

INVOLVING 'THE OTHER GENDER'
MEN'S INSIGTS INTO REPRODUCTIVE HEALTH AND RIGHTS
IN WOLISO TOWN

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BY
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MAY, 2007

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

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ACRONOMYS

CPR	Contraceptive Prevalent Rate
FGAE	Family Guidance Association of Ethiopia
FCI	Family Care International
FP	Family Planning
HSDP	Health Sector Development Programme
HTP	Harmful Traditional Practices
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPS	Inter Press Service
MHC	Maternal Health Care
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NGOS	Non Government Organizations
PfA	Platform for Action
RH	Reproductive Health
STIS	Sexual Transmitted Infection
UN	United Nations
UNDP	United Nation Development Program
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary Counseling and Testing
WAO	Women Affair Office
WHO	World Health Organization

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ABSTRACT

Reproductive health and rights are affected by societal norms and value systems that indicate ideal behaviors for men and women, and therefore, it is a gender issue. Much of the responsibilities of reproductive health lie on women. On the other hand, reproductive and sexual rights are in the hands of men. In most instances issues relating to reproductive health are left for women, and men participation and involvement has been given little attention. Therefore, the current study is an outcome of men's insights into their involvement and women-men partnership in reproductive health and rights in Woliso town. The target population comprised men of different ages in Woliso town. Focus group discussion, in-depth interviews, observation and survey questionnaires were used to gather quantitative and qualitative information.

Generally, the results of both data sources revealed that there is low men's involvement and absence of focusing on men in reproductive health and rights issues. The study highlights the positive tendencies on the part of the respondents to change the gender stereotypes related to reproductive health. The study disclosed that partnership in RH could be formed through empowering women and increasing the power within men, and also found out that men's involvement could have multiple advantage in promoting reproductive decision-making such as sexuality, contraceptive prevalent rate, family planning, and fertility decision-making as well as in combating gender-based violence. The existing opportunities such as family, community networks, the efforts excreted by Gos and NGOs, and religions are identified as social capital in facilitating and promoting men's involvement and partnership in the issues raised.

The study concludes by highlighting the multi advantage of involving men in reproductive health and right issues, and suggests as to how men could involve and partnership between them could be established and strengthened. The study further suggests that there is a need for programs that would involve men and change their attitude towards gender and reproductive health and rights issues and motivate them to be partners. To this end, proper socialization of boys and girls and facilitating discourse among men and women upon gender and reproductive matters, promoting health IEC extension prorammes are identified as a way to resolve the imbalance power relationships between the sexes, and ultimately to ensure gender equity and equality.

I. INTRODUCTION

Background

In the years since the 1994 International Conference on Population and Development in Cairo (ICPD), program planners and researchers in many countries have begun to recognize the importance of sexual and reproductive health (RH) of gender-based power dynamics within the sexual relationships of women and men (Gupta and Weis, 1993 cited in Blanc, 2001:189). The Beijing platform for Action has also emphasized on women's health, including reproductive health, and urged to scale up women's decision-making abilities and roles on sexual and reproductive lives to minimize the potential consequences (UNFPA, 2005: 8).

Following the Beijing conference of 1995, Ethiopia had also identified seven priority areas that need to be addressed in order to ensure gender-equitable development among which reproductive right and health including HIV/AIDS is the focus of attention (WAO, 2005: 1). The document further indicated that the health of Ethiopian people is in poor condition; particularly women. For instance, the ratio of Maternal Mortality Rate (MMR) 871/100000, female morbidity is 75.5 percent vs. male morbidity 25.5 percent. There is also limited family planning service that resulted in high fertility rate; and low level of reproductive health services (MOH, 2005: 6).

ICPD, in Cairo, pointed out that RH is a very broad term related primarily with sexuality and reproduction. It should not merely the absence of diseases, in all matters relating to the reproductive system and to its functions and processes. Hence:

Reproductive health implies the ability of people to have satisfied and safe sex life and their capacity to reproduce and to maintain sexual rights or the freedom to decide it, and when and how often to do so. It also implies that both women and men have the right to be informed and have access to effective, affordable and acceptable health services (UNFPA, 2005: 6).

Sexual and reproductive health, according to (FCI, 2000: 2) and (Ogbaselassie, 1998:3) includes: family planning information, counseling services; prenatal, postnatal, and delivery

care; health care for infants; prevention and treatment of sexually transmitted diseases (STI) and reproductive tract infections; prevention and treatment of infertility and fertility; and information, education and counseling on human sexuality, reproductive health, parenthood, and factors that affect sexual and reproductive health. Sexual and reproductive health is defined by Blanc (2001) in the domain of that is related to sexual health, i.e. the ability to have voluntary sexual relations. It includes fertility regulation, disease protection and treatment, pregnancy support, abortion early child health. Besides, (Ogbaselassie, 1998) has identified gender concerns and male involvement as cross cutting components of reproductive health. In order people to have satisfied and safe sex life, their sexual rights must be respected. In most instances, due to many factors, which are mainly categorized under influences of structural factors, there is imbalance of power relation between women and men, and sexual and reproductive rights are in favor of men.

Although reproductive health is affected by societal norms and value systems that indicate ideal behaviors for men and women, it is a gender issue. Therefore, working with sexual and reproductive health from a gender perspective allows us to go beyond a biological focus on women's bodies to a better understanding of men and women's socially constructed identities and needs. Therefore, service providers should recognize that men and women have different needs because they understand sexuality differently. Certain health needs may be shared on the basis of gender dimension (Kabeer, 2003: 218).

Hence, achieving gender equality and women's and girls' empowerment requires addressing complex web of discrimination and disadvantages that women face throughout the world. Therefore, protecting the human rights of women, including their reproductive rights, and ensuring a woman's sexual and reproductive health is central to empowering women. This is due to the fact that women's ability to make decisions about their sexuality and fertility has a profound effect on their prospects in terms of education, employment, political participation, and involvement in socio-cultural life (Ahemed, 2005: 1). This means the freedom to make reproductive choices is the first of women's empowerment freedoms and the one from which others follow.

Although increasing numbers of women today are working towards their own empowerment they could not do it alone. Men's support in eliminating gender based inequalities is essential, because men hold the power to influence societal thinking in most parts of the world (UNFPA, 1999). In this regard, exploring men's knowledge, attitudes views understanding, decision and practices towards gender in general and women's rights in particular is essential. Among these women's rights, sexual and reproductive rights are where gender power relation is tilted towards men. It is where men domination is exercised.

In order to have better insights regarding reproductive health, one needs to have some understanding about reproductive rights. Generally, reproductive rights could be understood as:

The rights of both women and men. It includes the rights of sexual partners and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information, education, and means to do so. It implies attaining the highest standard of sexual and reproductive health; and make decisions about reproduction free of discrimination, coercion, and violence (FCI, 2000: 1).

Disch (1997: 411) preferred the term reproductive freedom to reproductive rights, and described as a knowledge or information available in a society that is necessary for the optimum maintenance of one's reproductive health freedom.

FCI (2000: 2) also define Sexuality as:

The quality of being sexual; sexual activity. Sexuality refers to physical, emotional, intellectual, and social aspects of being sexual. Sexuality is self determined by each individual, although significant social pressure exist to conform to sexual activity that is considered acceptable. Sexuality that defies those social norms can lead to oppression of individual group like-minded individuals.

The capacity to reproduce and to have freedom to decide sex should be directed through plan or conscious activity, which is commonly known as family planning. Family planning according to Ross, (1982: 205) refers to planning on the part of woman, men or couples to have the number of children they want when they want them.

The study emphasized on men's insights into reproductive health and rights rather than family planning, where the former deals with health and development; integrated approach, participatory, quality services and women and men/young people and the later emphasized on demographic

imperative, isolated approach, non-participatory, quantity programmes and services and woman-focused only (Ogbaselassie, 1998).

Therefore, the purpose of this research is to explore men's insights into reproductive health with special emphasis on exploring the views and roles of men so as to build and strength partnership between women and men. In so doing, data regarding men's perspectives have been collected through examining issues on gender power relation such as fertility, family planning, contraceptive decision and use, gender and sexuality. In addition, data regarding how men could involve on RH matters and how could women-men partnership could be formed and strengthened in RH and in combating gender based violence also examined. The research also did not fail to assess factors influencing men involvement and partnership. However, the research has limitations for using limited sample size and incorporating only men's views.

The thesis is divided into six parts. What follow is the introduction, objectives and research questions. Part two explains conceptual framework and the reviews of the study. Part three presents methodology of the study. The fourth and the fifth parts are presentation and discussion of the research findings. The last part is devoted for concluding remarks.

1.2 Statement of the Problem

The dismal reality of the condition of women in Ethiopia needs no elaboration. Eighty percent of the female population lives in rural areas under grinding poverty where pattern of inequality, discrimination and prejudice against women are engrained than male (Ipss, 2005: 38). This is primarily, among other factors, because of the fact that women had historically unequal power. Women who live in the urban centers are not in better conditions. In reproductive health, for example, differences in socialization and the power imbalance between the sexes heighten women's vulnerability to negative health consequences (WHO, 1995: 26). It means that the burden of ill health associated with reproductive health is unevenly divided between the two sexes. Obviously, women face the health hazards of pregnancy and childbirth. Sexually Transmitted Infection /STI/, including HIV/AIDS has affected more women than men (UNIFEM. 2006). Women are forced to take the responsibilities of family planning program. For example, according to WHO, (1995: 4)

women use contraceptive three times than men, and among all available methods, those used by women carry more potential health hazards.

Therefore, in order to balance the historical unequal power that women have and their responsibilities in reproductive health, enhancing the decision making power of women is crucial. In this regard, among other factors, men's involvement in enhancing the decision-making power of women is important. But in many cases it is observed that the issue of involving men in RH remains untouched. In addition, most RH programmes tend to address women only, and the programmes tend to be grounded on negative premises about men. In fact, in the last few years, few attempts have been made to focus on the issue of male involvement in reproductive health (WHO, 1998: 1). Therefore, this study has tried to address the power relation between women and men, and try to explore how men could play viable role to bring gender equity and equality. In this regard attempts have been made to focus on men, and take into account the way in which many decisions were made and the context that influence them. Emphasis has been given more on understanding of gender relations or dynamics, regarding the power relations and the gender roles that influence decision-making regarding reproductive health and rights.

The gender power relation with regard to reproductive health has been examined through such issues as family planning and contraceptive decision-making. Besides, socio-cultural factors and gender-based violence have influence on reproductive rights and health. Therefore, this research has looked in to these perspectives.

In reality, the power imbalance that exist between women and men in most developing countries, often means that although a couple may discuss family matters, the husband still has the ultimate decision making power regarding the number of children and whether she can use contraceptive. For example, for many Ethiopian women, fertility is one of a guaranteeing factor to stay with their marriage. The average national fertility is 5.9, and for rural woman it is as high as 6.4 (MOH, 2005: 6). The cardinal reason that emerges for the need to promote men's involvement in family planning is that of fostering partnership between men and women through the practice of family planning as a joint and equal responsibility (IPPF, 1984 cited in Kiefle, 1999: 33). Some authors have suggested that African family planning programs are

severely hampered by their neglect of men (Salway, 1994 cited in Kifle, 1999: 34). To ensure male involvement in sexual and reproductive rights and health Kifle (1999) and Mohammed (2001) argued the importance of couple discussion about family planning.

Contraceptive decision-making is fertile ground for examining gender relations, and gender dynamics are important for understanding the rationale for or against male responsibility for contraceptive/ and reproductive health. As Nyblade and Menken (1993) cited in Kifle (1999) suggested the male partner's positive attitude had a strong impact on actual contraceptive use. Therefore, unlike most researchers, such as Kifle, (1999) and Mohammed (2001) which emphasized on spouses discussion as a means to ensure contraceptive decision-making, this research has tried to explore the gender dynamics in relation to socio cultural factors, and investigated the ways and means of enhancing women contraceptive decision-making by working with men.

Gender-based violence, is the most compelling manifestation of unequal power in sexual relationship, and has a multitude negative effect on women's sexual and reproductive issues (Blanc, 2001: 195). This means violence not only limits a woman's control over her own sexuality and reproduction, but may also have a direct impact on a woman's reproductive and sexual health. Most argue that violence against women is a result of socio cultural factors, and learned in socialization. Since there are differences in socialization of men and women, in most community and men are socialized to be aggressive and superior, there by tending to gender based violence. Therefore, assessing the cause of gender-based violence particularly those related with sexual and reproductive health, and looking for ways and means of enhancing the role of men towards combating gender-based violence is a paramount important.

Gender analyses of contemporary relations between women and men find women's subordinate status in many ways and in different countries. Although, the position of women varies from country to country and across different cultures within a given country, the writer of this paper presumes that the situation for majority of women, especially, African and Ethiopian, women have not improved as expected due to, among other things, less participation of men. Therefore, the paper has tried to assess how men become part of the solution for gender inequality.

Overall, the writer has tried to assess men's insights into reproductive health and rights, and exploring the views and roles of men in sexual and reproductive decision-making or rights at community level in *Woliso* town. It also has tried to look into the socio-cultural aspects that shape male's perspectives, based on the socially embedded gender relations in the study.

Hence, with the belief that this research could provide some information on the issues raised above, the objectives and the research questions are presented here below

Objectives and Research Questions

The overall aim of this research is to assess men's insights into reproductive health in *Woliso* town.

In this regard, the study aims at understanding the existing gender power relations and experiences in reproductive health and rights. It tries to explore, especially, how men perceive and practice sexuality and reproductive health among the study community.

The research will also explore the views and roles of men with respect to constraints on sexual and reproductive rights as well as reproductive health in the study area. It looks into structural factors that have influenced power relations and how these situations can be changed or improved.

The study also made attempts to examine the importance of men's participation in reproductive health in combating gender based violence against women. It also aims at drawing lessons.

In order to attain the research objectives, the study attempts to provide answers to the following questions.

- What are the activities undertaken to engender reproductive health services, particularly to enhance and sustain men's involvement in reproductive health service in the study area? And how are gender power relations and experiences with respect to reproductive health and rights in the study community; and?

- Why and how men are contributing to reproductive health services? And how can the imbalanced gender power relation between women and men are improved? And how can we ensure and sustain women's sexual and reproductive health and rights by working with men?
- What are men's views and roles in combating violence against women and how can we ensure and sustain men's roles and responsibilities to protect gender-based violence that affect women's reproductive health?
- What are the influences, challenges and constraints in engendering the reproductive health services in the study area? And what are the social capitals and efforts that could utilize to overcome the challenges and constraints?

1.4 The Setting

The present study is carried out in the South Western *Shewa* Zone of *Oromia* region in *Woliso* town. The town is located approximately 115 kms from Addis Ababa. At present the town is the capital of the South Western *Shewa* zone. The majority of the people in the town are followers of Orthodox religion. The town is surrounded by predominantly rural *Woredas* which produce 'teff', cereals, *Chat*, and vegetables which are used as a principal cash crop for producers and consumption goods to the people in *Woliso* town. The staple food for the people is 'Teff' and 'Inset'. The potable water supply to the town is motorized borehole. The town has one health center which is government owned, four clinics which are privately owned, and St. Lukas Catholic hospital which is owned and run by the Catholic Church. Save the Children UK, The Family Guidance Association of Ethiopian (FGAE), and The Ethiopian Red Cross Society (ERCS) are among non-governmental organizations providing health related services in the areas (*Woliso Woreda Administration*, 2005: 8).

The total population of the zone is 1154546; off which 572810 are males and 581736 are females (almost fifty-fifty). The total population of the study locality approximately is 45537. Whereas, the total population, which is in the age group 15-49, is 33801, 0-15 age group is 35191, and the population above 49 ages is 6121(*Woliso Woreda Administration*, 2005: 3). According to the Wereds Health Office, even though the reproductive health services data for the town have not yet been fully analyzed, it is clear that reproductive health related services are not widely practiced

So far, there have not been any properly documented studies to show the factors that affect reproductive health and gender (such as sexuality, fertility behavior and/or family planning) practices in the community. Regarding research on gender and reproductive health, research has not been done. These and other reasons as well as the interest of the writer made the town to be appropriate site for the study.

II. CONCEPTUAL FRAMWORK AND HIGHLIGHTS OF THE REVIEW OF LITERATURE

2.1. Conceptual Framework

The conceptual framework of empowerment is believed by the writer as appropriate guiding principle for discussion.

There are various definitions about the concept of empowerment. However, for this paper the writer prefers to use what Elson (in EWLA, 2002: 9) pointed out. According to her empowerment is understood in relation to changing the existing imbalance of power relation that exists in society. For Elison, empowerment is fundamentally about changing social institutions and practices; changing rules, norms and rights; and changing the balance between women's obligations and responsibilities and their command over the resources they need to discharge these obligations and responsibilities. Empowerment is basically balancing or changing power relations between women and men such as giving women the mandate to take control over their own lives, including reproductive lives or rights at various levels and making their own decision and choice.

When we talk about empowerment, we need to address such questions as: What type of power do we want to achieve? How do we measure the achievement of this power? The most important feature of empowerment is the word power, which is defined as control over material resources, intellectual resources and ideology (Agarwal, 1995 quoted in EWLA, 2002: 9). Therefore, it is found helpful to look in to the different aspects of power in order to have better understanding about the concept of empowerment.

The power of domination can be seen from different aspects. For example, there is a difference between `power-over` and `power-to`. `Power over` refers to the ability to assert wishes and goals even in the face of opposition from other (Riley, 1997 cited in Blanc, 2001:189). For Riley this type of power is an either/or relationship of domination /subordination. It requires the creations of simple dualities: man/women; rich/poor; black/white. It is ultimately based on socially sanctioned threats of violence, such as gender-based violence. The exercise of men power over women or the gender power relation could be understood as power-over.

Riley also pointed out that ‘power to’ as providing the ability to act or exercise one’s power to accomplish various responsibilities. ‘Power to’ or increased capacity for change for individual woman may result in improving the status of women health (including reproductive health) nutrition; increasing accesses to income and etc, and therefore, would not create conflicts (EWLA, 2002: 10).

Power-within recognizes the strengths and weaknesses that exist in all of us and does not automatically condemn difference, or categories in either/or terms as ‘power over’. It stresses self-acceptance and self-respect; complementary rather than duality; recognition of aspects of the other-women in men. A healthy society will admit and value the gender aspect of differences, and strive to change them for its betterment (Flintan, 2006: 16). Therefore, it could be also understood that by changing the power within an individual man regarding gender concerns, we could improve the existing gender imbalance and power relations. Thus, individual man self-acceptance of women's rights, including reproductive health and rights, can be seen as power-within.

People feel empowered through being organized and united by common purpose or common understanding. Power that creates from such organized group involves power-with. Power-with designates the creation or increasing of solidarity with other (EWLA, 2002; Flintan, 2006). The solidarity of an individual woman with other women for change at household, community and macro levels can be seen as ‘power with’.

Over all, while working on or talking about gender issues such as reproductive health, one needs to address some of the imbalance and inequities that exist in societies. One of these inequities in the level of power is that men usually have more power than women. Rather than trying to take away some of men’s power to make the balance, it would be better to try to give women extra power e.g. skills, understanding, cooperation, confidence, respect –‘power-to’-etc. This process of opening up opportunities for people to increase their power, in this case women’s power is commonly known as empowerment (Flintan, 2006: 16). Empowering women in reproductive right and health can be viable if women have the power to decide on the issues. In addition, people’s appreciation and value toward the positive aspect of

differences and react to change the situations accordingly will have significance. In this regard, changing the attitudes of men by increasing the power within individual man to understand the gender differences is also helpful. Empowerment can be measured using indicators that measured relative power.

Measurements of empowerment

Drawing defensible conclusions about the role of power relations could be a difficult task. As Blanc,

(2001:191) indicated in measuring the level of gender power, a distinction should be made between the measurement of women's 'empowerment' and their 'autonomy' by using indicators that measure absolute dimensions of power and by measuring the balance of power within relationships using indicators that measure relative power. The later is of primary concern here.

Examining the role of power in sexual relationship and reproductive rights refers to the relative ability of one partner to act independently, to dominate decision-making; to engage in behavior against the other partner's wishes, or control a partner's actions could be used. Here, what is important is not the absolute power of either member of a couple but the comparative influence of each partner relative to the other (Pulerwitz, 2000 cited in Blanc, 2001).

In order to understand or measure the power relation between women and men, Blanc (2001) argues that one of the more common approaches is to assess the relative "say" of partners in a series of decision-making arenas. According to Blanc, questions about women's perceptions regarding the weight of their point of view with regards to household issues decisions, such as household budget decision, could be used to examine the use of contraceptives and women's role in reproductive decision. The writer here also tried to gauge the power balance using partners' discussion on some house hold issues (see chapter five).

2.2 Related literature

2.2.1. The Socio-Cultural Dimensions of Sexual and Reproductive Rights and Health.

In order to analyze the hierarchal gender system in any given society one must begin with a basic assessment of social structure. According to WHO (1998: 3), gender perspectives

(including those concerning reproductive health and rights, and sexuality) are thus embedded in this large structure. It is thus necessary to know or identify the salient social structure for each group or society or segment of society or region. For example, in many parts of Asia and Africa, the social structure is patrilineal, and is based upon male descent, authority, and power. It means all children are born into kinship group of their father, while females leave their family upon marriage and join the kinship of their respective husbands. In such society, males are the sole heirs to property (primarily land) upon the death of their father Miz-Hasab Research Centre (MHRC, 2004: 33).

In such social and economic structure the implication for sex preference of children, cost and values of males and females are in favor of males. Socialization of males and females is also different. Males are taught that daughters are less valuable; the concept of manhood which emphasizes male dominance, power, authority, and entitlements are inculcated. In many societies, men play the dominant role in many aspects of social life, including sexual, reproductive health and rights (Blanc, 2001: 198). However, women play a major role in socialization processes which keeps the norms in place that implicitly and/or explicitly grant women secondary status (Advancing Women Status, 2005). Men, like women, face barriers that arise from cultural norms about appropriate gender role. Negative reaction from other men and family members when male partner attempts to become involved in women's or children's health have been mentioned as a barrier in several studies (Raju and Leonard, 2000 cited in Blanc, 2001).

There are evidences, which show male dominance in making family decisions. Most countries of the world, particularly developing nations, still have male dominated cultures (Lasee and Becker, 1997: 18). In Sub-Saharan Africa, for example, ancestral customs give men rights over women's procreative power. In such society, setting, spousal influence rather than being mutual or reciprocal is an exclusive right exercised only by the husband (Ezech, 1993: 165). To substantiate this view, Caldwell (cited in Ezech, 1993) revealed that in most traditional societies the decisions about contraception are made solely by the husband or occasionally by members of an extended family unit.

Studies by Getenet, (2006: 110) and MHRC, (2004: 61) in Ethiopia also revealed that, sexual enjoyment is influenced by social construction of male and female sexuality. In many societies, including Ethiopia men are thought to be more interested than women in sex and to acquire sex to maintain their health, although sex is also thought to cause male weakness in some settings. Women are considered to have strong sexual impulses, where in others they are characterized as indifferent to sex.

A more devastating situation for women in some cultures is the failure to produce any children at all. This situation may lead to divorce, as in many Ethiopian cultures. The freedom of men to have multiple-partner sex is considered as normal and legitimate act. Besides men's power over women, is accepted as masculine behavior in many societies (Getenet, 2006: 113). Similar findings were obtained by (MHRC, 2004: 46).

Reproductive health problems are affecting the socio-economic status of people, particularly, women. For example, world wide, an estimated 250 million years of productive life are lost every year as a result of reproductive health problems. The poor disproportionately suffer the consequences, especially women, and have the most to gain from the expanded access to reproductive health services (UNFPA, 2005: 2). The inability to determine when and how many children to have limit a woman's life choices. According to UNFPA, enabling individuals to freely choose their family size will result in smaller family size, slower population growth and reduce pressure on land and other natural resources. This, in turn, can result in economic benefits through what, UNFPA called, the "demographic dividend" since lower fertility means higher active population and lower dependency rate.

In general the above review implies that cultural factors have influences on reproductive health and rights of women, and also disfavored women.

2.2.2 The 'Rights-Based Approach' to Sexual and Reproductive Health

The rights-based approach to sexual and reproductive health adapted at the International Conference on Population and Development (ICPD) in 1994 reflects a new global policy consensus on the relationship between population policy and sexual and reproductive health and rights (FCI, 2000: 3)). The main theme of the consensus is that if women are empowered

and people's needs for sexual and reproductive health are met, population stabilization could be achieved by virtues of choice and opportunity; not coercion and control. The rights-based approach is designed to fit the existing international human rights agreements such as the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and 1993, the Vienna World Conference on Human Rights declared women's rights as human rights and recognize sexual and reproductive health and rights as important ends in themselves (UNFPA, 2005). This means that violation of sexual and reproductive rights of women and men is considered as violation of international human rights conventions. In this regard, their men counter parts influence women's reproductive health and rights. Therefore, the conference called for men's partnership to rights-based approach to sexual and reproductive health (UNFPA, 2005).

One of the critical areas indicated by The Beijing Platform for Action, (PfA) paragraph 92, is women's health. Accordingly, attending to woman's sexual and reproductive health care needs throughout the life cycle is one of the many strategies for achieving gender equality and empowerment of women. The paragraph states:

Women's rights to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of Influence in decision-making is social realities which have an adverse impact on their health (UNFPA, 2005: 8).

2.2.3 Men's Involvement in Reproductive Health

Reproductive health is almost universally regarded as women's responsibility, and, therefore, men do not try to know about contraception because to do so would violate gender norms. Men were found to be expressing many traditional pro-fertility cultural attitudes and opinions (Robinson, 1992: 447). As a result most men had not practiced contraception, and viewed it as women's activity.

Unfortunately, perspectives on males' involvement are often rooted in negative assumptions. That is, program planners view men as potential obstructionist who, if involved in decision making; will defeat women's efforts to regulate fertility (Kara, Stark, and Wolf, 1997: 24). This appears to have been a wrong perception since, in most societies, especially in developing countries; men are the main decision makers in families. Particularly, in Africa men often make the couple's decision about fertility limitation (Salway, 1994: 20). In most African states, too much emphasis has been put on the health of women; associating family planning only with women. This, according to Salway, may be responsible for the negative attitude African men have towards family planning methods. In addition, family planning services have been associated with health services and are not considered a family welfare service (Bankole and Singh, 1998 cited in Blanc, 2001). .

Men's involvement is very crucial in promoting reproductive health because men play a key role in their partner's adoption of contraception. In Ethiopia, a study to examine the relative effectiveness of home visitation on the use of modern contraceptives with and without husband's participation found that those couples in which husbands participated were more likely to have continued use during the year (Terefe and Larson, 1993 cited in Blanc, 2001: 201).

In general, the above review implies that men were not given due attention in the course of planning. Women were regarded as the primary beneficiaries of the reproductive health services, such as family planning, and even the service were looked as women's activity not of men.

Why involve men? There are several reasons why men's involvement in reproductive health is useful. According to WHO, (1998: 10), due to their ascribed gender roles, men tend to have little knowledge about their own health including sexual and reproductive health. Thus, men have their own sexual and reproductive health' concerns and needs which are not always met. The other reason, according WHO, is men's involvement increases their awareness, acceptance and support to their partners' need, choice and rights. For example, ICPD PoA underlines the importance of having men as the major duty bearers for the prevention of sexual transmitted diseases.

Taking of female alone or male alone is not an adequate approach to reproductive issues. This is due to the fact that many of the decisions regarding reproductive health and family planning are made within a set of gender relations that affects them or their implementation. Involving men can create rooms for discussion and communication which ultimately lead or contribute to the road to gender equality. The process of involving and empowering men, regarding reproductive health issues, will help them to be more sensitive to women's health (Blanc (2001). While examining the effect of power in sexual relationships on sexual and reproductive health, Blanc pointed out that involving men often has led to better reproductive health outcomes for women.

Positive climate to address emerging issues has also contributed to encourage male involvement. For instance, ICPD has provided the opportunity of moving from family planning to reproductive health and from a woman only approach to a gender approach. Following Cairo and Beijing, in most developing countries, including Ethiopia, and as it was mentioned in back ground information, there is a positive climate to promote and address a broader variety of issues on sexual and reproductive health including gender issues and male's involvement and partnership for women empowerment (UNFPA, 1999:).

The other question that needs to be addressed on the issue of men involvement is how men involvement could be achieved. Several studies have tried to address in different perspectives and provide their answers. For example, in the Ethiopia context, some studies have approached in relation to communication and discussion among partners, and others indicate that men's educational status is the most significant positive indication of their participation in fertility discussion (Mulu, 1996) and (Kefle, 1999). The results suggest that communication between partners could be improved by enhancing the consciousness of men, in particular by improving their level of education, and ultimately contribute to bring about and strength partnership between women and men. Education can provide boys with a different interpretation of masculinity, thus can replace the one based men domination to one defined by share responsibilities between partners (UNFPA, 1999). UNFPA calls interventions of different stakeholders-government (GOs) and non-government organization(NGOs)- to begin to confront cultural barriers to successfully promote male's involvement, in the family including in reproductive health matters so that to prepare boys and men for a broader fathering role.

The study further disclosed the need to teach young people about responsible sexual relations, the meaning and responsibilities of marriage and other adult relationships.

In recent years, the issue of how men could be involved in reproductive health and right has been given emphasis in research. One of the approaches that have been pointed out by Blanc (2001) is the intervention approach which acknowledging or affecting the gender power relations. He suggested that interventions that range from providing most basic information that acknowledge the role of partners-to the most ambitious-transforming community norms. Blanc provided a series of alternatives as to how men can involve in RH. According to Blanc, acknowledging the role of men; addressing the context of sexual relations; promoting peer education and communication; intervention that invite partner participation; integrating the dynamic of sexual relations into services for men; and, the intervention that intend to change community norms.

The National Action Plan of the Government of Ethiopia (NAP-GE) (Hareg, 2005: 12) for gender equality includes promoting male involvement in reproductive rights health activities. The plan activities have tried to address how men could be involved in RH. The activities include: providing reproductive rights and health education to men; promoting safe sexual behavior among men and women through awareness creation programmes; involving men in family planning programs including utilization of contraception; conducting advocacy campaign; and disseminating information using media.

The reviews of the literature have suggested that men's involvement could be viable, among other things, through changing the power within individual man, mainly, through what is commonly known as Information, Education, and Communication (IEC). Blanc, (2001: 204) pointed out that mass media campaign could address community norms about such issues as gender.

III. METHODOLOGY

The study explores men's insights into reproductive health and rights in the study area. In order to capture the data and information, I employed both qualitative and quantitative methodologies. The research mainly relied on qualitative methods (focus group discussion, in-depth interview and observation) in order to collect data on men's insights into reproductive health and rights. In addition, I also used qualitative research method to obtain men's views with regard to the advantages of their involvement in reproductive rights and health, and the influences of structural factors on issues raised. In order to generate data on demographic characteristics, fertility desire, etc, the researcher employed quantitative method, namely, a small-scale survey. The research aimed at answering the research questions that were listed previously.

3.1 Methods and Techniques of samplings

To get pertinent data and information, I used triangulation of secondary and primary sources.

3.1.1. Secondary Sources

Archive/document has been consulted as secondary source of data collection. I went through all pertinent documents that were considered useful for the study. These include: reports of FGAE branch office, and health centre, Woliso *Woreda* Health office. Violence cases reported to Women Affairs Desk, and different literatures and written documents that are believed pertinent to the issue under discussion also gathered. Most of the secondary data obtained from FGAE branch office and Woliso Health Centre consisted figures by beneficiaries and by types (see Annex Two). The data from the *Woreda* health office were a consolidate reports of different health institutions and NGOs. The data, which were collected from women affairs desk, provided information about major causes of gender-based violence. I also reviewed few related literatures that are believed to be helpful. As there was problem of tracing literature on gender and reproductive rights and health, in general, and men involvement in particular, I tried my best and reviewed, among other research and literatures, the works of: Blanc (2001), to asses the effect of power on sexual and reproductive health. Getnet Tadel (2006) and (MHRC) about sexuality, gender and HIV/AIDS related issues. Kefle (1999), Mohamed

(2001), Kiros (1986), and Mulu (1996) focusing on family planning and fertility in the Ethiopia context.

3.1.2 Primary Sources

Target Population and sampling Techniques

As the study used purposive and systematic random sampling, the target groups include:

1. Adult and young men
1. Local and religious leaders
2. Health professionals and program managers in reproductive health services

Site selection and Data Collection Procedures

The research site was selected based on my interest to conduct my thesis out of big cities, particularly, out of Addis Ababa. In addition, the possible facilitation that could be obtained from individuals contributed to my site selection.

The actual research sites /*Keble*s was selected using purposeful sampling technique and included all four *Kebles*. Almost equal numbers of respondents were selected from each *kebele*. For example, the hundred-fifty survey respondents were divided among four *Kebles*.

Regarding data collection procedure, people, particularly the zonal health bureau head introduced me to the local community leaders, *Woreda* Health Office head, and explained the purpose why I was there to each *Keble* administrator. In addition, a woman whom I met in the way to Woliso in the bus who is the head of Ethiopia Red Cross Society Woliso branch has played a significant role in facilitating the study. She introduced me to religious leaders and FGAE branch head.

Finally, I managed to have four graduate students from each *Keble* to be assistants during the research period. The assistants were given orientation on how to proceed with the study. I informed them about the nature and implications of the study. Their assignments were both as a facilitator for each *Keble* focus group discussion and survey data encoder. In all *Kebles*, I identified focus group and in-depth interview participants using purposeful sampling techniques. For all of them, I informed the purposes and implications of the study. I also

asked their willingness for participation or to be interviewed and to be tape recorded in the interview and focus group programs. I made observation and simultaneously did informal chat. With the consent of the participants, I fixed the interview places, date and times.

3.2.3 Field Research Methods

Focus Group Discussion

In order to meet the study objectives, I mainly used focus group discussion (FGDs) with the aim of collecting data on attitudes, values, beliefs, and assumptions that underpin the prevailing men's perceptions towards gender, sexuality, and reproductive health and rights. I attempted to incorporate married men and unmarried men participants. In this regard, I interviewed the respondents from the community using purposive sampling technique. In order to be able to gather different views, I also attempted to incorporate participants who literate and illiterate. Members were not familiar with each other and they were homogeneous in terms of economic and social status. The total numbers of the respondents for focus group discussion were 72, and were organized in eight focus groups (7-10 members in a group). Of the eight focus groups, four consists of young men and the rest adult men groups. This had assisted me to critically observe and compare the age variations on the issues raised. The discussions lasted for an average of two hours, and I conducted them in *Keble* administration compounds, in *Idir* (traditional social insurance scheme) halls where the participants hold regular meetings, in FGAE and Ethiopia Red Cross Society branch offices. The selection of discussion places or locations were made upon the consent of the participants. In all discussion programs, I took notes and list of participants and additional notes were also taken by each assistant researcher or facilitator. The discussion was directed by the researcher. As a result, I made to empower the participants through critical dialogue and reciprocally learning processes. In addition, I took care to record and compare the adult and young men focus group discussion results separately in order to assist me during data presentation and discussion.

In-Depth Interview

In-depth interviews were undertaken with a total of 18 people. Two experts from women affairs desk; two key informants from each *Kebele*; FGAE and ERCS branches heads, two

health professional from *Woreda* Health centre; and four religious leaders. All were selected using purposeful sampling techniques.

Survey

Sampling of Survey Respondents

As it has been indicated previously, I undertook small-scale survey in order to collect quantitative information. I prepared and administered questionnaires to men in selected *Kebles* (*Keble* 01, 02, 03, and 04). This method has assisted me to have more but general data and information about the subject under study. One hundred fifty respondents were selected using purposive and simple random sampling techniques. Thirty eight respondents were selected from 01 and 04 *Kebles* and thirty seven respondents each were selected from the remaining *Kebles*. I employed purposive sampling technique to determine the target population and the respective *Kebles* as well as *Gottes* within the *Keble* (*Gotte* also sometimes called *Sefer* is the smallest unit area where people live). Two *Gottes* from each *Keble* were selected and assigned for each adult and young men respondents using purposeful sampling method. I applied random sampling technique to select the respondents. I did stratification on the basis of mainly age of the respondents. I listed all men members of household from the selected *Gottes* in a *Keble*.

The sample intervals were obtained by dividing the total number of men household members by number of sample population. Only one man member was included from one household, and age was taken as major variable. The sample population in each *Keble* was divided into almost equal number of young and adult men respondents. Having established the starting number at random, I selected the first 19 adult men and the next 19 or 18 young men respondents from the lists for inclusion in to the sample beginning with the starting number and following the sample interval. For simplicity purpose one *Gotte* is selected for each group of respondents (adult and young men). Therefore, I continued the counting until the desired combination of respondents was obtained (See Chapter Four).

In order to include a large number of respondents, due care has been taken so that only very few respondent were made to participate in more than one method. In addition, I also carried out quality checks. In order to maintain the quality of data and information collected through

questionnaires, only five questionnaires were filled out daily by each enumerator. I filled out 20 questionnaires, five questionnaires from each Keble, for verification purpose. In addition, I tried to identify problems in the data collection process, and accordingly corrective measures on incomplete questionnaires and improper markings were made.

Observation

Information also gathered through observation technique. I observed the actual setting of the research area so as to assess the different aspects of the setting, more particularly very few respondents' family relations, FGAE and ERCS branches activities, and the activities of the health centre were closely observed. The writer attended and observed panel discussions made by young people or girls and boys, and observed the coffee ceremony of young women in FGAE Woliso branch office, one of the programmes which are provided by the branch office. I also made observation on the program of ERCS Woliso branch on reproductive health and HIV/AIDS related programmes activities. In both sites the aim of observation was mainly at gathering information regarding the programmes and activities of the organizations on young people with respect to sexuality, reproductive rights and health Information, Education and Communication (IEC). At the Woliso Health Centre, the focus of attention was on Maternal Health Care (MHC) and Family Planning (FP) services. Proper and special attention was given to observe the gender mix and aspects of the different programmes and activities. I gave particular emphasis to observe the family relation, but, I found it more difficulty to observe and collect the appropriate data. I managed to observe very small number of families' interactions when ever appropriate. In all cases, the writer observed, properly recorded and documented using observation check list (See Annex II).

3.4 Data Analysis

The data were collected using the research methods mentioned above. Data and information were recorded using tape record, notebook, and dairies. The kind of data that were collected were, mostly qualitative, and therefore I used qualitative analysis while analyzing the result of focus group discussion, in-depth interviews, and observation in terms of reasons and advantages of men involvement in sexual and reproductive health and rights. I also used qualitative analysis to present participants' attitudes on sexuality, reproductive health, and

gender power relations. I analyzed information obtained through observations and in-depth interviews methods mainly in the course of the field work. I properly transcribed and entered most of the data onto the computer. The data were organized and analyzed to generate coherent meanings. The data and information obtained through archival method such as empirical studies of the subject are analyzed through the lenses of qualitative analysis and gender. To protect the anonymity of the respondents, all names mentioned in the report are pseudonyms. I checked, encoded and summarized and analyzed quantitative data with help of Statistical Program for Social Science (SPSS) using lower level quantitative analysis, namely tables, percentages and frequency.

The data were interpreted on the basis of feminist research guiding principles and by using empowerment as a conceptual framework. In addition, attempts were made to triangulate information in order to reach at generalization by overcoming the limitations of one method through the strength of another.

IV. THE CONTEXT OF SEXUALITY, GENDER AND REPRODUCTIVE HEALTH AND RIGHTS

This chapter presents findings. The main themes include: demographic characteristics of the survey respondents, gender power relation in terms of regulating fertility, contraceptive, and gender and sexuality.

4.1 Demographic Characteristics of Survey Respondents.

In this part of the chapter I shall present demographic characteristics of survey respondents namely: age, types of marriage and martial status, education, religious affiliation, and occupations. The data indicated that the sample population is heterogeneous in terms of respondents' characteristics and this assisted the writer to gather different views on the issues raised.

Table 1: Distribution of Respondents by Keble and Gotte

Keble	Gotte	Adult men	Young men
01	2	19	19
02	2	19	18
03	2	19	18
04	2	19	19
Total	8	76	74

Table2: Respondents' Age, Martial Types and Status.

	Frequency	Percent
Age		
15-24	74	49.33
25-34	24	16.00
35-44	18	12.00
45-54	26	17.33
55-64	8	5.34
Total	150	100.00
Martial status		
Married	109	72.67
Unmarried	31	20.67
Widowed	10	6.67
Total	150	100.00
Marriage type		
Monogamous	81	88.05
Polygamy	11	11.95
Total	92	100.00

As age is known to be the most important variable in gender and reproductive health and rights studies, data were collected on age during the study. Therefore, the highest proportions of respondents (49.33) percent were in the age interval of 15-24. On the other hand, 17.33 percent of the respondents were aged 45-54. The respondents in the age interval of 25-34 were 16 percent. The remaining, (12 and 5.34 percent) of the respondents were between the ages of 35-44 and 55-64 respectively.

The majority of the respondents, 72.67 percent, reported that they were married. The remaining, 20.67 and 6.67 percent, of the respondents were unmarried and widowed respectively. Among currently married respondents, monogamy was reported by 88.05 percent of the respondents while polygamy was reported by 11.95 percent of the respondents.

These descriptions indicate that the sample population has differences in age distribution, marital type and status, and this assisted researcher to collect different perspectives about the issues raised.

Similarly, data were collected on other socio-economic characteristics of the respondents (Table three).

Table3: Respondents' Education, Religious Affiliation, and Occupation

	Frequency	Percentage
Education		
Illiterate	27	18.00
Church or Kuranjh	12	8.00
Literacy campaign	11	7.33
Grade 1-6	14	9.33
“ 7-12	16	10.67
“ completed	38	25.33
College diploma	18	12.00
First degree and above	14	9.33
Total	150	100.00
Religion		
Christian Orthodox	84	56.00
Muslim	35	23.33
Christian Protestant	15	10.00
Christian catholic	10	6.67
Other	6	4.00
Total	150	100.00
Occupation		
Civil servants	54	36.00
Private business	45	30.00
Students	18	12.00
Others	14	9.33
Total	150	100

Information on educational level of the respondents was collected in order to assist the researcher to look in to the influences of educational background on respondents' perceptions, attitudes and views. As it can be observed, educational attainment of the respondents is quite high; and (46.67 percent) reported that they had twelve grade and above education. On the other hand, 18 percent of the respondents have no schooling, while those respondents who had literacy educational level account for 7.33 percent. Eight percent of the respondents had church and Koran schooling. This description shows that the sample population has differences in the distribution of educational level. This implies that in the study area men are encouraged to enroll or to complete high school. This indicates also that a remarkable size of the respondents may have information and knowledge about reproductive health (RH) matters.

Regarding religious affiliation, the highest proportion of respondents were Christians (72.67 percent), whereas, Muslims accounted for 23.33 percent.

As far as occupational status of the respondents is concerned, the highest proportions of respondents were civil servants (36 percent). Those respondents engaged in private business were 30 percent. The respondents who were students and unemployed were 12 and 12.67 percent respectively; while the remaining (9.33 percent) of the respondents were soldiers, NGO employees, pensioners, etc.

4.2 Gender power Relation

4.2.1 Regulating Fertility

The study explored the existing gender power relations in the study area. The level of power that exists between women and men has been examined using fertility desire and decision-making perspectives.

Survey respondents were asked to forward their views whether they would like to have more children, the number of children they would like to have, regarding their sex preference, and decision on fertility desire (Table 4).

Table 4: Fertility Desire and Decision of Respondents

Desire to have more children	Frequency	Percent
Want more	23	15.33
I would not want more	70	46.67
God/Alha decides	25	16.67
Undecided	32	21.33
Total	150	100.00
Number of children desired		
One	22	14.67
Two	40	26.67
Three	30	20.00
Four	22	14.67
Five and above	17	11.33
God/Alha	10	6.66
Undecided	9	6.00
Total	150	100.00
Sex preference		
More boys than girls	55	36.67
More girls than boys	14	9.33
Equal preference	66	44.00
No preference	15	10.00
Total	150	100.00
Decision on Fertility is made by		
Men	74	51.33
Women	11	7.33
Both	54	36.00
Other	11	7.34
Total	150	100.00

The majority of the respondents (46.67 percent) reported that they do not want additional children than they have now. On the other hand, 15.33 percent of the respondents reported that they would like to have more. For measuring desired family size, respondents were asked to respond to a question: “If you could choose exactly the number of children you want to have in your life, how many would that be?” The highest proportion of respondents (76 percent) expressed to have four or less children. Respondents were further asked to provide their views with regard to sex preference if they would have decided to have children. The result showed that the majority of the respondents (44 percent) reported that they would have equal preference; while 36.67 and 9.33 percent maintained that they would prefer boys than girls and

girls than boys respectively. The remaining, (10 percent) reported that they are indifferent to sex preference.

Attempts were also made to see the gender aspects of reproductive health with regard to fertility decision -making. Accordingly, 32 percent of the survey respondents reported that the decision is made mutually. Whereas, 51.33 and 7.33 percent of them responded that the decision could be made by men and by women respectively. Those reported 'other' includes: relatives, friends, God or Allah. The findings disclosed that women had little decision-making power than men. This is due to the fact that the existing gender ideology prevailing in the study society favors male dominance over women. This might have happened due to some factors such as access to information and services of family planning as well as the influences of structural factors.

Contrary to what have been explained by survey respondents, the result of the in-depth interview with religious leaders indicated that traditional religious values have sustained high fertility.

Similarly, the interview with elders also supports the views of religious leaders. That is, they associated fertility with virtue and spiritual development and associated reproductive failure with sin. The findings showed that family planning practices encounter obstacles, especially religious opposition.

In contrast, almost all young men informants argued that larger families are not desirable; and they expressed that as family gets larger, the proper way of raising children becomes difficult. This indicates that young men are more likely aware of childbearing costs than adult residents. Therefore, they reported that men too would like to tend to control fertility, or would not want to have the desire for more children like women. However, the same respondents further disclosed that women take contraceptives without the knowledge of their partners was admitted; and this might be due to both the desire not to have more children and the existence of unequal power relationship that exist between women and men. In addition, the researcher presumes that patriarchal domination, as the dominant social structure in the study community; could play roles in shaping men's attitudes and practices on contraceptive methods.

A discussion on the same issue with adult men focus group participants indicated that men also viewed and understood that women face unique costs in having children, including the pain of exhaustion and elevated risks of morbidity and mortality associated with pregnancy and childbirth. The participants have also reported the influence of structural factors with regard to fertility issues. Particularly, poverty and low economic status were identified as causes of poor women's health care and nutrition status and cause for reproductive health problems. As a result, adult men viewed that they consequently want to have fewer children or space births further apart like women would wish.

Few adult men's view further indicated that the desire to have children is emanated from children contribution in reducing the workload around the home and their contribution to harmonize marriage. They perceived that those couples that have children are less likely to make divorce than those who do not have.

Educational status of the respondents was indicated as a factor that differentiates the views of the respondents. As a result, most of the respondents argued that those who are educated than non-educated member of their community encourage small family size. Regarding large family size, with the exception of one group of adult men in Keble 02 and few individual views, other groups hold opposite views of those of elders and religious leaders.

Men's prefer boys to girls. Contrary to what the majority of focus group discussion participants have explained, some key informants declared that couples not only attempt to assure that they have male offspring, but also appear to provide different treatment to boys and girls. The reasons for this difference were that having boys is prestigious, and girls are perceived as inactive than boys; difficulty to take care of girls, as they are subject to violence, girls could not move freely as boys, and therefore, have less contribution to assist their families. This indicates that informants' views are influenced by the existing gender stereotypes that often based on socially accepted gender roles.

With regard to fertility decision-making, all religious leaders and the majority of focus group participants indicated that men make decision. Some of them pointed out that few educated spouses make decision on common accord.

The findings showed that men largely make fertility decision. This means the gender power relations between the sexes are unevenly divided and there is a power-over exercised by men. There is positive tendency to regulate fertility by majority of the sample population due to the influences of education. This implies that education could provide ‘power to’ women or increased their capacity for change the gender stats quo. It means it increases their power to decide on many gender issues including fertility desire, and result in improving the status of women health (including reproductive health) nutrition; increasing accesses to income and etc.

It was reported that education also has a positive contribution in changing the power within an individual man, and ultimately could change the existing gender imbalance and power relation. On the other hand, poverty and low economic status of most members of the community are found as factors that influence fertility desire. The findings revealed that men perceived that due to low economic status and poverty they tend to regulate fertility. The implication here is that as a result of factors influencing, men perceive the same way as women regarding the disadvantages of having more children.

In nutshell, it was found out that men too would like to control fertility. But, decision about fertility is mainly made on gender context and the gender power relations tilted towards men, i.e., men have a relative power than women. It was also identified that structural factors such as poverty and respondents’ educational level influence fertility decisions.

4.3. The Gender Power Dynamics on Contraceptive and Men’s view

The main objective of this section is to show regarding contraceptives knowledge, attitude, decision and practices. I begin with the survey results and discussion and then move on to qualitative findings and analysis.

Survey respondents were asked to explain their knowledge and practices of contraceptives. The results showed that they have heard modern contraceptive methods such as pills, nor plants, condom, and injectible methods of delaying pregnancy. Their sources of information include: mass media, leaflets, FGAE, health centre, ERCS, schools, and friends.

Table 5: Respondents' Views on Contraceptive Knowledge, Decision, and Usage

Knowledge about type of contraceptive their partners' use	Frequency	Percent
Well informed	89	59.33
Not well informed	52	34.67
No response	9	6.00
Total	150	100.00
Decision		
Men	78	52.00
Women	20	13.33
Together	38	25.33
Unknown	14	9.34
Total	150	100.00
Usage of contraceptives		
Practiced	8	5.33
Not yet practiced	138	92.00
Do not know	4	2.67
Total	150	100.00
Future intention of using contraceptive methods		
Want to use	97	64.67
Do not want to use	42	28.00
No response	11	7.33
Total	150	100.00

About, (34.67 percent), of the respondents do not think that they are well informed about contraceptives their partners use, while (59.33 percent) of the respondents claimed that they know about their partners' contraceptive usage. The data showed that there is no remarkable difference between respondents who had the knowledge regarding their partners' contraceptive practices and those who have not.

The data showed that (92 percent) of the respondents never practiced or used contraceptive methods and the most available and best known and/or used method is condom (see Annex Three).

Regarding the decision involved in contraceptive use, 25.33 percent of the respondents reported that the decision is made jointly and 52 percent answered men's decision power and 8.67 percent declared that women make the decision. Respondents were also asked whether they have the intention to use the methods in the future or not. The result showed that 64.67 and 28 percent reported "yes" and "no" respectively.

Those respondents who reported that they would not use the methods in the future were asked to forward their reason(s). Accordingly, the major reasons for men's refusal were: respondents opt to have more or additional children (57.67 percent); the religious influence (24.67 percent); and its side effect on health (12.66 percent). The survey results further that those respondents who reported such reasons as "God's/Allha" believed that limiting or delaying births could not be performed by their own choice rather it is the power of God/Allah. This means that religion also has influence on the use of contraceptive for some respondents. Again, the third reason, which is related to the side effect caused by contraceptive, indicates that respondents do not intend to use contraceptive methods for fear of the side effects. They did not mention the unavailability of the methods as reason. This might be due to the study site location. Respondents declared that contraceptives are easy to get (Table 6).

Table 6: Men's Views on the Availability of Contraceptives

	Frequency	Percent
Easily Accessible	124	82.67
Difficult to get	8	5.33
Not accessible at all	6	4.00
I do not know	12	8.00
Total	150	100.00

The research confirmed that 82.67 percent of respondents declared that they have easy access to contraceptives. The data shows that the availability of modern contraceptives is not a serious problem. This indicates that it might be lack of knowledge of the advantages of contraceptives and the attitude to react accordingly is found more serious than its availability.

Respondents were also asked to forward their views with regard to the attitudes of religious leaders, elders, men, women and youth groups towards the use of contraceptive in the study community (Table 7).

Table7. Survey Respondents’ Views on Attitudes of Religious Leaders, Elders, Men, Women and Youth towards use of Contraceptive.

	Positive		Negative/oppose		Uncertain		No response		Total	
	F	P	F	P	F	P	F	P	F	P
Religious leaders	21	14.00	115	76.67	6	5.33	6	4.00	150	100
Elders	20	13.33	119	79.33	4	4.67	4	2.67	150	100
Adult Men	78	52.00	52	34.67	3	11.33	3	2.00	150	100
Women	128	85.33	8	5.33	-	9.33	-	-	150	100
Young men	133	75.33	9	6.00	2	4.00	2	1.33	150	100

According to respondents’ perceptions modern contraceptive faced opposition from religious leaders and elders 76.67 and 79.33 percent respectively. On the other hand, respondents perceived that women and young men might have positive attitudes towards modern contraceptive methods. Respondents perceived that 52 percent of men support the methods, while 34.67 percent could have negative attitudes. According to respondents’ views women have positive views and attitudes towards contraceptive (85.33 percent). The findings revealed that the majority of men’s attitudes were positive, and this in turn implies that there might be possibilities of making the issue as partners’ agenda where men could involve in reproductive health issues or matters, such as contraception.

The qualitative data obtained from in-depth interviewees regarding modern contraceptives use and religious matter indicated that some community members tend to have sought natural family planning service because they wanted to space their children in a religious or cultural manner or because they wanted to avoid artificial methods. According to the respondents, the Christian Orthodox churches and the Roman Catholic churches tended to oppose the widespread distribution of contraceptive methods, particularly, did not support the so-called artificial means of fertility control. This is because any change in the position on birth control was seen as a sin and a threat to the entire structure of church thinking on marriage and the family as well as to the nature and governance of the church itself. The other reason, which

was mentioned by focus group informants and also confirmed by in-depth interviewees, was that population growth on earth meant more souls to glorify God in heaven.

On the contrary, Muslim religious leader did not totally condemn modern methods, as long as it is used for delaying fertility. According to Haji Abdela, 45 year, member of *Kadi*:

Abortion is prohibited in Muslim religion; but spacing between children (Tenzium) is allowed. On the other hand, as far as I know determining the number of children in advance by Muslim religion followers (Thidid) is not allowed. If it is for Thinzim contraceptive is not prohibited. But it is allowed for women only. Besides, life-time methods are not allowed.

In addition, the Muslim religious leaders also provided their views in support of the use of contraceptive as long as problems to care of the children are prevailing due to the fact that families could not afford to care for more children. They explained that family planning is useful and must be encouraged too.

The study pointed out that religious views are not synonymous. Some of them, in general, do not support modern contraceptives, or do not condemn high fertility. This is due to the fact that they directly equated fertility with virtue and spiritual blessing. Therefore, family planning practices encountered obstacles, especially religious opposition on one hand, and on the other hand, the data indicated the positive roles that religion could play on the issues raised. Therefore, it may be important to gain the support of religious leaders, who really oppose the rationale for reproductive health, in order to bring future changes on reproductive health and rights. Therefore, those who work on RH in general and family planning in particular, need to gain the support of religious leaders.

Adult focus group participants disclosed that community norms do not oppose the control of fertility, or specify certain number of children as desirable. According to the informants, in Woliso community, the majority of women and men have similar fertility goals to have 2-4 mixed sex children. They may also have similar fertility desires and goals because they have been taught or told to perceive the same costs and benefits of children. On the other hand, very few of them, reported that they did not support contraceptives because of their suspect that

partners might have extra-sex affairs with other men. This is due to the fact that they perceived and assumed that non pregnancy other than their husbands implies no extra martial relationship or sex.

The focus group discussion with young men disclosed that contraceptive is considered as women's responsibility. It was reported that few women who use reproductive health services such as family planning were presumed to be promiscuous. So they did it secretly and did not discuss it among themselves or with their partners, and also revealed that in case of disagreement with their partners over fertility, women tended to use covert means of birth control, for example, secretive abortion, which have become a major means of birth control rather than use contraceptives. According to young men's views, this particularly, is common and that their sexual partners commit abortion secretly because fear of their family and their boyfriends. Ayle Hunde, 18, years, young man one of the active participants during focus group discussion was asked to tell me more about what he has been forwarded during the discussion after the FGD was over. He became volunteered and proceeds to tell me about his own experience. He began:

Aster Tulu was my second girl friend next to Wodie Gena. By the time we met for the first time, we decided not to have sex before marriage. But, this promise was only lasted for few months. One day, we met in one of the cafeterias and discussed about sexual issues. This was unusual for both of us. Finally, I felt a sort of sexual feeling and decided to ask her for sex. She refused and has tried to convince me to keep my promise. But, I insisted, and finally, she understood the situation and agreed for sexual intercourse next day with condom. We enjoy for the first time in one of my friend's room. She was not virgin, but I did say nothing about her virginity. After having for the second time, I proposed to have HIV/AIDS counseling and testing and to enjoy sex with out condom. She agreed. Fortunately, our blood test results were both negative. The next day we started sex with out condom. [I interrupt him and asked whether they use contraceptive or not] He smiled and said: Never. For your information until she became pregnant, that is, for almost four months, we never used contraceptives. This was our problem. Because when she became pregnant, I left her alone. She was stressed. Finally, I realized that more than HIV/AIDS girls in our community fear not to be pregnant. Then, after a week, I felt guilty consciousness and pleaded her for pardon. She was positive and reestablished our friendship, and made abortion. But do not ask me where it was done.

Over all, the findings of the study with regard to knowledge, attitude, practice, and decision on contraceptives showed that men perceived that there are gender disparities on the use of modern contraceptive methods. The study showed the existence power-over of men. Regarding contraceptive practice, the data showed that, with the exception of very few respondents, most never practiced or used contraceptive methods. However, the findings on men's attitude towards contraceptives indicate that respondents have knowledge about the use of contraceptives. This could be taken as a fertile condition for men's involvement in RH matters. Obviously, the intention to decide jointly could pave the way to establish and strengthen partnership between women and men.

It was indicated that informants would use the method to delay or prevent pregnancy in the future. The study also indicated that when it comes to practice, there could be conscious or unconscious resistance which might not be easy to observe on the part of men, but influenced by educational attainment. As it was pointed out by Ato Ayle , 33 years, key informant:

In our community, usually those who are educated show their positive attitudes and practices towards modern contraceptive method. I some times observed that some of them even try to teach other men regarding the advantages of RH in general and that of modern contraceptive in particular informally. We see small family size and better child care from those who are relatively educated. I think they enjoy life better than people like me who are uneducated and usually prefer women to take almost all family responsibilities.

Contrary to what has been stated by Haji Abdela's, the survey result showed that religious leaders and elders were found to resist on the use of contraceptive. But the data obtained through in-depth interview, particularly from religious leaders, were not synonymous, and did not indicate the prevalence of organized opposition to the idea of reproductive health in general and modern contraceptive in particular. This implies that religious leaders did not teach their followers not to use contraceptive methods officially. However, from the researcher's point of view, it could not be concluded that there is no religious opposition to modern contraceptive at all. As patriarchal institution, religions are preaching the superiority of men and the subordination of women. They advocate male domination as natural and acceptable.

The finding indicated that most of the gender power relation on contraceptive is in favor of men. It means there is gender inequity in the study community. Men perceive that contraceptive is women's activity. This indicates that the gender stereotype that exists in the community that is often based on socially accepted gender roles have influences and viewed as normal.

4.4 Gender and Sexuality

Sex remains a central biological and social need for human beings. However, sex and sexuality is perceived in terms of reproduction from women's perspective. The enjoyment part is often considered taboo and thus cannot be discussed openly even between spouses. Although there is culture of silence that exists in sex and sexuality, both women and men have sexual needs which is mostly unmet, and unevenly exercised between the two sexes (MHRC 2004). This may happen due to gender differences between women and men. Therefore, since gender and sexuality are closely related to reproductive health and rights, the following section presents and discusses the context of gender and sexuality in relation to gender power relation in the study community.

The attitude of men with regard to their sex mates' inequality of sexual relationship was corroborated by quantitative data. Accordingly, 74.67 percent maintained that men control what happens during sex. Only 29.33 percent reported that women decide when to have sex. The majority, (72.67 percent), of respondents agreed that men decide with whom to have sex. On the contrary, the report showed that women were less likely (32 percent) to choose their sexual partners. The majority of the respondents (65.33 percent) disagree about the preposition. It was also maintained that men could have sex with their sexual partners any time they want. This was reported by 78.67 percent of the respondents, while 21.33 percent declare their disagreement.

Table 8: Respondents Views towards some aspects of Sex and Sexuality

	Agree		Disagree		Do not known	
	F	P	F	P	F	P
Men tend to control during sexual intercourse	112	74.67	26	17.33	9	6.00
Women decide when to have sex	44	29.33	106	70.67	-	-
Women are expected to choose sexual partner	48	32.00	98	65.33	4	2.67
Men decide with whom to have sex	109	72.67	21	14.00	20	13.33
Men have sex with women any time	118	78.67	32	21.33		
Women must serve their sexual partners	89	59.33	61	40.67	-	-

Those respondents who reported their disagreement on women's choice of their sexual partners as well as reasons for favoring men to decide were further asked to list their reason(s). Accordingly, they reported that: men might be embarrassed to be asked by women (12 percent); men might disagree (13.67 percent); men would be the one who decide with whom to have sex (10.33 percent); and it is not expected from women (64 percent),

Data on men's perspectives with regard to extra-martial relationship had been collected using survey questionnaires. The freedom to have extra-martial or sex relationship could indicate the gender power imbalance within the study community (Table 9).

Table 9: Respondents, Views with Regard to Extra-Martial or Sex Relationship

If a man suspects his sexual partner have affairs with another man he would:	Frequency	Percent
➤ Ask for divorce	95	63.33
➤ Beat the woman	25	16.67
➤ Kick her out of the house	17	11.33
➤ Report to the relatives/friends	8	5.33
➤ Others	5	3.34
Total	150	100.00
If a woman suspects her sexual partner have affairs with another woman she would:		
➤ Report to the relatives/friends	82	54.67
➤ A woman can ask for safe sex	43	28.67
➤ Ask for divorce	19	12.66
➤ A man can ask for safe sex	6	4.00
➤ A man may force for sex	-	
➤ Other		
Total	150	100.00

Problems with sex and sexuality have effects on the reproductive health rights of women and men. If men did not get satisfied in sexual intercourse they usually tend to go to other women even if they know that they would be exposed to STIs including HIV/AIDS. In some cases, women also look for sexual partners in secret. In order to collect the perception of men with regard to extra-marital or sex relationship, respondents were asked two questions. The survey finding indicated that if a man suspects his sexual partner have affairs with another man, he would ask for divorce (63.33 percent of the respondents); whereas in case where if a woman suspects his sexual partner have affairs with another woman she would report the case to relatives (54.67 percent of the respondents) while only 5.33 percent reported that men would report to relatives or friends.

The respondents who reported 'other' reasons include: a man would discuss the matter with his sex partner or wife in the presence of her relatives or friends (46 percent); ask test for HIV/AIDS (10 percent); a man would tell for God/Allha (31 percent); a man might take physical action on the suspect whom his partner found sexual affairs (13 percent). Most of the reasons, somehow contribute to solve the problem peacefully as well as mutually. This shows that there are men who have positive attitude towards gender and sexuality.

Similarly, respondents' views that were reported as 'other' when a woman suspects her sexual partner have sexual affairs with another woman/girl include: she will keep silent (52 percent); discuss with her partner (13 percent); she may leave the matter for God/Allha (26 percent); and do not know (5 percent).

The descriptions showed that in case a man suspects his sexual partner have affairs with another man, he tend to solve the situation with harsh measures such as divorce, beating, and by kicking out the woman from her home which are all masculine characteristics while women tend to do it in peaceful manners such as reporting to relatives or friends and by asking safe sex so that their relationship could be continued. The data further indicate that men in Woliso town, like any patriarchal communities in other places, have more sexual and reproductive rights than women. This implies that in order to balance the imbalanced sexual power relation that exists between women and men, balancing the power relation, i.e. empowering women is desirable.

In the same way, in order to gauge the imbalance of gender power relation between women and men, their sexual power relationship has been assessed (Table 10).

. **Table 10: Respondents Views with Regard to Sexual Relationships.**

If you want to have sexual intercourse, but refused by partner	Frequency	Percent
➤ I will keep silent	76	50.67
➤ I tend to make by force	55	36.67
➤ I retaliate by other means	14	9.33
➤ No responses	5	3.33
Total	150	100.00
Ever discussed how to make sexual intercourse with your partner		
➤ Yes	14	9.33
➤ No	127	84.67
➤ No responses	9	6.00
Total	150	100.00
Interest/decision to make sexual intercourse with sexual partner (14=100% i.e. those who discuss)		
➤ Mine/men's	11	78.57
➤ My partner's	-	
➤ Mutual	3	21.43
➤ No responses	-	-
Total	14	100.00
Expressing the truth when satisfied during sexual intercourse		
➤ I do	23	15.33
➤ Never	124	82.67
➤ No response	3	2.00
Total	150	100.00
Partner's openness to tell the truth when she is satisfied during sexual intercourse		
➤ Yes she does	12	8.00
➤ Never	134	93.33
➤ No response	4	2.67
Total	150	100.00

Informants also asked to provide their views regarding the gender aspects of sexual power relation and openness between women and men in their community. The data indicated that 84.67 percent of the respondents never discussed how to make sexual intercourse with their partners. On the other hand, it was reported that (9.33 percent) of the respondents discussed

with their sexual partners as to how to make sex further asked to provide their views with regard to the 'power over' while making decision. The majority, (78.57percent), of them confirmed that their interest is maintained than their partners.

The data also indicate that the majority (82.67 percent), of the respondents would not declare when they are satisfied during sexual intercourse.

Respondents were also asked to respond on: "What happen if you want to have sexual intercourse, but if your partner refuses to do so?" The data indicate that 50.67 and 36.67 percent of the respondents reported that they would keep silent and they would tend to make it by force respectively.

The survey data disclosed that there are both the existence of uneven sexual power relation between women and men, as well as the prevalence of silence and frustration with regard to sexuality.

Sexual intercourse before marriage was not allowed to both women and men. Informants further reported that in the past if a woman is found not virgin she would return back to her family after having beaten. But, currently things are changing most people do not take in to account virginity as prerequisite for marriage in the study community.

With regard to extra-martial relationship, the participants strongly stated that sexual intercourse out side marriage is condemned by religion, and therefore, it is prohibited.

Most informants reported that if a woman or a man found with another man/ woman, it is unacceptable. It works for both women and men. For instance, divorce is forbidden unless he/she is found with extra-martial relationship/another person.

The Muslim religious leader, on the other hand, reported that in the past when a woman found not virgin during her marriage the husband would beat and return her to her family automatically, but no one asked about male virginity. Abduction is also prohibited. A man is allowed to marry up to four women. The informants accepted that one man could not meet the sex need of four women. It was declared that in practice if a woman found in extra-martial

relationship, she would be killed. But, informants explained the change that occurred through time. The findings further disclosed that a woman could tell for husband if her sexual needs could not satisfy or could appeal to *kadi*. According to *Kadi*, religious court decision she might be allowed to make divorce. They reported that the “*Sheria*” law does not allow forceful sex. It was also disclosed that sexual intercourse would harmonize the soul of human creature and a man must be on top of a woman during intercourse.

On the other hand, as the data obtained from elders indicated sexual intercourse outside marriage was exercised during old days. They reported that just putting sword in front of the house with a woman whom sexual intercourse is made previously practiced official sex outside marriage. It was not considered as shameful act. But, now things are changing. Haji Bdru, 52 year, key respondent explained as:

In previous time in our community sex out side marriage or extra-sex relationship was common. Even sometimes it was considered as culture of the community though it was recently decreased and exercised by some members of the community. Even now, during Meskel celebration which is traditionally known as /Adabina/, in the market places, especially, in rural areas, sexual intercourse out side marriage is exercised officially for that particular day. During that particular day, I rember, both the wife and the husband make sex outside their marriage officially. Especially, the day is considered as a special day for those who were engaged in marriage during April, May and June. This day is considered as an opportunity for them to show that they are pretty. Therefore, this day is a special day, and people will have sex out side their marriage officially.

Ato Wordofa, 34 year, from Keble 04 disclosed the context of gender and sexuality. He stated that:

Divorce will occur when he or she found extra martial relationship or if a woman fail to give birth. But no body asked about the impotency of male in our community. In the past, sex out side marriage was considered as unacceptable when committed by women not by men. Men’s extra-martial relationship out side is considered as legitimate act. Recently, I can say that there are some changes with respect to gender and sexuality.

Focus group discussions with young men indicated that reproductive health services that are focused on men were not well spread. There is male dominance culture too. For instance, women in the study community would fear that their sexual partners or boy friends might quit

their relationship with some reasons and prefer to remain silent. It was reported that most women did not discuss with their sexual partners openly about sexual related issues.

As it was indicated by one of Keble 02 young men focus group participants some times young men tend to have sexual intercourse by force. As a result, if a woman became pregnant she would not declare for her partner because of fear of leaving her alone.

Young men also reported that even if some of them have got chances to increase their awareness and knowledge about gender, sexuality, and reproductive health and rights by being member of youth club in FGAE, discussion on issues of sexuality such as reproductive health was not widely exercised, and therefore it would be shameful for women to ask men for sexual intercourse; whether a woman was satisfied or not. Besides, men have power on what happens during sex. It means women still expected not to control what happens in sex. On the other hand, the study findings revealed that men were perceived to be less concerned about the consequences of sex such as pregnancy and STIs including HIV infection than women.

With regard to virginity, participants have different views; the majority of adult men support the need for women to be virgin; but not for men. Others, the majority of young men like Gremeu, 22 years from Keble 01 reported that “Virginity is nothing; what matters is love between partners; nothing else” he concluded.

Similar data were obtained from adult men focus groups discussion participants. Accordingly, issues on sexuality such as sexual intercourse and reproductive health were not openly discussed and also practiced in favor of men. It was reported that women usually are not expected to express any sexual desire one way or another. There is power-over of men, i.e. men decide when and how to have sex. Some of the focus group participants declared that sexual satisfaction of a woman is not an issue at all. This was also confirmed by survey results, and therefore, in past, if a woman did not found virgin and also refuses to comply with the sexual needs of a man, she would be beaten and even kicked out of her home. But, they pointed out that conditions are changing currently

This study also pointed out the influences of socio-cultural factors on gender and sexuality. In this regard, informants reported that religious doctrines and socialization have also favored men than women.

With regard to gender power relation in sexuality, it was pointed out that men dominate in sexual aspects of life. The study clearly demonstrated that the study community is dominantly characterized by imbalanced sexual relationship, which are typically male dominant and the passiveness of females who should serve men sexually. On the other hand, the study also uncovered the positive perception of young men with regard to gender and sexuality, as it could be understood from some respondents' Such as Ayle, a businessman. He was one of the active participants of the adult FGDS. Having being impressed by his explanation, I asked him for individual interview. He agreed and we fixed the interview the next day. " I requested him to tell me about his relationship with his wife. He began:

Zinash and I were born and grown up here in Woliso. I met her on a Sunday at a church program. As we became closer, I fall in love with her and wanted to be with her forever. By the time we met, I was 19 and she was 16 years old. Although we were young, we never had sex before marriage. For almost 7 years we spent as boy and girl friends with out even thinking about sex.

As soon as I failed to join higher education, I started to engage in business and lucky enough became successful within short period of time.

We finally decided to arrange our marriage ceremony and engaged. For the first time, on that particular day we made sex and I dis-flowered her. [I insisted him to tell me what they felt]. He laughed and continued " I was so worried the whole day as to how I would make sex. Finally, the time came and I managed to dis-virgin her without sexual pleasure for both of us. In fact, we were happy to be together. We thank our almighty God. Now we have two children-one son and a daughter. [I asked him to tell the sexual experiences and whether they use contraceptive or not, and about their openness in their sexual relationship]. He said that: We are free. To the extent, we always naked in bath room. She washes me. So do I. We always discuss about family planning issues such as contraceptive. We have attended health education provided by the health centre and collect contraceptive too. We are always solve misunderstanding through discussion. I love her; I respect her. So does she. But, I am the one who initiate for sex. She never did. [He strongly stated]

The data gathered disclosed that sexual rights are in favor of men. This in turn indicates that problems with sex and sexuality would have effects on the reproductive health and rights of

women and men. For instance, the extra-marital relationship not only affects the reproductive health and rights of women but also of men. Abortion on the other hand, affects women's health and would some time be resulted due to unsafe sex or gender based violence, which the later is mainly caused as a result of masculine behavior. But, generally, the research disclosed that there are improvements regarding sex and sexuality currently.

Therefore, in order to have better understanding about the issue at hand, it might be helpful to see further men's contribution and partnership to reproductive rights and health such as men's attitudes towards family planning and men's views regarding partners' discussion on gender, sexuality, and reproductive health and rights issues such as family planning. Therefore, in the following chapter, I attempted to present data and discussion on these issues.

V. PERCEPTIONS ON MEN'S INVOLVEMENT AND WOMEN-MEN PARTNERSHIP IN REPRODUCTIVE HEALTH AND RIGHTS

5.1 Men's Attitude towards Family Planning

Respondents viewed family planning methods as method used for delaying or spacing subsequent births, and for preventing conception when no more children are wanted.

Table11: Respondents' Attitude towards Family Planning

Attitudes towards family planning	Agree		Disagree		uncertain	
	F	P	F	P	F	P
Men and women have to use contraceptive methods limits births	128	85.33	12	8.00	10	6.67
Every woman should bear as many children as she can	16	10.67	114	76.00	20	13.33
People should continue to bear as many children as they can if the desired number is met but not sex preference.	45	30.00	92	61.33	13	8.67
It is a good idea to wait a while between one pregnancy and the next.	124	82.67	22	14.67	4	2.66
If one has enough money, he/she needs to have a large family.	66	44.00	80	53.33	4	2.67
Modern contraceptive can affect fertility or produce sterility in women.	99	66.00	36	24.00	15	10.00
Modern contraceptive methods are effective in preventive pregnancy.	97	64.67	45	30.00	8	5.33
Men should have equal role in family planning	116	77.33	34	22.67	-	-
Men should take contraceptive ,like women, to delay or stop having additional children	79	52.67	63	42.00	8	5.33

(F=Frequency, and P=Percentage)

To see the degree of attitude of respondents about family planning, respondents were asked to provide their attitudes on different issues. The results show that the majority, (85.33 percent), of the respondents agreed that men and women should use contraceptive methods to limit births. Similarly, 76 percent of the respondents were against large family size, Respondents have positive attitudes towards many aspects of family planning issue. The idea to wait a while between one pregnancy and the next was approved by 82.67 percent of the respondents.

Similarly, 77.33 percent of the respondents supported men's equal role in family planning as women.

Respondents' attitudes towards advantages of contraceptive as a means of family planning were also found positive. For instance, 64.67 percent of the respondents have appreciated the use of modern contraceptives methods in preventing pregnancy. The majority (52.67 percent), of them reported that men should have to take contraceptive like women to delay or to stop having additional children. Generally, the data indicated that the majority of men have positive attitude towards family planning. This might, however, be due to various reasons. But the bare fact is that like most urban residents, the majority of the respondents might have many alternatives and accesses to reproductive health information. As the findings through in-depth interview with Maternal and Child care Health (MCH) head in Woliso Health Centre indicated information and services about family planning are delivered in two ways. Firstly, the service is provided to those individuals who visit the health center for various health services. Secondly, the health workers using the monthly outreach vaccination program deliver the information. The interview with head of FGAE Woliso branch pointed out that information regarding the advantages of family planning, mainly focusing on young men and girls is provided by the branch clinic. I also managed to observe some of the activities of the association during my stay in Woliso.

The focus group participants argued that family planning is almost regarded as women's responsibility. They viewed that men are not striving to inform themselves about contraception. This is due to the fact that they do not want to be distracted from their own 'responsibility' or because to do so would violate gender norms. The informants also reported the influence of religion on RH, in general, and on family planning in particular. Some of the groups' members reported that since there is economic problem, they would prefer to focus in generating family income rather than dealing on family planning issues. One of the participants, Gremew, 37 said that:

To be frank I assume as if RH was women's activity like other domestic activities. I consider myself as breadwinner of the family whose responsibility is to generate family income; nothing else.

Key informants argued that family planning should be the responsibility of both women and men. The interviewees also pointed out that the reasons for low level men's interest and participation in family planning programs was found the result of the outright neglect of men on the parts of these programs, on hand, and inaccurate gender stereotypes characterizing men as unconcerned and irresponsible, on the other. It was reported that men simply had not thought about their own active participation.

The interviewees expressed their keen awareness of the cost of raising children especially education costs. They also indicated accurate awareness of the growing difficulties in providing for larger families, and agreed that times are changing. It was maintained that men's attitudes tend to support family planning even to the extent of supporting the views that call the need for men participation in using modern contraceptive methods.

The views of young men focus group discussion participants were similar. They pointed out that people should receive comprehensive information on reproductive health in general, and family planning in particular so that they could decide for themselves what their best course of action could be. They appreciated the role of FGAE, that provides services in many parts of the country for multi faceted programmes on RH, focusing on youth (even though the association's programs and activities mainly focus on young women/girls).

Taken together, family planning programs traditionally were gender biased, i.e. it was considered and focused on women as the primary beneficiaries of service provisions. That is, women are the main targets for family planning campaigns. On the other hand, this study revealed that men's attitudes towards family planning were positive. In addition to programs failure to accommodate participation and involvement of men in reproductive health in general, and in family planning in particular, the data indicated that structural factors such as religion, poverty and low economic and education status of men and women also influence family planning practices. Therefore, creating awareness and educating men to have the knowledge of the advantage of small family size, and the disadvantages large family size such as the cost of child rearing as well as the cost associated costs such as delivery, maternal and child health care etc is essential. In this regard, the study calls for gender awareness raising

programmes to men and empowering women through education so as to enhance their decision-making power.

5.2. Women's and Men's Communication and Discussion for Partnership

The first step in a rational process of sexual intercourse reproductive decision making, such as reproductive health and rights, involve or require communication between women and men. Such communication should thus be among the most important precursors of lower desired fertility and increased contraceptive use, and as well as factor that assist to make many of the decisions with regard to sexuality, reproductive health and rights. Evidences suggest that the most successful family planning programs target men as well as women, and promote communication and discussion between them (Blanc, 2001, Mulu, 1996, and Kefle, 2001). This means that men's involvement and partnership in reproductive health and rights could emanate, among other factors, from the level of communication and discussion between women and men. Thus, this section presents findings and discussion about the issue raised.

Table12: Respondents' Views on Women and Men Discussion

	Yes		No		No response	
	F	P	F	P	F	P
Discussion with your partner regarding:						
➤ The number of children you would like to have	105	70.00	34	22.67	11	7.33
➤ The use of contraceptive	46	30.67	97	64.67	7	4.67
➤ spacing of birth	91	60.67	56	37.33	3	2.00
➤ Sexual matters such as when and how to make sexual intercourse	14	9.33	118	78.67	7	4.67
➤ Problem of large family size	92	61.33	55	36.67	3	2.00
➤ Budget or finance affairs	95	63.33	48	32.00	12	8.00
➤ Child caring	96	64.00	52	34.67	12	8.00
➤ Education and future carrier	114	76.00	21	14.00	15	10.00
➤ Gender based violence	22	14.67	108	72.00	20	13.33
➤ STIs including HIV/AIDS	34	22.67	105	70.00	11	7.33

The majority of the respondents reported that they discussed with their partners about various issues. For instance, 70, 60.67, 63.33, 64, and 76 percent of the respondents reported that they discussed on issues such as the number of children they would like to have; spacing of birth; regarding family budget or finance affairs; child caring and responsibilities; and education and future carrier of partners respectively.

The findings also showed that partners' communication and discussion on contraceptive was found to be less (30.67) percent. On the other hand, 78.67, 72 and 70 percent of respondents maintained that they did not discuss on such issues as sexuality, gender-based violence and of STIs including HIV/AIDS with their partners.

Partners' discussion and communication on many issues raised about could be considered as encouraging, and need to be enhanced and motivated accordingly. On the contrary, the discussion and communication with regard to contraceptive use was found to be below the average. From the findings, it would be easy to understand partners' discussion and communication in the study community concerning the effect of gender-based violence and STIs including HIV/AIDS was not widely practiced. This, in turn, indicates that the community still could not succeed in breaking the 'silence' with regard to HIV/AIDS, and indicated the need for multi-dimensional intervention efforts and programs.

Through this study it was found that only a few partners discussed about sex and sexuality issues. The findings disclosed that partners did not discuss openly about when and how to make sex. The situation might indicate the gender disparities of reproductive health and rights which might be affected by structural factors that exist in the study community.

The study also obtained qualitative data and information regarding partners' discussion and communication in promoting men involvement and partnership in RH and reproductive rights. The data obtained from key informants pointed out that partners' communication and discussion could facilitate to narrow the gender gap and to maintain a better reproductive health and rights of individuals. It was indicated that for integrating and improving the qualities of reproductive health services such as family planning, the importance of promoting more discussion between partners or spouses about family planning and contraception, and encouraging more open discussion about advantages of fewer children and larger birth intervals are necessary actions to be taken.

Similarly, the focus group discussion participants suggested that educated partners are better able to more likely to converse about different issues, more particularly, sexuality, reproductive health and rights. They also pointed out that education influences communication

and discussion between partners in ways that are conducive to better reproductive health. Therefore, in the views of the participants, by increasing educational levels of partners, communication and discussion regarding sexuality and reproductive health between them could be improved.

It was indicated that communication between partners' could be improved by enhancing the status of women or by empowering women, particularly, by improving their level of education. For instance, respondents held position that education would not only expose women to new knowledge about reproductive health and rights but improve interpersonal communication on various issues including family income, child caring, and thereby paving the way to manage their sexual as well as reproductive health and rights, and ultimately to have better position in public spheres. Therefore, it was also indicated that empowering women could also contribute to understand the role that men could play in narrowing the gender gaps in general and their roles and involvements in reproductive rights and health in particular.

Therefore, the findings of this study revealed that communication and discussion between partners could be helpful to change the andocentric perceptions, views and attitudes of men by changing the power within them to be able to contribute to reproductive health and rights issues, particularly, to challenge the imbalanced gender power relation, and ultimately to bring about the desired gender equality.

The young men's views disclosed the unwillingness of men to discuss the issue among them. They particularly reported that communication and discussion among partners, especially on sexuality and reproductive health and rights issues is not common. Kebede, 19 from Keble 04 reported that:

In my point of view, there is no open discussion between partners regarding sex and sexuality in our community. In addition, conflicts that arise between young men and women due to incompatibility in sexual intercourse are not reported correctly to a partner. The cause of conflict is attributed to other reasons. Partners are found blaming one another. Never tell the truth. I even have a doubt that a single family is discussing on sex and sexual issues openly.

Similarly, the adult focus group participants reported that communication and discussion regarding sexuality and reproductive health and rights issues among couples face obstacles due to the fact that a large number of men did not even know whether it is helpful or not. The study indicated that women usually initiated discussion on some of the issues such as fertility, even though the benefit goes to both. Besides, the data pointed out that only a few families discussed about family planning. However, it was reported that there are improvements these days.

Informants were asked to provide their views as to how to promote communication and discussion between partners. According to their answers, improving the current, mostly, disorganized and women centered programmes that are conducted by NGOs such as FGAE-Woliso branch was forwarded as remedy. In addition, the participants have insisted that if partners discussed about sexuality, it would be a decisive major to break the ‘silent’ atmosphere where women are disadvantaged. It would also solve many of the problems that are related to gender, sexuality, and reproductive health and rights that might arise between partners, and thereby transform society. Kebede once again stated that:

Generally, I believe that many things have changed regarding the issues of partners’ discussion over the years, but there is still variability among different agenda or issues such as sexuality, reproductive rights and health. I personally, still have not yet started to discuss openly with Almaz, my girl friend.

The findings show that the respondents’ views on communication and discussion between partners in different issues were not similar. Informants would tend to discuss on issues that would not be considered ‘sensitive’ by study community. In addition, informants showed their willingness to discuss on issues that are related to family planning such as spacing of children, the desire not to have additional children, and problem of large family size. The descriptions also show that informants’ intention to discuss on reproductive health and on other health related issues are found to be not comprehensive and sexuality and gender based violence remain untouched. This might be as a result of socio-cultural influence prevailing in the study community.

The study further highlights the changes that have occurred over the years around the issues. This would indicate that things would be improved in the coming years too if there are efforts

towards minimizing the influences of structural factors such as empowering women and encouraging and ensuring men involvement in the areas of reproductive health and rights.

5.3 Acknowledging the Role of partnership

Men's exclusion from reproductive health program undermines efforts both to change their attitudes on population matters and to motivate them and through them, their partners, towards reproductive health. Therefore, acknowledging partnership between women and men might contribute to have success in reproductive health and rights efforts and interventions. Programs that invite partners to participate in services tend to focus including men in reproductive health. But, in most instances, this remains as an issue that has given little attention. Therefore, in this section I presented respondents views as to how one promotes reproductive health services by working with men; and as to why it is important to involve men in reproductive health and right issues. All data were obtained by using qualitative methods.

In order to know men's insights into reproductive health and rights issues participants asked to address as to why men need to involve in reproductive health and rights issues. They noted that men sometimes play key role in their partners' adoption of contraception. They suggested that men might be able to provide different and more realistic views as women could about reproductive related behavior and family size preference. They also pointed out that the male partner might play important roles in decision making regarding contraceptive use.

Therefore, the study challenged the andocentric and conventional views on men's involvement. It revealed that in promoting reproductive health such as family planning, the dissemination of contraceptive methods and orientation of women about reproductive health is not quite enough. The informants call for the need for men participation and involvement.

But in many instances, men's involvement in reproductive health mostly could not provide answer(s) satisfactorily for questions 'how', such as: How could men-women partnership can be formed and or strengthened so that a better and mutually-agreed upon responsibilities and tasks in the area of reproductive health could be performed? How can women's reproductive health and right be maintained by working with men? Therefore, the main concern, here, is to present and discuss informants' views or answers related to the above questions.

Generally, respondents gave emphasis on the need to provide orientation for men about reproductive rights and health, especially initiating women-men communication and discussion. This particular view was closely related to one of the strategies of Population Policy of Ethiopia which advocate for dissemination of Information, Education and Communication (IEC) programs specially designed to promote men involvement in reproductive health in general and in family planning in particular (TGE 1993: 16). For instance, the data obtained during focus group discussion with adult men underscored the need to discuss about sexuality, reproductive health and rights issues openly within a family. Moreover, informants emphasized that fathers should discuss and communicate with their sons about those issues as mothers do with their daughters.

Young men's perspectives regarding the ways and means of enhancing men participation and partnership with regards of reproductive health was in the support of adult men's views. They pointed out the importance of disseminating information and education through mass media and schooling, since media could influence attitude and behavior of men by publicizing non-traditional life style, including smaller families and by creating a climate conducive for behavioral change. For instance, schooling has come to be regarded by the respondents as decisive stimulus in the shift from traditional sentiments to modern where people could make positive changes in their life style. That is, reproductive health education could foster an awareness of individual's power to control what was previously considered as destiny, fate or "up to God". Young men urged that schools should educate young men through organizing men's reproductive health clubs addressing gender and power concerns. Their views include that as programs develop for girls to participate in group discussions that allow them to share their sexual and reproductive health concerns with other women and to practice partner negotiation skills by FGAE branch office through coffee ceremony, they insisted that the same type of program need to be organized to young men too.

The views of religious leaders and elder with regard to partnership between women and men indicated that a wife is 'God's gift'. Husband and wives are considered as one person. A key informant from the Orthodox Church Aba Mlekete Tsehay stated that:

When bible says wife is the slave of her husband it means she has to obey him; nothing else. But, people usually misunderstood what bible says. Bible never says there has to be 'a slave and a slave owner relationship' between women and men. There are dos and undo in religion. I personally always teach these words of bible. I know some religious leaders and fathers teach in the wrong ways, and that is a problem for followers' perceptions. In addition, contraceptive is forbidden in Christian religion. But, there are many things that indicate bible support partnership between women and men. For example, in case of incompatibility during sex both have the right to make divorce; and abortion of fetus up to 40 days is allowed when health problem is encountered. Regarding power relation between women and men, men's superiority is due to God's creation. It was man who first created by God.

Elders accepted the existence of gender power relation that favors men; though some improvements were seen recently. It was reported that the *Oromo Geda* system could be used to inculcate the youth, because the *Geda* system gives 'freedom' to women. However, since the study community is urban, and residents are belonging to different ethnic groups, the writer presumes that the *Geda* contribution might not as effective as the respondents might expect it.

Muslim religious leaders' views support what elders and Christian Orthodox Church leaders have said. It was reported that in Islamic religion marriage is respected, not only reproduction but also it gives a sense of spiritual satisfaction and life stability to partners. It has high contribution to psychological and spiritual satisfaction to both women and men. The data further indicated the existence of some important elements, which assist partnership between women and men in reproductive health. For example, Haji Abdela, 45 years, member of *Kadi* stated that:

I can tell you that Islamic religion has many important elements in relation to sex and gender aspects. For instance, 'Bikir' or virginity works both for males and females; sex before marriage and out side marriage is prohibited to both partners; sex outside marriage is the cause for separation for couples, and it works for both women and men. Abduction is prohibited in Islamic religion. If a woman is not satisfied she would have the right to ask for divorce. Spacing between children (Tenzium) is allowed. Division of labor is not advocated by Islamic religion. Men can do domestic works like women. Even prophet Mohamed himself has exercised this. As far as I know, abortion when there is risk is allowed to save the life of one of them-the mother or the newborn, and this is agreed by 'Olamas'.

Therefore, the Islamic religion, according to the informants, comprises some major elements with regard to gender and reproductive health that could assist men's involvement in reproductive health.

The qualitative data described that to maintain gender power balance religion could have roles. It means partnership can be created through religious teaching. However, it is clearly understood that religion as one of structural factors plays roles and create situations for gender inequalities. This is due to the fact that the major functionaries of religious system are male and male dominance is rooted in religion. As a result, religious rituals reflect and reinforce system of male dominance. It means religion defines the ultimate meanings of our universe for a people. Since male dominance is embodied within religion, which is less open to question and more resistance to change than other social area, it becomes resistant to changes in gender power relations as well.

Target groups, especially by program managers, reported intervention that introduced sexuality counseling in reproductive health to both women and men as "not accepted but desired". Informants maintained that men and women were willing to talk about sexual and reproductive health matters, but difficult to say that they found it easy due to their past experiences and socialization. Respondents reported that men often expressed their desire for information, which some find it 'mysterious' and consider it as 'for women only'. Besides, respondents reported that diversifying methods of contraception with particular attention to increasing the availability of men dependent methods could enhance men's involvement in reproductive health and rights. However, practically, male oriented methods were rarely practiced as FGAE branch head pointed it out during in-depth interview.

In addition, similar views were obtained with regard to promoting peer education and communication. The informants also emphasized the need for interventions that address the context of sexual relation within the community. In this regard, respondents maintained that in order to respond to reproductive health problems such as STI, including HIV/AIDS, programs should accommodate and facilitate men involvement in reproductive health and rights. Almost all program coordinators/managers declared that men dependent methods are limited, and are mainly vasectomy or STIs or both. It was reported that those methods, frequently, have been

recognized at an early stage. Therefore, a great demand exists among men for a wider range of services.

The views of key informants in this regards also calls for intervention that is intended to change community norms, and calls for the need for proper socialization of boys. This view was also maintained almost by all respondents. The data further hints the need to give recognition to gender concerns in sexual and reproductive health interventions that assist to modify community norms. It was also pointed out that to change the power within men and enhance partnership in RH and reproductive rights, health IEC programmes need to be promoted. They underlined the need for specially designed health education extension programme to reach both women and men.

The study revealed that religions views with regard to gender relation, in general, and reproductive health and rights in particular, were found to be comprise of positive elements and could assist in promoting reproductive health in general, and men's involvement and partnership in particular.

5.4 Men's Involvement and Partnership in Combating Gender –Based Violence

Violence against women can occur: in the family, like beating, sexual abuse of female children in the household rape, female genital mutilation (FGM), and other traditional practices harmful to women and in the community including rape, abduction, early marriage, sexual harassment and intimidation at work schools, etc. These problems have caused negative effects on individual woman as well as women in society. This section attempts to assess gender-based violence that is related with reproductive health and rights and try to look in to the ways and means of making men parts of the solution. Thus, the researcher here will attempt to seek answers to questions: What are men's views and roles in combating violence against women? And how can we ensure and sustain men's roles and responsibilities to protect gender-based violence that affect women's reproductive health?

Table13: Respondents' Views Regarding Violence Against Women

	Frequency	Percentage
Different gender-based violence in order of prevalence		
Sexual harassment	62	41.33
Sexual abuse	51	34.00
Beating	37	24.67
Abduction		
Early marriage		
Total	150	100.00
Gender-based violence occurs		
In the family	52	34.67
Outside home	92	61.33
No response	6	4.00
Total	150	100.00
Is gender-based violence considered as health problem?		
Yes	81	54.00
No	69	46.00
Total	150	100.00

Respondents were asked to identify and rate different forms of gender-based violence that exist in the community in order of prevalence. The data indicate that sexual harassment was ranked first (41.33 percent). The second and third ranked are sexual abuse and beating (34 and 24.67 percent) respectively.

The majority, (61.33 percent) of the respondents maintained that in many cases violence against women and girls that occurs out side home, 34.67 percent of the respondents in the family or within the home, and the remaining four percent did not reply.

Fifty four percent of the respondents answered that violence against women is not considered as violence that affects women's health, while 46 percent replied the act as a cause for women's health problems.

The findings through focus group discussion and in-depth interview confirmed what has been reported by survey respondents; and maintained that a number of gender-based violence exist in the community, and often tolerated, even condoned because it is considered a tradition and not a human rights violation.

Ato Bre, from women's desk reported that violence against women was exacerbated by social pressures, notably the shame of denouncing certain acts; women's lack of access to legal information; ineffective measures taken by the existing laws; failure properly to address the causes and consequences of violence among community members, (by NGOs working in the area as well as by schools) etc. He stated that:

Here, in Woliso, there are a number of genders –based violence. My past experiences revealed that the most common violence in the community includes: sexual abuse including rape, and sexual harassment, and beating are common. Efforts to educate people, particularly, about the consequences of gender-based violence are very less; and the acts are not considered as violence and a cause for reproductive health and rights problems. The acts are not considered as one of the causes for HIV/AIDS spreads. [I interrupted him to tell me the advantages of men involvement in combating gender-based violence]. The interviewee stated that: No body has, so far, been thinking about men's involvement in combating violence against women. Men are only perceived as a cause of the problem. But from my little experience, I have seen that few men have positive attitudes, and also condemn the acts. Even some of them are volunteers when asked for witness. There could be many advantages in involving men. I think, involving men could save the time and costs that judges, police, and even NGOs are incurring to mitigate the problem.

Most of the focus group participants had similar views with Ato Bre regarding the causes and consequences of gender-based violence. However, some of the adult informants did not consider gender-based violence within the family as violent act. In addition, regarding the types and causes of gender-based violence the views of the adults revealed that it was almost the same as the one mentioned by key informants.

The discussions on solutions were a great concern and had been a long debate between participants in each adult group. Some said that the issue should be left to NGOS and GOs. Others emphasized the role of family in teaching children about the effects of violence, Therefore, some of the remedies, according to adult men participants include: Confronting cultural barriers to successfully promote men's involvement in the family by GOs and NGOs; promoting gender equity, responsible sexuality and reproductive choice as a matter of family policy through education; educating young people about responsible sexual relations and the meaning and responsibilities of marriage and other adult relationships. Involving men or

fathers in all programmes that deal with the family including those that addresses gender-based violence, pregnancy support, post-partum care and child welfare were indicated as important measures to be taken.

The same respondents also indicated empowering women for partnership as a proposed solution. They insisted that men must come to recognize that women's empowerment is not a threat but rather a way to improve families and societies. They emphasized that achieving equality between men and women in the family could be helpful and it could be the foundation on which empowerment in other areas be based. It was indicated that gender-based violence might arise due to gender relation, i.e. if decision-making was not shared by partners, and suggested the need to empower women as well as to change the power within individual man towards combating gender-based violence.

The young men focus group discussion participants mentioned communication and discussion, as well as education and media as effective means of remedies to combat gender-based violence. The need for open discussion on the consequences of gender-based violence such as its effect on reproductive health was focus of attention of the group participants. Teaching young people about responsible sexual relations, the meaning and consequences of gender-based violence on women's health in general and reproductive health in particular were reported as a solution. They emphasized the need to form linkage between gender-based violence, reproductive health, and HIV/AIDS. The same idea also emphasized by the key informant from FGAE branch office.

Young men informants further maintained the importance of socialization of young men. Besides, they called for the need to open discussion among men as well as within the family, and inculcate men to be part of the campaign against gender-based violence. They maintained that those men who hold positive sentiments and attitudes need to be able to teach others; condemn the act of gender-based violence. They insisted on the need to celebrate men's day to show the solidarity of those men who are against gender-based violence. This might increase the number of men who are against gender-based violence.

Overall, the findings of the study indicate that to combat gender-based violence, it would be advantageous to involve men in the campaign.

5.5. Existing opportunities and Constraints

5.6.1. Existing Opportunities

It appears important that social capitals or existing opportunities of the community contribute to men's involvement and partnership in reproductive health and rights. In this regard, the NGOs, community structures and networks, government interventions such as education and health, religious institutions were considered as social capital.

Some NGOs such as FGAE Woliso branch have tried to take steps to deal with the community norms, values, beliefs that hinder men's participation and partnership in reproductive health and rights. Young men reported that their participation in different programs provided by the association assisted to change the power within or to bring behavioral changes among young men. The association works with young people and identifies problems prevailing in the community, particularly those related to reproductive health (such as STI with special emphasis on HIV/AIDS). The strategies designed include coffee ceremony; panel discussion; peer group discussion, and these could be considered as the ways forward to achieve the desired behavioral changes among young men and women. These approaches make the conversations to continue both in formal gatherings and in the neighborhood. According to the key informants, the impact of FGAE in Woliso is tremendous. It provides Voluntary Testing and Counseling (VCT), youth focused activities such as training on HIV/AIDS prevention and transmission, assertiveness, life skills, prevention against rape; prevention of harmful traditional practices (HTP) such as female circumcision; peer education skills, conversation and discussions to discourage alcohol and *Chat* consumption among youth; and increase contraceptives use.

The Ethiopia Red Cross Association branch office has also youth focused program, which mainly emphasized on HIV/AIDS prevention. It provides different programs such as volunteers group to help in time of accidents and other Red Cross activities, conversations and

discussions about reproductive health issues such as STI, especially, HIV/AIDS designed for young men and girls.

Further more, as many Ethiopian communities; there are also social structure and net works for exchanging information and collectively dealing with social problems. These include social structures such as *Edir* (traditional insurance scheme), *Ekub* (traditional rotating credit scheme) and *Mahber* (community religious or otherwise get-together), especially, *Yabro Adeg Mahber*, sports and music clubs among youth play significant role to discuss on the issues of reproductive health among men, and will enhance men's involvement and partnership on the issues raised. Although these social structures are very much used to maintain the social norms, values, and customary practices prevailing in the community with the aim of maintaining social harmony, informants indicted that they could be used to create values and norms appropriate to deal with reproductive health and rights issues, such as to regulate fertility and to combat gender based violence.

The informants said that government interventions, especially education and health services provisions, could also contribute to bring both the desired attitudinal changes among people and create rooms for men's involvement in reproductive health matters. Schools can sensitize students to gender, sexuality, and reproductive health and rights and practices. Respondents declared that as result of interventions there are students'-centered activities on HIV/AIDS. Young men's views indicated that the number of cases related to harassment on girls had declined as a result of education given to both girls and boys through school mini-media.

The data obtained from the key informants in the health centre indicated that the maternal and childcare health (MCH) department has been providing health education, mainly for those who came for various services in the health centre. The VCT centre, which mainly provides services for adults, could serve to teach adult men to involve in reproductive health matters. It was reported that the efforts that are made so far were found limited, and diversifying the health IEC programmes was highlighted

Religious institutions were mentioned as social capital that could play roles in men's involvement and partnership in reproductive health and rights. The religious structures, both

Islam and Christian, as well as other traditional belief system such as *Wakefata* could enhance partnership between women and men in some aspects of life. Muslim and Christian religious leaders are involved in HIV prevention, care and support programs and activities. They work to stop harmful traditional practices such as extra-marital sex, early or underage marriage, sexual violence including rape and abduction. These, according to the respondents, indicated that religious institutions could be considered as opportunities towards men's involvement and partnership in reproductive health and rights.

6.5.2. Constraints

Participants were also asked to raise some of the problems that hindered the participation and partnership formation in reproductive health and rights. They argued that men are not targeted. For instance, coffee ceremony prepared by FGAE branch office is for girls only; absence of RH education and club for young men is another problem. In addition, youths centers are not available and, therefore, young men have the habit of consuming alcohols and *Chat*, and unable to have a room to discuss gender, sexuality and RH and rights issues.

The gender stereotypes and gender biasness are also identified as constraints. The informants indicated that the tendency to make decisions or take actions based on the interest and perspectives of men and ignoring and undermining women's interest and perspectives. Almost all decision, including reproductive health and related issues are made in the interest of men. It was also indicated that the existing gender stereotype constrained men not to involve themselves in RH. Such serotype led men to accept domestication of women and the decision-making power of men, as normal.

The study findings showed that the existing opportunities or social capitals of the community could be used to promote men involvement and partnership in RH and constraints need to be addressed.

VI. CONCLUSIONS

The aim of the study was to assess men's insights into reproductive health with special emphasis on exploring the views of men. In this regard, men's perspectives have been collected on issues such as gender power relation to regulating fertility, family planning, contraceptive decision and use, and gender and sexuality. The study also examined the influence of structural factors as well as the existing opportunities of the community on men involvement and partnership in reproductive health and rights. Therefore, the following conclusions can be drawn:

Absence of focus on men's involvement is a reason for the low rate of reproductive health participation. A study in 18 developing countries showed that the use of modern contraceptive varied depending on partners' agreement or disagreement to stop or to continue to bear children. It was found that usage of contraception is highest when both partners agree to stop childbearing and lowest when they have agreed to have more children (Blanc, 2001: 195). Therefore, respondents argued involvement of men could lead to better reproductive and sexual health outcomes for women.

Regarding decision-making on issues raised, men have a relative power than women. Therefore, the study findings call for women's empowerment. The findings indicate two advantages. First, it could provide power to women so as to challenge the existing gender inequalities within the study community. Secondly, it would create opportunities to recognize gender differences and roles of men towards gender equality.

The study by MHRC (2004) with regard to gender power relation in sexuality has shown that men dominate in sexual aspects of life. This unequal relations in sexual and RH relationships could have a determinant influence on both women's and men's sexual and reproductive health and acted as barriers to men's involvement. (Collumbien and Hawkes, 2000, cited in Blanc, 2001) indicates that men's limited information on RH and sexual matters could cause psychological and physical problems such as impotence. Men have limited information cause failure to discuss with their partners as well as health service providers due to masculinity behavior, which determined their gender roles. Similarly, this study confirmed that there are

gender power imbalances and, therefore, the study community is dominantly characterized by imbalanced sexual relationship typified by the valorization of sexuality, the seductiveness of males, and the passiveness of females who should serve men sexually.

Partners' educational attainment could be most significant positive indication of their participation, communication and discussion in reproductive health matters such as family planning. Therefore, the findings showed that with increasing education of women and men, reproductive health issues such as lower fertility and contraceptive use communication could be improved. The findings revealed that education influences communication and discussion between partners in ways that are conducive to better reproductive health and right achievements. A previous study by (Lil 1993, cited in Kefle, (1999), Kiros (1986) and Mulu (1996) reached similar results. Their findings showed that a spouses' educational attainment could be most significant positive indication of partners' participation, communication and discussion in family health matters. But, unlike the above researches, this study emphasized on reproductive health and rights rather than family planning, and also pointed out that empowering women could also contribute to understand the role that men could play in narrowing the gender gaps in general and their roles and involvements in reproductive health and rights in particular.

Partners' communication and discussion is an important factor in the process of decision making with regard to gender, sexuality, and reproductive health and rights such as family size and the adoption of family planning practices including using contraceptives. In this regard, men views were found in support of communication and discussion on many issues. On the other hand the study uncovered low tendency to discuss on sensitive issues such as sexuality, reproductive rights, and gender-based violence that directly affects reproductive health of partners.

The conventional views and the position of many people with regard to men as the prime decision makers as well as a serious bottlenecks to promote reproductive health and rights has been challenged through this research findings. Therefore, the finding of the research reveals men, too, have positive attitudes for mutual decision-making.

Problems of low levels of men's interest and participation in reproductive health are found as the result of the outright neglect of men on the part of the programs and inaccurate gender stereotypes characterizing men as unconcerned and irresponsible. On the other hand, men expressed little opposition to contraception and did know quite a bit about modern methods, but, had not thought about their own active participation. More significantly, the study pointed out that men's keen awareness of the costs of raising children especially education costs.

The fear of violence especially sexual harassment is a permanent constraint on the mobility of women limiting their access to resources and jobs. Therefore, the study showed that violence against women is exacerbated, among other factors, due to failure to change the power within men to participate and involve them in combating gender based violence which is one of the main factor that disharmonize women-men relationship.

The study underlined that achieving equality between men and women in the family is the foundation on which empowerment in other areas is based. In this regard socialization of boys is found crucial issue in enhancing men's participation and call for the need to include both genders.

Empowering women through education, skill development (such as enhancing their skills of communication, discussion, negotiation etc.) giving a paramount importance to alleviate the influences of structural factors such as poverty, illiteracy and reproductive and other ill health among women is essential. The study also identified the synergy between women's empowerment and poverty and reproductive health problems as well as men's involvement. This means as women are empowered they could be able to actively participate in the household income generating activities and appreciate the role of men in RH matters. This means that empowering women is found useful and contribute to understand the role that men could play in narrowing the gender gaps in general and their roles and involvements in reproductive rights and health in particular.

Involving the 'other gender'-men, and men's support for women's empowerment is essential. Therefore, enhancing the power within an individual man is found useful so that men's insights into reproductive health could be improved in order to achieve the desired gender

equality and social transformation. The study indicates that men perceive that women might view men as potential obstructionist who, if involved in decision making, would defeat women's efforts to ensure their reproductive health and rights. Therefore, it was found that men's insights into reproductive health and rights matter need to be reversed through consciousness raising.

The study also explained the intervention approaches acknowledging power relation and as well as assisting partnership in reproductive health and rights. In this regard, the efforts to provide male dependent methods were limited and were not widely known. Intervention that aimed primarily to empower women through micro credit and income generating programs could have bearings to influence men to change the power within them by appreciating that women could also be "bread winners". The study pointed out that intervention should invite partners' participation in RH services. In this regard, the study calls for effective health extension IEC programmes.

Over all, the study revealed that in promoting reproductive health, the dissemination of contraceptive methods and orientation of women about reproductive health and rights are not quite enough. The study highlighted the need for men's participation and involvement. In this regard, men's attitudes tend to support reproductive health even to the extent of supporting the views that call the need for men's participation in using modern contraceptive methods.

Hence, it appears important to conduct gender related study considering men's involvement and partnership on women's reproductive health and rights.

Reference

- Ahemed, Obadi Thoraya. (2005). Promote: Gender Equality and Empower women. UNFPA.
- Blanc. K. Ann. (2001). The effect of power in sexual relationships on sexual and reproductive health; an examination of the evidence. *Studies in Family Planning*, (32) (3), 189-213.
- Bissewar Indra . (2005) Basic Gender. Handout for Introduction to Gender Studies. Addis Ababa University. Addis Ababa.
- Disch Estelle. (1997). Reconstructing Gender-A Multicultural Anthology. Mayfield Publishing Company, London.
- Ethiopia women Layers Association. (2002). Study on Microfinance and Impact on Women. *Berchi*. 1(3). EWLA Addis Ababa
- Ezech Alex Chika. (1993). The influence of spouses over each other's contraceptive attitude in Ghana. *Studies in Family Planning* 24(3):163-174.
- Family Care International. Sexual and Reproductive Health. (2000)Family Care International, New York.
- Flintina, Fiona. (2006). Gender and Pastoralist Training Manual. Gender and Pastoralist Action Research Project. SOS Sahel (unpublished), Addis Ababa.
- Getnet Tadele. (2006). Bleak Prospects: Young men, Sexuality and HIV/AIDS in an Ethiopian town. Leiden. African Studies Center.
- Ipas. (2005). Proceedings of Workshop on uilding a Proactive Movement for Women's Health and Rights. Ipas, Ethiopia.
- Kabeer, N. (2003). Gender Mainstreaming in poverty Reduction and the Millennium Development Goals. London, Commomwealth Secretariat.
- Karra, M.U., Stark, N.N. and Wolf, J. (1997). Male involvement in family planning: A case study spanning fire generations of south India family *Studies in Family Planning*, 28(1), 24 – 34.

- Kifle Zeleke, (1999). Husband-wife discourse upon family planning as correlates of desired fertility: The case of Enemorena Ener Worked. Senior Thesis, A.A University. Addis Ababa.
- Kiros G/Egziabher. (1986). Family planning knowledge, attitude, and practices in two selected areas of A.A-Arat Kilo and Bole. (Unpublished) Thesis, AAU. Addis Ababa.
- Lasee, Ashraf and Stan Becker. (1997). Husband-wife communication about family planning and contraceptive use in Kenya. *International Family Planning Perspectives* 23(1).15-20.
- MHRC. (2004). Gender and HHIV/AIDS in Ethiopia. Addis Ababa, Ethiopia. Unpublished raw data. Addis Ababa.
- Mohmed Hasen Ahemed (2001). Determinant factors that influence the use of family planning among eligible couples in rural Amhara: The case of Bahirdar Zuria. Maser Thesis. Addis Ababa.
- Ministry of Health (2005). Report on Health Service Development Programme III. MOH, Addis Ababa.
- Ministry of Health. (2005). Health and Health Related Indicators. MOH, Addis Ababa.
- Mulu Nega. (1996). Factors that influence attitude behavior relation in fertility control. (Unpublished) Master Thesis, AAU. Addis Ababa.
- Ogbaselassie, G. (1998). Reproductive Health and Rights for Men and Women: A Life cycle approach.. Paper presented at UNFPA/CST Addis ababa. International Workshop on Male Involvement (MI) in RH and Mainstreaming Gender (MSG) in population and development. Addis Ababa. UNDP.
- Robinson, W.C. (1992). Kenya enters the fertility transition, *Population Studies*. 46(3), 445-457.
- Ross, J.A. (Ed). (1982). International Encyclopedia of population. New York. The Free press.
- Salway, S. (1994). How attitudes towards family panning and discussion between wives and husbands affect contraceptive use in Ghana. *International family Planning Perspectives*. 20(2), 44-47.

Stockard, Jean and Johnson. M. Miriam (1992). Sex and Gender in Society. (2nd ed). New Jersey. PRENTICE HALL.

The national health policy of the transitional government of Ethiopia.. (1993) MOH.. Addis Ababa.

The national policy on Ethiopia women. The transitional government of Ethiopia. . (1993). Addis Ababa,

The National Population Policy of the transitional government of Ethiopia. . (1993). Addis Ababa,

UN. (1996), Platform for Action and The Beijing Declaration, Fourth World Conference on Women, Beijing, China 1-15 Sept., 1995.

UNFPA, (2005). State of world population 2005: The promise of equality gender equity, reproductive health and the millennium development goals. UNFPA, Addis Ababa.

UNFPA. (2005). Beijing at Ten: UNFPA's commitment to the Platform for Action. New York, UNFPA.

UNFPA. (1999). A New Role for Men: Partners for Women's Empowerment.

UNIFEM, (2006). Gender and HIV/AIDS. From on line sources.

[http://www.genderandaids.org/modules.php?name=Content&pa=showpage&pid=6,](http://www.genderandaids.org/modules.php?name=Content&pa=showpage&pid=6)
2/28/2006.

Hareg Consult Plc. (2005). National Action Plan for Gender Equality. WAO, Addis Ababa.

WHO. 1998). The world health report: Life in the 21st century a vision for all. Geneva: Author.

WHO. (1995). Programming for adolescent health and development. Report of WHO, UNFPA and UNICEF. Switzerland, Saillon.

Woliso Woreda Administration Office. (2005). Woliso town Strategic Plan. Woliso, Ethiopia.

Women Affairs Office. (2005). The National Action Plan of the Government of Ethiopia (NAP-GE). WAO, Addis Ababa, Ethiopia.

ANNEX-I
RESEARCH INSTRUMENTS

I. SURVEY QUESTIONNAIRES

Instruction

The basic objective of this research is to collect information from people like you in your village about gender and reproductive health. So now I am going to ask you questions about male perspective in reproductive health which includes issues such as contraceptive and family planning matters, gender, sexuality, as well as, violence that are common in your community.

4. This discussion has no any effect on you as well as your family.

5. We do not write your name and address.

6. We will also make interview with other ----- residents in your area.

7. We met you just by chance, therefore, you are free to tell and respond the following questions.

SECTION ONE

Male Survey Respondents

1. Respondent's Background or Characteristics

1.1. What is your present age?

- | | |
|---------------------------------|---------------------------------|
| 1. 15 – 24 <input type="text"/> | 4. 45 - 54 <input type="text"/> |
| 2. 25 – 34 <input type="text"/> | 5. 55 – 64 <input type="text"/> |
| 3. 35 – 44 <input type="text"/> | |

1.2. Marital Status:

- | | | |
|---------------------------------|-----------------------------------|---------------------------------|
| 1. Married <input type="text"/> | 2. Unmarried <input type="text"/> | 3. Widowed <input type="text"/> |
|---------------------------------|-----------------------------------|---------------------------------|

1.3. Types of marriage

- | | |
|---------------|----------------------|
| 1. Monogamous | <input type="text"/> |
| 2. Polygamous | <input type="text"/> |

1.4. How many children do you have?

- | | |
|---------------|--------------------|
| 1. Sons _____ | 2. Daughters _____ |
|---------------|--------------------|

1.5. What is the highest level of schooling you have attended?

- | | | |
|------------------------------------|---------------------------------------|--------------------------------------|
| 1. Illiterate <input type="text"/> | 2. Church school <input type="text"/> | 3. Koran school <input type="text"/> |
|------------------------------------|---------------------------------------|--------------------------------------|

4. Literacy campaign ☐ 5. Grade 1-6 ☐ 6. Grade 7-12 ☐

7. Grade 12 complete ☐

8. College Diploma ☐

9. First Degree and above ☐

1.6: Religion

1. Muslim ☐ 2. Christian orthodox ☐

3. Protestant ☐ 4. Catholic ☐

5. Other (specify) _____

1.7. What is your current occupation?

1. Civil servant ☐ 2. Private business ☐ 3. Soldier ☐

4. Students ☐

5. Do not have ☐

6. Other specify-----

SECTION TWO

2. Respondent's fertility desire

2.1. Would you like to have any more children than the one you have now?

1. Want more ☐ 3. I do not want more ☐

2. God/Allah decide ☐ 4. Undecided ☐

2.1.1. If your response for 2.1. is 'want more'

What is/are your reason(s)?

2.2. If you could choose exactly the number of children you have in your whole life, how many would that be?

1. One ☐ 2. Two ☐ 3. Three ☐

4. Four ☐ 5. Five ☐ 6. Six ☐

7. Seven or more ☐ 8. It is up to God ☐ 9. Undecided ☐

2.3. What is your sex preference, boys/girls?

1. More boys than girls' ☐

3. More girls than boys ☐

2. Equal preference ☐

4. No preference ☐

2.4. If your response for 2.3. is 'prefer more boys than girls', what is (are) your possible reason(s) for your preference _____

2.5. Who is deciding to have additional child?

1, Men ☐

2. Women ☐

3. Both ☐

4. Other, specify-----

SECTION THREE

3. Contraceptive knowledge, Attitude, and decision practice

3.1 Which method(s) have you heard about that a man can use to delay?

Or avoid pregnancy? Please list.

3.2 Which methods have you ever used that to delay or avoid pregnancy? Please list.

3.3 Do you know what type of method that your partner uses?

1. Well informed ☐

2. Not well informed ☐

3. No response ☐

3.4. From where or whom have you heard these methods?

3.5. Who decide to take contraceptive?

1. Men ☐

b) Women ☐

c) Together ☐

e) unknown ☐

3.6 If your answer for question 3.5 is 'Husband'. Please specify the reason (s)?

3.7 Do you use modern contraceptives?

1. Practiced ☐

2. Not yet practiced ☐

3. do not know ☐

3.8. If do not so far use contraceptive, Do you intend to use the method to delay or prevent at some time in the future

1. Want to use ☐ 2. do not want to use ☐ 3.No response ☐

3.8.1. If your answer for 3.5 is “No”, would you mind telling me why you do not want to use a method?

1. Want to have as many children as possible ☐
3. Modern contraceptive methods causes health problem ☐
4. Spouse oppose ☐ 5 Hard to get method ☐
6. It is against religion' ☐ 7.Other (specify) _____

□

3.9. How is the accessibility of the contraceptives?

1. Easily accessible ☐ 2. Difficult to get ☐ 3.Not accessible at all ☐
4. I do not know ☐

□

3.10. How do you think attitudes of religious leaders, husbands, elderly, and youth groups towards the use of contraceptive?

- | | | | |
|-----------------------|---------------------|---------------------|--------------|
| A. Religious leaders' | a. positive | b. negative/oppose | c. Uncertain |
| B. Husbands' | a. positive | b. negative/oppose | c. uncertain |
| C. Mothers | a. positive | b. negative /oppose | c. uncertain |
| D. Elders | a. positive | b. negative /oppose | c. uncertain |
| E. Youth | a. positive/support | b negative/oppose | c uncertain |

3.11. How is the level of power that your wife/sexual partner regarding reproductive right?

1. Absolute ☐ 2.Partly ☐ 3.No right ☐ I do not know ☐

3.12.If your answer for question n-“3.10” is the “wife” What are the reasons?-----

3.13It your spouse/partner does not agree on the use of Modern contraceptive method, what would you do?

SECTION FOUR

Attitude of men towards Gender and Sexuality

4. Sexuality

4. 1. Men tend to control what happens in sex more than women.

a) Agree ☐ b) disagree ☐ c) unknown ☐

4.2. Women decide when to have sex as a wife/sex partner.

a) Agree ☐ b) disagree ☐ c) unknown ☐

4.3. Women aren't expected to choose sexual partner.

a) Agree ☐ b) disagree ☐ c) unknown ☐

4.4. Men decide with whom to have sex.

a) Agree ☐ b) disagree ☐ c) unknown ☐

4.5. Men have sex with wife any time.

a) Agree ☐ b) disagree ☐ c) unknown ☐

4.6. Woman must serve her husband.

a) Agree ☐ b) disagree ☐ c) unknown ☐

4.7 If a man suspect wife to have affair with another man, (Please place a tick mark in front of one or many reason(s) that you considered appropriate).

a) Ask for divorce ----- ☐
b) Beat the woman ----- ☐
c) Kicks her out of the house----- ☐
d) Report to relatives..... ☐
e) Other----- ☐

4.8 If a woman suspect a husband to have an affair with another women (Please place a tick mark in front of one or many reason(s) that you considered appropriate).

a) Ask for divorce----- ☐
b) Report to relatives----- ☐
c) A woman can ask safe sex----- ☐
d) A man can ask safe sex----- ☐
e) Husband may force sex----- ☐
f) Other----- ☐

4.7. If you want to have sexual inter course, but if a woman or your wife refuse to do so, what do you do?

1. I will keep silent
2. I tend to make by force
3. I retaliate by other means
4. No response

4.8. Have you ever discuss how to make sexual inter course with your wife or girl friend or any other woman?

1. Yes
2. No
3. No response

4.9. If your answer for 4.8 is 'Yes' whose interest usually dominate?

1. mine/men
2. Wife/a woman
3. Mutual
4. No response

4. 10. Do you tell to your spouse/sexual partner the truth when you are satisfied?

1. I do
2. Never
3. No response

4. 11. Do your spouse/girl friend tell the truth when she satisfied or not satisfied during intercourse?

1. She does
2. Never
3. No response

SECTION FIVE

6. Men's Attitude towards Family Planning.

	Positive	Negative/oppose	Uncertain
5.1 Do you agree that men and women to use contraceptive methods to limit birth			
5.2 Every women should bear as many children as she can			
5.3 People should continue to bear as many children as they can if the desire number is met but not sex preference.			
5.4 It is a good idea to wait a while between one pregnancy and the next.			
5.5 If one has enough money, he/she needs to have a large family.			
5.6 Modern contraceptive can affect fertility or produce sterility in women.			
5.7 Modern contraceptive methods are effective in preventive pregnancy.			
5.8 Men should have equal role in family planning			
5.9 Men should take contraceptive ,like women, to delay or stop having additional children			

SECTION SIX

6. Men's Views Regarding Partners' discussion about family

Planning and sexuality

	Yes	No	No response
Have you discuss with your partner about			
➤ the number of children you would like to have			
➤ the use of contraceptive			
➤ spacing of birth			
➤ sexual matters such as when and how to make sexual intercourse			
➤ problem of large family size			
➤ budget or finance affairs			
➤ child caring			
➤ education and future carrier			
➤ gender based violence			
➤ STIs including HIV/AIDS			

SECTION SEVEN

Gender-based violence

7.1 Rank the top three gender-based violence in order of prevalence

1. Sexual harassment
2. Sexual abuse
3. Beating
4. Rape
5. FGM

7.2 Where do you think that gender-based violence occur?

1. In the family
2. outside home
3. No response

7.3 Is gender-based violence considered as health problem?

1. Yes
2. No

II. Focus group Discussion

Gender, Sexuality and Reproductive Rights, and Health among men issues are taken as center of discussion or as the topic of occasional communication. The need to make focus groups discussion is to gain an understanding about the gender perspectives of reproductive health in general and the attitude, practices of the men in the community in particular, and examine men perspectives in communication and power relation concerning sexuality and reproductive rights and health.

A. Basic data

1. Kebele

Age

1. 15 – 19

5. 35 - 39

2. 20 – 24

6. 40 - 44

3. 25 – 29

7. 45 - 49

4. 30 – 34

8. Educational background-----

B. Issues for discussion:

A. Sexuality

1. Do husband and wife discuss on sexuality-about safe sex, when and how often to do sex, about the etc.
2. Do you think women's/females' met their sexual needs by their husbands'/males'? Do women/girls ask for sex? Why?
3. What is sex and sexual intercourse for you? Do you discuss the enjoyment part of sex with your spouses/ girl friend?
4. What is your understanding and opinion about virginity and heterosexual relationships regarding the seductiveness of males and the passive nature of female?
5. Who decide to have sexual intercourse in your community? Are females or males?)
6. What do you feel if your wife you are found her with another man?

B. Family Planning

7. Who decide on fertility, usage of contraceptive and on other reproductive health matters? And Why? What is your opinion about modern contraceptive methods?
8. Is there preference of boys than girls in your locality? If yes why? Whose preference is gives priority-men or males or females?

C. Decision-making

9. What men can do if their wives have refused on the use of contraceptives or decide to use it?
10. How can men and women partnership is strengthen with respect to sexual and reproductive rights and health?
11. What are the challenges and prospects with regard to men involvement in reproductive health, and to bring men as part of ensuring gender equity and equality?

D. Socio-cultural Factors

12. What are the socio cultural factor that influences/affect sexual and reproductive rights and health in your community?
13. What are the effects of socialization on women and men decision-making regarding sexual and reproductive rights and health such as family planning?
14. Is male involvement in reproductive health acceptable in your community? If 'No' what are some of the reasons? What are the positive conditions or social capitals to ensure men involvement in reproductive health?
15. How can men be involved in reproductive health issues?

E. Violation of women's/Sexual and Reproductive rights

16. Is there gender-based violence in your community? What are the main types of violence are common in your localities? And what are the reasons?
17. Are women disclosed when they are facing violence from their men counter parts, especially those related with sex and reproduction?
18. How can men be involved in combating gender –based violence, particularly those related to sexual and reproductive right and health? What are the social capitals both to reduce gender based-violence and men involvement on the issues at hand?
19. Any other opinion you want to make?

Thank you

In-depth interview –Elders and Religious Leaders

How do elders viewed?

- What is your opinion regarding Marriage and Virginitv vs. being not virginitv
- What is your opinion about men Sexual affairs outside marriage
- Are there balanced sexual affairs and power relations in marriage? How men can be partner in women sexual and reproductive rights and health?
- Is sexual affair accepted by society before marriage?
- What are the religious views/doctrines with regard to contraceptive?
- Do men involvement in reproductive health acceptable in your religion or community culture?
- What do you propose to bring some changes at individuals and societal levels regarding male involvement in reproductive health?

B. Health professional and program managers

1. Do your health institutions provide reproductive health services? Who are the beneficiaries?
2. Do spouses / men and women/ come together to ask for contraceptive? If “no” who is asking for service most of the time?
3. What are the gender issues that determine the sexual relations and reproductive health between women and men in your community that helps the policies/programs are to be effective?
4. Are people well informed about reproductive health matters and the dangers associated with STI such as HIV/AIDS etc.?
5. What efforts do your health facilities do to encourage men involvement in reproductive health?
6. What are positive values towards gender and reproductive health in this community
7. Do spouses/friends come to discuss sexual and reproductive issues/problems with your health facility?
8. Do you want some thing to add? Or do you have any opinion with regard to sexual and reproductive health matters?
9. What are men’s views and roles in combating violence against women and how can we ensure and sustain men roles and responsibilities to protect gender-based violence that affect women’s reproductive health?
10. Any thing you want to add?

Thank you!

In-Depth interview for youth/young men and adult

- What are the activities undertaken to ensure gender perspectives, particularly to enhance and sustain men involvement in reproductive health service in your locality? Do youths inculcate in such manner?
- How youths are contributing to reproductive health services? And how is the imbalance gender power relation between them be solved? And how can we ensure and sustain women sexual and reproductive health right by working with men/boys?
- Do women and men communicate and discuss regarding family planning issues, such as fertility desire and contraceptives, as well as sexuality, and the effect of gender based violence?
- What are the challenges and constraints in engendering the reproductive health services in your locality? And what efforts are made to overcome the challenges?
- What are men's views and roles in combating violence against women and how can we ensure and sustain men roles and responsibilities to protect gender-based violence that affect women's reproductive health?
- Any thing you want to add?

Thank you!

Annex II

Observation Check List

A. Ethiopia Family Guidance Association and Ethiopia Red Cross Society

Branch Offices Activities

- Family Guidance Association Ethiopia (FGA)branch office
- Ethiopia Red Cross Society (ERCS)Branch office
- Types of services provided by FGAE
- FGAE branch office youth -centered programs
- ERS branch office youth -centered programs
- Panel discussion held at FGAE branch for young men and women
- Coffee ceremony programs of FGAE branch
- Services beneficiaries by gender at FGAE branch clinic
- ERCS youth-centered activities

C. Woliso Health Centre

- Maternal Health Care (MHC) services
- Reproductive health services
- Health information education and communication services
- Service receivers by gender
- Men participation in reproductive health services
- Contraceptive dispensary by client and type

D. Household

- Family size
- Family interactions
- Economy conditions

Annex III

Table 1. Contraceptive usage by sex July, 2005---May, 2006

No	Sex	Pills	Depo-Provera	Condom	Norplant
1	Male	-----	----	214	
2	Female	5087	7267	--	5
	Total	5087	7267	214	5

Table 2. STD and HIV/AIDS prevalence by sex July, 2005---May, 2006

No	Sex	STD other than HIV/AIDS	HIV/AIDS	
			Positive	Negative
1	Female	49	39	207
2	Male	77	30	300
	Total	126	69	507

ANNEX IV

Contraceptive methods

- Pills- Women can take every day for 28 days
- IUCD (Intrauterine Contraceptive Device)- Women can have a loop or coil placed inside them by trained health professionals
- Injection- Women can have an injection by health professionals which stop them from becoming pregnant for several months.
- Diaphragm, Foam, Jelly- Women can place a sponge, suppository, diaphragm, jelly or cream inside them before intercourse.
- Condom- Men or female can use a rubber sheath during sexual intercourse to avoid pregnancy
- Female Sterilization- women can have an operation to avoid having any more children.
- Other