለ-መጠይቁ ከ 20-25 ደቂቃዎች ሊወስድ ይችላል። ግልጽ ያልሆነ ነገር ካለ መጠየቅ ይቻላል?

አመሰግናለሁ በመቀጠል የስምምነት ቅጽ አነባለሁ፡ይህም በጥናቱ ለመሳተፍ ያለዎትን ፍላጎት ያረጋግጣል።

<u>የስምምነት ቅጽ</u>

መረጃ ሰብሳቢው የጥናቱን ዓላማ በሚገባ ግልጽ በሆነ ቋንቋ አስረድተውኛል።በዚህም መሠረት የጥናቱን ዓላማ ስለተረዳሁ ለመሳተፍ ዉሳንዬን በሚከተለዉ መንገድ አረጋግጣለሁ።

1. **አዎ እሳተፋለሁ።** 2. **አልስማማም/ አልሳተፍም** (አመስግነዉ በዚህ ያብቁ ።)

ተጠያቂዉ ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ

የተመረማሪዉ ስም: ከባድነዉ ሙላቱ
ስልክ ቁጥር: 0924491976

የመረጃ ሰብሳቢ ፊርማ ደንበኛዉ በቃል ስምምነት መስጠቱን ያረጋግጣል።

የመረጃ ሰብሳቢ ስም ----------ፊርማ ----------ቀን ----------

ያስታዉሱ፡ **ደንበኛዉ በግድ በጥናቱ እንዲሳተፍ አያስገድዱ።**

ሱፐርቫይዘር ስም----------ፊርማ----------

ክፍል1. ማህበራዊ ና ሰነ-ህዝባዊ ባህሪያት

ቁጥር	ጥያቄ	መልስ		አለፍ
101	መለያ ቁጥር			
102	ቀበሌ			
103	የመጨረሻ ልደትዎን ሲያከብሩ እድሜዎ ሰንት ነበር?	በሙሉ ዓመት----------		
104	ቋሚ የመኖሪያ ቦታዎ የትነዉ?	1. ገጠር 2. ከተማ		
105	ሀይማኖትዎ ምንድ ነዉ?	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ሌላ		
106	ብሔርዎ/ ብሄረሰብዎ ምንድን ነዉ?	1. ቤንች 2. ከፋ 3. አማራ	4. ኦሮሞ 5.ትግሬ 6. ሌላ	
107	በማነኛዉም በሚቸሉት ቋንቋ ማንበብ እና መፃፍይችላሉ ?	1. አዎ 2. የለም		
108	ለጥያቄ 107 መልስዎ አዎ ከሆነ ከፍተኛው ያጠናቀቁት የትምህርት ደረጃ (ክፍል) ስንት ነው?	መደበኛ ያልሆነ-- 00 ክፍል----------		
109	ባለቤትዎ በማነኛዉም በሚቸሉት ቋንቋ ማንበብ እና መፃፍ ይችላሉ	1. አዎ 2 የለም		
110	ለጥያቄ109መልስዎ አዎ ከሆነ ከፍተኛው ያጠናቀቁት የትምህርት ደረጃ (ክፍል) ስንት ነው?	መደበኛ ያልሆነ-- 00 ክፍል----------		
111	የተሰማሩበት ዋና የስራ ዘርፍዎ ምንድነዉ?	1. አርሶ አደር 2. ነጋዴ 3. የመንግስት ተቀጣሪ 4. የግል ተቀጣሪ 5. የቀን ሰራተኛ 6. ተማሪ 7. .ሌላ ካለ ይግለፁ		
112	ባለቤትዎ የተሰማሩበት ዋና የስራ ዘርፍ ምንድነዉ?	*1. የቤት እመቤት* *2. የመንግስት ተቀጣሪ* *3. የግል ተቀጣሪ* *4. የቀን ሰራተኛ* *5. አርሶ አደር* *6. ተማሪ* ***7. ሌላ ካለ ይግለፀ---------***		
113	በዚህ ቀበሌ ምን ያህል ጊዜ ቆይተዎል?	ዓመት_____ ወር_____		
114	መጀመሪያ ሲያገቡ ስንት ዓመትዎ ነበር?			
115	አሁን ካገቡ ስንት ጊዜ ሆንዎት?	1. ዓመት_____ ወራት_____		
116	እርሰዎን ጨምሮ በቤተሰብ ዉሰጥ ስንት ቀሚ አባላትአሉ?			
117	ስንት ባለቤት አለዎት			

ክፍል 2: - የኢኮኖሚ ሁኔታ (ደረጃ)

ቁ	መጠይቅ	መልስ	አለፍ
201	ቴሌቪዥን ወይም/እና ሬድዮ አለዎት?	1 ሬድዮ ብቻ 2 ቴሌቪዥን ብቻ 3 ሬዲዮ ና ቴሌቪዥን 4 የለም	
202	ጠቅላላ የቤተሰብዎ ዓመታዊ ገቢ ስንት ነዉ?(ከሁሉም የቤተሰብ አባላት የሚገኘዉን ጠቅላላ ገቢንም ያጠቃልላል ፡፡ እባክዎን ገቢዉ በዓይነት ከሆነ በወቅቱ የገቢያ ምንዛሬ መሠረት ወደ ብር ተቀይሮ ይቀመጥ፡፡	የብሩን መጠን በቁጥር ያስገቡ----------	
203	ስት የቤት እንስሳት አሏችሁ?	1. ከብት..... 2. ፍየል..... 3. በግ ..... 4. ሌላ	

ክፍል3: - ሰነ-ተዋሎዶዊ ባህሪያት

No	መጠይቅ	መልስ	አለፍ
301	ልጅ ወልደዉ ያዉቃሉ?(በህዎት ተወልደዉ (ወዲያዉ) የሞቱትንም ይጨመራል)	1.አዎ 2.የለም ⟶	 305
302	በስንት ዓመትዎ የመጀመሪያ ልጅዎን ወለዱ?	_____	
303	ባጠቃላይ ስንት ልጆች ወልደዋል? (በህዎት ተወልደዉ(ወዲያዉ)የሞቱትንም ይጨመራል) (ከሁሉም ባለቤትዎ)	_____	
304	አሁን በህይወት ስንት ልጆች አሉዎት? (ከሁሉም ባለቤትዎ)	_____	
305	አሁን በህወት የሌሉ ስንት ልጆች ነበሩዎት (ከሁሉም ባለቤትዎ)		
306	ወደ ፊት ሌሎች (ተጨማሪ) ልጆች መውለድ ትፈልጋላችሁ?	1. አዎ 2. አንፈልግም ⟶ 3. አላውቅም	 ወደ 308
307	የ306ኛው ጥያቄ መልስዎ አዎ ከሆነ ስንት (ተጨማሪ)ልጆችን መውለድ ትፈልጋላችሁ?	_____	
308	(ልጅ ወደ አልነበርዎት ጊዜ ቢመለሱ) ስንት ልጆች እንዲኖሩዎት ይፈልጋሉ?	_____	
309	ስንት ልጆች መውለድ እንዳለባችሁ ከባለቤትዎ ጋር ተወየይተው ያውቃሉ ?	1. አዎ 2. የለም ⟶	ወደ 311
310	ጥያቄ 308 መልስዎ አዎ ከሆነ እርስዎ ለመውለድ የሚፈልጓቸው ልጆች ቁጥር ባለቤትዎ ከሚፈልጓቸው ልጆች ቁጥር ጋር ተመሳሳይ ነው ወይንስ ያነሰ ወይም እርስዎ ከሚፈልጉት የበለጥ ለመውልድ ይፈልጋሉ ?	1. ተመሳሳይ ነው 2. የበለጠ 3. ያነሰ 4. አላውቅም	
311	ሁለት ልጆች በተከታታይ በሚወለዱበት ጊዜ በመካከላቸው ምን ያህል የዕድሜ ልዩነት ቢኖር ጥሩ ነው ብለው ያስባሉ?	----------	
313	(ተጨማሪ) ልጅ ለመውለድ/ ላለመዉለድ ውሳኔ የሚወስነው ማን ነው?	1 እኔ ብቻ	

		2 ባለቤቴ ብቻ 3 ሁለታችንም 4 የቤተሰቡ ታላላቆች 5 እግዚአብሔር/አላህ 6 ሌላ ካል ይግለጹ_____	

ክፍል 4: - ስለየረጅም ጊዜ ና የቋሚ የቤተሰብ ምጣኔ አገልግሎት ያላቸዉ እዉቀት

No	ጥያቄ	መልስ	እለፍ
401	ስለ ዘመናዊ የቤተሰብ ምጣኔ አገልግሎት ስምተዉ ያዉቀቃሉ?	1. አዎ 0. የለም →	501
402	ለጥያቄ 401 መልሰዎ አዎ ከሆነ ስለየትኛዉ የቤተሰብ ምጣኔ አገልግሎት ነዉ የሰሙት? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. እንክብል 2. በመርፌ የሚሰጥ 3. በማህፀን ውስጥ የሚገባ /ሉፕ 4. በክንድ የሚቀበረዉን የወልድ መከላከያ(እምፕላንት) 5. በቀዶ ጥገና የሚሰራ ቋሚ (የወንድ) 6. በቀዶ ጥገና የሚሰራ ቋሚ (የሴት) 7. የወንድ ኮንዶም 8. የሴትየሴት 9. ሌላ ካለ ይገለጽ ----------	
403	ከአንድ አመት በላይ እና በቋሚነት ስለሚያገለግለዉ የቤተሰብ ምጣኔ አገልግሎት ስምተዉ ያዉቃሉ?	1. አዎን 0. የለም →	501
404	ለጥያቄ 403 መልስዎ አዎ ከሆነ ከአንድ አመት በላይ እና በቋሚነት ስለሚያገለግሉ የቤተሰብ ምጣኔ አገልግሎትየትኞቹንያዉቃሉ? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. በማህፀን ውስጥ የሚቀመጥ/ የሚገባ(IUCD) 2. በክንድ የሚቀበረዉን የወልድ መከላከያ 3. በቀዶ ጥገና የሚሰራ ቋሚ (የወንድ) 4. በቀዶ ጥገና የሚሰራ ቋሚ (የሴት) 5. ሌላ ----------	
405	የጥያቄ ቁጥር 403 መልሱ አዎ ከሆነ ከአንድ አመት በላይ እና በቋሚነት የሚያገለግለዉ የቤተሰብ ምጣኔ አገልግሎትከሚሰጠዉ ጠቅላላ ጥቅም ምን ምን ያዉቃሉ? (የተጠቀሰዉን ሁሉ ያክብቡ) *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. ያልተፈለገ እርግዝናን ይከላከላል 2. ሊከሰት የሚችለዉን የእናቶችና የሕጻናት ሞትንና በሽታን ይቀንሳል 3. የቤተሰብ ቁጥርን ለመወሰን 4. ልጅን አራርቆ ለመዉለድ 5. ሌላ----------	
406	ስለ ቋሚእና ከአንድ አመት በላይ ስለሚያገለግሉ የቤተሰብ ምጣኔ አገልግሎት ያወቁት ከየት ነዉ? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. ከጤና ድርጅት 2. ከቤተሰብ 3. ከጓደኛ 4. ከመገናኛ ብዙሃን (ቴለቭዥን, ሬድዮ, ወዘተ.) 5. መንግሥታዊ ካልሆነ ድርጅት 6. ሌላ ይገለጽ----------	

407	ባለፉት12 ወራት ዉስጥ ስለ ቋሚእና ከአንድ አመት በላይ ስለሚያገለግሉ የወሊድ መከላከያ በብዙሃን መገናኛ መልክት ሰምተዉ/አይተዉ ያዉቃሉ ?	1. አዎ 2. የለም →	409
408	ለጥያቄ 407 መልሰዎ አዎ ከሆነ ብዙሃን መገናኛዉ ምን ነበር?*(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. ቴሌቭዥን 2. ራዲዮ 3. የህትመት ወይም በራሪ ወረቀት 4. ሌላ ካለ ይገለፅ------	
	ከዚ በታች ስለተወሰኑየቤተሰብ ምጣኔ አገልግሎቶች ያልዎትን እዉቀት ለማዎቅ እፈልጋለሁ?		
409	ሴቶችን በቀዶ ጥገና (ተጨማሪ)ልጆች እንዳይወልዱ ስለማድረግ ቋሚ የወሊድ የመከላከያ ዘዴያዉቃሉን?	1. አዎን 0. የለም	
410	ወንዶችን በቀዶ ጥገና (ተጨማሪ)ልጆች እንዳይወልዱ ስለማድረግ ቋሚ የወሊድ የመከላከያ ዘዴያዉቃሉን?	1. አዎን 0. የለም	
411	በሴቶች ማህፀን ዉስጥ በጤና ባለሙያ አማካኝነት የሚቀመጥ የወሊድ መከላከያ ሰምተዉ ያዉቃሉ?	1. አዎን 0. የለም	
412	ሴቶች (ተጨማሪ) ልጆች እንዳይወልዱ በክንድ ውስጥ በጤና ባለሙያ አማካኝነት ስለሚቀበረዉ (የክብሪት እንጨት መስል)ወሊድን ከአንድ ዓመትና ከዚያ በላይ የመከላከያ ዘዴ ያዉቃሉን?	1. አዎን 0. የለም	
413	በማህፀን ውስጥ የሚቀመጥ(አይ.ዩ.ሲ.ዲ)፤ እርግዝናን ከአሥር ዓመት በላይ ሊከላከል ይችላል፡፡	1. አዎን 0. የለም	
414	በቀዶ ጥገና የሚሰራ ቋሚ (የሴት)፤ ከተሠራላት በኋላ ዳግመኛ እርግዝና ሊከሰት አይችልም፡፡	1. አዎን 0. የለም	
415	በማህፀን ውስጥ የሚቀመጥ(IUCD) በአባለ ዘር በሽታ የመጋለጥ አደጋ ላይ ላሉ ሴቶች ምቹ አይደለም፡፡	1. አዎን 0. የለም	

ክፍል 5: ስለ ቋሚእና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎት ያላቸዉ አመለካከት

ቁ	*መጠይቅ*	*መልስ*	እለፍ
501	እርስዎ ቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎትን መጠቀም ይደግፋሉ?	1. አዎ → 2. የለም	503
502	ካልደገፉ ምክንያቱዎ ምንድን ነዉ? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. እኔ ስለማልቀበል 2. ባለቤቴ ስለማትቀበል 3. ቤተሰብ ስለማይደግፉ 4. ሀይማኖታችን ስለማይፈቅድ 5. ባህላቸን ስለማይፈቅድ	

		6. ተጨማሪልጅ ሰለምንፈልግ 7. የጎንዮሽ ጉዳቱን ሰለምንፈራ 8. የጤና ችግር 9. ሌላካለ ይገለጽ_____	
503	ባለቤትዎ ቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎት መጠቀምንይደግፋሉ?	1. አዎ 2. የለም 3. አላዉቅመ	
	ከዚህ በታች ለሚዘረዘሩት ሀሳቦችመስማማት/አለመስማማትዎን ማወቅ እፈልጋለሁ		
504	ሰለ ቋሚ እና ከአንድ አመት በላይ ሰለሚያገለግሉ የቤተሰብ ምጣኔ አገልግሎት ለወንዶች መረጃ ና አገልግሎት መኖር አለበት።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	
505	በቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎት ላይ ከባለቤቴ ወይም ከጓደኛየ ጋር መወያየት አሰፈላጊ አይመሰለኝም።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	
506	በቀዶ ጥገና የሚሰራ ቋሚ (የወንድ ወይም የሴቶች) ዘዴ መጠቀም ተቀባይነት የለውም።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	
507	ሉፕ/ በማህፀን የሚቀበር የቤተሰብ ምጣኔ አገልግሎት መከላከያ መጠቀም የእለት ከለት ሰራን ያደናቅፋል።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	
508	የረጅም ጊዜ(ከአንድ አመት በላይ) የሚያገለግል የወሊድ መከላከያ መጠቀም በሴቶች ላይ መከካንነት ያሰከትላል ።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	
509	ወንዶች ቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎትን የመጠቀም ሃላፊነትን መጋራት/ መዉሰድ አለባቸዉ።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	
510	ወንዶችን በቀዶ ጥገና የማምከን ዘዴ ሰንፈተወሲብን ያመጣል።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም	

		5. በጣም አልሰማም	
511	በቤተሰብ ምጣኔ አገልግሎት ላይ መወሰን ያለባቸዉ ወዶቾ ናቸዉ።	1. በጣምእሰማማለሁ 2. እሰማማለሁ 3. እርግጠኛ አይደለሁም 4. አልሰማም 5. በጣም አልሰማም	

ክፍል6:- የረጅም ጊዜ ና የዘለቄታዊ የቤተሰብ ምጣኔ አገልግሎት መጠቀምን በተመለከተ

ቁ	መጠይቅ	መልስ	እለፍ
601	እርስዎ ወይንም ባለቤትዎ ቋሚ እና ከአንድ አመት በላይ የሚያገለግል የወሊድ መከላከያ ተጠቅመዉ ያዉቃሉ ?	1. አዎ 2. የለም → 610	
602	ተጠቅማችሁ የምታዉቁ ከሆነ ስትጠቀሙ የነበረዉ የወሊድ መከላከያ ዘዴ ምንድን ነዉ?	መከላከያዉ ይጠቀ _____ _____ _____ _____	
603	አሁን ትጠቀማላችሁ ወይሰ አቋርጣችዋል?	1. እንጠቀማለን → To605 2. አቋርጠናል	
604	ለጥያቄ 602 መልስዎ አቋርጠናል ከሆነ የተቋረጠበት ዋናዉ ምክንያ ትምን ነበር? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. የጎንዮሽ ጉዳቱን በመፍራት 2. መካንነትን በመፍራት 3. ተጨማሪ ልጅ ሰለምን ፈልግ 4. የጤና ችግር 5. የምንፈልገዉ የቤተሰብ እቅድ መከላከያ ባለመኖሩ 6. የእርግዝናተጋላጭነት ሰለነበረ 7. በባህላችን ሰለማይደገፍ 8. ሀይማኖታችን ሰለሚከለክል 9. ሌላ ካለ ይገጽ_____	
605	ባለቤትዎ/ እርስዎ አሁን የትኛዉን ቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎትነዉ የምትጠቀሙት? የምትጠቀሙትን መከላከያ የያዘዉን ቁጥር ብቻ ይከበብ *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. በማህፀን የሚገባ/ሉፕ የወሊድ መከላከያ 2. ክንድ ላይ የሚቀበር የወሊድ መከላከያ 3. የሴቶችን የማህፀን ቱቦ የማሰቋጠር(በቀዶ ጥገና የማምከን ዘዴ) 4. ወንዶችን በቀዶ ጥገና የማምከን ዘዴ 5. ሌላ----------	
606	እርስዎ ወይንም ባለቤትዎ አሁን የመትጠቀሙት የወሊድ መከላከያ የማን ምርጫ ነዉ?	1. የኔ 2. የባለቤቴ 3. የሁለታችን 4. የሌላ ሰዉ ከሆነ ይጠቀሰ	
607	እርስዎ ወይንም ባለቤትዎ አገልግሎቱንየምታገኙት ከየትነዉ?*(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. ከመንግሰት ጤና ተቋም 2. ከግል ጤና ተቋም 3. መንግሰታዊ ካልሆነ ድርጅት 4. ሌላ---	
608	አርስዎ ወይም ባለቤቴዎ ለምትጠቀሙት የቤተሰብ ምጣኔ አገልግሎ ክፍያ ትከፍላላችሁ?	1. አዎ 2. የለም	
609	ለምትጠቀሙት የቤተሰብ ምጣኔ አገልግሎት ዉሳኔ የሚሰጥ ማነዉ?	1. ራሴ 2. ባለቤቴ	

		3. ሁለታችንም 4. የቤተሰቡ ታላላቆች 5. ሌላ ካለ ይገለፅ	
610	ቤተሰባችሁ ያልተፈለገን እርግዝና ለመከላከል /ለማዘግየት ቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔአገልግሎት የማትጠቀሙ ከሆነ ምክንያታችሁ ምንድን ነዉ? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. አኔ ሰለምቃወም 2. ባለቤቴ ስለምትቃወም 3. የዘመድ ተቃዉሞ 4. የቤተሰብ እቅድ መከላከያ ባለማወቃችን 5. ምንጭ/መገኛ ባለማወቅ 6. የጎንዮሽጉዳቱን በመፍራት 7. የአቅርቦት እጥረት/ ርቀት 8. በጣም ወጪ ሰላለዉ 9. ተጨማሪ ልጅ እዲኖረን ሰለምፈልግ 10. ሀይማኖታችን ሰለማይፈቀድ 11. የባህል ተጽኖ 12. መካንነትን በመፍራት 13. ሌላ -----	
611	በባለፈዉ አንድ አመት/12 ወራት ዉስጥ ሰለየዘለቄታዊ(ከአንድ አመት በላይ) ና ቋሚ የቤተሰብ ምጣኔ አገልግሎት ላይ ከባለቤትዎ ጋር ተወያይታችሁ ታዉቃላችሁ?	1. አዎ 2. የለም ——————→ 3. አላሰታዉሰም	615
612	ለጥያቄ ቁጥር 610 መልሰዎ አዎ ከሆነ ባለፈዉ አንድ አመት ዉስጥ ሰንቴ ተወያይታችኃል?	1. አንዴ 2. ሁለቴ 3. ብዙ ጊዜ 4. ተወያይተን አናዉቅም 5. አላሰታዉሰም	
613	በዉይይታችሁ ጊዜ የማን ምርጫ/ ሀሳብ ነዉ ተቀባይነትየሚያገኘዉ?	1. የኔ ምርጫ 2. የባለቤቴ /ጓኛየ ምረጫ 3. የሌላ ሰዉ ምረጫ 4. ሌላ ካለ ይገለፅ---	
614	ሰለ ቤተሰብ ምጣኔ አገልግሎት ከጤና ባለሙያ ጋር ለመወያየት ወደ ጤናተቋም ከባለቤቴዎ /ጓኛዎ ጋር ሄደዉ ያዎቃሉ?	1. አዎ ——————→ 2. የለም	617
615	*ሄደዉ የማያዎቁ ከሆነ ምክንያትዎ ምንድ ነዉ?* *ከአንድበላይ መምረጥ ይቻላል*	1. የሴቶች ተግባር ሰለሆነ 2. አገልግሎቱን የሚሰጡት ሰለማይፈቅዱ 3. እኔ ሰለማልጠቀም 4. ባህላችን ስለማይፈቅድ 5. ሀይማኖታች ሰለሚከለክል 6. ሌላ ካለ ይገለጽ_____	
616	ወደፊት ባለቤትዎ/ እርስዎ የረጅምጊዜ ወይም ቋሚ የቤተሰብ ምጣኔ አገልግሎት መጠቀም ትፈልጋላችሁ?	1. አዎ 2. የለም——————→	619
617	ለጥያቄ ቁጥር 613 መልሰዎ አዎ ከሆነ የትኛዉን የረጅምጊዜ ወይም ቋሚ የወሊድ መከላከያ መጠቀም ይመርጣሉ?	1. በማህፀን የሚገባ/ ሉፕ የወሊድ መከላከያ 2. ከንድ ላይ የሚቀበር የወሊድ መከላከያ 3. የሴቶችን የማህህፀንቱቦ የማሰቋጠር 4. የወዶችንችን የዘር ፍሬ ማሰተላለፊያ ቱቦ ማሰቆረጥ(በቀዶ ጥገና ማምከን)	

		5. ሌላ----------	
618	ለጥያቄ ቁጥር613 መልሰዎ የለም ከሆነ፡ለምን? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. የጎንዮሽ ጉዳቱን በመፍራት 2. መካንነትን በመፍራት 3. ተጨማሪ ልጅ ሰለምን ፈልግ 4. በባህላችን ሰለማይደገፍ 5. ሀይማኖታችን ሰለሚከለክል 6. ሌላ ካለ ይገጽ_____	
619	የወንዶች ሚና በረጅም ጊዜ ና በቋሚ የወለዲ መከላከያ አጠቃቀም ላይ ምን መሆን አለበት ብለው ያስባሉ? *(ብዙ አማራጭ መልሶች ከተሰጡ ይቻላል)*	1. ባለቤታቸውንእዲጠቀሙ ማበረታታት 2. መከላከያውን በራሳቸው መጠቀም 3. ለዚህ የሚውል ገንዘብ መበጀት 4. ባለቤቶቻቸውን መከላከያውን እንዲጠቀሙ የቤት ሥራቸውን ማገዝ 5. ስለአጠቃቀሙከባለቤቶቻቸውጋር መወያየት 6. ያለውን ጠቀሜታ ማወቅና ባለቤቶቻቸውን እዲጠቀሙ ማድረግ 7. ምንምአይነት ሚና የላቸውም 8. ሌላ	

ስለ ሰጡኝ ምላሽ በጣም አመሰግናለሁ

2. **ከሴቶች ና ወዶቸ ጋር የሚካሄድ ጠለቅ ያለ መጠይቅ**

ጤና ይስጥልን፤ ስሜ----------ይባላል፡፡ እኔ በአዲስ አበባ ዩኒቨርስቲ፤ጤና ሳይንስ ኮሌጅ የጤና አጠባበቅ ት/ቤት ተማሪ ስሆን ለድህረምረቃ ማሟያ ጥናት በደቡብ ክልል ፣ በበሚዛን-አማን ከተማ/ወረዳ በቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎት ላይ ስላለዉ የወዶቸን ሚና ላይ ጥናት እያጠናዉ እገኛለሁ፡፡:: እርሶ የሚሰጡን መረጃ ከሌሎች መረጃ ምንጮች ጋር ተዳምሮ የቤተሰብ ምጣኔ አገልግሎት የሚሻሻልበትን ሁኔታ ለዚህ አከባቢና ለሌሎቹም ለማመቻቸት ታልሞ የተዘጋጀ ጥናት ነዉ፡፡በዚህ መጠይቅ ውስጥ ስሞዎትንና እርሶን ለመለየት የሚያገለግል ነገር አይፃፍም፡፡ እርስዎ የሚሰጡን ምላሽ ሁሉ በሚስጥር ይያዛሉ፡፡መጠይቁም የግል ምቾትን በጠበቀ ሁኔታ ይካሄዳል፡፡ በጥናቱ ውስጥ የመሳተፍ ወይንም ያለመሳተፍ መብትዎ የተጠበቀነዉ፡፡ በጥያቄዉ ለመሳተፍ ፈቃደኛ ከሆኑ ከ35- 40 ደቂቃ ዉስጥ አጠናቅቃለሁ፡፡ሁሉንም ጥያቄዎች እንዲመልሱልን እናበረታታለን፡፡ግልፅ ያልሆነ ነገር ካለ ሊጠይቁን ይችላሉ፡

አመሰግናለሁ በመቀጠል የስምምነት ቅጽ አነባለሁ፡ይህም በጥናቱ ለመሳተፍ ያለዎትን ፍላጎት ያረጋግጣል።

<u>የስምምነት ቅጽ</u>

ተመራማሪው የጥናቱን ዓላማ በሚገባና ግልጽ በሆነ ቋንቋ አስረድተውኛል፡፡በዚህም መሠረት የጥናቱን ዓላማ ስለተረዳሁ ለመሳተፍ ዉሳንዬን በሚከተለዉ መንገድ አረጋግጣለሁ፡፡

1. አዎ እሳተፋለሁ 2.አልስማማም/ አልሳተፍም (አመስግነዉ መጠይቁን ያብቁ፡፡)

የጥያቄ አቅራቢዉ ፊርማ_____ቀን_____

የደንበኛዉ ፊርማ _____ ቀን _____መለያ ቁጥር: _____

ዕድሜ ---------- ጾታ----------፤ሥራ----------

<u>የቃለ መጠይቅ መምሪያ ቅጽ</u>

1. የሕዝብ ቁጥር መጨመርን እንዴት ያዩታል?
2. ፈጣን የህዝን ቁጥርመጨመርን ለመከላከል ምን መደረግአለበት ይላሉ?
3. የቤተሰብ ምጣኔአገልግሎትን/ የወሊድ መከላከያን እንዴት ያዩታል?
4. ስለ ቋሚ እና ከአንድ አመት በላይ የቤተሰብ ምጣኔ አገልግሎት እርስዎ /ማህበረሰቡ ምንያዉቃሉ?
   I. በማህፀን ስለሚገባ/ሉፕ የወሊድ መከላከያ
   II. በክንድ ላይ ስለሚቀበር የወሊድ መከላከያ
   III. የሴቶችን የማህፀን ቱቦ የማሰቋጠር(በቀዶ ጥገና የማምከን ዘዴ)
   IV. ወንዶችን በቀዶጥገና ስለማምከን ዘዴ
5. እርስዎ /ማህበረሰቡ የቋሚ እና ከአንድ አመት በላይ የቤተሰብምጣኔ አገልግሎት የማትጠቀሙበት ምክንንያት ምንድን ነዉ?
6. በዚህ ማህበረሰብ ውስጥ የረጅም ጊዜን ና የቋሚ የወሊድመከላከያ እንዳይጠቀሙ የሚያደርጉ ባህላዊ ምክንያቶች ምንምን ናቸው?
7. የረጅም ጊዜና ቋሚ የወሊድ መከላከያ ለመጠቀም የሚያግዱ ሃይማኖታዊ ምክንያቶች ምንድን ናቸው?
8. በዚህ ማህበረሰብ ዉስተጥ አገልግሎት አሠጣጥላይ በተመለከተ ያሉት ችግሮች ምንድንናቸው?
9. በጤናጣቢያቸው የአቅርቦት፣ የመሳሪያና የሠለጠነ የባለሙያ ችግር አለባቸሁ?
10. በቤተሰብ አባላት ቁጥር ላይ ዉሳኔ የሚሰጠዉ ማነዉ? ለምን?
11. ወንዶችን በቀዶ ጥገና የማምከን የቤተሰብ ምጣኔ አገልግሎት ላይ የእርስዎ /የማህበረሰቡ ያላችሁ አመለካከት ምንድን ነዉ ?

12. ወንዶች ወይም ሴቶች ቋሚ እና ከአንድ አመት በላይ የወሊድ መከላከያ እዳይጠቀሙየሚያግዱ የተሳሳቱ ግንዛቤዎች ወይም አመለካከቶች ና ሃሳቦች ምንድ ናቸው?
13. ሰለ ቋሚ እና ከአንድ አመት በላይ የወሊድመከላከያ አጠቃቅም ላይ የወንዶች ሚና ምን መሆን አለበት ብለዉ ያስባሉ?
14. ሌላ ተጨ ማሪ ሀሳብ ካለዎት
    1. አመሰግናለሁ