

ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
SCHOOL OF PUBLIC HEALTH

**FACTORS INFLUENCING CONTRACEPTIVE METHOD
MIX AMONG MARRIED WOMEN OF REPRODUCTIVE
AGE GROUP IN RURAL EAST HARARGE ZONE**

By

Rahel Dubiwak (BSc)

**THESIS SUBMITTED TO THE SCHOOL OF GRADUATE
STUDIES ADDIS ABABA UNIVERSITY IN PARTIAL
FULFILLMENT OF THE REQUIREMENT OF THE DEGREE OF
MASTERS OF PUBLIC HEALTH**

JULY, 2008

ADDIS ABABA, ETHIOPIA

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Advisor

D/r Assefa Semie

JULY, 2008

ADDIS ABABA, ETHIOPIA

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List of Abbreviations

AAU	Addis Ababa University
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CBD	Community Based Distribution
CBRHAs	Community Based Reproductive Health Agents
CI	Confidence Interval
CORHA	Consortium of Reproductive Health Association
CPR	Contraceptive Prevalence Rate
EDHS	Ethiopian Demographic and Health Survey
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FP	Family Planning
HEWs	Health Extension Workers
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IUD	Intra Uterine Device
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry Of Health
MPH	Masters in Public Health
NGO	Nongovernmental organization
ODA	Oromiya Development Association
PPS	Probability proportional to size
RH	Reproductive Health
SPH	School of Public Health
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate

Executive summary

Back ground- Family planning methods include methods which prevent pregnancy for a duration of short time, long time and permanently. Currently, family planning method mix of Ethiopia is highly dominated with short term methods such as pills and injectables. Nevertheless, the contribution of long term and permanent methods is minimal. But for a country like Ethiopia where health service coverage is low, family planning is donor dependent and mothers finish their desired family size in the early age, it is essential to shift to long term and permanent methods.

Objectives The objective of this study is to assess the contraceptive method mix and its determinants in woredas of ODA RH/FP project in East Hararghe zone of the Oromia region.

Methods- A cross-sectional study was employed from September 2007 to May 2008. Quantitative data was collected from 473 married contraceptive users in four rural kebeles selected from two woredas with ODA RH/FP project. The two woredas were selected by SRS and the two rural kebeles were selected from each woredas using simple random sampling. The name of family planning users was listed with the help of CBRHAs. And short term and long term clients were selected with PPS. On the other hand, qualitative data was collected from two FGDs conducted with religious leaders and key informant interview with zonal ODA RH/FP project coordinator. Trained supervisors, data collectors and note takers were used in data collection. Quantitative data was entered using Epi Info version 3.3 and was analyzed using SPSS Version 13 statistical package. Descriptive statistics and associations between variables were

assessed by using chi-squares, p-values, Odds Ratios, and 95% CIs. Qualitative data was transcribed, translated, coded, classified segment by segment, categories and themes were developed to answer the research questions.

Result -From the total study participants 24.3 %(115) were using long term methods while 75.7 %(358) were using short term methods. Educational status, preferred number of children, initial source of family planning information, duration of family planning use, family planning intention was found to have significant association with family planning method used. Qualitative findings show that religious and cultural beliefs mostly affect family planning method used and the value given to children.

Conclusion and recommendations- This study addressed that the majority of mothers in the study area are using short term methods. Religious and cultural beliefs influence the FP method mix in the area. The study also showed that CBRHAs play a major role in expansion of family planning. To expand and improve family planning service, CBRHA program should be expanded to other parts of the country. Family planning service outlets should include all methods of family planning especially permanent family planning methods in their routine service. Studies are recommended to provide in depth information on family planning method mix.

1.0 Introduction

1.1 Back ground

Family planning refers to the use of various methods of fertility control that will help individual men and women or couples to have the number of children they want when they want them in order to assure the well being of the children and the parents. Family planning means simply preventing unwanted pregnancies by safe methods of prevention, which is considered to be part of the basic human rights of all individuals or couples (1).

All the information and education that people need to make the right decision for family planning should be made available to them. They should know that there is a right age for pregnancy before and after which it is not safe. They should also know that they can choose a wide variety of safe methods of preventing pregnancy (1).

Families and individuals currently use either modern or traditional methods to space or permanently stop having children. Contraceptive method mix differs from program to program and region to region based on the availability of the methods, affordability of the services and other barriers such as socio-cultural factors (2).

In health and health related indicators of 1998 the contraceptive method mix was composed of 47.6% Depo-Provera, 31.1% pills, 19.4% condom, 1.1% IUD, 0.77% Norplant and other methods comprise of 0.4%, which shows that the method mix is dominated by short term family planning methods. The method mix of Oromiya region is also similar to that of the national 50.2 % Depo-Provera, 26.3% pills, 18.6% condom, 2.8 % IUD, 2 % Norplant and other methods comprise of 0.2 % (4).

According to the 2005 EDHS the CPR was only 15 % among current users for all contraceptive methods. Although there is significant improvement in the CPR in the past five years from 8% to 15%, the unmet need is still very high, indicating that more and more needy people are being added to the pool from time to time. Unmet need for family planning of the Oromiya region is 41.4% and the met need for contraceptive in the region is 13.6 %. Thus, the region has relatively high unmet need for family planning than other regions in Ethiopia (3).

The study was conducted in woredas with Oromiya Development Association Reproductive Health /Family planning (ODA RH/FP) project. The project was started to work in the zone in April 2006 to make family planning service accessible to rural people through CBRHA program. During this time the project was operating in four woredas of east Hararge namely Gursum, Fedis, Kersa and Jarso. A total of 779,682 populations are covered in the project in the four woredas. In March, 2008 four new woredas were added as project site namely Meta, Gorogutu, Deder and M/ Bello which is expected to serve a total of 794,164. There are a total of 357 CBRHAs and 15 health professionals trained in the long term family planning method administration.

1.2 Statement of the problem

In Ethiopia contraceptive sources are donor dependent, as a result service and supply sustainability is a challenge. Shifting to permanent and long term methods is a key strategy to ensure program sustainability. It increases the confidence of clients because they do not worry about pregnancy, the time of taking the methods and it relieves them from repeated visit to health facility by walking long distance. But the situation is controversial in Ethiopia the contraceptive method mix is dominated by short term methods like pills and injectables (5).

The contraceptive method mix of east Hararge zone is highly dominated by short term methods and also in woredas where Oromiya Development Association Reproductive Health Family Planning Project (ODA RH/FP) is operating the contraceptive method mix is highly dominated by pills and injectables followed by implant.

The rural East Hararge is highly dominated by Islamic religion. Although there is no previously done study in the area, some studies have shown that some Muslims are opposing the use of family planning, especially that of permanent methods.

So studies should be done in these areas where Islamic religion is predominant, so as to know the determinants of method mix. Previously done studies on family planning do not answer the question what factors are influencing the contraceptive method mix.

2.0 Literature review

2.1 Benefits of family planning

Contraceptive use reduces maternal mortality and improves women's health by preventing unwanted pregnancy, high-risk pregnancies and unsafe abortions. Some contraceptives also improve women's health by reducing the risk of disease transmission, protecting against certain cancers and health problems (7).

Contraceptive use also improves women's status and quality of life. Access to contraceptives allows women to decide the number and spacing of their children. Women with smaller and healthier families are likely to have increased opportunities for participation in educational, economic, and social activities. Family planning helps reduce the economic and emotional burden of parenthood. Families with fewer children can devote more resources to provide their children with adequate food, clothing, housing, and educational opportunities (7).

The other benefit of family planning is that it largely contributes to peace the limited resource of the world that are necessary for survival are diminishing as the world population is increasing, that makes individuals and nations to fight for scarce resources such as food and land that may result in war. But the expansion of family planning stabilizes population growth and the rate at which the natural resources are depleting (1).

2.2 Knowledge of contraception

During trend analysis of EDHS except female sterilization, knowledge of modern methods of family planning has increased from 2000 to 2005. The pill has remained the most heard method among women, while knowledge of injectables and condom has increased substantially and that of all traditional methods have declined among both women and men during the five year period. However Ethiopian women are less knowledgeable of methods of family planning than women in most other sub-Saharan Africa (8).

The 2005 EDHS report showed that modern methods are more widely known than traditional methods. Eighty seven percent of currently married women know of a modern method, and only 17% know of a traditional method. The pill was the most widely known method 84%, followed by injectables 83% (3).

In a study conducted in Tehuledere woreda, South Wollo zone, on clients of long-term and permanent family planning methods, knowledge of modern family planning methods was over 90% except for foaming tablets which is 70%. The majority (73.9%) of the respondents got information on family planning from the Community Based Reproductive Health (CBRH) program. The study has shown that the Community Based Reproductive Health Agents (CBRHAs) are the basic source of information on family planning in the rural setup (6).

2.3 Ever use of contraception

The 2005 EDHS indicates that only 18% of all women and 24% of currently married women have used a method at some time. Among currently married women ever use of any method rises from 16% among those age 15-19 years , peaks at 27% among those age 25-29 years, and remains consistently high until age 40-44 years, before falling markedly to 14% among the oldest age group (3). Women are much more likely to have used a modern method than a traditional method. Twenty three percent of currently married women have used a modern method at some time compared with 2% who have used a traditional method. Injectables and rhythm methods have been the most commonly used methods among currently married women (3).

2.4 Current use of contraceptive methods

The contraceptive prevalence rate for married Ethiopian women who are currently using a method of family planning is 15%. Almost all of these users are using modern methods. The most widely used method was injectable followed by pills (3).

There are marked differences in the contraceptive prevalence rate among currently married women by background characteristics. Contraceptive use is associated with the number of living children. It is highest among currently married women with one or two children 17% and lowest among women with no children 12% (3).

2.5 Method mix

Contraceptive method mix is the percentage distribution of contraceptive users by method. There is a significant variation in contraceptive method mix among regions and countries. Sterilization is less common in Africa than in Asia and Latin America. In

Africa mothers rely on pills or traditional methods. Sterilization is equally common in Asia and Latin America, but in Asia the prevalence of IUD is much higher and pill use is lower than in Latin America (2).

The 2003 Ghana DHS shows that the contraceptive prevalence rate among currently married women is 25%. Among currently married women, the pill is the most commonly used modern method, followed by injectables. Male and female condoms are used by 3 percent and 2 percent among currently married women respectively, while implants and IUD are used by 1 percent each. The contraceptive method mix in Ghana is dominated by short term contraceptive methods (9).

The 2003 Egypt DHS shows that 60 percent of currently married women are using contraception currently, with 57 percent depending on modern methods and 3 percent on traditional methods. The IUD, pill, and injectables are the most widely used methods: 37 percent of married women are using the IUD, 9 percent currently rely on the pill, and 8 percent on injectables. Relatively small proportions of married women are using other modern methods, like condom, implant and prolonged breast feeding. The shift towards IUD rose continuously, from 4% in 1980 to 37% in 2003. In contrast, the rate of pill use declined from 17% in 1980 to 9% in the late 1990s, where it has remained stable. Use of the injectable has risen continuously following its introduction into the family planning program in the 1990s, increasing from less than 1% in 1992 to 8% in 2003 (10).

The mix of contraceptive methods will continue to evolve in response to changes in several factors; one of these factors is improved access. In many developing countries

potential users have a very limited choice of methods. The main reason for this is that program managers often emphasize on one or two methods largely to reduce costs (17).

The other factor is characteristics of users. Knowledge of contraception has increased enormously in recent decades. In most countries women and men are fairly well informed about different methods and their costs, side effects, benefits, and sources of supply. Another important trend with implications for the selection of methods is a continuation of the decline in desired family size. In pre transitional societies women often want large families and, as a consequence, demand for contraception is low and focused on methods for spacing births rather than limiting them. This situation has characterized much of sub-Saharan Africa until recently. However, as countries develop, desired family size declines and the demand for limiting family size rises sharply. Permanent methods are often used by women who want no more children. This, in turn, will lead to a high future demand for long-acting methods. In the past these women have often relied on sterilization, but the irreversible nature of this method is an important drawback (17).

The other factor is the technology of contraception, among the available methods, users select methods that are least costly, most convenient, most effective, and that have the fewest side effects. This explains why traditional methods were largely abandoned in the 1960s and 1970s when modern methods became widely available. The availability of new and improved technology is likely to lead to further changes in method use in future decades (17).

2.6 Contraceptive method shift

In a study done on improving the range of contraceptive choice in rural Ethiopia, there was very high demand for long-term and permanent contraceptive methods given the availability of methods and adequate awareness creation in the community. In addition to health service providers the contribution of CBRHAs was significant. The majority of the respondents shifted to long term and permanent methods from temporary family planning methods such as pills and injectables. From those who shifted to long term and permanent methods 52% have undergone voluntary surgical contraception followed by Norplant 39% and IUD 8.7%. The major reasons mentioned for the use of the current family planning methods were limiting family size 45.9%, spacing 27.5%, and side effects of the previous method 12.4% (6).

2.7 Unmet need for family planning

Unmet need for family planning can lead to high maternal and infant mortality rates. Abortion related deaths and disabilities are indications of unintended pregnancies and women's limited access to comprehensive reproductive health care and information that might have prevented those abortions. In addition, closely spaced pregnancies and births, early childbearing, and childbearing at the end of the reproductive years all contribute to increased maternal and infant mortality rates (11).

Unmet need is relatively higher in Ethiopia than in most sub-Saharan African countries. The proportion of currently married women with unmet need for family planning ranges from the lowest 4% in Lesotho to the highest of 38% in Rwanda (8).

The 2005 EDHS showed that Ethiopia has high unmet need for family planning which was 33.8%. While 20.1% of mothers have unmet need for spacing 13.7% have unmet need for limiting. Oromiya has the highest unmet need for family planning 41.4% compared to other regions in the country (3).

Further analysis of the 2000 EDHS indicates that there are variations in the level of unmet need among currently married women with different background characteristics. There is a strong variation when distinction is made between unmet need for spacing and unmet need for limiting. Unmet need for spacing is higher among younger women, while unmet need for limiting is higher among older women. Total unmet need is higher in rural areas than in urban areas because of wider use of family planning in urban areas. The use of family planning increases sharply with the increase in the level of education and unmet need for limiting increases sharply with the number of children (18).

2.8 Family planning method choice

In a study conducted on quality of family planning services in Northwest Ethiopia, 74.1% of the family planning clients said that they chose the methods they are using with the assistance of the provider, while in 22.4% of the cases the provider by himself/herself selected the method. For new and switching clients, the most commonly discussed contraceptive was injectable 78% followed by the pill 60%. The issue of condom was discussed with 12.1% of the clients. Progestin only pill and Norplant were discussed with only 10.3% of the clients each. No discussions were made on female sterilization (12).

The most commonly used family planning method was found to be the injectables (74.4%) followed by combined pills (20%). The type of family planning method received

is influenced by knowledge about family planning methods and the availability and acceptability of the method by those who use the services. In the study, injectables appear to be the most preferred family planning method because of its longer term effect (12).

2.9 Availability and accessibility of contraceptives

The 2002 national family planning program effort index for Ethiopia showed that the overall score for the availability and accessibility of contraceptive methods increased over the years and rated 31% in 2002. The highest rating was given to the availability and accessibility of condoms rated at 73% followed by pills and injectables at 59% each. Although the ratings for the other methods were low, there has been gradual improvement over the years. The availability and accessibility of male sterilization was rated at 10%, female sterilization at 9%, IUD at 13% and abortion related services at 11% (13).

In a study conducted on contraceptive method choice in developing countries using data from national surveys, except for condom, the use of each method of contraceptive was highest where the availability of that method was high. In countries with greatest use of the pills (36–44%), the level of availability was 76–80%. Likewise, the highest prevalence of female sterilization (35–41%) was found in countries where 71–80% of the population has access to the method. The freedom to choose from a range of contraceptive methods, according to one's needs and preferences, rests partly on the sheer availability of those methods. While it is certainly true that family opposition, fear, cost and uncongenial supply sources also affect choice, the research showed that the

availability of methods and the prevalence of their use are intimately related. In general, the prevalence of use of each method follows its availability (16).

2.10 Determinants of family planning use

There is a marked change in contraceptive behavior in developing world. The revolution in contraceptive behavior has been driven by a desire to reduce family size due to social and economic changes that increased the cost of children by reducing their benefits and other factors that increase access to family planning information and service (2).

Family planning and birth spacing is an area on which mothers have a little control over. Women approve the concept of family panning but are constrained in their utilization of modern contraceptive methods by physical access factors combined with male opposition to the modes and principles of birth control. Some women are forced to use natural contraceptive methods such as lactational amenorrhea (20).

2.11 Sources of family planning

The 2005 EDHS showed that 80% of mothers get family planning service from the public sector, 17% get from private medical sector and 3% get from other sources. The most common source of contraceptives in the public sector was the government health centre. From the private medical sector 1.4% of mothers get family planning service from Community Based Distribution (CBD) or Community Based Reproductive Health Agents (CBRHAs). The public sector is the leading source of injectables and the pill, distributed mainly through government health centers. More than half of condom users get their supply from other sources, predominantly shops (3).

2.12 Millennium Development Goals, ICPD and family planning

Reducing maternal mortality ratio by three quarters, between 1990 and 2015, is a target to improve maternal health, the fifth MDG. Unmet need for family planning and contraceptive prevalence rate are part of the indicators for the goal.

Efforts to reduce maternal mortality need to be tailored to local conditions, since the causes of death vary. In Asia, anemia is a major contributor to maternal death, but is a less important cause in Africa and a negligible factor in Latin America. In Africa, particularly parts of Southern Africa, HIV/AIDS is frequently involved in deaths during pregnancy and childbirth (14).

Preventing unplanned pregnancies alone could avert around one quarter of maternal deaths, including those that result from unsafe abortion. Still, an estimated 137 million women have an unmet need for family planning. An additional 64 million women are using traditional methods of contraception with high failure rates. Globally contraceptive prevalence increased slowly from 55% in 1990 to 64% in 2005, but remains very low in sub-Saharan Africa at 21% (14).

Family planning, as part of comprehensive approach, the ICPD Program of Action signaled the world's renewed commitment to launch high quality, voluntary family planning programs with the aim of making them available to all who want them as early as possible (15).

2.13 Family planning methods and Islamic religion

On the issue of family planning methods in Islamic religion, some religious leaders argue that sterilization does permanent harm to a person therefore, it is unacceptable to Islam but others agree that since sterilization is reversible, it is permitted. In keeping with predominate Islamic attitudes toward birth control the legal status of contraception in Muslim countries is overwhelmingly permissive. The exception to this rule is sterilization, which is illegal in some countries and remains the subject of ongoing debate within Muslim communities. Iran, Turkey and Tunisia are among those countries that allow both tuballigation and vasectomy, while Jordan and Egypt do not allow either (17).

The Koran does not explicitly address abortion, but there is general agreement in Islam that abortion is only permitted for the most serious reasons, such as saving a woman's life. And even then, it is only allowed before "life is breathed" into the fetus, variously regarded as within the first 40, 80 or 120 days. A minority of religious scholar oppose abortion at any stage of development based on the belief that the embryo is already on its way to have a soul from the moment of conception (17).

3.0 Objectives

3.1 General objective

To assess the contraceptive method mix and its determinants in woredas with Oromia Development Association /Reproductive Health /Family Planning project in East Hararge Zone, Oromiya region.

3.2 Specific objectives

- To assess contraceptive method mix from the perspective of users' socio-demographic characteristics, knowledge, experience and need in the study area.
- To assess whether mothers are using the method available or their preferences.
- To assess factors determining the method mix of family planning in the area.

4.0 Methods and materials

4.1 The study area and period

The study was conducted in East Hararge zone of Oromiya region from September 2007 to July 2008. East Hararge is one of the zones in Oromiya Regional State. Its capital town is Harar which is located at 530 Kilometers to the east of Addis Ababa. The total population of the zone is 2,804,317. There are 2 hospitals, 24 health centers, 60 clinics and 152 health posts in the zone. Contraceptive prevalence rate of the zone is 14.3%.

The study was conducted in the selected two woredas of the zone namely Gursum and Kersa woredas.

4.2 Study design

Cross sectional survey on rural, married, contraceptive users in woredas with ODA RH/FP project in East Hararge zone was employed to assess the status of contraceptive method mix and its determinants.

4.3 Source population

The source population of the study was all married, reproductive age, contraceptive users who live in the zone.

4.3.1 Study population

The study population was all women who were married, reproductive age, contraceptive users and who live in selected rural kebeles. The study participants were selected by systematic sampling from list of their names which was listed by each method. This method was chosen to ensure that all individuals in the rural kebele could have equal probability of being included in the sample.

4.4 Sample size Determination

- The sample size was determined using single population proportion.
- Based on literature review 15% of married women currently use any form of contraception in Ethiopia (contraceptive prevalence rate), i.e. $P = 0.15$.
- Confidence level of 95% was used.
- Degree of precision (Margin of error) was 3.3%.

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

$$n = \frac{1.96^2 * 0.15 * 0.85}{0.033^2}$$

$$= 450$$

- Considering non response rate of 5% and
- The total sample size was = $(450 + (5\% * (450)))$.

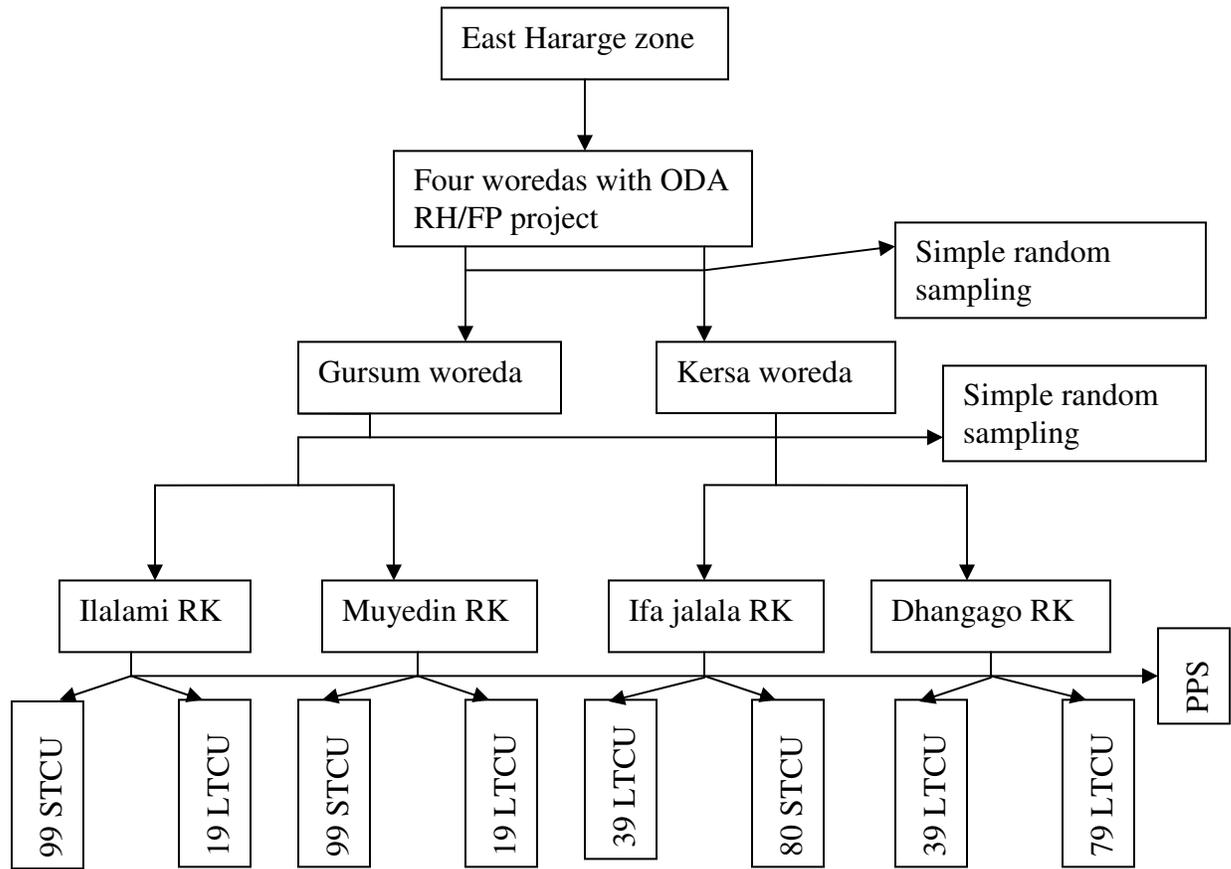
$$N = 450 + 23$$

$$N = 473 \text{ mothers.}$$

4.5 Sampling Procedure

- From the four woredas with ODA RH/FP project in the zone, two woredas were selected by simple random sampling.
- From each woreda two rural kebeles were selected by simple random sampling.
- From each rural kebele contraceptive users were listed separately by contraceptive method used with the help of CBRHAs. The study participants were selected by systematic sampling from each method users by probability proportional to size.

Figure1. Schematic representation of the sampling frame used.



Key

LTCU-long term contraceptive users

RK- rural kebele

STCU-short term contraceptive users

4.5.1 Inclusion criteria

- A married woman of reproductive age group and contraceptive user who lives in rural kebele was targeted for the study.

4.5.2 Exclusion criteria

- Mothers above the age of 49 years.
- Mothers who have discontinued contraceptive use.

4.6 Data collection for quantitative survey

4.6.1 Data collection instrument

The survey questionnaire was first prepared in English language and then translated to Afan Oromo (Annex 3). The questioner includes socio demographic questions and questions related to knowledge and practice on family planning (Annex 2).

Interview: the study participants were interviewed face- to- face using structured and pre tested questionnaires.

4.6.2 Interviewers

The interviewers were female elementary school teachers in the selected rural kebeles who know and speak the local language. They were trained on objective of the study, method of data collection and discussed thoroughly on the tools prepared for data collection.

4.6.3 Supervisors

The supervisors were woreda ODA RH/FP project coordinators. They were trained by the researcher. During the training days explanation was given on the purpose of the study

and discussed on the tool designed for data collection, how to implement, potential problems that can arise & how to solve them.

4.6.4 Data collection procedure

By going to the house of the selected mother with the help of CBRHAs, the data collectors asked the selected study participants for informed consent and explanation was given on the purpose of the study and the importance of their involvement. Respondents who volunteered were then interviewed.

4.7 Variables and definitions

4.7.1 Dependent variables

The dependent variable for the study was the contraceptive method mix.

4.7.2 Independent variables

Age, educational status, current occupation, religion, ethnicity, number of living children, desired number of children, reason for using family planning, knowledge on family planning, husbands knowledge of family planning use and source of family planning were the independent variables for the study.

4.7.3 Operational definitions

Contraceptive method mix: percentage distribution of contraceptive users by method.

Long term family planning methods: family planning methods which are used for longer time, includes implant and IUD.

Short term family planning methods: family planning methods which are used for shorter time, includes Depo-Provera, pills, condom, and traditional methods.

4.8 Data Quality Control

The following key strategies were used for data quality control:

- All data collection tools were translated to local language and back translated to English by people who have proficiency in translation to ensure its consistency.
- Training of data collectors and supervisors was made to enable them acquire basic skills necessary for data collection and supervision, respectively.
- Pre-testing of data collection tool was made in a Haromaya woreda in East Hararge zone and based on the results of pre-testing necessary adjustment to the data collection tools was made.
- Spot check was done on the field.
- Filled questionnaires were checked daily.

4.9 Data processing and Analysis Methods

Collected quantitative data was edited, coded and entered to Epi info version 3.3 computer packages. It was then transported to SPSS version 13.0 for analysis. Frequencies and percentages of the responses were calculated. Associations between variables were assessed by using chi-squares, Odds Ratio, 95% Confidence Intervals and p-values. Multiple logistic-regression was used to adjust for possible confounding variables.

4.10 Qualitative survey

4.10.1 Study Population

For the focus group discussion study participants were Islamic religious leaders who were influential and respected people in Gursum and Kersa woreda. For the key informant interview zonal ODA RH/FP project officer was interviewed. Participant was selected purposefully based on his prior knowledge and experience on family planning information in the zone.

4.10.2. Sample size

The two focus group discussions were held with religious leaders in Gursum and Kersa woreda. The number of participants in each focus group discussion was six. Key informant interview was made with the zonal ODA RH/FP project officer.

4.10.3. Sampling procedure

During the fieldwork, the investigator contacted Woreda ODA RH/FP project coordinators. The contacted persons selected the religious leaders from different mosques in the woreda. Individual proposed for the key informant interview was selected by judgment sampling.

4.10.4. Data collection instrument

For both focus group discussion and the key informant interview guiding topics were used (Annexes 4, 6). Both the interview and the focus group discussions were moderated by the principal investigator. One facilitator and one note taker who was trained participated in the qualitative data collection. Tape recorders were used to record the interviews and discussions.

4.10.5. Data collection procedure

For the key informant interview part selected individual was contacted personally and was told the purpose of the study. He was asked for informed consent and interviewed.

Religious leaders who participated in the focus group discussion were organized by the woreda ODA/RH/FP project coordinators. The participants were told about the purpose of the study and asked for informed consent. The FGD guide was translated to Afan Oromo (Annex 5) and then the discussion was held with Afan Oromo.

4.10.6. Data processing and analysis methods

Participants' conversations were audio taped, transcribed verbatim and translated. Then the data were systematically coded segment by segment based on the research questions. Categories were formed and then based on the emerged relationships between the categories themes were developed and used to answer the research questions in conjunction with the data from the quantitative survey.

4.11. Ethical Considerations

Ethical clearance was obtained from the ethical clearance committee of the School of Public Health (SPH), FM of AAU. Ethical clearance was also obtained from the administration of the zone, from Zonal health and ODARH/FP project offices and woreda health offices.

To collect data from participants, explanation was given on the purpose of the study, the importance of their participation and true response. It was also explained that the study had no connection with individual affairs of respondents. For the quantitative data collection structured questionnaire was used (Annex 2). Confidentiality of all data collected was kept. All sample populations were encouraged to participate in the study while at the same time they were told their right not to participate.

5.0 Results

5.1 Socio-demographic characteristics of the study participants

A total of 473 married contraceptive users were interviewed. The response rate was 100%. Table 1 shows the socio-demographic characteristics of the study participants. The mean, minimum and maximum age of participants was 29.5, 16 and 44 years, respectively. The educational background of the participants showed that 425 (89.9%) were illiterate while 48 (10.1%) were literate (includes those who can read and write, who are at elementary, high school and above levels). Ethnically, almost all of the study participants 466 (98.5%) were Oromos, 3 (0.6%) were Amharas and 4 (0.8%) were Somalis. Of the total participants the majority, 467 (98.8 %) were Muslims while 6 (1.2 %) were Christians. By occupation 383 (81%) were house wives, 66 (14%) were merchants and 24 (5%) had other occupations.

Table1. Socio-demographic characteristics of study participants, Gursum and Kersa Woredas, East Hararge zone, Oromiya region, May, 2008. (N=473)

Variables	Number	Percentage
Age	86	18.2%
15-24	278	58.8%
24-34	109	23.0%
35+	473	100%
Total		
Educational status		
Illiterate	425	89.9%
Literate	48	10.1%
Total	473	100%
Ethnicity		
Oromo	466	98.6 %
Amhara	3	0.6%
Somali	4	0.8%
Total	473	100%
Religion		
Muslim	467	98.8%
Christians	6	1.2%
Total	473	100%
Occupation		
House wife	383	81%
Merchant	66	14%
Others	24	5%
Total	473	100%

5.2 Reproductive history of the study participants

From the total study participants 44 (9.3%) of them do not remember their age at first marriage, for the rest 429 (90.7%) the mean, minimum and maximum age at marriage was 16.6, 13 and 25 years respectively. Fifty six (11.8%) of the participants do not remember their age at first pregnancy and 3 (0.6%) of them have never been pregnant, for the rest 414 (87.6%) the mean, minimum and maximum age at first pregnancy was 17.8, 14 and 30 years respectively. From the total respondents 57 (12.1%) of them do not remember their age at first child birth and 3 (0.6%) of the respondents have never gave birth, for the rest 413 (87.3%) the mean, minimum and maximum age at first child birth of the participants was 18, 15 and 30 years, respectively.

5.3 Fertility preferences

On the preferred number of children 216 (45.7%) of the respondents said that they want to have “what God gives them”. For the rest 257 (54.3%) who gave numeric responses the mean, minimum and maximum preferred number of children was 6.9, 2, and 14 children respectively. The mean, minimum and maximum number of living children of the participants was 4.4, 0 and 14 children, respectively.

5.4 Family planning information

5.4.1 Method Mix of the study area

Out of the total study participants 178 (37.6%) were using injectables, 178 (37.6%) were using pills, 110 (23.3%) were using implant, 5 (1.1%) were using IUD, 2 (0.4%) were using condom. In general, 115 (24.3%) were using long term methods and 358 (75.7%) were using short term contraceptive methods.

Table 2. Contraceptive method mix of the study area, Gursum and Kersa Woredas, East Hararge zone, Oromiya region, May, 2008. (N=473)

Methods used	Number	Percentage
Injectables	178	37.6%
Pills	178	37.6%
Condom	2	0.4%
Implant	110	23.3%
IUD	5	1.1%
Total	473	100%

Table 3. The association between socio-demographic characteristics, reproductive history of the participants and the type of FP method used, Gursum and Kersa Woredas, East Hararge zone, Oromiya region, May, 2008. (N=473)

Variable	Types of FP method used		Crude OR	Adjusted OR
	Long term users	Short term users		
Age				
15-24	13(15.1%)	73 (84.9%)	2.88(1.4-5.9)*	1.65(0.66-4.14)
25-34	65(23.4%)	213(76.6%)	1.68(1.03-2.7)*	1.68(0.99-2.87)
35+	37(33.9%)	72(66.1%)	1.00	
Educational status				
Illiterate	112(26.4%)	313(73.6%)	0.18(0.057-0.6)*	0.18(0.053-0.64)*
Literate	3(6.3%)	45(93.8%)	1.00	
Current Occupation				
House wife	86(22.5 %)	297(77.5%)	1.4(0.57-3.5)	1.47(0.55-3.98)
Merchant	22(33.3%)	44(66.7%)	0.8(0.29-2.28)	0.56(0.18-1.7)
Others	7(29.2%)	17(70.8%)	1.00	
Preferred number of children				
1-3	3(16.7%)	15(83.3%)	2.4(0.7-8.7)	1.6(0.43-6.1)
4-6	17(15.7%)	91(84.3%)	2.6(1.4-4.7)*	2.1(1.12-3.97)*
7+	24(18.3%)	107(81.7%)	2.18(1.29-3.7)*	2.27(1.32-3.9)*
As God gave me	71(32.9%)	145(67.1%)	1.00	
Number of living children				
0-2	12(12.1%)	87(87.9%)	2.9(1.4-5.9)*	1.95(0.74-5.2)
3-5	67(27.0%)	181(73.0%)	1.08(0.6-1.7)	1.01(0.59-1.7)
6+	36(28.6%)	90(71.4%)	1.00	

In crude analysis, age group of mothers was found to be associated with the family planning method used. Those who were in the age group fifteen to twenty four and twenty five to thirty four were more likely to use short term methods compared to mothers who were in the age group thirty five and above [COR(95%CI) 2.88(1.4-5.9) and 1.68(1.03-2.7)] as shown in table 3. But the association was insignificant after adjusting for possible confounders (socio-demographic variables).

Educational status of mothers was also found to be significantly associated with family planning method used ($\chi^2 = 8.4$, $p < 0.004$). Mothers who were illiterate were less likely to use short term methods than long term methods compared to mothers who were literate [AOR (95%CI) 0.18(0.053-0.64)] as shown in table 3.

Preferred number of children was found to be significantly associated with FP method used ($\chi^2 = 1.6$, $p < 0.001$). Mothers who want to have more than seven children were more likely to use short term methods than long term methods compared to mothers who want to have what God gives them. Mothers who want to have four to six children were more likely to use short term methods than long term methods compared to mothers who want to have what God gives them [AOR (95%CI) 2.1(1.12-3.97) and 2.27(1.32-3.9)] as shown in table 3.

In crude analysis, mothers who have zero to two children were more likely to use short term than long term methods compared to mothers who have more than six children.

5.4.2 Knowledge of modern family planning methods

From the seven types of modern family planning methods asked, the most known method was injectable 463 (97.9 %) followed by pills 454 (96%), implant 433 (91.5%), condom 159 (33.6%) , IUD 84 (17.8%), tuballigation 58 (12.3%) and vasectomy 25 (5.3%). The mean, minimum and maximum number of family planning methods known was calculated by adding the number of methods known for each participant and finally by calculating the mean, minimum and maximum method known for all the participants. The mean, minimum and maximum knowledge of modern family planning was 3.5, 1 and 7 respectively. Respondents whose knowledge of modern family planning methods was below the mean were considered as having inadequate knowledge and those whose knowledge was above the mean knowledge were considered as having adequate knowledge. Accordingly, 275 (58.1%) had inadequate knowledge while 198 (41.9%) had adequate knowledge. As can be viewed from table 4, knowledge of modern family planning method was found to have no association with method used.

5.4.3 Knowledge of traditional family planning methods

The most known traditional family planning method was LAM 368 (77.8%) followed by sexual abstinence 182 (38.5%), periodic abstinence 100 (21.1%) and withdrawal 26 (5.5%). For the four traditional methods asked the mean, minimum and maximum knowledge of traditional methods of the study participants is 1.4, 0, and 4.

5.4.4 Knowledge of sources of family planning methods

Study participants were asked which sources of family planning they know and the mean, minimum and maximum number of sources known was calculated by adding the number of sources known for each respondents and then by calculating the mean, minimum and maximum source known. According to the respondents, the most known source of family planning was government health institution 393 (83.1%) followed by CBRHAs 359 (75.9%), private health facility 90 (19%), pharmacy 23 (4.9%), rural drug vendor 9 (1.9%), NGO health facility 6 (1.3%), shop 3 (0.6%), relatives and friends 2 (0.4%). The mean, minimum and maximum knowledge of sources of family planning was 1.87, 1 and 8 respectively. Respondents whose knowledge was below the mean were considered as having inadequate knowledge and those whose knowledge was above the mean were considered as having adequate knowledge. Accordingly, 146 (30.9%) of the respondents had inadequate knowledge and 327 (69.1%) had adequate knowledge. The mean knowledge among short term users was 1.7 while that of the long term users was 1.66. In view of table 4, one can conclude that knowledge of source of family planning was found to have no association with method used.

5.4.5 Initial source of family planning information

Study participants were asked from whom they heard about family planning for the first time. The main initial sources of family planning information, according to the respondents, were CBRHAs 295 (62.4%) followed by neighbors 77 (16.3%), health professionals 69 (14.6%) and 32 (9.6%) other sources.

In crude analysis, mothers whose initial source of FP information were CBRHAs, health professionals and their neighbors were less likely to use short term methods than long term methods compared to mothers whose initial sources of FP information were others like their mothers. In adjusted analysis, mothers whose initial source of family planning information were health professionals were less likely to use short term methods than long term methods compared to mothers whose initial source of FP information were others [AOR(95%CI) 0.09(0.01-0.74)] as shown in table 4.

5.4.6 Ever use of family planning methods

The study participants were asked which methods of traditional and modern family planning methods they have ever used. In this respect, 239 (50.5%) have ever used pills, 225 (47.6%) have ever used injectable, 123 (26%) have ever used implant, 5 (1.1%) have ever used IUD and 3 (0.6%) condom. From the traditional methods 15 (3.2%) have ever used LAM, 1 (0.2%) have ever used sexual abstinence. Nobody has ever used tubal ligation, vasectomy or other traditional methods.

5.4.7 Duration of family planning use

From the total study participants 78 (16.5 %) used family planning for duration of less than one year, 293 (61.9%) used family planning for one to three years and 102 (21.6%) used family planning for duration of more than three years.

Duration of FP use was found to be significantly associated with method used; mothers who used family planning for duration of less than one year were more likely to use short term methods than long term methods compared to those who used FP for duration of more than one year [AOR(95%CI) 5.39(1.89-15.4)] as shown in table 4.

5.4.8 Family planning method shift

Only 127 (26.8%) of the respondents have shifted from one family planning method to another and the reasons for method shift were 38 (29.9%) due to side effect, 31 (24.4%) need for long term method, 23 (18.1%) inconveniency of previous method, 15 (11.8%) for convenience of the new method, 7 (5.5%) lack of access to previous method, 3 (2.3%) advised by provider, 1 (0.78%) influenced by partner, 9 (7%) mentioned other reasons.

From those who have ever shifted, 5 (3.9%) of them were forced by the provider to shift to another method due to absence of their first method of choice, 1 (20%) of the respondent was forced to shift to injectable while 4 (80%) of the respondents were forced to shift to pills.

5.4.9 Family planning method discontinuation

Of the total study participants 80 (16.9%) of them have discontinued the method they were using. The reasons for discontinuation were, 22 (27.5%) due to side effect, 8 (10%) due to lack of access to method, 32 (40%) needed to get pregnant, 8 (10%) lost to follow up and 10 (12.5%) mentioned other reasons.

Ever discontinuation of family planning method was found to be significantly associated with method used ($\chi^2 = 5.2$, $p < 0.02$). Mothers who were using short term methods are more likely to have discontinued family planning methods compared to those who were using long term methods as shown in table 4 [AOR(95%CI) 2.05(1.001-4.2)].

Table 4. The association between FP method used and knowledge and experience variables related to Family planning, Gursum and Kersa woredas, East Hararge zone, Oromiya region, May, 2008. (N=473)

Variables	Type of FP method used		Crude OR	Adjusted OR
	Long term Users	Short term Users		
Knowledge of modern FP methods				
Inadequate knowledge	71(25.8%)	204(74.2%)	0.82(0.5-1.26)	
Adequate knowledge	44(22.2%)	154(77.8%)	1.00	
Knowledge of sources of FP methods				
Inadequate knowledge	39(26.7%)	107(73.3 %)	0.83(0.53-1.3)	
Adequate knowledge	76(23.2%)	251(76.8%)	1.00	
Initial source of FP information				
My neighbors	16(20.8%)	61(79.2%)	0.12(0.02-0.97) *	0.14(0.02-1.12)
H. professionals	18(26.1%)	51(73.9%)	0.09(0.01-0.72) *	0.09(0.01-0.74)*
CBRHAs	80(27.1%)	215(72.9%)	0.87(0.01-0.65) *	0.13(0.02-1.04)
Other sources like mothers	1(3.1%)	31(96.9%)	1.00	
Duration of FP use				
Less than 1 year	4(5.1%)	74(94.9%)	3.7(1.19-11.5)*	5.39(1.89-15.4)*
More than 1 year	111(28.1%)	284(71.9%)	1.00	
Ever discontinued FP method				
Yes	11(13.8%)	69(86.3%)	2.25(1.15-4.43)*	2.05(1.001-4.2)*
No	104(26.5%)	289(73.5%)	1.00	
FP method shift				
Yes	33(26.0%)	94(74.0%)	0.89(0.55-1.4)	0.74(0.44-1.26)
No	82(23.7%)	264(76.3%)	1.00	

* Only variables which have p value less than 0.25 were targeted for adjusted analysis.

5.3.10 Use of first method of choice

Of the total participants, only 35 (7.4%) were not using their first method of choice. The reasons for not using their first method of choice for 9 (25.7%) was due to absence of their first method of choice, 7 (20%) was due to husband disapproval of the method, 1 (2.9%) was due to provider disapproval of the method and 18 (51%) mentioned other reasons like traveling long distance to get the method. Nobody mentioned cost of contraception as a reason for not using their first method of choice.

From the 9 participants who were not using the first method of their choice due to the absence of the method 2 of them mentioned that the method of their choice was implant while 7 of them mentioned that the method of their choice was injectable. Use of first method of choice had no association with family planning method used as shown in table 5.

5.3.11 Family planning method of choice

Regarding family planning method choice 329 (69.6%) of the respondents chose the method they were using by themselves, for 86 (18.2%) the provider chose the method, for 40 (8.5%) their husband chose, for 14 (3%) their neighbor chose and for 4 (0.8%) others chose the method they were using.

Those who chose the methods by themselves were asked reasons for their preference. Among them 65 (19.8%) said that they are familiar with the method, 105 (31.9%) said the method is convenient to use, 85 (25.8%) said the method is used for longer time, 38 (11.5%) said that they have easy access to the method , 25 (7.6%) said that their friends

are using the method, 5 (1.5%) said that the method is delivered at home, 5 (1.5%) said that they do not have another option and 1 (0.3%) of the respondents mentioned other reason.

Mothers for whom the provider chose family planning method were less likely to use short term methods than long term methods compared to mothers who chose family planning method by themselves [AOR (95%CI) 0.22(0.13-0.38)] and in crude analysis mothers for whom others like their mothers and husbands chose them a method are more likely to use short term methods than long term methods compared to mothers who chose a method by themselves [COR (95%CI) 2.6(1.003-6.8)] as shown in table 5.

Only 12 (2.5%) of the study participants were forced by the provider to choose a method. Among these, 8 (66.8%) of the respondents were forced to choose implant, 2 (16.6%) were forced to choose pills, and 2 (16.6%) were forced to choose injectable and IUD each.

5.3.12 Family planning intention

Of the total study participants 383 (81%) of the participants are using family planning for spacing while 84 (17.8%) are using for limiting. Family planning intention and family planning method used was found to be significantly associated ($\chi^2 = 13.5$, $p < 0.00$). Mothers who want to space their children were more likely to use short term method than long term methods compared to those who want to limit their family size [AOR(95%CI) 1.8(1.01-3.29)] as shown in table 5.

5.3.13 Satisfaction with FP methods available in the source

All study participants were asked whether they are satisfied with the modern family planning methods available in their source or not and 452 (95.6%) were satisfied with the modern methods available. Those who are not satisfied were asked for reason of dissatisfaction and 3 (14.3%) said that the methods available are not their first method of choice, 2 (9.5%) said the methods available are less effective, 1 (4.8%) said the methods prevent pregnancy for shorter time, 4 (19%) said that the methods have severe side effects and 11 (52.4%) said other reasons like inconveniency of the method.

Table 5. The association between FP method used and other family planning variables, Gursum and Kersa woredas, East Hararge zone, Oromiya region, 2008. (N=473)

Variables	Long term users	Short term Users	Crude OR	Adjusted OR
Using your first method of choice				
Yes	106(24.2%)	332(75.8%)	1.08(0.49-2.38)	
No	9(25.7%)	26(74.3%)	1.00	
FP intention				
For spacing	81(20.8%)	305(78.8%)	2.58(1.56-4.26)*	1.8(1.01-3.29)*
For limiting	34(40.5%)	50(59.5%)	1.00	
Who chose the method of FP				
My self	65(19.8%)	264(80.2%)	1.00	
The provider	45(52.3%)	41(47.7%)	0.22(0.14-0.37)*	0.22(0.13-0.38)*
Others	5(8.6%)	53(91.4%)	2.6(1.003-6.8) *	2.6(0.99-6.9)

5.3.14 Current source of family planning methods

The sources of family planning methods for 167 (35.3%) of the respondents were CBRHAs, for 258 (54.5 %) was government health facility, for 46 (9.7%) was private health facility and for 2 (0.4%) was pharmacy.

5.3.15 Referral due to lack of method of choice

Of the total study participants 260 (55%) of them were referred to other place due to lack of their method of choice and 257 (98.8%) of them have gone to place of referral while 3 (1.2%) have not gone to place of referral. The reasons are 1 (33.3%) due to husband prohibition and 2 (66.7%) gave other reasons. The majority of them 194 (75.5%) were sent to health center, 57 (22.2%) were sent to private health facility, 5 (1.9%) to health post and 4 (1.5%) to hospital.

5.3.16 Cost of family planning service

From all study participants 374 (79.1%) paid money for family planning service. They were asked to comment on the money paid and 290 (77.5%) said it is low cost, 41 (11%) said that the payment is enough, 38 (10.2%) said it is costly, and 5 (1.3%) said it is very costly.

5.3.17 Family planning methods as cultural and religious taboos

All the study participants were asked to mention family planning methods which are considered as religious and cultural taboos. Accordingly 280 (59.2%), 229 (48.4%), 60 (12.7%), 128 (27.1%), 42 (8.9%), 152 (32.1%), 147 (31.1%) of the study participants mentioned that condom, implant, injectable, IUD, pills, tubal ligation and vasectomy are religious taboo respectively while 82 (17.3%), 21 (4.4%), 15 (3.2%), 20 (4.2%), 5

(1.1%), 23 (4.9%) and 23 (4.9%) mentioned condom, implant, injectable, IUD, pills, tuballigation and vasectomy as a cultural taboo respectively.

5.3.18 Husbands' knowledge of family planning use

From the total study participants 56 (11.8%) said that their husband do not know that they are using family planning while 417 (88.2%) said that their husband knows that they are using family planning. From the 417 respondents whose husband knows that they are using family planning, for 350 (83.9%) the husband gives them support to use family planning, for 27 (6.5%) their husband reminds them the time for taking contraceptives, for 12 (2.9%) their husband helped them to start family planning use, for 1 (0.2%) her husband chose her the method she is using and 27 (6.5%) mentioned others.

The rest 56 (11.8%) respondents were asked for the reasons why they are not telling their husband that they are using family planning. In this regard 31 (55.4%) said that their husband needs more children, 13 (23.2%) said that their husband do not bother about their use of family planning, 8 (14.3%) said that their husband prohibits them from using family planning, 1 (1.8%) said that her husband quarrels with her if he hears that she is using family planning, and 13 (23.2%) said others.

5.4 Result from FGD and key informant interview

5.4.1 Result from key informant interview

The following results are obtained from key informant interview conducted with the zonal ODA RH/FP project coordinator.

Family planning demand

Currently, the demand for family planning is indeed very high in East Hararge zone. Previously, they were opposing family planning by relating it with religion. In the two woredas of the project namely Jarso and Gursum there was a strong religious opposition especially on implant. Some part of the community members used to argue that a mother with implant cannot participate in religious rituals and should not be buried in Muslim burial areas. Then the problem was resolved by discussing with religious leaders in the area who were members of the kebele advisory committee. The society started to realize family planning when they are told about the drawbacks of population growth and large family size.

The demand for family planning is increasing especially in woredas where ODA RH/FP project is working. The project addressed 9 woredas in the zone. The communities welcome the project and told to the ODA RH/FP officers that they are suffering from large family size as it resulted in land insufficiency. For instance, there was a conflict between a son and his father, where they injured each other with “mencha” (a local name referring to sword) because of land scarcity. So they are very pleased of getting family planning services than any other aids.

The demand for condom was very low at the beginning, but now it is rising due to increased awareness

Family planning supply and the role of CBRHAs

The project mostly works using CBRHAs. After having training the CBRHAs give house to house health education on family planning, MCH, child health and fistula. The CBRHAs then help the mothers to choose family planning method of their choice. Then they distribute pills and condom at house to house level for those who need them. But they refer mothers to hospital, health center, clinic or health post for other methods like Depo-Provera, implant and IUD using referral form. They also refer pregnant mothers for ANC to health facilities.

Method mix and factors affecting contraceptive method mix

At the beginning of the project most of the clients were using pills; but after a year and half they started to shift to Depo-Provera. Recently, the contribution of implant and Depo-Provera to the method mix is high. However, condom and IUD users are very few in number. At the beginning of the project, there were only Depo-Provera, pills and condom but not IUD and implant. The project started to provide IUD and implant 6 months later after administration of the above methods which may have effect on the method mix.

One of the factors which influence contraceptive method mix in the study area is religious rumors. For instance, the community opposed condom promotion saying that it opposes their religion and promotes promiscuity. But the project convinced the

community that they can use condom as an alternative choice of family planning method not to promote promiscuity as they perceive.

Mothers who have much awareness about family planning prefer long term methods such as implant. However, those who mistrust the method say that implant prevents pregnancy for five years and even after removal it may stay in the body for two years so that it lasts a total of seven years. Though the project helps people to use family planning method of their choice, the focus is to make people shift to long term methods.

Family planning Campaigns

There were campaigns done on family planning by the project. During the campaigns mothers had different family planning options to choose from. The problem with campaign is that it losses effectiveness. There was a case in which implant was given to pregnant mothers. So, routine services are better than campaigns for the quality of the services.

Male involvement in family planning

At the beginning, CBRHAs were teaching only women and give them contraceptive. Therefore, male involvement was minimal. According to the zonal ODA RH/FP project coordinator, in this area a man mainly marries a woman to get children; if the wife is not giving birth, he marries another wife. So the woman changes her name to be registered for family planning because her husband may check her name and know that she is using contraception. And if the husband knows that she is using contraceptive, he divorces her. For instance, there was a man in Gursum Woreda who divorced his wife because of the reason that she was using family planning.

Later on to alleviate the problem, CBRHAs started to target male in family planning service provision and education and the presence of male CBRHAs also alleviated the problem to some extent.

Training of health professionals on long term method

In the zone the project has given training to 15 health professionals on long term methods. In addition, training was given to nurses and HEWs as supervisors of family planning on RH management. But yet high turn over of trained staff is a key problem in the area.

Benefits of ODA RH/FP project to the community

Previously the community has no exposure to family planning information and service. Having large family size and unwanted pregnancy was the major reproductive health problem in the area; mothers were giving birth every year with out spacing. Nevertheless, they started to use family planning after the arrival of the project. Before the project arrives, the community perceives that God raises their children. After the arrival of the project, there was a discussion held between the project officers and the community. In the discussion the community came to realize that children need clothing, food, and schooling. But the mere fact is that they themselves do not have adequate food to eat. Then the project alleviated the major problems of the community in this regards. Currently, other woredas in the zone are also asking for the expansion of the project to their woredas.

Provider preference from CBRHAs and HEWs

On family planning provision most mothers prefer CBRHAs to HEWs because CBRHAs live with them in their village, they start the utilization of family planning service from

themselves that makes them a role model to the community, go to their neighbors and then to their kebele in order to provide family planning services. So the CBRHAs are much more trusted and have a wide acceptance in the community. On the other hand, the community less likely prefers HEWs because they are young and some of them come from other areas.

Traditional family planning methods

Despite the knowledge of both traditional family planning methods, CBRHAs are teaching only about modern. While training was given to CBRHAs, they were told that traditional methods are contingent and have higher failure rates. So they are stressing on modern methods than traditional methods.

In conclusion family planning demand is high in the zone regardless of the opposition of some group of the community. CBRHAs are playing a major role in the success of the project by distributing family planning information and service and by giving referral service with small incentives. There are also regular contraceptive campaigns held in the zone. There are about fifteen health professionals trained on long term methods. The community is highly benefited from the project.

5.4.2 Result from focus group discussion

Back ground characteristics of discussants

Two focus group discussions were held with Islamic religious leaders in Gursum and Kersa woredas to collect qualitative information on determinants of family planning method mix because the study area is highly dominated with Islamic religion. The discussion was held using discussion guides and relevant information was collected. All the participants were married, male, Islamic religious leaders working in different mosques in the woredas. A total of twelve religious leaders were participated, their mean age was 43 years and the average number of children they have was 4.6 children. Discussants have freely and actively expressed their ideas about family planning and family planning methods in relation to religion.

Value of children in Islamic religion

Almost all the participants mentioned a quote from Koran which says “*children are gift of God, the decoration of life*” to express the value they have for children. They mentioned that, in their society having large number of children is perceived as a proud and it is also advantageous for the country if they are educated and productive. The other belief is that if Muslims have large number of children then the followers of Allah will be large in number and Allah will be proud of them.

Family planning in Islamic religion

Some FGD participant said that, God assigns the number of children to have for every body; so unless the assigned number of children is fulfilled, nobody can stop child birth.

Some others added a quote from Koran which says “*when a fetus is at four months of age in the womb, Allah sends his angel to the fetus and assigns the future of the fetus, what he*

eats, how he lives, when he dies, etc". So he will feed the baby and it is not a worry to have large number of children unless the mother gave birth with out spacing since it will be difficult for the mother to raise the children and it may also harm the mother. Some of the participants mentioned what Allah said "*marry a woman who loves you and who is fertile, so that I feed you and your children*".

Some others yet argued that the number assigned can be stopped using the technology of contraception and by praying to God to make the number of children fewer than what is assigned. Further more they said that Allah will not overburden his followers so a person will not be asked for not having more children. One participant said that "*Although the Koran encourages people to have large number of children, from our experience, these days those who have large number of children have many problems. They can't feed, dress and teach them*".

Majority of the participants agreed that if a person has large number of children and he can't feed and dress them while they are living with him, his soul will be in problem and he will have punishment for that.

On the spacing of children they mentioned what the Koran recommends; after a birth a child must breast feed for two years and then the mother can get pregnant after the two years of breast feeding. So that there will be a total of three years spacing between children. But mothers are getting pregnant before that.

At last, the participants agreed that it is good to have large number of children if the person can feed and dress them well. But if the person is unable to feed, dress and teach his children, it is better to limit the family size to his ability.

Responsibility in family planning

On the issue of responsibility in family planning, most of the respondents said that both wife and husband are responsible for their family, though the husband is more responsible, because if the children have no food to eat, the husband will be asked for that in front of God. So he has to use family planning by discussing with his wife and convincing her. In the rule of marriage the Koran says “*husband and wife should discuss upon what ever they are going to do*”. After having discussion, preventing pregnancy before conception is acceptable in front of God. Finally they concluded that both wife and husband are responsible for family planning.

Benefits of ODA RH/FP project to the community

On the benefit of ODARH/FP project all the discussants appreciated the project saying the government has brought a very nice program. Previously, people were having large number of children with many difficulties such as food insufficiency. However, after the introduction of the project they started to have control over their fertility.

One of the discussant said “*I am a witness for the advantage of family planning. My daughter in law was giving birth every year without spacing while she was with many problems. But after the time she started to use family planning she began to space her*

children". All FGD participants agreed that they are much benefited from ODA RH/FP project and they recommended for further expansion of the project to other woredas too.

Contraceptive methods and Islamic religion

On the family planning methods all the respondents agreed that, Condom is strictly forbidden in "Sharia" by underlying that it promotes prostitution which is Sin in front of Allah. Further more, condom is not recommendable for husband and wife for it reduces sexual satisfaction. It is also "haram" (meaning sin) to use withdrawal as a family planning method. In general, using condom and withdrawal may harm the woman because the woman doesn't get the fluid she is expected to get from her husband during sexual intercourse which results in dryness and may cause disease to the woman.

On permanent family planning methods some of the participants agreed that, if a mother has the risk of dying due to pregnancy, it is possible to use permanent family planning methods to save the life of the mother. Nevertheless, if the woman has no problem, Allah does not allow her. In general, preventing pregnancy permanently is not allowed in "sheriya" (Islamic law) for both men and women.

All the participants agreed that, abortion is not allowed in Islamic religion. It is considered as murder. Abortion is allowed only in one case. If the pregnancy is earlier and fatal to the mother, the life of the mother can be saved by terminating the pregnancy because Allah has allowed "ruhe" for saving life. "Ruhe" means some thing that is not allowed by Allah.

One of the discussant opposed the use of long term methods saying that *“Pills and injectables are allowed, but I heard that there are family planning methods which prevent pregnancy for five and ten years these methods space pregnancy beyond 3 years which Allah has not allowed”*.

All the participants agreed that religious rituals are not prohibited for a mother with family planning method. If a woman stood in front of Allah with contraceptive, it is not harmful. One of the participants said that *“participating in religious rituals means nothing for a mother with contraception because our women are having an artificial ear ring which is the same as using contraception that are also artificial.”*

Generally, children are highly valued in Islamic religion and having large number of children has societal and religious acceptance. The Koran encourages to have large family size and to space children for three years. Majority of the participants agreed that a person should limit his family size according to his ability and family planning is the responsibility of both wife and husband. From family planning methods condom, withdrawal and permanent family planning methods are strictly forbidden in Islamic religion. It may be allowed in order to save life if the life of the mother is at risk of death. The religious leaders also appreciated the benefit ODA FP/RH project is giving to the community.

6.0 Discussion

The socio-demographic characteristics of the study participants were similar to that of the zone; where majority of the mothers were Muslim, Oromo and illiterate. From socio-demographic variables age was found to be associated with the method used. Mothers who were in the earlier age were more likely to use short term methods as compared to mothers who were at and above thirty five years of age. Occupation of mothers had no association with family planning method used.

The mean age at marriage of the participants was 16.6 years. The mean age at pregnancy and child birth was 17.8 and 18 years respectively.

Regarding fertility preference of the study participants, 45.7% gave nonnumeric response “*what God gives me*”, which is much higher than that of 2005 EDHS in which only 10% of women gave nonnumeric responses (3), which may be due to the belief that Allah has control over every thing and they don’t have control over their own fertility. This idea has been supported by FGD where one of the discussants said that “*God assigns the number of children to have for every body, so unless the assigned number of children is fulfilled, nobody can stop child birth*”.

For the rest 54.3% of the study participants who gave numeric responses, the mean preferred number of children was 6.9 which is higher than that of 2005 EDHS whose preferred number was 5.1 children for currently married women (3).

FGD participants mentioned a quote from Koran which says “*Children are gift of God, the decoration of life*” to express the value they have for children. Having large number of children is highly valuable in the society as well as in the religion. The other belief is

that if Muslims are having large number of children then the followers of Allah will be large in number and Allah will be proud of them. But the reality is that mothers in the study area are using family planning due to the overwhelming economic problem. Mothers who want to have more than four children are more likely to use short term methods as compared to those who want to have what God gives them and it was significant.

The mean number of living children for the study participants was 4.4; which is higher than that of 2005 EDHS 3.57 children (3). This can be explained by presence of high fertility in the rural setup, lack of access to contraceptive methods prior to the beginning of ODA RH/FP project. Number of living children had no association with family planning method used.

In this study the family planning method mix of the study area is dominated by short term methods, pills and injectable which is similar with the report on health and health related indicators. But what is different from the national figure is that the contribution of implant to the method mix is very high (23.3%) in the study area as compared to the 1998 health and health related indicators (2%) (4). This can be explained by the availability and accessibility of implant in ODA RH/FP project areas. In contrary to that of health and health indicators condom has very low contribution to method mix (0.4%) and that of health and health related indicators was 19.4%. This may be due to the cultural and religious misconception that condom promotes prostitution and decreases sexual satisfaction.

There is a change in trend of family planning method mix of the study area. Currently mothers are shifting to family planning methods which are used for longer time. During key informant interview, the Zonal ODA RH/FP project coordinator said that *“there is a trend that as the project gets matured the clients start to shift to family planning methods which are used for longer period of time, at the beginning of the project the method mix was highly dominated by pills but currently it is shifting to injectable and implant”*.

Time at which a family planning method is started to be given may affect the family planning method mix; the key informant informed that, pills, injectable and condom were started to be provided at the beginning of the project and long term methods like implant and IUD were provided later.

The availability and accessibility of family planning is one of the factors which influence family planning method mix. For instance, in 2002 national family planning program effort index condom, pills and injectable are methods which have high rate of availability and accessibility (13) that made the methods to be used widely.

Large proportions of women in the developing world complete their desired family size by age 30 and face a fifteen years period during which they need protection from unwanted births and abortions. Sterilization has also a prominent importance in the family planning method mix due to its near zero failure rate and long term continuation. The absence of male and female sterilization in the contraceptive offerings is a serious limitation in family planning program in Ethiopia. But it will be easier for this country to move toward replacement fertility if they are offered widely (23). But in the study area

permanent family planning methods are non existent and there is strong religious opposition on the use of the method.

Permanent family planning methods are less available and accessible than any other family planning methods. The availability and accessibility score of female sterilization was 10 % and that of male sterilization was 9 %, which is less than the score of IUD and abortion related services (13).

So making family planning methods available and accessible is critical for family planning quality improvement and to give a wide range of contraceptive choices.

In contrary to this study, in a study done in Tehuldere woreda where the majority of the respondents were also Muslims, 52% of the respondents had voluntary surgical contraception (6) which revealed that if there is a strong awareness creation and services are made available, it is possible to expand permanent family planning methods even within the Muslim society.

Concerning the knowledge of family planning methods the knowledge was high (above 90%) for pills, injectable and implant. In similar study done in Bure woreda the knowledge of pills and injectable was very high but that of the implant was lower than that of this study (19), the higher knowledge of implant in the study area might be explained by the wide availability, accessibility and repetitive campaigns prepared on the method.

The knowledge of condom was higher in similar studies done in Bure and Tehuledere (19, 6) woredas of Amhara region as compared to this study area, which is very low (33.6%). It might be due to the reason that CBRHAs are not giving attention to the promotion of condom because it is highly considered as cultural and religious taboo in the Muslim societies in the area. The zonal ODA RH/FP project officer said that *“at the beginning of the project there was a strong opposition from the community for promoting condom as a family planning choice”*.

The mean knowledge of contraception was almost similar to that of 2005 EDHS and the study done in Bure woreda. The mean knowledge of traditional FP method was 1.4 and that of the modern method was 3.5, modern family planning methods were well known than traditional methods. The key informant said that *“CBRHAs have learnt about traditional family planning methods but they are not promoting them because they are less effective”*.

Concerning the knowledge of sources of family planning methods government health institution and CBRHAs were the most known sources because they are the main current sources of family planning methods (greater than 89%), implying that the contribution of the private institution was very low (less than 11%) unlike that of 2005 EDHS where (17%) got family planning service from private sector (3). Knowledge of family planning methods and sources of family planning methods were found to have no association with family planning method used.

Like the study done in Tehuldere woreda (6), in this study more than half of the study participants (62.4%) got family planning information for the first time from CBRHAs. But only (2.1%) got from HEWs. In crude analysis mother whose initial source of information were CBRHAs, health professionals and their neighbors were less likely to use short term methods compared to those whose initial source of information were others such as mothers and husbands. After adjustment mothers whose initial source of family planning information were health professionals were less likely to use short term methods.

Pills and injectables were highly ever used compared to other methods which may be due to the earlier introduction of the methods. And that of the pills may be due to the easily availability of the method on the hand of CBRHAs. Compared to 2005 EDHS, implant was highly ever used which may be due to the factors which were identified during key informant interview that the method is available, accessible and highly promoted by the project.

Condom was ever used only by 0.6% (3) of the study participants similar to that of 2005 EDHS which was 0.7% among married women, because condom use is common among sexually active unmarried women who are not part of the study and also 59.2% and 17.3% of the study participants considered condom as religious and cultural taboo, respectively.

On the duration of family planning use more than half of the study participants used family planning for the duration of one to three years, which might be due to the timing

of administration of CBRHA program to the study area which is about two years. So, most mothers started to use family planning after the arrival of the project to the area.

Twenty six point eight percent (127) mothers have ever shifted from one contraceptive method to another. The main reason for shifting was side effect and family planning method shift found to have no association with method used.

Of the total study participants 16.9% (80) of them had discontinued family planning use in the past and the main reason for discontinuation was the need to get pregnant followed by side effect. The DHS analytical report on determinants of contraceptive discontinuation showed that method characteristics influence discontinuation rate by directly influencing the risk of discontinuation among those who choose a particular method (24). Mothers who are using short term methods are more likely to discontinue family planning methods compared to mothers who are using long term methods which may be due to the nature of the methods.

On the use of first method of choice only 7.4% (35) of the study participants were not using their first method of choice. The main reason for not using their first method of choice was due to absence of first method of choice. Use of first method of choice was not significantly associated with family planning method used.

Mothers for whom the provider chose family planning method were less likely to use short term methods than long term methods compared to mothers who chose family planning method by themselves [AOR (95%CI) 0.22(0.13-0.38)], which may be due to

provider bias that the providers prefer to give long term methods than short term methods.

Of the total study participants 69.6% chose the method they are using by them selves and the main reason for choosing the methods was convenience of the method to use followed by protection of the method for longer time. In adjusted analysis those mothers for whom the provider chose the method they were using were less likely to use short term methods, which may be due to the focus of the providers on long term methods than short term methods.

The majority, 82.2% of study participants were using family planning for spacing. The association between family planning methods used and family planning intention was found to be significant and mothers who need to space their children were more likely to use short term methods than long term methods.

Of the study participants, 95.6% (452) said that they are satisfied with the modern family planning methods available in their source and 92.6% (438) of the study participants said that they are using their first method of choice. In similar study done in Bure worda, only 79.5% of the study participants were using their first method of choice (19). This difference can be explained by different factors identified during key informant interview; presence of repetitive campaigns with availability of wide range of methods, well established referral system between CBRHAs and government health facilities, presence of trained health professionals on long term methods at health center level and the affordability of the contraceptive methods can indicate that mothers have access to FP

method they want to use. Those who were using short term family planning methods were more likely to be satisfied with the methods available in their source than those who were using long term methods.

Strengthening referral system is one of the key action areas to achieve the goals in family planning service in national reproductive health strategy (21). The referral system between CBRHAs and government health facilities was strong in the project areas. Mothers are referred for clinical family planning methods to health facilities.

Seventy seven point five percent of the study participants said that the money they are paying for contraception was of low cost. The project is giving family planning service at a reasonable fee which is an incentive for CBRHAs, increases the value given to contraception within the community and it is also important for program sustainability.

More than half of study participants and about half of the study participants considered condom and implant as religious taboo, respectively. During FGD with Islamic religious leaders all discussants agreed that condom use is strictly forbidden in “Shariya” (Islamic law) underlying that it promotes prostitution, decreases sexual satisfaction and it harms the woman because she misses the fluid she is getting from her husband. The religious leaders said that implant, pills, injectable, and IUD are not forbidden in their religion. But permanent family planning methods, withdrawal and condom are completely forbidden. An exception for permanent methods is that if the health of the mother will be at risk due to pregnancy it is allowed to use permanent methods. In a study done on the cultural context of condom use among the Maasai in Tanzania, the study found that there is a belief that good sex, in addition to procreation involves the giving of sperm from men to

women which benefits the woman. And sperm is essential to the social and physiological development of young girls (22).

On male involvement, like in 2005 EDHS majority of the study participant said that their husband knows that they are using family planning and gives them support to use. Only about 11.8% of mothers said that their husband don't know that they are using family planning and the main reason for not telling their husband was that their husband wants to have more children. During FGD discussants said that *“the husband has to think of family planning because if the children are starved the husband will be asked for that in front of God. In the rule of marriage the Koran says husband and wife should discuss up on every thing they are going to do. So both wife and husband are responsible for family planning and they should discuss on it”*.

During key informant interview the project coordinator said that *“at the beginning of the project CBRHAs were focusing on women for education and service provision, so male involvement was very low. There was a man in Gursum woreda who divorced his wife after he heard that she is using family planning. Currently the condition is improving by targeting male in education and service provision and there are male CBRHAs in the project which increases male involvement in family planning”*.

This study showed that CBRHAs play a major role in family planning programs; they are the initial source of information for about 62.4% of the study participants addressing mothers in the rural set up where there is no access to information. They are also the sources of family planning methods for 35.3% of the study participants making

contraceptives available and accessible to mothers. The key informant said that “*CBRHAs play a major role in teaching the community about RH issues. They have wide acceptance with in the community because CBRHAs by them selves are the beneficiaries of family planning that they can be used as a role model. Since they are part of the community, the community trusts them than any other service provider. Mothers prefer CBRHAs than HEWs for family planning service because the HEWs are young, in some of the cases they are not from the community. The other benefit of he CBRHAs is that they do not need monthly salary because they are volunteers. The only benefit they are getting from the project is that they get transportation allowance monthly when they bring reports and they get few incentives from the fee for contraception*”. Similar study done in Tehuldere woreda has approved the importance of CBRHAs in family planning programs (6). CBRHAs may be more effective than HEWs in providing family planning service in the rural set up because HEWs have so many areas to address other than family planning wbut CBRHAs focus only on FP

7.0 Strength and Limitation of the study

7.1 Strength of the study

- The study tried to address areas which were not covered in previous studies.
- The study tried to generate as rich information as possible by employing triangulation of quantitative and qualitative methods of data collection.

7.2 Limitation of the study

- The study includes only married women.
- The study includes only woredas with ODARH/FP project due to resource constraint.
- Traditional family planning users were not included in the study.
- Individual selected for key informant interview is ODA RH/FP project officer which may introduce selection bias.

8.0 Conclusion and recommendations

8.1 Conclusion

In woredas with ODA RH/FP project, even though the contraceptive method mix is dominated with short term methods pills and injectable, implant also highly contributes to the method mix (23.3%). The contribution of IUD and condom is very minute and permanent family planning methods are nonexistent.

Majority of mothers in the study area are using their first family planning method of choice.

Preferred number of children, initial source of family planning information, duration of family planning use, family planning intention, provider bias and informed choice are among the factors which influence family planning method mix.

Religious and cultural misconceptions, method availability, accessibility and acceptability are also among the factors which influence method mix in the area.

CBRH program is very important for the expansion of family planning programs and to meet the high unmet need for family planning in countries like Ethiopia where the majority of the population is living in rural areas, where health service coverage is very low and resources are scarce.

8.2 Recommendations

Based on the finding from this study the following recommendations are forwarded.

- Permanent family planning methods are crucial in family planning programs in countries like Ethiopia; so permanent family planning methods should be promoted in family planning service provisions.
- Community Based Reproductive Health Agents (CBRHA) programs play a major role in expansion of family planning methods in the rural setup, so the program should be expanded to every woredas, zones and regions in the country in line with health extension program .
- Similar studies are recommended to generate more in-depth information on family planning method mix.

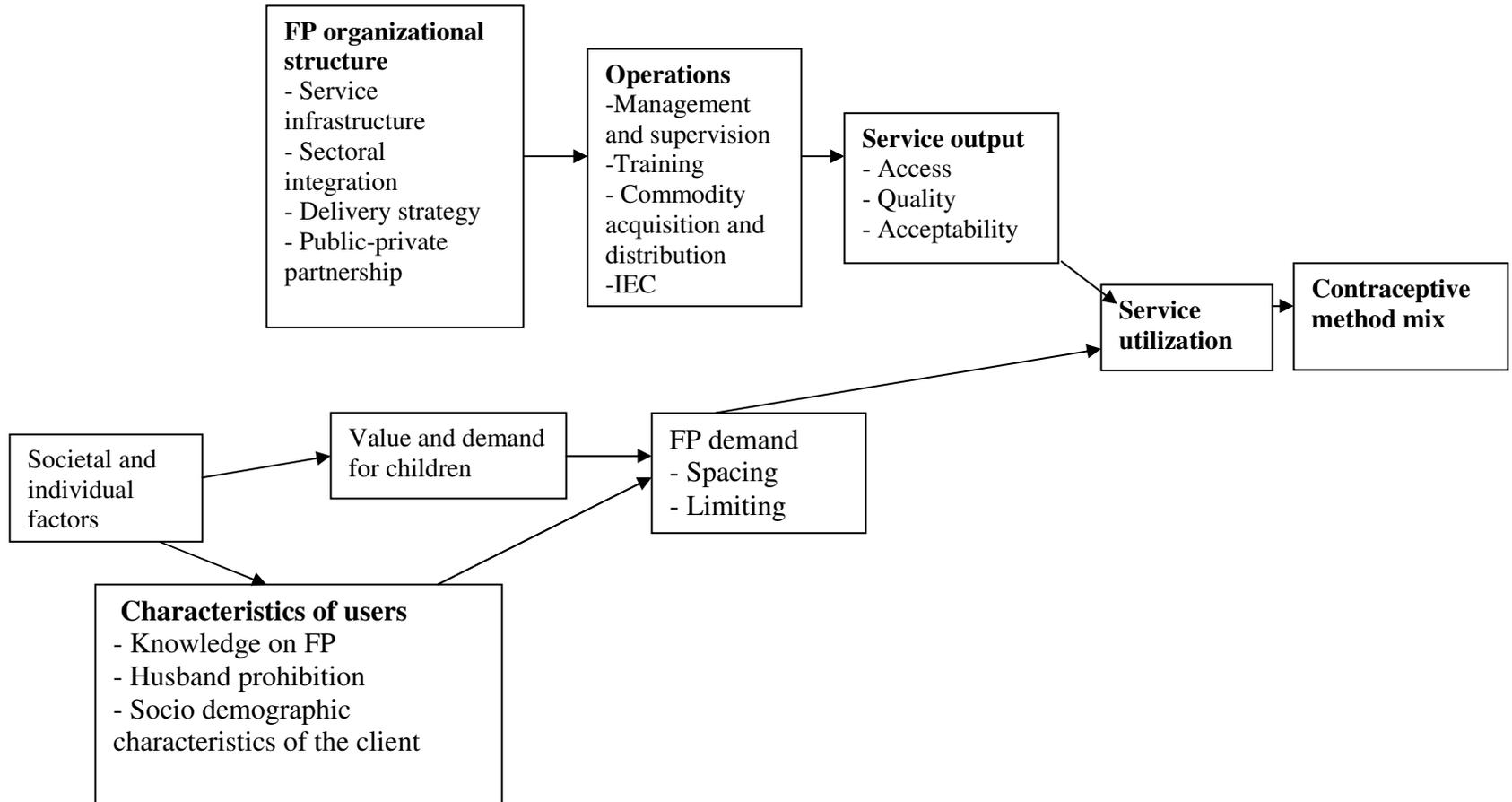
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Annex 1. Conceptual frame work



Annex 2

Addis Ababa University Medical Faculty School of Public health Questionnaire on contraceptive method mix

Dear Participant;

My name is _____: I am working with Rahel Dubiwak, a student of master of public health in Addis Ababa University. I am here to study the method mix for family planning in the Zone. The purpose of this study is to generate information necessary for strengthening family planning program and to make possible amendments for programmers and police makers. Therefore your participation and genuine response is important for the achievement the study objective.

Here; I have some questions to be responded by you. Some of the questions are personal that that needs privacy. Your answers are completely confidential. Your name will not be written on this form and will never be used in connection with any of the information you give. Your participation by answering the questions that I am going to provide you is strictly on voluntary basis. Your honest answers are important for my understanding of family planning method mix. The Interview will take about 20 to 30 minutes.

Do you wish to participate in this study?

Yes, I want to participant

No, I don't wan to participate

Respondent No. _____

Woreda _____

Peasant association _____

Interviewer No. _____

Interviewee No. _____

Date of interview _____

I. Demographic character sticks

Code	Questions	Possible responses	Skip to
101	Age	1. ----- years	
102	Current occupation	1.Farmer 2.House wife 3.Merchant 4.House maid 5.Daily laborer 6.Government employee 7.Private organization employee 8.Student 99.Others(specify) -----	
103	Ethnicity	1.Oromo 2.Amhara 3.Somale 99.Others(specify) -----	
104	Religion	1.Muslim 2.Protestant 3.Orthodox 99.Others(specify) -----	
105	Educational status of the mother	1.Illiterate 2.Read and write 3.1-8 4.9-12 5.12+	

II. Reproductive History

Code	Questions	Possible responses	Skip to ques.
201	What was your age at first marriage?	1. ----- years. 88.I don't remember	
202	Have you ever been pregnant?	1.Yes 2.No	If No skip to Q 208
203	If Q202 is yes, How old were you when you first get pregnant?	1.----- years 88.I don't remember	
204	Have you ever given birth to a child?	1.Yes 2.No	
205	How old were you when your first child was born?	1. ----- years 88.I don't remember	
206	What is the number of your children alive now?	1.Enter NO-----	
207	If you go back to the time when you don't have children and could choose exactly the number of children you want to have in your life, how many children could that be?	1. Enter NO----- 44. As God gave me	Skip to 301
208	How many children would you like to have in your life (for those who don't have children)?	1. Enter NO----- 2. Not yet decided 44.As God gave me	

III. Family planning information

Code	Questions	Possible responses	Skip to
301	What type/s of modern contraceptive methods do you know? (tick all mentioned)	1.Pills 2.Injectables 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 99. Others(specify) -----	
302	What types of traditional contraceptive	1.Withdrawal	

	methods do you know? (tick all mentioned)	2. Periodic abstinence 3. Sexual abstinence 4. LAM 99. Others(specify) -----	
303	From whom do you get information on family planning for the first time?	1.From my neighbors/friends/relatives 2.From health professionals 3.From CBRHAs 4.From health extension workers 5.From my husband 99. Others(specify) -----	
304	What sources of family planning do you know?	1.CBRHAs 2.Government health institution 3.Private hospital/clinic/doctor 4.Pharmacy 5.NGO Health facility 6.Drug vendor 7.Shop 8.Friends, relatives 99. Others(specify) -----	
305	Which methods have you ever used? (tick all mentioned)	1.Pills 2.Injectable 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 8.LAM 9.Withdrawal 10. Periodic abstinence 11. Sexual abstinence 99. Others(specify) -----	
306	Which method are you using now?	1.Pills 2.Inject able 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 8.LAM 9.Withdrawal 10.Periodic abstinence 11.Sexual abstinence 99. Others(specify) -----	
307	For how long have you used contraception?	1.Less than one year 2.1-3 years	

		3. More than 3 years 99. Others(specify) -----	
308	Does your husband know that you are using family planning?	1. Yes 2. No 33. I don't know	
309	If yes, what is the role of your husband in making you use family planning?	_____	
310	If no, why don't you tell him that you are using family planning?	_____	
311	From where do you get family planning service currently?	1. From CBRHAs 2. Government health institution 3. Private hospital/clinic 4. Pharmacy 5. NGO Health facility 6. Drug vendor 7. Shop 8. Friends, relatives 99. Others(specify) -----	
312	Are you satisfied with the modern contraceptive methods available in the source of your family planning service?	1. Yes 2. No	If yes, skip to 315
313	If 312 is No, what is the reason? the methods available-----	1. are not my first choice 2. are less effective 3. prevent pregnancy for shorter time 4. have severe side effects 99. Others(specify) -----	
314	In addition to methods available in your source of family planning, What more methods need to be available?	1. Pills 2. Inject able 3. Norplant 4. IUD 5. Female sterilization 6. Male sterilization 7. Condom 99. Others(specify) -----	
315	Are you using your first method of choice?	1. Yes 2. No	If yes, skip to 318
316	If 315 is No, what is the reason?	1. Absence of my first method of choice 2. Husband disapproval of the method 3. Provider disapproval of the method 4. Too much cost of the preferred	

		method of contraception 99. Others(specify) -----	
317	If the answer to Q.316 is due to the absence of first method of choice, what was your first method of choice?	1.Pills 2.Inject able 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 99. Others(specify) -----	
318	Have you ever shifted from one contraceptive method to another?	1.Yes 2.No	If no, skip to 322
319	If yes, Why did you shift from one method to another?	1.For inconveniency of previous method 2.For the convenience of the new method 3.Due to lack of access to the previous method 4.Due to side effect 5.Need for long term method 6. Provider advised me 7.Partner influenced me 99. Others(specify) -----	
320	If answer to 319 is No 3, Have you ever been told by the provider that your first method of choice is not available and forced to shift to another method?	1.Yes 2.No	If No, skip to 322
321	If 320 is yes, to which methods are you forced to shift?	1.Pills 2.Inject able 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 8.LAM 9.Withdrawal 10.Periodic abstinence 11.Sexual abstinence 99. Others(specify) -----	
322	Have you ever told by the provider that your method of choice is not available and you were sent to get it from other institution?	1.Yes 2.No	If No skip to 326
323	Where did the provider send you to get the contraceptive?	1.Hospital 2.Health centre	

		3.Health post 4.Private institution 5.CBRHAs 6.NGO Health facility 99. Others(specify) -----	
324	Have you gone to the place where you are sent?	1.Yes 2.No	If yes, skip to 326
325	If No, why don't you go to the place where you are sent to get contraception?	1.Lack of money for transportation 2.Long distance 3.Lack of time 4.Husband prohibition 5.Lack of money for the service 99. Others(specify) -----	
326	What do you comment on the money you are paying for contraception compared to the service you are getting?	1.it is low cost 2.it is enough 3. it is costly 4. it is very costly 5. 99. Others(specify) -----	
327	On which methods do your provider give you counseling as a choice of family planning methods?	1.Pills 2.Inject able 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 8.LAM 9.Withdrawal 10.Periodic abstinence 11.Sexual abstinence 99. Others(specify) -----	
328	Who chooses the method you are using for you?	1.By my self 2.The provider 3.My husband 4.My neighbors 99. Others(specify) -----	
329	Did your provider force you to choose a method?	1.Yes 2.No	If No skip to 331
330	If 329 is yes, which method do your provider forced you to choose?	1.Pills 2.Inject able 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom	

		8.LAM 9.Withdrawal 10.Periodic abstinence 11.Sexual abstinence 99. Others(specify) -----	
331	If you chose the method by yourself, why you prefer the method you are using?	1.I am familiar with the method 2.My friends are using it 3.I have access to the method 4.I don't have another option 5.Convenient to use 6.It is delivered at home 7.Came from family, friends or Neighbors 8. it is used for longer time 99. Others(specify) -----	

332	For what reason are you using family planning methods?	1.For spacing 2.For limiting 99. Others(specify) -----	
333	Have you ever discontinued contraceptive use in the last three years?	1.Yes 2.No	If No skip to 335
334	If you have discontinued, what is/are the reason for your discontinuation?	1. Due to side effect 2. Lack of access to the method 3. Lack of time 4. I need to get pregnant 5. Husband prohibition 6. Due to distance 7. Lost to follow up 8. Became pregnant while using 9. Health concerns 10.Wanted more effective method 11.Inconvenient to use 12. Cost too much 13. Need long term method 14.Marital dissolution 99. Others(specify) -----	
335	Are there family planning methods which are considered as religious taboo in your area?	1.Yes 2.No	If No skip to 337
336	If yes, What are/is the method/s which is considered as religious taboo?	1.Pills 2.Inject able 3.Norplant	

		4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 8.LAM 9.Withdrawal 10.Periodic abstinence 11.Sexual abstinence 99. Others(specify) -----	
337	Are there family planning methods which are considered as cultural taboo?	1.Yes 2.No	
338	If yes, what are/is the method/s which is considered as cultural taboo?	1.Pills 2.Inject able 3.Norplant 4.IUD 5.Female sterilization 6.Male sterilization 7.Condom 8.LAM 9.Withdrawal 10.Periodic abstinence 11.Sexual abstinence 99. Others(specify) -----	

Thank you for your participation!

Annex 3

Addis Ababaa Yuunivesiitiitti Faakultii Medikaala Mana Barumsaa Fayyaa Hawaasaa Gaaffilee Karroora maati irratti gaafataman

Kabajamoo hirmaatootaa;

Maqaan kiyya_____ jedhama. Kan ani hojedhu Raaheel Dubiiwaaq baratuu maastersii digrii Fayyaa Hawaasaa Yuunivesiitiitti Finfinnee wajjini. Ani amma kanan isin barbaadeefi waa'ee karroora maatii godina kanaa qo'achuufi. Faayidaan qo'annoo kanaas sagantaa karroora maatii foyyesuu fi odeefanno ga'a ta'e burqisiisuu fi, saganticharratti fooyyee adda addaa gochuufi saganteesistoonni itti fayadamu. Hirmaanaan keessan garaa gutuu bakka ga'uu qoranichaarratti gumaacha guddaa gumaacha.

Gaafileen armaan gadii kan isin deebistani dha. Gaafileen tokko tokko gafilee dhunfaati. Deebileen isin naaf kenitanii dhoksaa dhaan eegamu. Maqaan keesan waraqaa kana irratti hinbareefamu akkasumas odeefannoo issin keenitanii wajjin waliin qabamee hin illaalamu. Gaaffilee ani isinii dhiyeesu deebisuun fedhii keesani gutumaa irratti kan hundaa'e dha. Deebii isin sirriitti naaf deebistanii waa'ee karroora maatii baruf baay'ee nagargaara. Gaafiifi deebiin kun daqiiqaa 20 hanga 30tti fudhata.

Qoranicharratti hirmaachuu nibarbaadu ?

Eyyee, hirmaachuun barbaada.

Lakkii, hirmaachuu hinbarbaadu

Lak. deebistuu _____ Anaa/ Aradaa _____ Lak. Gaafataa _____ Guyyaa

I. Haala Deemoograafii

Koodii	Gaafilee	deebilee	Gara
101	Umurii	1. Amata -----	
102	Dalagaa amaa	1.Qotee bultuu 2.Haadha manaa 3.Kan daldaltu 4.Hojetuu mana namaa 5.Dafqaan bultuu 6.Hojetuu mootummaa 7. Hojetuu dhaabata miti motumaa 8.Baratuu. 99.Addi biraa yoo jiraate -----	
103	Sabumaa	1.Oromoo 2.Amaaraa 3.Somaalee 99.Addi biraa yoo jiraate -----	
104	Amantaa	1.Musliima 2.Prootestantii 3.Ortodoksii 99. Addi biraa yoo jiraate -----	
105	Sadarkaa barumsaa	1.Kan hinbaratiin 2.bareesuu fi dubisuu 3.1-8 4.9-12 6.12+	

II. Seenaa walhormaataa

201	Jalqaba yena heerumtee umuriin kee meeqaa ture?	1. Amata ----- 88.Hin yaadadhu	
202	Ulfa taatee/garaa qabaatee nibeektaa?	1.Eyyee 2.Lakki	Yoo 2 ta'e gara 208
203	Yoo lak.202 eyye ta'e yeroo jalqaba ulfa taatee umuriin kee meeqa ture?	1. Amata ----- 88.Hin yaadadhu	
204	Mucaa dhaltee nibeektaa?	1.Eyyee 2.Lakki	

205	Gaafa mucaan kee jalqabaa dhalate umuriin kee meeqa ture?	1. Amata ----- 88. Hin yaadadhu	
206	Amma daa'ima kee meeqatu lubuu dhaan jira?	1. Lak. barreessaa-----	
207	Uttuu bara ijoolummaa kee, bara ijoollee hinqabiinitti deebitee lakoofsa Ijoollee keeti qabaachuu barbaadu filatee meeqa filattaa?	1. Lak. bareessaa----- 44. Amma rabbi naaf kene	
208	Bara jireenyaa kee keessati ijoollee meeqa qabaachuu barbaada (warra ijoollee hinqabineef)?	1. Lak. barreessaa----- 2. Amma hinmurteesine 44. Amma rabi naaf kene	

III. Odeefannoo karoora maatii

301	Mala karoora maatii hammayyaa maalfaa beektaa? (kan himamee hunda filadhaa)	1. Kiniina liqimsamuu/ Pills 2. Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4. kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7. Kondomii 99. Adda biraa-----	
302	Mala karoora maatii aadaa maalfaa beektaa? (kan himamee hunda filadhaa)	1. Yeroo sanyiin dhiiraa dhangala'u walquunamtii saalaa addaan kutu 2. Yeroo ulfa ta'u danda'anitti walqunamtii saalaa dhiisuu 3. walumaagalatti wal qunamtii saalaa dhiisuu 4. Harma hoosisuu 99. Adda biraa-----	
303	Yeroo jalqabaaf odeefannoo karoora maatii eenyuraa argatee?	1. Olaa /hiriiraa/fira kiyya irraa 2. Ogeesa fayyaa irraa 3. CBRHA 4. Hojetoota eksteenshinii fayyaa irraa 5. Abaa waraa kiyya irraa 99. Adda biraa-----	
304	Madda karoora maatii maalfaa beektaa?	1. CBRHA 2. Dhaabata fayyaa mootuma 3. Hospiataala/klinikii dhunfaa 4. Faarmaasii 5. Dhaabata fayyaa MM/NGO 6. Mana qorichaa baadiyyaa 7. Dukaana 8. Firootanii/hiriyoota 99. Adda biraa-----	

305	Mala karoora maatii kamiin fayyadamtee bekta?	<ol style="list-style-type: none"> 1. Kiniina liqimsamuu/ Pills 2.Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4.kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7.Kondomii 8.Harma hoosisuu 9.Yeroo sanyiin dhiiraa dhangala'u walqunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11.Walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa----- 	
306	Amma mala karoora matii kamiin fayyadamaa jirtaa?	<ol style="list-style-type: none"> 1. Kiniina liqimsamuu/ Pills 2.Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4.kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7.Kondomii 8.Harma hoosisuu 9.Yeroo sanyiin dhiiraa dhangala'u walqunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11.walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa----- 	
307	Yeroo hammamiif karoora maatii fayyadamtee?	<ol style="list-style-type: none"> 1. Amata tokkoo gadiifi 2. Amata 1-3 3. Amata 3 oli 99. Adda biraa----- 	
308	Abaan waraa kee akka ati karoora maatii fayyadamtu nibeekaa?	<ol style="list-style-type: none"> 1. Eeyyee 2. Lakki 33. Ani hinbeekne 	
309	Eyyee yoo ta'e ga'een abaa manaa keetii karoora maatii kessatti maali?	_____	
310	Lakki, yoo ta'e maaliif akka karoora maatii fayyadamtu itti hin himne?	_____	
311	Mala karoora maatii amma eessaa argata/te?	<ol style="list-style-type: none"> 1.CBRHA irraa 2.Dhaabata fayyaa mootummaa 3.Hospitaala/Klinikii/ dhunfaa 4.Faarmaasii irraa 5.Dhaabata fayyaa miti mootummaa irraa 	

		6.Dawaa kan gurgurani irraa 7.Duukaana 8.Hiriyoota, firootan koo irraa 99. Addi biraa yoojiraate -----	
312	Mala karoora maatii hamayaa lafa ati fudhatu jirutti niigamadaa?	1. Eeyyee 2. Lakki	Yoo 1 ta'e gara 315
313	Yoo lak.307 lakkii ta'ee maalinni sababiin isaa?	1. Isaan filanookoo warra jalqabaa miti 2. Isaan badaa bu'a qabeesa miti 3. Yeroo gabaabaaf ulfa dhorku 4. Miidhaa hamaa qaba 99. Addi biraa yoojiraate -----	
314	Mala karoora maatii amma jiran malee dabalataan maaltu akka jiraatu feetaa?	1. Kiniina liqimsamuu/ Pills 2.Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4.kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7.Kondomii 99.Adda biraa-----	
315	Amma karoora maatii filanoo kee isa jalqabaa fayyadamaa jirtaa?	1.Eyyee 2.Lakki	Yoo 1 ta'e gara 318
316	Yoo gaaffiin 315 lakkii ta'ee maalini sababiin isaa?	1. Filanoon koo jalqabaa hinjiru 2. Abbaan warraa kiyya hinjaalattu 3. Warri nuuf kenan hinjaalattani 4. Gatiin isaa gudaadha 99. Addi biraa yoojiraate -----	
317	Yoo gaaffiin 316,sababii filanoo jalqabaa dhabuuraan yoo ta'ee filanoon karoora maatii kee jalqabaa maalinni?	1. Kiniina liqimsamuu/ Pills 2.Lilme/ Inject able 3.Kan irree keessa awaalamuu/ Norplant 4.kan hoffaa/gadameesa keessa awaalamuu/ IUD 5.Dubartii baqaqsanii maseensuu/ Tuballigation 6.Dhiira baqaqsanii maseensu/ VSC 7.Kondomii 99.Adda biraa-----	
318	Mala karoora maatii tokko gara adda biraatti geedaratee beektaa?	1.Eyyee 2.Lakki	Yoo 2 ta'e gara 322
319	Yoo eeyyee ta'e mala tokkoo gara adda biraatti maalif	1. Malli duraani waan naaf hinmijaneef 2. Mali haraan mijawaa waan taa'eef	

	jijjiratee?	3. Mala duraanii waanan dhabeef 4. Midhaa inni naraan ga'eeraan kan ka'e 5. Kan yeroo dheeraaf turu waanan barbaadeef 6. Ogeessatu nagorsinaan 7. Abbaa warraa kiyyatu nadirqisiisee 99. Adda biraa-----	
320	Deebiin gaafii 319 yoo lak. 3 ta'e ogeessi waan filanoon kee jalqabaa hinjireef akka ati mala adda biraatti geedaruuf sidirqisiisee beekaa?	1. Eyyee 2. Lakki	Yoo 2 ta'e gara 322
321	Lak. 320 eeyyee yoo ta'e mala kami akka ati fayyadamtuuf sidirqisiisee?	1. Kiniina liqimsamuu/ Pills 2. Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4. kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7. Kondomii 8. Harma hoosisuu 9. Yeroo sanyiin dhiiraa dhangala'u walqunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11. walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa-----	
322	Ogeesi waan filanoon karoora maatii kee jalqabaa hinjireef kara dhaabata fayyaa addabiraatti si'ergee beekaa?	1. Eyyee 2. Lakki	Yoo 2 ta'e gara 326
323	Ogeesi akka isin karoora maatii barbaadani argatanitti eessatti isin erge?	1. Hospitaala 2. Buufata fayyaa 3. Keelaa fayyaa 4. Dhaabata fayyaa dhunfaa 5. CBRHA 6. Dhaabata fayyaa MM/NGO 99. Adda biraa-----	
324	Lafa ogeessi si'erge deemtee?	1. Eyyee 2. Lakki	Yoo 1 ta'e gara 326
325	Yoo deebiin lak. 324 lakki ta'e, maaliif lafa ergamte hindeemne?	1. Qarshii tiranspoortii dhabeef 2. Karaan fagoo waan ta'eef 3. Yeroo dhabuuraan kan ka'e 4. Abaan waraa kiyya nadhorkee 5. Tajaajilichaaf qarshii dhabeef 99. Adda biraa-----	

326	Qarshiin mala karoora maatiifi kafalamu tajaajilla isin argatanii wajjin yeroo madaalamu akkami?	1. Gati xiqqaa dhaa 2. Gati gahaa dha 3. Gati guddaa dha 4. Gati baayee guddaa dha 99. Adda biraa-----	
327	Mala karoora maatii kam irratti ogeesi akka filanootti gorsa siif kene?	1. Kiniina liqimsamuu/ Pills 2. Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4. kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7. Kondomii 8. Harma hoosisuu 9. Yeroo sanyiin dhiiraa dhangala'u walquunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11. walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa-----	
328	Mala karoora maatii ati fayyadamaa jirtu eenyutu siif filee?	1. Ofii kootiin 2. Ogeessa 3. Abbaa warraa kiyya 4. Olaa kiyya 99. Adda biraa-----	
329	Ogeesi akka ati mala tokko filatuuf sidirqisisee beekaa?	1. Eyyee 2. Lakki	Yoo 2 ta'e gara 331
330	Yoo gaafiin 329 eyyee ta'e, Ogeesi mala kami akka ati fayyadamtuuf sidirqisiise?	1. Kiniina liqimsamuu/ Pills 2. Lilme/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4. kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7. Kondomii 8. Harma hoosisuu 9. yeroo sanyiin dhiiraa dhangala'u walquunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11. walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa-----	
331	Yoo karoora maatii ofiin filatte maaliif malicha filatte?	1. Malicha wanan beekuuf 2. Hiriyooni koo waan fayyadamaniif 3. Malicha salphaatti waanan argadhuuf 4. Filannoo adda biraa waan hinqabneef	

		5.Fayyadamuuf waan naaf miijatuuf 6.Mannatti waan kenamuuf 7.Olaa,fira YKN hiriyoootakoora waan argadhuuf 8.Yeroo dheeraaf waan natajaajiluuf 99. Adda biraa-----	
332	Karoora maatii maaliif fayyadamtaa?	1.Daa'ima gargar fageesuuf 2.Ijoolee godhachuu dhaabuufi 99. Adda biraa-----	
333	Mala karoora maatii amata sadan dabran keessatti addaan kuttee beektaa?	1.Eyyee 2.Lakki	Yoo 2 ta'e gara 335
334	Yoo gargar kute ta'e sababa maaliif gargar kute?	1. Midhaa inni naraan ga'eraan kan ka'e 2. Mala dhabuuraan kan ka'e 3. Yeroo dhabuuraan kan ka'e 4.Daa'ima godhachuu waanan barbaadeef 5. Abbaan warraa kiyya nadhorkee 6. Fageenyaraan kan ka'e 7.Guyyaa beelamaa hafuukoodhaan 8. Utuun fayyadamuu ulfaa'uukooraan kan ka'e 9. Rakina fayyaa irraan kan ka'e 10. Mala fooya'aa barbaadeen 11.Fayyadamuuf waan naaf hinmijaneef 12.Gatiin isaa guda waan ta'eef 13.Kan yeroo dheeraa barbaadeen 14. Jaarsa kiyya hiikee 99. Adda biraa-----	
335	Mala karoora maatii keesaa kan akka amantaatti dhorkaman jiruu?	1.Eyyee 2.Lakki	Yoo 2 ta'e gara 337
336	Yoo deebiin 335 eyyee ta'e mala kami fa'ii?	1. Kiniina liqimsamuu/ Pills 2.Lilmeef/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4.kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tubaligation 6. Dhiira baqaqsanii maseensuu/ VSC 7.Kondomii 8.Harma hoosisuu 9..Yeroo sanyiin dhiiraa dhangala'u walqunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11.walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa-----	

337	Mala karoora maatii keesaa kan akka adaatti dhorkaman jiruu	1.Eyyee 2.Lakki	
338	Yoo deebiin 337 eyyee ta'e mala kami fa'ii	1. Kiniina liqimsamuu/ Pills 2.Lilmeel/ Inject able 3. Kan irree keessa awaalamuu/ Norplant 4.kan hoffaa/gadameesa keessa awaalamuu/ IUD 5. Dubartii baqaqsanii maseensuu/ Tuballigation 6. Dhiira baqaqsanii maseensu/ VSC 7.Kondomii 8.Harma hoosisuu 9. Yeroo sanyiin dhiiraa dhangala'u walqunamtii saalaa addaan kutu 10. Yeroo ulfa ta'ani walqunamtii saalaa dhiisuu 11.walumaagalatti wal qunamtii saalaa dhiisuu 99. Adda biraa-----	

Hirmaanaa Keessaniif Galatoomaa!

Annex 4

**Addis Ababa University Medical Faculty
School of Public health
FGD guide for religious leaders on contraceptive method mix**

Dear Participant;

My name is Rahel Dubiwak, a student of master of public health in Addis Ababa University. I am here to study the method mix for family planning in the Zone. The purpose of this study is to generate information necessary for strengthening family planning program, to make possible amendments for programmers and police makers. Therefore your participation and genuine response is important for the achievement the study objective.

Here; I have some points to be discussed with you. Your answers are completely confidential. Your name will not be written on this form and will never be used in connection with any of the information you give. Your participation is on voluntary basis. Your honest opinions are important for my understanding of family planning method mix. Your voice will be recorded using tape recorder; the recorded discussion will not be used for another purpose it is simply used for transcription. The Interview will take about 1 to 2 hours. Do you wish to participate in this study?

Starting time _____ Ending time _____

Back ground characteristics of participants

S.No	Age	Marital status	Occupation	No of living children
1				
2				
3				
4				
5				
6				

FGD guide for religious leaders

1. What is the value of children in Islamic religion?
2. What is the general perception of having large family size and small family size in relation to Islamic religion? What is the effect on economy?
3. Describe the importance of family planning?
4. Whose duty is it to plan family size?
5. What is the role of women in family planning?
6. What is the role of men in family planning?
7. How do you see limiting or spacing the number of children in Islamic religion?
8. Is there any method of family planning which is forbidden in your religion?
Which methods of family planning are forbidden in Islamic religion? And why?
9. Is it allowed to use permanent family planning methods in Islamic religion?
10. What is the role of ODA RH/FP project in expanding family planning service?
11. Can a mother with implant participate in religious activities such as salat?

Annex 5

Addis Ababaa Yuunivesiitiitti Faakultii Medikaala Mana Barumsaa Fayyaa Hawaasaa Qajeelcha maree Abootii Amantii Wajjinnin Godhame

Kabajamoo hirmaatootaa;

Maqaan kiyya Raaheel Dubiiwaaq Jedhama. Ani baratuu maastersii digrii Fayyaa Hawaasaa Yuunivesiitiitti Finfinneetti. Ani amma kanan isin barbaadeefi waa'ee karoora maatii godina kanaa qo'achuufi. Faayidaan qo'annoo kanaas sagantaa karoora maatii foyyesuu fi odeefanno ga'a ta'e burqisiisuu fi, saganticharratti fooyyee adda addaa gochuufi saganteesistoonni itti fayadamu. Hirmaanaan keessan garaa gutuu bakka ga'uu qoranicharratti gumaacha guddaa gumaacha.

Xuqaaleen armaan gadii irratti mari'atamuuf kan qophaa'ani dha. Yaadni yookiin deebiin isin naaf kenitanii dhoksa dhaan eegama. Maqaan keesan waraqaa kana irratti hinbareefamu akkasumas odeefannoo issin keenitanii wajjin waliin qabamee hin illaalamu. Gaafilee ani isinii dhiyeesu deebisuun yookiin yaada kennun fedhii keesan gutumaa irratti kan hundaa'e dha. Deebii yookiin yaadii isin naaf kenitan waa'ee karoora maatii baruf baay'ee nagargaara. Yeroo mari'anu sagaleen keessan teepiitti niwaraabama innis yaada keessan bareesuuf nufayada malee dhima addabiraatiif itti hinfayadamnu. Mareen keenya sa'a tokko hanga sa'a lamaatti fudhata.

Qoranicharratti hirmaachuu nibarbaadu ?

Eyyee, hirmaachuun barbaada.

Lakkii, hirmaachuu hinbarbaadu

Lak.	Umurii	Haala fudhaaf heerumaa	Dalagaa	Lak. Idaa'imman lubuun jiranii
1				
2				
3				
4				
5				
6				

Qajeelcha maree abootii amantii wajjin gegefamuu

1. Akka amantaa islaamaatti gatiin/iddoon ijoolleef fakaataa?
2. Ilaalchi walii galaa maatii baayee fi maatii xiqqaafi qabdan akka amantii keessanitti maal fakaataa? Midhaa isaan dinagdee irratti qabani maalinni?
3. Karoorri maatii barbaachisaa dha jettanii yaaduu?
4. Karoorri maatii ge'e eenyuutii?
5. Ga'een dubartoonni karoorra maatii keessatti qabani maalii?
6. Ga'een dhirootti karoora maatii keessatti qabani maalii?
7. Amantii Islaamaa keessatti daa'imman gargar butufi dhaabuun maal akkani fakaattu ibsaa?
8. Mala karrora maatii keesaa akka amantii keessanitti kan dhorkamu jiraa? Mala karoora maatii warra kamittu dhorkaa dha? Maaliifi?
9. Amantaa Islaamaa keessatti mala karoora maatii dhaabataa fayyadamuun ni eyemamaa?
10. Ga'een WMO RH/FP projektii karoorra maatii babalisuu keessatti inni qabu maalii?

11. Haatii Implaanții godhatte tokko sosochii amantaa kan akka salaataa keessatti
hirmaachuu nidandeesii?

Annex 6

Addis Ababa University Medical Faculty School of Public Health Guide for key informant interview on contraceptive method mix

Dear Participant;

My name is Rahel Dubiwak, a student of master of public health in Addis Ababa University. I am here to study the method mix for family planning in the Zone. The purpose of this study is to generate information necessary for strengthening family planning program, to make possible amendments for programmers and police makers. Therefore your participation and genuine response is important for the achievement the study objective.

Here; I have some questions to be discussed with you. Your answers are completely confidential. Your name will not be written on this form and will never be used in connection with any of the information you give. Your participation by answering the questions that I am going to provide you is strictly on voluntary basis. Your honest answers are important for my understanding of family planning method mix. The Interview will take about 1 to 2 hours. Do you wish to participate in this study?

Starting time_____

Ending time_____

Key informant interview with zonal family health expert and ODA RH/FP project officer

1. What does the family planning demand and supply seem in your zone?
2. What does the method mix for family planning in your area seem to be?
3. Is there regular training given to family planning providers (especially on long term methods) in your area?
4. What is the role of CBRHAs in expanding family planning service?
5. Whom do mothers prefer for family planning provision from CBRHAs and HEWs?
6. Do you have equipments for provision of long term methods of family planning in the health institutions?
7. From where do you get contraceptive supplies? Is the stock depending on demand of the methods?
8. What factors do you think affect the contraceptive method mix in your area?
9. Mention if there are contraceptive campaigns held in your area, which are thought to affect the contraceptive method mix in your area?
10. Are there special cases by which contraceptive methods are promoted?
11. Which method of contraception is widely available in your zone?
12. Describe if there are religious and cultural factors which are thought to affect the contraceptive method mix in your area?
13. In which year each method of family planning became available in your zone?
14. In which days of the week family planning service outlets are open?
15. What is the role of ODA RH/FP project in expanding family planning?

