

Saint Paul's Hospital Millennium Medical College department of public
health



Decision making autonomy of women on contraceptive use and its
factors in Dalocha woreda, silte zone southern
Ethiopia

A Student research thesis to be submitted to the department of public health
SPMMC in partial fulfilment of degree of doctor of medicine

By:

Etenesh Yirba (M. Intern)

July, 2018

Addis Ababa

Ethiopia

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Acknowledgement

We would like to thank our supporter SPHMMC public health departments and our advisor Mr. Andamlak Gizaw and clinical advisor Dr. Munir, who help us financially and technically to do this research well. I would also grateful to all the data collectors and friends who are supportive during the research activity; and, above all, to the study participants who are willing to share their experience.

Summary

Background: Majority of women, Who Live in developing country, have little health care decision making and contraceptive use autonomy. Even if it has improvement, women's independence and autonomy, with respect to health-related decision-making, may be restricted by many factors and a little investigation has done to identify the factors.

Objective: to assess the autonomy of women in decision making on contraceptive use and its factors in Dolucha wereda, silte zone

Method: A community based analytic study has been used to assessing the autonomy of women in decision making on contraceptive use and its factors in Dolucha woreda of site zone. In which systematic random sampling technique was used.

Result: In this study, 264 respondent mothers who were in reproductive age group from which 173(65.5%) of respondent mothers are autonomous on decision making on contraceptive use. most of contraceptive use 155(58.7%) decision were done together followed by her husband 91(34.5%) which include nonuser decision and by herself 18(6.8%). Binary logistic regression has revealed that religion, woman attending school, husband's educational status, and current employment respondent has association with decision making autonomy women on contraceptive use. When multivariable logistic regression analysis was done for those factor, the association are not significant.

Conclusion: The study shows that participant's mothers are fairly autonomous on decision making on contraceptive use despite her involvement alone is not significant compare to her husband involvement alone. Religion, woman attending school, husband's educational status, and current employment of respondents has significance but not has significant association in multivariable logistic regression analysis.

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Abbreviations and Acronyms

EDHS.	Ethiopia Demographic and Health Survey.
SPSS.	Statistical package for Social Sciences software.
SPHMMC.	Saint Paul's Hospital Millennium Medical College.
MPH	Master of public health
OCT	October

1. Introduction

1.1. Background

Majority of women have little health care decision making autonomy in many country's cultures (1). Especially, African women are mostly perceived to have little participation in health care decisions (1). In the 2016 EDHS, 21% of women said their husbands usually makes decisions about major household purchases, 18% said the husband decides about the woman's health care, and 16% said the husband is primarily responsible for making decisions about visits to her family or relatives. So majority of women reported that they are involved either alone (11-18%) or jointly (66-68%) in these decisions (2). In other study, around 20.6% of them usually made decisions themselves, whereas 37.8% made decisions jointly with their husbands. However, decisions made by their husbands/partners alone is 40.9% (1).

The autonomy of women is the ability of women to obtain information from any site and make decisions by themselves on things concerns them which help to access material resources such as food, land, income and other forms of wealth, and social resources like knowledge, power, prestige within the family and community (3).

Family planning is a burning issue for many developing countries worldwide (4). Their use in developing countries are associated with various markers of socioeconomic status, especially with women's education; the well documented link between female education and use of contraception plays an important role in development of family planning policies in lower income countries (4). So the autonomy of women is one of the mechanisms through which education influences contraceptive use in developing countries (4). However, women's independence and autonomy, with respect to health-related decision-making, may be restricted in a society where women are embedded in social relationships and have strong cultural and structural ties to men (5).

Women's autonomy which consisting of three dimensions in which women make decisions and control resources within the family: freedom of movement (mobility autonomy), household decision making autonomy, and access to finances (financial mobility) (6). All these are important in order to influence contraceptive use. (6) Women, who are free to move anywhere, have ability to control over economic resources or decision making, would be able to travel to health facility,

if needed, gain knowledge about methods of birth spacing, spend money to pay for the travel and other health services and make decisions if and when they need the next child(6).

All these influence with woman's and husband's educational status, household wealth index, birth order, number of pregnancies, current age of woman, family size, husband's and woman's occupation (1).

Evidence from Africa and South-East Asian countries has shown that women usually have less power and decision making autonomy than men, concerning issues related to their own health care (1). Their low status and autonomy has association with lower fertility control (4). Improving women's education has been seen one way to increase their status and autonomy, which acts as a mediator of the link between education and contraception use (4).

1.2. Statement of the problem

Despite of woman full right to participate in their own health care decision making, more than two fifths of them have no role in making health care decisions about their own health (1). The autonomy of women on family planning around 73% of currently married women age 15-49 who are using a family planning method, the decision was made jointly with their husband; for 22% of them the decision was made mainly by themselves, and for 5% the husband mainly made the decision. Among currently married women who are not using a family planning method, 58% made the decision not to use family planning jointly with their husband, 30% decided themselves, and for 10% the husband decided(2). Even if there is many factors which affect the ability of women to take part in the decision-making process in the household, there is some factor which affect more like her education level, her age, husband's literacy, household economy, family size, and her involvement in income generating activities (3).

A comprehensive strategy needs to be implemented in order to empower women, as well as to challenge the traditional male dominance. Special attention has to be given to women esp. for those living in rural areas in order to reduce their dependency through education and income generating activities (1).

1.3. Significance of the study

Women's power in health care decision making is essential in a range of situations, from health care seeking and utilization of different options based on their own choose. Empowering women

is crucial for achieving and building a good family which have unity and good income. Making a women to participation in decision making esp. on their own issues, reduce their dependency on others which have a positive impact on their life and family. To empower women by providing non-formal and formal education to both women and their husbands/partners, identifying the factors and work on them is important. Contraceptive use important to limit the family size, which in turn allows freedom and independency of women with regard to health care decision making and family happiness.

Despite this, a little investigation was done to identify number of factors contributing to decision making autonomy. Hence, it is important to obtain information on the contributing factors of decision making autonomy and disparities across different socio-cultural contexts.

2. Literature Review

On community based cross-sectional study conducted in southern Ethiopia on April 2017; show 58.4% of women have autonomy either alone or jointly, Concerning women' decision making autonomy with regards to their own health care, 20.6% of them usually made decisions themselves, whereas 37.8% made decisions jointly with their husbands. While 40.9% of study participants' health care decisions were made by their husbands, of protestant religion (74.4%), and from Wolaita ethnic group (70.5%). Less than one third (32.3%) of the households had a family size of less than five individuals/household, while 37.2% and 30.5% of them had a family size of 5–6 and more than six individuals/household, respectively. Women whose husband's educational status is secondary and above, are twice as likely to participate in health care decision making compared to women whose husbands have no formal education; Women from higher wealth index households have a 38% lower chance of participating in decision making than those from lower wealth index households. Women found in the age category of 21–30 years are twice as likely to participate in decision making compared to those aged below 20 years. women with a family size of five to six persons have a 47% lower chance of participating in health care decision making as compared to women with a family size of less than five persons; women are more likely than housewives to participate in health care decision making.

On national study using multi-stage sampling method in Pakistan on 21 oct 2005 show The life time prevalence of contraceptive use was 40%, and 28% of women were current users. There were marked and statistically significant differences in contraceptive use and autonomy scores by all socio-demographic characteristics. In exploratory multivariate analyses, most socio-demo- graphic variables were associated with both indicators contraception use; the most prominent predictors of contraception use were the number of living children and women's education. For example, the fully adjusted odds ratio for the highest vs. the lowest educational category was 3.6 (2.5–5.0) for ever use and 2.4 (1.8–3.3) for current use. Distribution of both autonomy scores was highly asymmetrical, indicating low levels of autonomy of most women. In crude analyses, decision autonomy was strongly associated with both lifetime and current contraceptive use; the odds ratios for the highest vs. the lowest quintile were 4.8 (3.8–6.0) and 5.0 (3.7–6.9), respectively. The higher odds ratios for current use compared with ever use, is probably due to more recent and slightly more precise information on current use. Controlling for demographic variables reduced the odds ratios considerably. Nevertheless, in the full model, decision autonomy remained significantly

associated with contraception use, Women's decision autonomy is significantly associated with contraceptive use but it does not appear to mediate the link between woman's education and contraception

2011 Ethiopia Demographic and Health Survey (EDHS) show that the majority of currently married men report that key household decisions are made jointly with their wives. Those women who were asked about their participation in decisions about their own health care, major household purchases, and visits to their family or relatives, The majority of them reported that they are involved either alone (11-18%) or jointly (66-68%) in these decisions. However, 21% of women said their husbands usually makes decisions about major household purchases, 18% said the husband decides about the woman's health care, and 16% said the husband is primarily responsible for making decisions about visits to her family or relatives. Overall, 71 percent of women participate in all decisions and only 10% are not involved in any of the three decisions. Women's participation in decision making increases with increasing education level and wealth quintile. Eighty-seven percent of women with more than secondary education participate in all three decisions, compared with 68% of women with no education. Similarly, 80% of women in the highest wealth quintile participate in all three decisions compared with 65% in the lowest wealth quintile.

3. Objectives

3.1. General Objective

The general objective of this study is to assess the autonomy of women in decision making on contraceptive use and its factors in Dolucha, silte zone southern Ethiopia

3.2. Specific Objectives

- ❖ To determine the autonomy of women in decision making on contraceptive use
- ❖ To assess the possible factors that affect the autonomy of women

4. Methods

4.1. Study area

This study was conducted in Dolucha woreda which is one of the woredas in the Silte Zone, Southern Nations, Nationalities, and Peoples' Region of Ethiopia, Dalocha town is located at 180 Kms from Addis Ababa, latitude 7°47' north and 38°15' east at an elevation of 1,952 meters above sea level. Based on the 2007 Census conducted by the CSA, this woreda has a total population of 89,807, of whom 44,960 are men and 44,847 women; 6,793 or 7.56% of its population are urban dwellers. The majority of the inhabitants were Muslim, with 98.07% of the population reporting that belief, while 1.64% practiced Ethiopian Orthodox Christianity.

4.2. Study design

A community based descriptive cross sectional study used to assessing the autonomy of women in decision making on contraceptive use and its factors in Dolucha woreda of site zone.

4.3. Population

4.3.1. Source population

Our source population were the households located in a single Kebele in Dolucha woreda of silte zone.

4.3.2. Study population

Our study population were sample of households in chosen kebele in Dolucha woreda.

4.3.3. Study subjects

Our study subjects were a female resident of the households living during the time of data collection in kebele in woreda who full fill the exclusion and inclusion criteria.

4.3.3.1. Inclusion criteria

- ☐ Female residents who were living in the households for greater than 6 months.
- ☐ Female residents who were greater than or equal to the age of 15 and less than 49.

4.3.3.2. Exclusion criteria

- Unmarried women
- Peoples who were not eligible to participate due to medical diseases or mental handicaps.

4.4. Sampling

4.4.1. Sample size determination

The sample size for the study was determined using single population proportion formula:

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

Where: n = required sample size

$Z_{\alpha/2}$ = Critical value=1.96 (Standard normal deviation usually set at 1.96 which corresponds to 95% confidence interval)

p = prevalence contraceptive use in autonomous women is 22% from study done in 2016 EDHS.

d = precision (marginal error) =0.05 (5%)

α = degree of accuracy

Supposing $N > 10,000$

$$n = \frac{(1.96)^2 0.22(1-0.22)}{(0.05)^2} = 263.68 \approx 264$$

4.4.2. Sampling technique

The sampling technique we have chosen for this research was systematic random sampling technique where we selected randomly one woreda from list of woreda in silte zone from which we selected kebele randomly again. After random selection of the kebele, we had get the number of required sampling unit by choosing one households after leaving two households at regular interval($k=N/n$) from sampling frame.

4.5. Data Collection methods

The research was conducted by using investigator-administered questionnaire. The questionnaire was developed by reviewing relevant literatures.

4.6. Data Quality control

Before we start the main study the questionnaire and the whole method was pretested on some professionals to find out mistakes and to correct them.

4.7. Study Variables

4.7.1. Dependent Variables

The dependent variable is autonomy of women on contraceptive use

4.7.2. Independent Variables

Socio-demographic characteristics

- age,
- religion,
- ethnicity,
- monthly income,
- marital status,
- occupation,
- educational level of woman and husband,
- number of children and total number Household
- Family size,
- Household decision making:
- Ownership of assets:

4.8. Operational definitions

Autonomy: Autonomy is the power to obtain information and arrive at decisions about personal concerns. The ability of women to seek health services and visit health care facilities, use contraceptive depends on their decision making autonomy. We assessed through

- Freedom of movement (mobility autonomy), whether a woman is allowed to go to: market, health facility and places outside own community/village.
- Household decision making autonomy, whether a woman has any say: on her own health care, on large household purchases, purchase for daily needs, what to do with money husband earns, and visits to family or friend.
- Financial mobility; whether she has money for her own use or not

Women autonomy on contraceptive use: If the decision on contraceptive use was done alone, or jointly, she is autonomous or If partner alone was involved, she is non autonomous

4.9. Data processing and analysis

We began by selecting a total of 264 women's through systemic random sampling method. The questionnaire was administered by face-to-face through an interview format then checking the gathered data for accuracy and completeness. SPSS version 20 were used to enter and analyze data. Proportions and means were used to describe the study population. Variables with *P*-value, 0.05 in multivariable logistic regressions were identified as independent predictors. Odds ratios along with confidence intervals were used to determine the presence of association.

- To observe the overall trends in the data, descriptive statistics such as frequency, graphics and cross tabulations was calculated for dependent and independent variables; and association between dependent and independent variables was made.

4.10. Ethical Consideration

We had permission to do the research from SPHMMC public health department and the respective community leaders. The purpose of the research explained to the respondents before conducting the interview. Respondents informed of their right to refuse the interview or halt during the interview but if they were to consent the information they provide was kept private, their names would not be shared outside the concerned bodies.

4.11. Dissemination of findings

The finding will be first reported to SPHMMC public health department for evaluation purpose. Apart from this, we would like to share the contents of this research to worabe health center and other members of health science in the form of any other available outlet

5. Result

5.1. Socio-demographic characters of participant mothers in dalocha town, silte zone, southern Ethiopia, 2018.

The response was gathered from a total of 264 voluntary mothers from urban area of Dalocha. The given tables and figures below are assisted in illustration of the socio-demographic data of participant mothers in the town.

Table 1 show Sociodemographic Distribution of respondents, out of the sampled population the majority of mother were attended school 166(62.9%) but primary education level took slight majority 118(44.7%) in number followed by mothers who are uneducated 98(37.1%). The same distribution also found in the partner with 108(40.9%) of them attend primary school followed by uneducated 76(28.8%) and secondary 33 (12.5%). Despite above result, 100% of participant mothers are promote girls education and 259 of mother believe literature affect their household position and 5(1.9%) of them only believe that it is not affect their household position. Muslims constitute greater part which account for 234 (88.6%) of respondents, followed by orthodox Christians 30(11.4%), of respondents. Silte constitute majority of participate which account for 243 (92.0%) of respondents, followed by Amhara 8(3%) of respondents. Majority of mothers are married 252(95.5%) followed by divorced. majority of the respondent mothers around 159(60.2%) have no job and most of them are housewife 159(60.2%), followed by merchant 47(17.8%),farmer 28(10.6) and government employee 24(9.1%).And 232(87.9%) of respondent mothers have not employment previously and 32(12.1%) of them had employment from which 14(5.3%) of them leave their work due to marriage followed by 9(3.4%) due to illness. Most of respondent 225(85.2%) believe the employment affect their position in the house and 39(14.8%).of them believe it is not affect their position in house.

Table 1: Sociodemographic Distribution of respondents in dalocha town, silte zone, southern Ethiopia, 2018

educational level of women	Frequency	Percent
primary	118	44.7
uneducated	98	37.1
secondary	31	11.7
diploma	12	4.5
degree	5	1.9
partner educational level	Frequency	Percent
primary	108	40.9
uneducated	76	28.8
secondary	33	12.5
diploma	29	11
degree	18	6.8
religion	Frequency	Percent
Muslim	234	88.6
orthodox	30	11.4
ethnicity	Frequency	Percent
Silte	243	92.0
Amhara	8	3.0
Gurage	6	2.3
Oromia	4	1.5
other	3	1.1
marital status	Frequency	Percent
married	252	95.5
divorced	6	2.3
widow	5	1.9
separated	1	0.4
current employment	Frequency	Percent
no	159	60.2
yes	105	39.8
type of employment	Frequency	Percent
housewife	159	60.2
merchant	47	17.8
farmer	28	10.6
government	24	9.1
daily labor	6	2.3
previous employment	Frequency	Percent
no	233	87.9
yes	32	12.1
why you leave your work	Frequency	Percent
Not working	233	88.3
marriage	14	5.3
illness	9	3.4
child bearing	5	1.9
other	3	1.1

Respondents around 82(31.1%) are aged between 21 and 26 followed by 63(23.9%) are age between 27 and 32. The Mean and median age is 28.1 and 27, and the minimum and maximum ages are 17 and 48 respectively. With Std. deviation of 7.088.

Figure 1 Age distribution of participant mothers in dalocha town, silte zone, southern Ethiopia, 2018.

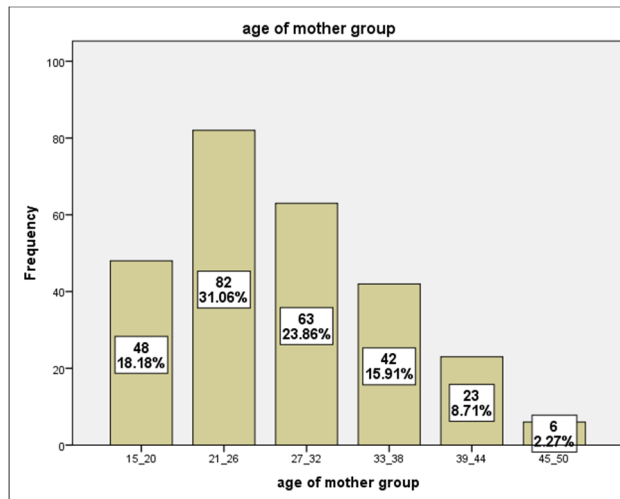


Figure 2 show the percentage distribution of partner by age and majority of partner 77(29.2%) are aged between 26 and 31 while 54(20.5%) are partner of age between 32 and 37. The median age is 35, and the minimum and maximum ages are 20 and 100 respectively. With Std. deviation of 10.381.

Figure 2 Age distribution of their partner in dalocha town, silte zone, southern Ethiopia, 2018

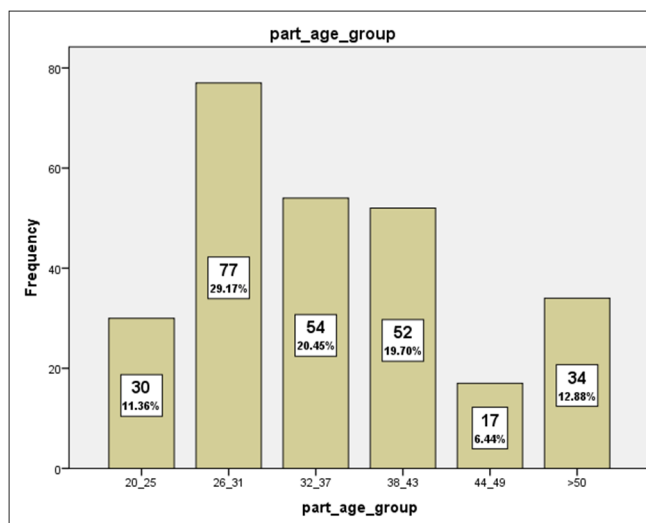


Table 2 show the majority of respondent 187(70.8%) their monthly income is below 2000 birr followed by 55(20.8 %) of them which is between 2000_4000. Most of source of income around 169(64.0%) from husband followed by both (20.1%). From all 166(62.9) of respondent have no share of earning to household income and 75(28.4%) of them have equal share. Around 208(78.8%) of respondent believe contribution to household income affect their position.

Table 2 Percentage distributions of their income in dalocha town, silte zone, southern Ethiopia, 2018

monthly income group	Frequency	Percent
<2000	187	70.8
2000_4000	55	20.8
4000_6000	16	6.1
>6000	6	2.3
source of your income	Frequency	Percent
husband	169	64
both	53	20.1
herself	38	14.4
other	4	1.5
your share of earning to household income	Frequency	Percent
non	166	62.9
equaly	75	28.4
all	23	8.7
contribution to household income affect your position	Frequency	Percent
yes	208	78.8
no	56	21.2

Table 3 show majority of respondent mothers have number of children between 0_4 which is 193(73.1%) followed by 5_9 which is 68(25.8%). And majority of number of household is between 5_9 which is 157(59.5) followed by 0_4 which is 102(38.6).

Table 3 Percentage distributions respondent by number of child in group and household in group in dalocha town, silte zone, southern Ethiopia, 2018.

number of child	Frequency	Percent
0_4	193	73.1
5_9	68	25.8
10_14	3	1.1
household in group	Frequency	Percent
0_4	102	38.6
5_9	157	59.5
10_14	5	1.9

5.2. Autonomy of women on decision making

Table 4 shows majority of respondent mothers 60.7% have autonomous on obtaining health care 120(45.5%) of them have decision making power on obtaining health care together with her husband and 101(38.3%) of them decision made by her husband, only 40(15.2%) of them have decided by themselves. Majority of respondent mothers 105(39.8%) have decision making power on purchasing jewelry or major household item together with her husband and 81(30.7%) of them decision made by her husband, 74(28.0%) of them have decided by themselves. When respondent mothers want to visit parents/relatives/friends, majority of decision were done by her husband around 148(56.1%) and 76(28.8%) of them decide together and 40(15.2%) by themselves.

Table 4 Percentage distributions of respondent on decision making in dalocha town, silte zone, southern Ethiopia, 2018.

Decision making on obtaining health care	Frequency	Percent
both	120	45.5
her husband	101	38.3
herself	40	15.2
her/his family	3	1.1
decision on purchasing jewelry or major household item	Frequency	Percent
both	105	39.8
her husband	81	30.7
herself	74	28.0
her/his family	4	1.5
decision when you want to visit parents/relatives/friends	Frequency	Percent
her husband	138	56.1
both	76	28.8
herself	40	15.2

5.3. Autonomy of women's decision making on contraceptive use

Figure 1 shows majority of respondent mothers 177(67.0%) are use contraceptive and 87(33%) of them not use contraceptive. From all of respondents, most of contraceptive use 155(58.7%) decision were done together followed by her husband 91(34.5%) which include no using decision and by herself 18(6.8%) (fig_2). Majority of respondent mothers 44.32% were used to an injectable contraceptive followed by non-user of contraceptive (33%) and oral contraceptive pill user (fig_3).

Figure 3 Percentage distributions of respondent mothers based on contraceptive use

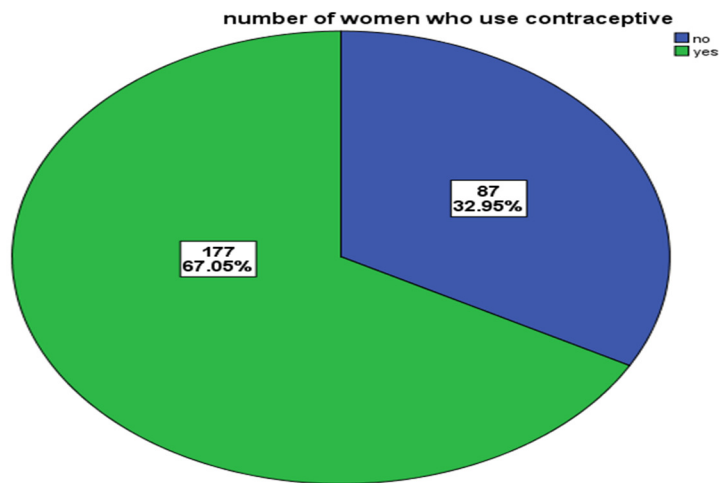


Figure 4 Percentage distributions of respondent mothers based on decision on contraceptive use

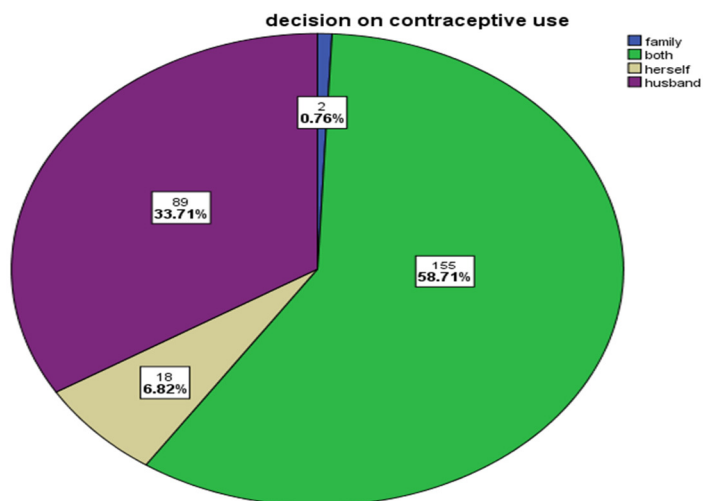
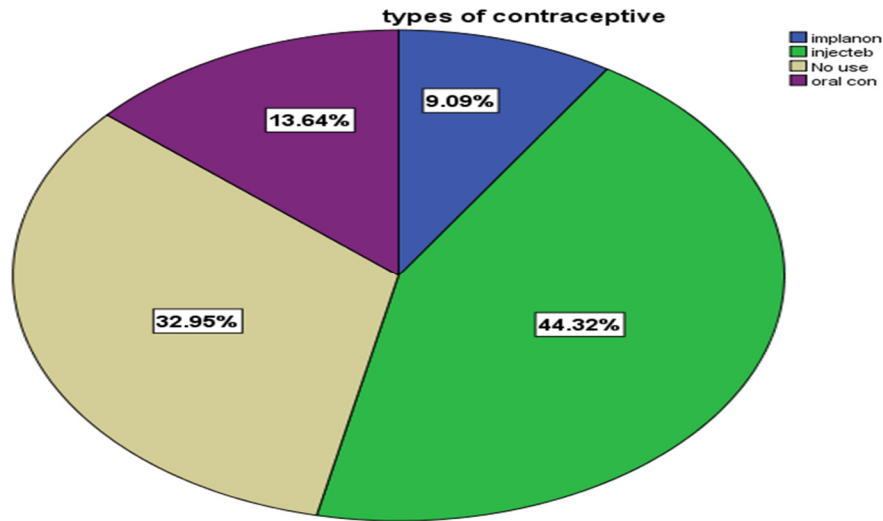


Figure 5 Percentage distributions of respondent mothers based on types of contraceptive



5.4. Association between factors and autonomy of women

Binary logistic regression has revealed that religion, woman attending school, husband's educational status, and current employment respondent are associated with decision making autonomy women on contraceptive use.

Table 5 Bivariate logistic analysis of respondents in dalocha town, silte zone, southern Ethiopia, 2018

Variable		Frequency	COR	P-value
Religion	Muslim	234	5.425	.007
	Orthodox	30	1	
Mother attending school	yes	166	1.791	.028
	no	98	1	
Current employment	no	159	1.946	.016
	yes	105	1	
partner educational level	primary	108	.261	.046
	uneducated	76	.340	.036
	secondary	33	.797	.457
	diploma	29	.417	.061
	degree	18	1	

When multivariable logistic regression analysis was done for those factor, the association are not significant.

Table 6 Multivariate logistic analysis of respondents in dalocha town, silte zone, southern Ethiopia, 2018

Variable		Frequency	AOR	P-value
Religion	Orthodox	30	8.922	.135
	Muslim	234	1	
Mother attending school	yes	166	1.592	.140
	no	98	1	
Current employment	yes	105	1.884	.130
	no	159	1	
partner educational level	primary	108	.711	.670
	uneducated	76	1.008	.990
	secondary	33	1.248	.529
	diploma	29	.787	.682
	degree	18	1	

6. Discussion

In this study, 264 respondent mothers who were in reproductive age group and residing in Dalocha were investigated. From them, majority of respondent mothers 177(67.0%) are use contraceptive and 173(65.5%) of respondent mothers are autonomous on decision making on contraceptive use. most of contraceptive use 155(58.7%) decision were done together followed by her husband 91(34.5%) which include nonuser decision and by herself 18(6.8%). Comparing this to research done on in the 2016 EDHS, shows that 73% of currently married women age 15-49 who are using a family planning,36%, the decision to use it was made jointly with their husband; for 22% of these women the decision was made mainly by themselves, and for 5% the husband mainly made the decision(2). Which is higher than our result. This difference might be the result of discrepancy in the scope of studies, where it use censuses rather than sampling technic which may represent all. Majority of respondent mothers 44.32% were used to injectable contraceptive followed by non-user of contraceptive (33%) and oral contraceptive pill user. Compare to other, the most commonly used contraceptive method for currently married women in Ethiopia is injectable (23%), followed by implants (8%).

Their mean age was 28.1 years. Muslims account for 234 (88.6%) of respondents followed by Amhara. 62.9% of them had education and primary education level mothers take slight majority (44.7%), and 243 (92.0%) and 252(95.5%) of respondents were silte and married respectively. over 159(60.2%) were housewives who have no employment followed by merchant 47(17.8%) and government employee 24(9.1%). 232(87.9%) of respondents had no previous employment and 32 of them stopped it from which 14(5.3%) of them due to marriage.225(85.2%) of mothers believe their employment affect their household position. most of source of income around 169(64.0%) came from husband. 166(62.9) of respondent have no share of earning to household income and 75(28.4%) of them have equal share. Around 208(78.8%) of respondent believe contribution to household income affect their position. majority of respondent mothers around 193(73.1%) and 157(59.5%) have number of children between 0_4 and number of household between 5_9 respectively. Comparing with other research the majority of women and men are under age 30 (58% of women and 55% of men), young age structure, which is a result of high fertility in past decades The main religions in Ethiopia are Orthodox Christianity (43%)and Muslim(31%). The largest ethnic group is Oromo (34%), followed by Amhara (30%).Men are much more literate than women. Two in three men (69%) men are literate, as compared with 42% of women. Current

employed woman account for 33%. And 42% of women are engaged in agricultural occupations, while 37% of women are employed in sales and services. Eight percent of women work in skilled manual labor. Only 5% of men and women are working in professional/technical/managerial occupation (2). And majority of number of household is between 5_9 which is 157(59.5) followed by 0_4 which is 102(38.6).

Majority of respondent mothers 120(45.5%) have decision making power on obtaining health care together with her husband and 101(38.3%) of them decision made by her husband only 40(15.2%) of them have decided by themselves. According to community based cross-sectional study conducted in southern Ethiopia on April 2017, 58.4% of study participants have autonomy in making health care decisions either alone or jointly which is slightly lower than our result it may be due to family size in which Less than one third (32.3%) of the households had a family size of less than five individuals/household, while 37.2% and 30.5% of them had a family size of 5–6 and more than six individuals/household, respectively (1). Comparing to other research, 18% said the husband decides about the woman's health care (2). the husband has high involvement in our result than other. This may be due to religion or education states of both partner. Respondent mothers around 105(39.8%) of them have decision making power on purchasing jewelry or major household item together with her husband and 81(30.7%) of them decision made by her husband and 74(28.0%) of them have decided by themselves. when respondent mothers want to visit parents/relatives/friends, majority of decision were done by her husband around 148(56.1%) and 76(28.8%) of them decide together and 40(15.2%) by themselves. Comparing this to research done on in the 2016 EDHS, which shows 16% of the husband is primarily responsible for making decisions about visits to her family or relatives And 21% of women said their husbands usually makes decisions about major household purchases (2), when we compare it, our results has higher score than this. It may be due to religious difference. From this, her husband involve more in decisions making process despite her involvement together with her husband is good.

Binary logistic regression has revealed that religion, woman attending school, husband's educational status, and current employment respondent are significantly associated with decision making autonomy women on contraceptive use. When multivariable logistic regression analysis was done for those factor, the association are not significant. On Cross Sectional Study done in Bangladesh, in 2018, bivariate analysis, the factors found to be associated with contraception use

found in this study include current age, women's education, husband education, place of residence, religion, division, socioeconomic status, mass media exposure, respondent current working status, ever heard of a sexually transmitted infection (STI), ever heard of AIDS, and age at first marriage. In multiple logistic regression analysis, findings suggest that current age, place of residence, religion, husband education, division, sex of household head, mass media exposure, respondent current working status, ever heard of a sexually transmitted infection (STI), and age at first marriage are important determinants of current use of contraception in Bangladesh(7). Even if some of factor is not include in our study, the difference may result due to participants and their partner education level in which most of them are below primary education level.

6.1. Limitations of the study

The major limitation of this study, it was difficult for respondents to recall and answer the question.

Other limitation was heaping in some categories, for example education level in which women who had stopped at primary level three were considered to be equal to those who had completed primary level seven.

7. Conclusions and Recommendations

7.1. Conclusions

According to this study, participant's mothers are slightly autonomous on decision making on contraceptive use despite her involvement alone is insignificant compare to her husband involvement alone. In binary logistic regression religion, woman attending school, husband's educational status, and current employment of respondents has significance but not has significant association in multivariable logistic regression analysis.

7.2. Recommendations

The following recommendations are for Dalocha town,

As town, empowering women and increasing her involvement is crucial for the achievement of woman autonomy on contraceptive use. To achieve this, full participation of couples in all of things should be encourage. As institution start discussing with religious institution on how to increase woman participation and use contraceptive by creating awareness among religious leader.

As nation, Even if we have not got significant association, we should have efforts to increase the education level and option of employment of both partner which may increase monthly household income. We also recommend to do other study which include all the factor that affect woman autonomy and act on it.

8. References

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9. Annexes

QUESTIONNAIRE

A questionnaire prepared in assessing the decision making autonomy of women in contraceptive use in siltie Zone Dalocha woreda

Sample on.....

Data collector code.....

Date.....

Dear respondents:

We the researcher are graduating student of saint Paul's millennium medical college, as we explained above, we are conducting a research on topic of decision making autonomy of women on contraceptive use in siltie Zone Dalocha woreda. As part of our research we have prepared a set of questions; which is going to be filled by women whose age between 15 and 49 and a permanent resident of the selected household. Our research has merely an academic purpose and being part of the research fully depend on your consent. All the information you give will be kept strictly confidential; and will not be given to a third party without your consent. Your responses are of great value and the whole interview will take 20-30 mint. Please be honest with your answers.

Thank you very much for your cooperation.

1. What is your age?	
2. What is your partner age?	
3. What is your ethnicity?	A. Amhara B. Oromia c. Silte D. Others
4. What is your religion?	A. Orthodox B. Muslim c. protestant D. Other
5. What is your Marital status?	A. Married B. Widow C. Divorcee C. Separated
6. Have you ever attended school?	A. Yes B. No
7. If answer is yes, What is your educational level?	
8. What is your partner educational level?	
9. How many children do you have?	
10. How many household live in the home?	

11. Will you promote girls education at higher level in your family?	A. Yes B. No
12. Do you think that, if you were literate your position at your family would have been better?	A. Yes B. No
13. What is the monthly household income of your family?	
14. Who is the sources of incomes in your home?	
15. Are you currently employed?	A. Yes B. No
16. What sort of employment do you have?	
17. If you are presently not working, did you ever work before?	A. Yes B. No
18. If the answer is yes, Why did you leave your work?	
19. Do you think, your employment would have affected your position in your house?	A. Yes B. No
20. What is your source of income?	
21. What is your share of earning to the entire household income?	

22. As you have a contribution to household income, does it affect your position in your family?	A. Yes B. No
23. Do you owe any assets? If Yes, list some	
24. Who decide on Obtaining health care for sick person including you.	
25. Who decide on Purchasing jewelry or major household items i.e. land, vehicles etc	
26. Who decide when you want to Visit parents/relatives,/friends/siblings?	
27. Are you using contraceptive currently or in the past?	A. Yes B. No
28. If yes, who decide the use of contraceptive?	
29. What types of contraceptive do you use?	