ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

SOCIAL MEARKETING AND FAMILY PLANNING: THE CASE OF MARIE STOPES INTERANTIONAL ETHIOPIA (MSIE)

BY:

GENET TAFESSE

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR MASTERS OF ARTS DEGREE IN MARKETING MANAGEMENT EDUCATION

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Approval by Board of Examiners:

Chairman, Department of Graduate Committee	**Signature**	**Date**
RAKSHIT NEGI		June 28, 2010
Advisor	**Signature**	**Date**
Tilahun Teklu (PhD)		28 June 2010
External Examiner	**Signature**	**Date**
Dr S. Nagarajan	S. Nag	28 June 2010
Internal Examiner	**Signature**	**Date**

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"Thank Be to God for his unspeakable Gift."
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ACCRONYMS/ ABBRIVIATIONS

AIDS:-	Acquired Immune Deficiency Syndrome
AAU:-	Addis Ababa University
CBRHS:-	Community Based Reproductive Health Services
CBD:-	Community -Based
CDC:-	Centers for Disease Control and Prevention
CDs: -	Centers for Diseases
CIA:-	Central Intelligence Agency
CRDA:-	Christian Relief and Development Association
CPR:	Contraceptive Prevalence Rate
DHS:-	Demographic Health Survey
EDHS:-	Ethiopian Demographic Health Survey
ETB:-	Ethiopian Birr
EU:-	European Union
FP:-	Family Planning
GBV:-	Gender Based Violence
HIV:-	Human Immunodeficiency Virus
HTPs:-	Harmful Traditional Practice
IEC:-	Information, Education and Communication
IUCD:-	Intra Uterine Contraceptive Device
MSI:-	Marie Stopes International
MSIE:-	Marie Stopes International Ethiopia
NGO's:-	Non Government Organization
RP:-	Reproductive Health
STDS:-	Sexually Transmitted Disease
SRH:-	Sexual Reproductive Health
SPSS:-	Statistical Package for Social Science
TGE:-	Transition Government of Ethiopia
TFR:	Total Fertility Rate
TWFR:	Total Wanted Fertility Rate
UK:-	United Kingdom
UN:-	United Nation

USAID:- United Sated Agency for International Development

UNAIDS:- Joint United Nations Program on HIV/AIDS

UNFPA:- United Nation Family Planning Association

WHO:- World Health Organization

WOM:- Word -of –Mouth

Definitions of Key Terms

Family Planning:- Is a program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control.

Reproductive health:- Is that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Contraceptives: - Involves various means and methods one can use to avoid becoming pregnant.

Methods Contraception: - Prevents pregnancy by interfering with the normal process of ovulation, fertilization and implementation.

Behavioral change: It refers to any transformation or modification of human behavior and it may also refer to a behavior change/public health. Or it may be defined as a person readiness change.

IUD: A device inserted in to the uterus (Womb) to prevent conception (pregnancy).

Social marketing:- Social marketing is a policy tool that can be used when the best policy response is to target behavioural change. It recognises the difficulties associated with true behavioural change and has a concrete focus on enabling that change and reducing the barriers tochange.

Social marketing mix : Are commenly known as 7Ps' (product, price,place, promotoion, publicity Policy and partnership) which are adopted from commercial marketing and important to conceder when planning intervention activities for reaching target audience/ clients from various dimensions.

MSIE: Marie Stopes International one of non profit organizations uses social marketing to expand access to contraceptive products through private sector outlets. It procures products from international suppliers, packages them to make them attractive to customers.

ABSTRACT

The objective of this study is to examine the social marketing and family planning practice of MSIE and reproductive health of women (married and unmarried) among the age group 15-49 on the study area(Arada branch of Addis Ababa). A total of 250 questionnaires were distributed from this 200 questionnaires were collected and used to the analysis purposes.. The study used descriptive analysis (mean and percentage) together with cross-tabulation (chi-square) and correlation analysis to examine the response of subjects. The study reveled that large numbers of respondents were accessible to message deliver through community-based by MSIE regarding their program targeted to FP/RH. Analysis result has shown that there were differences among women in their need for family planning due to there age differences. For instance, majority of women on the age group (21-25) need FP/RH for avoiding unwanted pregnancy. This reviled that usage of contraceptive need decline as the age increases, because, there were no respondents above the age of 40 using FP/RH methods. Finally to change the behavior of the clients the MSIE should directed towards the needs and requirements of the clients by focusing the promotional program on community –based to achieve its main objectives.

CHAPTER ONE

INTRODUCTION

This chapter indicates the setup basis of research. A general introduction and background of the study are provided to describe the area of the study. Further, the statement of research problem, specific objectives, and significance of the study, limitation and delimitation of the study are addressed. Finally, the outline of the paper is provided.

1.1 Background of the study

Social marketing was born as a discipline in the 1970s, when some marketing principles that were being used to sell products to consumers could be used to "sell" ideas, attitudes and behaviors. Therefore, social marketing emphasizes on behavioral exchange rather than profit based commercial aspect of pure marketing (Kotler & Zaltman, 1971). Kotler and Andresen (1991) define social marketing as differing from other areas of marketing only with respect to the objectives of marketer and his or her organization. Moreover, Kotler and Zaltman (1971) addressed social marketing as the design, implementation, and control of programs calculated to influence the acceptability of social idea and involving consideration of product planning, pricing, communication and marketing research.

Social marketing seeks to influence social behaviors not to benefit the marketer, but to benefit the target audience and the general society (http://www.SocialMarketing.com). Idea marketing has been labeled 'social marketing' since it involves the promotion of social causes such as antismoking campaigns, awareness about sexual transmitted disease (STDS) and the concept of family planning (Adel & Oscar, 1973). Among the great contributions of social marketing, family planning in order to minimize population is a significant one. Population growth rate has begun to slow in many developing countries. The surge in population growth that began when death rates declined earlier and faster than birth rate has begun to stabilize as more and more developing countries experience the transition to lower fertility. Even with slower growth rates, however, developing countries continue to experience large absolute increases in population (World Bank, 1994). Particularly in most part of Africa, the maintenance of fertility at high levels while mortality has been falling has resulted in a wide gap between birth rates and death rates. This widening gap has in turn resulted high rate of

population growth (Ohadike, 1988). This demands high concern in intervention of social marketing firms with the objectives of family planning.

African countries, particularly the majority of Sub-Saharan Africa countries are characterized by high population growth (UNFPA, 1999). Ethiopia is among those countries with a high fertility and population growth and the second populous country in Africa, next to Nigeria. Ethiopian population in mid 2009 was estimated to be 80.2 million and is growing at 3.208% per annum (CIA World fact Book, 2008). The country has a pyramidal age structure due to the large number of children less than fifteen years of age, a feature of population with high fertility level. Thus, children under 15 years of age account for 48% of the population, 51.2% of the population is in the age group of 15-64 and almost 2.7% are over 65 (CIA World Fact Book, 2008). Hence, the young age structure has in built potential for rapid population growth.

The world health organization defined family planning as the practice that helps individuals or couples to attend certain objectives such as avoiding unwanted pregnancies, bringing about unwanted babies, regulating the interval between pregnancies, controlling the time at which birth occurs in relation to the age of the parents and determining the number of children in the family (WHO , 2003).

Ethiopia is responding to the problems of population growth adopted within a population policy in 1993 with a goal of harmonizing population growth with the capacity of the country for the development and rational utilization of natural resources to the well-being of the people. The policy has aimed at mobilizing public and private resources to expand clinic and community based family planning services.

Ethiopia has long faced problems obtaining adequate contraceptives supplies. These problems are complex, and arise from a combination of logistical difficulties, general supply shortages and an extraordinary growth in demand for contraception. DHS (2000), survey statistic reveal that while more than 80% use Ethiopian women know about contraception, only 8.1% uses either modern or natural family planning methods. It is estimated that about 36% of married women have an unmet need for contraception. Unfortunately logistical difficulties faced by the Ministry of Health make it an unreliable source of contraceptive supplies (Wallchart, 2004). The contraceptive shortage has forced MSIE to turn towards social marketing agencies

to purchase supplies; thus redirecting its budget from other family planning services which were provided without payment previously (WHO, 2003).

Among the other major NGO's, Marie Stopes International (MSEI) is a non-profit organization that specializes in sexual and reproductive health and services with special emphasis on family planning and post abortion care. MSI has been operating in Ethiopia since 1990. MSIE is implementing a multi donor funded Sexual Reproductive Health (SRH) program targeting women of reproductive age in Ethiopia. The purpose of the programs is to make positive behavioral change regarding sexual and reproductive health, and by providing high quality SRH products and services as well as using various channels of demand generation for condoms, birth spacing products such as pills and injectables, female sterilization and safe post abortion care services (TGE, 1993).

Social marketing program of contraceptive methods was introduced in Ethiopia also in 1990 by DKT- Ethiopia with the objective of increasing the contraceptive prevalence in the country by producing a continuous supply of high quality contraceptives that are accessible and affordable. MSIE also involved in the same family planning service integrated with contraceptive products aimed at minimizing unwanted pregnancy. The services provided by MSIE are: fixed clinic base services in its four clinics found in Addis Ababa, outreach in rural parts of the country and social franchising with private health service providers. MSIE launches intensive promotion and awareness creation campaigns over the need for changing behaviors of the society by community- based reproductive health services (CBRHS), based on peer promoters (Word -of mouth- communication) and also, through mass media.

1.2 Rationale of the study

The role of family planning and reproductive health has gained attention due to its importance in decision making about population growth and areas related to development. Social marketing on the other hand, has gained popularity in addressing issues related to change in social behaviors, primarily family planning, particularly in developing countries. However, a social change happens when some one change internal feeling, external structures, and/or works to make behavior unnecessary. The approach of social marketing recognizes that in order for a campaign to be successful, increasing levels of awareness and knowledge will not be enough unless behavioral change is an out come of this (Kotler & Andersen, 1991).

In Ethiopia (together with other developing nations), family planning services have been almost directed at women exclusively with little attention paid to male counterpart, on religious beliefs. Hence there exists negative attitude towards family planning among male counterparts (Olawepo, 1998). Also, the cultural and ethical settings of Ethiopia force a large proportion of men to pay less attention on the issues related to family planning. This is fully observed from the practice/trend of the Ethiopian society. Rapid population growth and high fertility can hold back development and brings unbalanced socio-economic growth. High rates of population growth are associated with poverty; high fertility is a characteristic of poor house holds (World Bank, 1994). To overcome the problems related with population growth and high fertility, the study examines:

- The role of Social marketing practices in Marie Stopes International Ethiopia to help society to develop knowledge about family planning and better serve women of reproductive ages.
- The efforts carried out by MSIE in bringing behavioral changes among society members about family planning.
- The factors affecting the contraceptives usage as being offered by Marie Stopes Ethiopia to control births.
- The preference of women (aged 15-49) for usage of contraceptives being provided by MSIE.

1.3 Statement of the problem

Due to their nature and purpose of operations, organizations like MSIE can play significant role in influencing the societal behaviors in relation to challenges such as Family Planning (FP) and Reproductive Health (RH). The student researcher found the initiative of MSIE potentially wise and commendable; however, there expected to be a number of major limitations in its social marketing mixes towards family planning practices that further affects its potential to meet stated objectives. In spite of efforts made by MSIE to apply and benefit from modern marketing techniques, a number of concerns are raised from different directions regarding the proper utilization of such techniques and the degree of success to be achieved by the organization as a result of using the techniques.

To investigate the problem intensively the study attempts to answer the following basic questions:

1. To what extent does MSIE utilize social marketing approach to bring behavioral changes toward family planning?
2. How significant is social marketing mix in influencing the FP/RH related behaviors at MSIE?
3. What is the role of each marketing-mix element/dimension to influence overall individual behavior about FP/RH?
4. What socio-demographic factors affect contraceptive usage in the society?

1.4 Objectives of the study

The objectives of the study are manifold. However, the general objective is to examine and assess the social marketing mix development and implementation at MSIE. Basically, it is intended to assess the performance of the social marketing practices with respect to bringing attitudinal and behavioral changes about FP/RH users of MSIE. The specific objectives include:

1. To identify the extent to which social marketing is in practice to bring behavioral changes by MSIE.
2. To determine the relevance of MSIE's social marketing mix to influence FP/RH related behaviors.
3. To examine the role of marketing each marketing mix elements to determine appropriate individual behavior about FP/RH.
4. To identify the socio demographic factors influencing the usage of contraceptives in the society to control unwanted pregnancies.

1.5 Significance of the study

The study focuses on the idea of social marketing, as an approach to bringing change in the behavior of individuals, with concept of family planning based on social marketing practices.

As reported by many scholars, the use of social marketing practices contributes significantly to change people behavior towards social issues such as family planning. Therefore, the study contributes to see the social marketing acceptance in service program design at MSIE, while reporting the factors affecting behavior about FP/RH. Additionally, the study is helpful for the policy makers in the areas of population control and healthcare, together with adding to the existing literature in the areas of social marketing and consumer behavior.

1.6 Delimitations of the study

The study focuses on the analysis of social marketing performance at MSIE in Addis Ababa, Ethiopia, while maintaining a focus on FP/RH services provided by MSIE. Additionally, the study considers the female (both married and unmarried and aged 15-49 years) clients who received FP/RH products/services during 2010, in MSIE's Arada branch in Addis Ababa. The selection of the organization is subject to its commendable experience of applying social marketing approach to bring behavioral changes among society units/members about FP/RH. However, the reasons of limiting the scope to Arada branch of MSIE include:

- The first clinic/branch of MSIE.
- The branch maintains largest number of clients and staff members.
- Branch reported with maintaining prolonged permanent users of the FP/RH related services.

1.7 Limitations of the study

There were different obstacles to complete this research; the major limitations include non-cooperative behavior of respondents in filling up the questionnaire at the time when they receive the service. This is due to the reason that they were not found to be comfortable after receiving the service (FP/RH), perhaps, due to the pain they experience. Also, the student researcher could not get appropriate information from MSIE on social marketing practices, as the organization does not have a separate unit for organizing all the materials related to ongoing and performed activities together with their implications. Finally, problems were encountered in finding adequate secondary data sources and published material concerning to the study area from various libraries of AAU and outside.

1.8 Organization of the study

The study report is organized in to five chapters and presented in the form of a flow diagram (Figure 1). While chapter one is provide an introduction to the subject/research area by presenting the general background, statement of the problem , objective of the study, significance of the study , limitation, and delimitation of the study. Chapter two explores the related literature. Chapter three provides the research methodology by making clear the readers on the part of questionnaire design and data collection techniques/procedures and ethical consideration. Chapter four deals with detailed analysis of the responses scored through respondents of the study and focuses on the discussion of the research results. The last chapter of the report provides concluding remarks together with recommendations for the organization under the study and further lead to initiate new studies in the area.

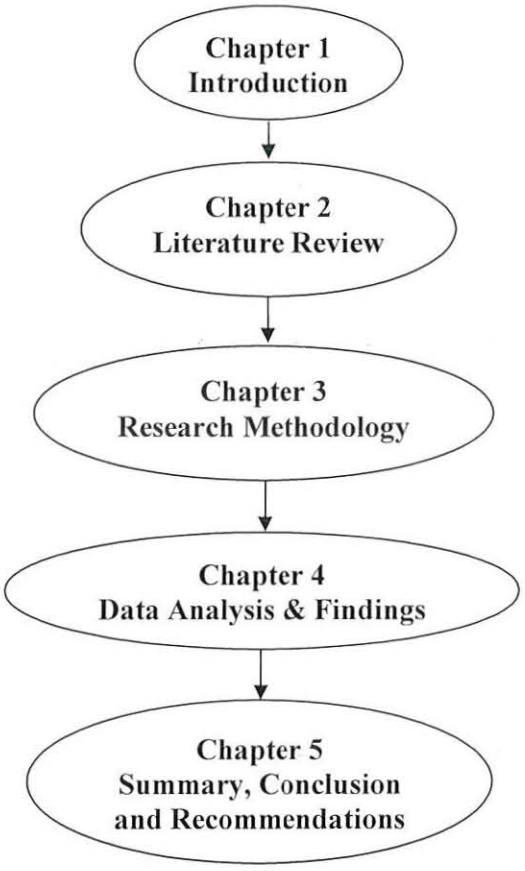

Figure 1. Outline of the study

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Social marketing can enhance the effectiveness of our efforts to protect and improve public health. Using marketing to conduct public health improvement campaigns can help clarify what we want to accomplish and can help us be more productive with limited public health resource. This chapter explores the available literature on social marketing family planning and reproductive health by exploring the high rate of population growth is largely the result of frequent childbearing or high fertility often corresponding with a large unmet need for family planning (FP) concepts.

2.1 Background of Social Marketing

Many people think of marketing only as selling and advertising. And no wonder every day we are bombarded with television commercials, direct mail officers, sales calls, and internet pitches. However, selling and advertising is only the tip of the marketing iceberg (Kotler, 2006). Today, marketing must be understood in terms of satisfying customer needs. If the marketer does a good job of understanding consumer needs, develops products that provide superior value and prices, distributes, and promotes them effectively, these products will sell easily.

Kotler (1999) defines marketing as "a social and managerial process by which individuals and groups obtain what they need and want through creating and exchanging value with others." In a narrower business context, marketing involves building profitable, value laden exchange relationships with customers. However, social marketing, in general, goes beyond social advertising and social communication in that it involves all "four P's not just one. It involves coordinating product, price, place, and promotion factors to maximally motivate and facilitate desired forms of behavior (Kotler and Zaltman, 1971). Furthermore, social marketing calls for marketing research and for preparation of a full marketing plan, strategy, and budget to get initial sales and to reinforce the new behavior over time.

2.2 Defining Social Marketing

Changing behaviour sometimes requires a specific kind of marketing- which attempts to change the perceptions, attitudes and opinions that underlie an individual's health or lifestyle habits. In the health promotion field, social marketing attempts to change social attitudes

towards activities that are harmful to health. The term 'social marketing' was first used by Philip Kotler and Gerald Zaltman in 1971. They realized that an approach that focused entirely on alerting the public to the dangers of certain health-related behaviours was often inadequate in fostering changes in attitudes, opinions and behaviours.

Social marketing recognizes that informing the public about a particular issue will not, by itself, lead to attitude or behaviour changes. Providing someone with up-to-date health information, for instance, will not necessarily lead to behaviour changes; if this were the case, doctors and nurses would not smoke. To effect attitude or behaviour changes, a strategic implementation of social marketing elements is required. Social marketing uses marketing techniques to generate discussion and promote information, attitudes, values and behaviours. By doing so, it helps to create a climate conducive to social change. (Health Promotion Directorate, 1991).

There is more than one way to define social marketing but there are three components that are essential to any definition. First is the role of marketing techniques which necessitate putting the primary audience or target audience (customer) at the center of every decision. Second is that the focus of the endeavor is on voluntary behavior change. Third, but not least, is that the behavior change is for the benefit of an individual, group, or population, not for profit or commercial gain.

Anderson (1995) defines social marketing as "the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviors of target audiences in order to improve their personal welfare and that of their society."

According to Kotler, Roberto and Lee (2002), "Social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify, or abandon a behavior for the benefit of individuals, groups, or society as a whole."

Therefore, social marketing is a process of influencing human behavior on a large scale, using marketing principles for the purpose of societal benefit rather than commercial profit. Like other health planning strategies and models, social marketing draws on behavioral research. Some features of social marketing, such as identifying a target audience, are not unique to social marketing. However, the way these features are employed and application of the three

key components described above distinguish social marketing from other approaches. Similarly, Shiavo (2007) defines social marketing similar to commercial marketing and considering behavioral change as its ultimate goal. However, in commercial marketing, behavior change is sought primarily to benefit the sponsoring organization. Even if, in some cases, marketing activities also encourage the adoption of health behaviors, such as immunization or compliance to Medication, that can improve the health conditions of target populations.

In connection with this, as stated in UNAID (2000), social marketing may be defined as the adaptation of commercial marketing and sales concepts and techniques to the attainment of social goals. It seeks to make health related information, product and services easily available and affordable to low income populations and those at risk while at the same time promoting the adoption of healthier behavior. In fact, it may be said that ultimate goal of social marketing is to affect health and sustainable behavior change. Similarly as stated by USAID (2000), social marketing is designed to improve the health of low income people by promoting healthy behavior, offering health products and services at affordable prices, and motivating people to use them. Social marketing is meant to increase both the supply of and demand for health products and service. Furthermore, Domogan (2008) sates that, social marketing is, broadly speaking, the application of marketing principles and exchange to social issues. It is best known for its use in campaigns related to public health and the environment. Successful strategies dealing with obesity tobacco consumption, family planning, safe sex, and recycling, waste management and water purity are the more common application.

2.3 Departures from Commercial Marketing

Social marketing differs from other fields of marketing simply with respect to its objectives (Kotler & Anderson, 1991). As Kotler (1975) states that, business marketers usually strive to meet the needs and desires of their target market, while; social marketers typically attempt to change the attitudes or behaviors of their target markets. The major aim for business marketers is to generate profit by serving the interest of the target market, while social marketers intend to serve the target market without personal profit. Moreover; business marketers generally promote products and services through the means of ideas, while social marketers most often market the actual ideas rather than tangible products or services. Further, the objectives of social marketing can be carried out by virtually any one; individuals, informal groups or formal organizations

According to Andersen (1995), social marketing is different from commercial marketing in that is often involve negative demand, highly sensitive topics, invisible benefits that are some times only available to third parties, intangibles that are hard to portray, changes That is a long time coming about, public scrutiny, multiple public to satisfy an absence of co-workers with the proper mind set and few opportunities to modify products. The selling of healthier behaviors and the selling products has much in common. Even so, neither health nor brotherhood can be sold like soap. There are some important differences between social and commercial marketing as sited by different scholars. specifically, in social marketing: the product tend to be more complex , demand is more varied, target groups are more challenging to reach, consumer involvement is more intense, and the competition is more subtle and varied.

2.3.1 The Products are more Complex

The marketing product has traditionally been conceived of as something tangible – a Physical good which can be exchanged with the target market for a price and which can be manipulated in terms of characteristics such as packaging, name, and physical attributes, positioning and so on. As marketing has extended its scope beyond physical goods, marketers have had to grapple with formulating product strategy for less tangible entities such as services (Woodruff, 1995). In social marketing, the product is extended even further from the tangible to encompass ideas, and behavior change.

2.3.2 Varied Demand

Marketing cannot create needs but commercial marketers do manage to harness needs previously unknown for new product categories such as CDs, catalytic converters and "New" washing powders. Social marketers must not only uncover new demand, but in addition must frequently deal with *negative demand* when the target group is apathetic about or strongly resistant to a proposed behavior change. Young recreational drug Users, for instance, may see no problems with their current behavior (Andresen, 1997). In these situations, social marketers must challenge entrenched attitudes and beliefs. Demarcating approaches may help here (Lawther et al., 1997., Hastings et al., 1998). Rangun et al (1996), suggest a typology of the benefits associated with a behavior Change. The benefits may be: tangible, intangible, and relevant to the individual or relevant to society. Demand is easier to generate where the benefits are both tangible and personally relevant. In those situations where the product

benefits are intangible and relevant to society rather than the individual, social marketers must work much harder to generate a need for the product. This, they argue, is the hardest type of behavior change, as the benefits are difficult to personalize and quantify.

2.3.3 Challenging Target Groups

As cited by Whitehead (1992) and Smith (1997), Social marketers must often target groups who commercial marketers tend to ignore .The least accessible, hardest to reach and least likely to change their behavior. For example, health agencies charged with improving population health status must, if they are to avoid widening health inequalities further in the general population target their efforts at those groups with the poorest health and the most needs (Hastings et al., 1998). Far from being the most profitable market segments, these groups often constitute the least attractive ones: hardest to reach, most resistant to changing health behavior, most lacking in the psychological, social and practical resources necessary to make the change, most unresponsive to interventions to influence their behavior and so on. This poses considerable challenges for segmentation and targeting.

2.3.4 Greater Consumer Involvement

As expressed by Kotler (1994) , marketing traditionally divides products into high and low involvement categories, With the former comprising purchases for items such as cars or mortgages which are "Expensive, bought infrequently, risky and highly self-expressive" and the latter comprising items such as confectionery or cigarettes which are much more Habitual. High involvement products typically command careful consideration by the Consumer ('central processing') and demand detailed factual information from the marketer. Low involvement products are consumed much more passively, with very Limited (or no) search and evaluation ('peripheral processing'), and simple advertising Emphasizing "visual symbols and imagery" is called for Both the categorization scheme - high and low - and its marketing implications need to be extended in social marketing. Social marketing frequently deals with products with which the consumer is very highly involved (complex lifestyle changes such as changing one's diet fall into this category). While high involvement can result in a motivated and attentive consumer, higher involvement may be associated with feelings of anxiety, guilt and denial which inhibit attempts to change. At the other extreme, social marketers might seek to stimulate change where there is very low or no involvement - for example, persuading Scots to save water.

2.3.5 More Varied Competition

Social marketers, like their commercial counterparts, must be aware of their competition the most obvious source of competition in social marketing is the consumer's tendency to continue in his or her current behavioral patterns, especially when addiction is involved. Inertia is a very powerful competitor. Other sources of competition involve alternative behaviors. For example, time spent donating blood is time which the consumer could spend doing other more enjoyable, more convenient and more personally beneficial activities. Competitive organizations include other health promoters, educators or government organizations trying to use similar methods to reach their target audiences. For example, the typical doctor's surgery in the UK displays such a plethora of leaflets and posters that any one message or idea stands little chance of being noticed. Social marketers must then be innovative and careful not to overwhelm their target audience. Finally, one of the most serious forms of competition comes from commercial marketing itself where this markets unhealthful or unsocial behaviors. The most obvious examples are the tobacco and alcohol industries (Andresen, 1995).

2.4 Social Marketing Mixes

The traditional marketing mix of the 4P's has been extended and adapted in order to generate a grater relevance to the marketing of social ideas (Sergeant, 1999). Different authors describe and explain the various features of the 7'ps of the social marketing mix.

2.4.1 Product

The product within social marketing is the concept that the marketer wishes to highlight and draw attention in order to stimulate a change in behavior (http://www.SocialMarketing.com). Therefore, social marketing "product" is not necessarily an offering; however, a continuum of products exists, ranging from tangible, physical products (e.g. condom) to service (e.g. medical exams), practices (e.g. breast feeding, ORT or eating healthy diet) and more intangible ideas (e.g. environmental protector).

In addition as expressed by Schiavo (2007), product is the behavior, service, product, or policy that the organization or program seeks to see adopted by the target audience. The component that includes interventions, objects, or services that support or facilitate behavior change. Examples include a journal to plan and track weekly exercise activities or a hotline

that parents can call with questions about drugs may also refer to the desired behavior or benefits that a social marketing program offers. "In social marketing, our **product** is what we are selling, the desired behavior and the associated benefits of the behavior. It also includes any tangible objects and services developed to support and facilitate the target audience's behavior change" (Andersen, 1982).

2.4.2 Price

Price, in social marketing, refers to what the consumer must do in order to obtain the social marketing product (http://www.SocialMarketing.com). This cost may be monetary, or it may instead require the consumer to give up intangibles, such as time or effort, or to risk embarrassment and disapproval the price of the product that is being promoted, or the emotional, physical, community or social cost of adopting the new behavior, policy or practice (Schiavo, 2007). Sergeant (1999) stated that the price may be viewed as the monetary cost of adopting a change in behavior the social programs might require funding the component that invites planning interventions that use incentives and disincentives (they may be monetary such as rebates/discounts or non-monetary such as recognition) to minimize the costs or barriers the audience members face in making the desired behavior change (financial, emotional, psychological, or time costs).

2.4.3 Place

Sergeant (1999) explains "place" as the location at which a service component involved on the social marketing mix, and also be regarded as the channels of information applied when reaching a target market. In addition to this, Fine (1990) refers 'place' in social marketing to the producer's place and involved in the marketing process. It describes the way that the product reaches the consumer (http://www.SocialMarketing.com). For a tangible product, 'place' refers to the distribution system including the warehouse, trucks, sales force, retail outlets where it is sold, or place where it is given out for free or product distribution channel (Schiavo, 2007).

2.4.4 Promotion

Promotion refers to all the various tools that could be used in order to awake and motivate an interest among the consumers (Sergeant, 1999). It thus, refers to how to motivate intended audiences to communication messages and tools to facilitate the adoption of the new

behavior. Schiavo (2007) stated 'promotion' as the way a message is conveyed. However, because of its visibility, this element is often mistakenly thought of as comprising the whole of social marketing, though it is only a piece (http://www.SocialMarketing.com). Promotion consists of the integrated use of advertising, public relations, promotions, media advocacy, and personal selling and entertainment vehicles. This component includes the communication messages, messengers, materials, channels, and activities that will effectively reach your audience to promote the benefits of the behavior change as well as the Product, Price, Place, and Policy factors of a program. Messages maybe delivered through public relations, advertising, print materials, small-group or one-on-one activities (mentoring, counseling, workshops, demonstrations, presentations), and other media (Kotler & Roberto, 1989).

2.4.5 Public

Social marketers often have many different audiences that their program has to address in order to be successful. 'Publics' refers to both the external and internal groups involved in the program (http://www.SocialMarketing.com). Additionally, Fine (1991) recognizes that the responsibility for social marketing policy is widely diffused and shared among organizational members and relevant external publics, and social actions are carried out by many participants who have different roles in the organization.

2.4.6 Partnership

Being an organization involved in social marketing practices, one needs to figure out the organizations with similar goals, if not necessarily the same, and identify the ways working together. In addition to this, Sergeant (1999) stated that due to fact that behavior is difficult to change, and many single non-profit organizations are too small to actually make a difference without assistance, partnerships often involve working closely together with a broad selection of different organizations which share the same purpose, both within the private and public sector. Similarly, Schiavo (2007) stated social and health issues are often so complex that one agency cannot make a dent by itself. Due to this, social marketing look for potential partnerships with other organizations with similar goals for working closely both in the private and public sector. Additionally, Fine (1991) argued that social marketer should take a serious attention for the constituent, volunteer and donor wants, expectations, and perceptions to create a competitive aged in the field in which the organization operates.

2.4.7 Policy

'Policy' is considered to be the 7th P in social marketing. This component leads to consideration of stimulating changes in policy and rules as a component of a social marketing plan (e.g. to accomplish environmental changes that support changes in individual behavior). It is essential that changes in these arenas support voluntary behavior change and not be coercive or punish "bad" behavior (Kotler, Roberto & Lee, 2002). Social marketing programs can do well in motivating individual behavior change, but it is difficult to sustain unless the environment they are in supports that change for the long run. Often, policy change is needed, and media advocacy programs can be an effective component to a social marketing (http://www.SocialMarketing.com). Similarly, Sergeant (1999) stated that individuals might have to be forced on in order to institute the required change in behavior. Hence, legislative changes are called for and the social marketer then has to influence the decision makers to implement change.

2.5 Elements of Social Marketing Program

A social marketing campaign or program contains the following elements: consumer orientation, an exchange, and a long-term planning outlook (Leathar & Hastings, 1987; Lefebvre & Flora, 1988; Lefebvre, 1992, 1996; Andreasen, 1995, Smith, 1997). However, Hastings et al. (1994) and Lawther and Lowry (1995) moved beyond an individual consumer.

2.5.1 A Consumer Orientation

Consumer orientation is probably the key element of all forms of marketing, distinguishing it from selling- a product- and expert-driven approaches (Kotler et al., 1996). In social marketing, the consumer is assumed to be an active participant in the change process. The social marketer seeks to build a relationship with target consumers over time and their input is sought at all stages in the development of aerogramme through formative, process and evaluative research. In short, the consumer centered approach of social marketing asks not "what is wrong with these people, why won't they understand?" but "what is wrong with us?"

2.5.2 An Exchange

Social marketing not only shares generic marketing's underlying philosophy of consumer orientation, but it also its key mechanism exchange (Kotler & Zaltman, 1971). While

marketing principles can be applied to a new and diverse range of issues- services, education, high technology, political parties, and social change - each with their own definitions and theories, the basic principle of exchange is at the core of each (Bagozzi, 1975). Kotler and Zaltman (1971), argue "marketing does not occur unless there are two or more parties, each with something to exchange, and both able to carry out communications and distribution". Exchange is defined as an exchange of resources or values between two or more parties with the expectation of some benefits. The motivation to become involved in an exchange is to satisfy needs (Houston & Gassenheimer, 1987).

Exchange is easily understood as the exchange of goods for money, but can also be conceived in variety of other ways: further education in return for fees; a vote in return for lower taxes; or immunization in return for the peace of mind that one's child is protected from rubella. Exchange in social marketing puts a key emphasis on voluntary behavior. To facilitate voluntary exchanges social marketers have to offer people something that they really want. For example, suppose that during the development of a program to reduce teenage prevalence of sexually transmitted diseases (STDs) by encouraging condom use, research with the target finds that they are more concerned with pregnancy than STDs. The social marketer should consider highlighting the contraceptive benefits of condoms, rather than, or at least as well as, the disease prevention ones. In this way consumer research can identify the benefits which are Associated with a particular behavior change, thereby facilitating the voluntary exchange process (Smith, 1997).

2.5.3 Long-term Planning Approach

Like generic marketing, social marketing should have a long term outlook based on Continuing programs rather than one-off campaigns. It should be strategic rather Than tactical. This is why the marketing planning function has been a consistent theme in social marketing definitions, from Kotler (1971) to Andresen (1996). The social marketing planning process is the same as in generic marketing. It starts and finishes with research, and research is conducted throughout to inform the development of the strategy. A situational analysis of the internal and external environment and of the consumer is conducted first. This assists in the segmentation of the market and the targeting strategy. Further research is needed to define the problem, to set objectives for the program and to inform the formulation of the marketing strategy. The elements of the social marketing mix are then developed and pre-tested, before

being implemented. Finally, the relative success of the plan is monitored and the outcome evaluated (Andersen, 1995).

2.5.4 Moving Beyond the Individual Consumer

Social marketing seeks to influence the behavior not only of individuals but also of groups, organizations and societies (Hastings et al., 1994; Lawther & Lowry, 1995; Lawther et al., 1997; Murray & Douglas, 1988). Furthermore, Levy and Zaltman (1975) suggest a six fold classification of the types of change sought in social marketing, incorporating two dimensions of time (short term and long term) and three dimensions of level in Society (micro, group, and macro). In this way social marketing can influence not just Individual consumers, but also the environment in which they operate.

2.6 Social Marketing in Non- profit organization

Throughout the years, manifold potential solutions have been proposed in order to manage innumerable social problems, and naturally, there are disagreements on how to most effectively solve them, although solutions are of varying nature, the call for social campaigns is recurrent (Kotler & Roberto, 1989).

2.6.1 Non-profit versus Profit-oriented Marketing

It is important to recognize that there are a number of significant similarities between non profit and non profit-oriented firms with regard to marketing, as well as many different. In today's uncertain and competitive environment, it is becoming increasing necessary for non profit organizations to learn and apply appropriate marketing concept and strategies). With non profit and profit-oriented marketing, consumers typically can choose among the offerings of competing companies; the benefits provided by competing organizations differ; consumer segments may have distinctive reasons for their choices; consumers are attracted by the most desirable marketing mix; consumers experience either satisfaction or dissatisfaction with performance (Evans & Joel, 1990).

There are also a number of differences in marketing between nonprofit and profit-oriented organizations. Non profit marketing is broad in scope and is frequently involved with social marketing. Non profit marketing includes organizations, people, places, and ideas, as well as goods and services. It is much more likely to promote social programs and ideas than it profit

oriented marketing e.g. recycling, highway safety, family planning, and energy conservation. The use of marketing to increase the acceptability of social ideas is referred to as social markets. The benefits of non profit organizations are often not distributor on the basis of consumer payment. Only a small portion of the population contracts a disease, requires humanitarian services, visits a museum, use a public library, or goes to a health clinic in a given year: yet the general public pays to find cures, support fellow citizens, or otherwise assist non profit organizations (Ibid).

In many cases, the group that would benefit most from a nonprofit organizations activities may be the one least prone to seek or use them. This occurs for libraries, health clinics, remedial programs and other non profit organizations and activities. With profit-oriented organizations benefits are usually distributed equitably, based on consumers' direct payment in exchange for goods or services. Non profit organizations are frequently expected, or even required, to service market segments that profit-oriented organizations find uneconomical. This may give profit oriented firms an advantage because they can concentrate their efforts on the most lucrative market segment. Although, profit-oriented firms have none primary constituency to which they offer goods and services and from which they receive payment, the typical nonprofit organization has two constituencies; clients for whom to provides memberships, elected officials locations, ideas, goods, and services and donors from whom it receives resources (which may be time from volunteers or money from foundations and individuals) often there is little overlap between clients and donors (Evans & Joel, 1990).

2.7 Different Approaches to Social Marketing

There are many ways of applying social marketing concepts approaches and the techniques at the national, local or community levels. Therefore, other ways of social marketing of products have been developed and also common. These approaches are not mutually exclusive although one or more may be applied exclusively by a program or project, or also as parts of a project for strengthening and improvement of existing 'traditional' approach (USAID, 2001). These models, or possible approaches to social marketing, include:

2.7.1 Community-based Distribution

System of product promotion and distribution (Community-Based Distribution/CBD) where non-professional sales agents are recruited form among particular groups within the general

population. The individuals receive basic training in IEC and sales and are usually rewarded financially form small margins on their sales. This approach is increasingly chosen as a means of reaching geographical areas and socio-cultural groups that are difficult to access. Many programs incorporate the method to complement more traditional, retail out let sales; some programs, usually run by local NGOS, are based entirely on the system.

2.7.2 The Manufacturer's Model

Where support is provided for the promotion and distribution of brands developed and owned by a manufacturer (foreign or Local) or local manufacturer's agent, frequently an importer of the product. The support usually takes the form of grants directly to the manufacturers and /or their distribution agents so as to reduce their commercial marketing costs and therefore allow greater investment in key activities, such as promotion and advertising.

2.7.3 The 'Target Service Delivery' Approach

Involves planning appropriate social marketing activities, through which the project strives to reach and distribute products to specific target groups, usually high-risk or other priority segments of the general public. These groups are often in adequately served by other service delivery mechanisms, including standard social marketing activities.

2.8 Factors Affecting Behavior about FP/RP Health

Due to Aids pandemic and the 1994 Cairo conference, and its program of action, reproductive health has become a major focus of research for those in the health and population field. Many studies and international conference conducted regarding to reproductive and health issue. Productive health activity is increasing globally with a trend of early onset. Hence, there are factors that lead to the early commencement of family planning and reproductive health of women such as social-demography factors (religion affiliation, education. and living arrangement) peer behavior and influence, family situations, parent adolescent communication (Abrahm & Kumar, 1999; Silieshi & Dejene, 2005).

2.8.1 Socio-demographic Factors

2.8.1.1 Religion: Different religious groups vary in their views of society and hence religious affiliation affects fertility behavior through its reaching and practice which shapes a women

beliefs norms and value orientations includes towards reproduction and family size. Religion has influenced the FP/RH usage behavior and attitude of an individual (Bnefo, 1995; Gregson et al., 1991).

2.8.1.2 Educational level: Many studies have documented significant difference in the involvement of family planning and reproductive health activity with educational level. Education of women has often been viewed as a strong factor, which can bring a change in every aspect of women's life. Education of women enhances their status, facilitates rational thinking of individual regarding family planning. Hence more educated people, make appropriate fertility decisions well in advance in the course of their marital life and tend to go for early contraceptive adoption. Finally, female education may assist in achieving the planned number of birth especially by facilitating knowledge of and access to contraception and by enhancing women's bargaining power with in the family (Cochrane, 1979).

2.8.1.3 Occupation and Women Status: Work status of women/occupation in one of measures of women's status which can affect contraception behavior of them and then fertility. Working women are more likely to use a contraceptive than those of housewives. Also, it is evident that the increasing status of women represented by education and employment decreases the number of children in Kazakhstan (Alsawi & Adamchak, 2000).

2.8.1.4 Peer Behavior and Influence: Research on peer influence on FP/RH initiation reflects the idea that women's decisions about whether or not to initiates RH/FP activity are strongly bound to social context, with peer playing an important role increasing a sense of normative behavior (Bongaarts, 1978).

2.8.1.5 Age: The age of an individual is one of the determinants of fertility that is associated with activities such as marriage, divorce and frequency of intercourse that affect fertility attitudes and behaviors. For married couples or an individual, the higher the age the higher the likelihood of having more surviving children. Thus shaping different contraceptive attitudes and behaviors among individuals, who are in different stages of their life cycle (Bongaarts, 1978), However, UN (1986) reports that age at first marriage is generally more significant, and from the total married women in the age group 15-49 in developing countries, the highest proportion in exhibited in Africa.

2.9 Relevance of Social Marketing

According to Jha (2005), the application of social marketing principles would have a far reaching impact on the development process. There are number of factors to testify the hypothesis that inclusion of public interest in the policy making processes of corporations would benefit organizations customer and society in many ways.

2.9.1 To Organization

The existence of an organization is very much related to the prosperity and well- being of the society. If the society is found non existent, we can not imagine the existence of an organization. An affluent society switches on the development processes. If, the defined Principles of social marketing are practiced in a right fashion; the demand cycle would not take a rest. And increase in the number of prospects result in an increase in the size of a market. And an increase in the size of a market results in to an increase in the strength of an organization this provides an opportunity to show the professional excellence a health environment to prosper (Jha, 2005).

2.9.2 To the Customer

Transformation of prospects in to habitual customers is a tough task which the marketers are supposed to perform. The customers' interests are involved in the essence of offering quality goods or services at moderate prices. It is significant here to mention that the social marketing principles advocate for a fair computation of costs and an optimal profit level which allows them to have a reasonable price structure. This protects customers' interests. In addition the social marketing principles are also opposed to products not friendly to the health of customers and the atmosphere in which they live. The social marketing principles advocate sensing, serving and guiding prospects in the right direction. A positive change in the organizational attitude would pave ways for multi-faceted positive service to the customer (Jha, 2005).

2.9.3 To the Society

The social interests are found well protected, if goods manufacturing or service is generating industries assign due to weight age to the application of social marketing principles. The protection of society is very much related to the protection and well-being of all the living

beings. The principles advocate that marketing decisions in no way ignore social interests. The Social marketing is relevant to the society since of late; the present and coming generations feel up protected (Jha, 2005).

2.10 Social Marketing: Behavioral Change Program

Andersen (1995) reported behavioral change as the bottom line for social marketing programs. This can not be said too often. It follows that target consumers hold the key to success for any social marketing program or campaign. They are the only ones who can actually change their behavior. Whether the target customer is a mother with a sickly child, an obstructionist health care worker, an important government official, or a major media figure, the social market must understand where the target customer is coming from and what can and should be done to bring about desired change. Jha (2005) stated that in simple cases, this may mean understanding the consumers' mood or pre-occupations. In more complex cases, it will mean understanding their perceptions, knowledge, attitudes, and predispositions. In still other cases it may involve understanding how environments affect their behavior. Anderson (1995) put five stages of behavioral changes as given below.

2.10.1 Stages of behavioral changes:

2.10.1.1 Pre contemplation: Consumers really are not thinking about the behavior as being appropriate for them at this point to their lives. Similarly this behavioral model also known as trans theoretical model in which individuals have no intention of adopting a recommended health behavior but are leaving about it.

2.10.1.2 Contemplation: Consumers are actually thinking about and evaluating recommended behaviors. In addition, the model in which individuals is considering adapting the recommended behavior.

2.10.1.3 Preparation: Consumers have decide to act and are trying to put in place whatever in needed to carry out behavior. In another ways the model is decision in which people decide to adopt the recommended behavior for a short period.

2.10.1.4 Action: Consumers are doing the behavior for the first time or first several times. And also it is the model in which people try to adopt the recommended behavior for a short period of time.

2.10.1.5 Conformation: Consumers are committed to the behavior and have no desire or intention to return to earlier behavior. Similarly as stated by Schivo (2007), this models said to a Maintenance in which people continue to perform the recommended health behavior for a period of time (at least above six months) and, ideally, in corporate it in their touting and life style.

2.11 Social Marketing: Health Communication

The health communications field has been rapidly changing over the past two decades it has evolved from a one dimensional reliance on public service announcements to more sophisticated approach which draws from successful techniques used by commercial marketers termed "social marketing". Rather than dictating the way that information is to be conveyed from the top-down, public health professional are learning to listen to the needs and desires of the target audience themselves, and building the program from there. This focus on the "consume" involves in-depth research and constant re-evaluation of every aspect of the program. In fact, research and evaluation together from the very cornerstone of the social marketing process (http://www.socialmarketing.com/what is.html).

The following diagram shows as to how health communication strategic model influence the social marketing mix.

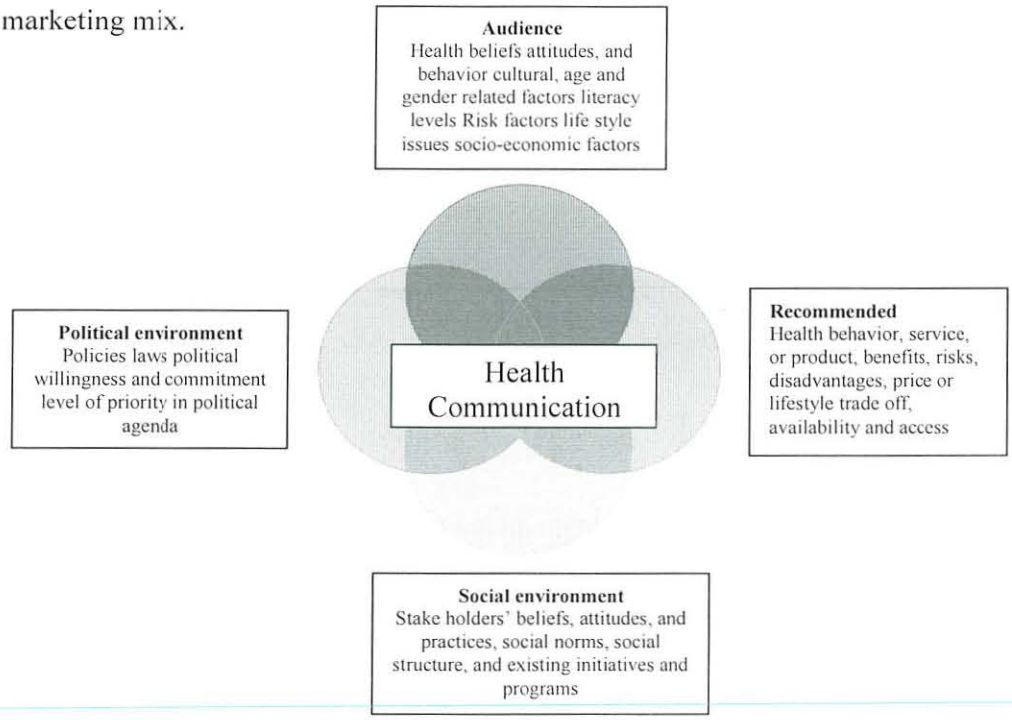

Figure 2. Health Communication Strategic Model (Source: Schiavo, 2007)

2.12 Social Marketing in Family Planning

2.12.1 Back Ground of Family Planning in Ethiopia

Some African countries particularly the majority of sub-Saharan African countries, are characterized by high population growth. This population growth can be attributed to high fertility. In sub-Saharan African countries, desired family size is typically more than four children (Bongats, 1999). Population has an impact on socio economic development, if there in no balance and harmony between the two. Economic and social growth will lag behind in the face of a rapidly increasing population. Due to this, the policy option is that to increase economic development, population growth has be reduced or kept within reasonable limits.

Ethiopia, the second most populous country in sub-Saharan Africa, has a population of more than 80 million and a high growth rate. But unlike many other African countries, it now also has a high demand for contraception; half of all women either wish to cease childbearing or to wait for at least two years to have another child. With the generous support of USAID, Ethiopia has implemented the RH/FP Project among a population of 32 million, which is 43 percent of the nation's population, achieving remarkable progress in creating demand for and use of contraception, improving awareness of HTPs and GBV, and raising consciousness of HIV/AIDS prevention (EDHS, 2005).

The current reproductive health situation in Ethiopia is challenging. The country continues to experience high fertility rates, low contraceptive prevalence and significant mortality due to maternal health issues and HIV/AIDS. While contraceptive knowledge is quite high, with nearly 84%of the population aware of at least one family planning method, utilization of such services remains low. According to the 2000 demographic and health Survey (DHS), total unmet need for family planning is around 36%, while the total fertility rate (TFR) remains at 5.9 children per woman nationally (6.4% in rural areas and 3.3 in urban areas). Ethiopia's high fertility and unmet need can be attributed to a host of factors, some related to the culture and society as a whole, and others to the service delivery environment. Among the former, for example, are traditional values- values that encourage large family size and early marriage, favor the boy-child, and discourage contraceptive use and promote harmful traditional practices (HTPs). Almost important are low literacy rates, the influence of religion and economic determinants that contribute to high fertility rate and unmet need (Health Communication Partnership, 2009).

2.12.2 Knowledge about Family Planning

Knowledge about family planning is an important step towards gaining access to and using a suitable contraceptive method in a timely and effective manner. Individuals who have adequate information about the available methods of contraception are better able to make choice about planning their pregnancies. It must be noted that knowledge about family planning is measured in terms of awareness about each method and not specifically about its correct use. Ever use of contraception provides a measure of the cumulative experience of a population with family planning. The current level of contraceptive use is measures depend on the actual contraceptive practice. It takes in to account all use of contraception, whether the concern of the user is permanent cessation of childbearing or a desire to space births. Current use of family planning services provides insight in to one the principal determinants of fertility. It also assesses the success of family planning programs (Moore et al., 2008).

2.12.3 Knowledge and Use of Contraception

Most women and men of reproductive age know about contraception. Knowledge of modern methods of family planning is substantially higher than knowledge of traditional methods among both women and men. Contraceptive knowledge increased from year to year especially for the age 15-24 and those never had sexual intercourse, though these groups remain less knowledgeable than older groups and those with sexual experience (Ibid).

2.12.4 Marketing of Family Planning

Before we go through marketing the family planning program, it is significant the we know about the concept when we say marketing family planning, our emphasis is on helping the organization, agencies involved in the process to formulate a service mix in tune with the target prospects or the segment for which the program is meant. This is Essential to increase acceptability of the program is vis-à-vis to strengthen the safety measures. The practices also help the organizations or agencies in promoting the Programs professionally go that whatever the advertisement campaigns or publicity measures are initiated show a positive result. In addition, the marketing family planning also focuses on simplifying the program in the process of its distribution to the ultimate users of the services. The channel should be small to minimize the five login the implementation process. In addition, we also go through the problem of making the program cost effective while developing or offering the services.

Thus, the perception of marketing family planning throws light on applying the principles of social or societal Marketing so that the concerned organizations or agencies succeed in sub serving the social interests (Jha, 2005).

2.12.5 Service-Mix for Family Planning

There are a number of devices to plan family, some of then are conventional where as same are non-conventional. It is upon the ultimate users to select a particular method. The main responsibility before the service provider is to motivate them in a right way so that what ever the confusion, misunderstanding they have perceived regarding a particular method is not to stand as a barrier to turn the prospects into actual users. The primary health centers, maternity homes and dispensaries and hospitals are found involved in the process to make the non-conventional methods popular. Striation, Tubectomy (for female), Vasectomy (for male), and Intrauterine Contraceptive Device (IUCD) are some of the measures which could be used to control the birth rate. Apart from these, service providers first find which device is the most appropriate for the audiences and also which contraceptive device is the best and safest for the clients. Of late, also find Intensive research regarding contraceptive vaccine and it is hoped that in near future, the scientists would be successful in making the device public (Jha, 2005).

2.12.6 Promoting Family Planning

Promotion, the most important dimension of marketing plays an outstanding role in raising the effectiveness of family planning. In the context of promoting family planning, intra-spouse communication inter-action or communication between wife and husband or the problem of family planning can also be helpful. The word-of-mouth communication or other promotional device can be instrumental in motivating them. The intra spouse communications develop a positive sense and the promoters then find it easier to motivate them or if they are convinced can also make other efforts to control birth rate (Jha, 2005) as shown in figure 3.

2.13 Elements of Success in Family Planning program

This element provides an overview of ten crucial elements that family planning Professionals around the world identified as contributing to the success of family (Richey & Salem, 2008).

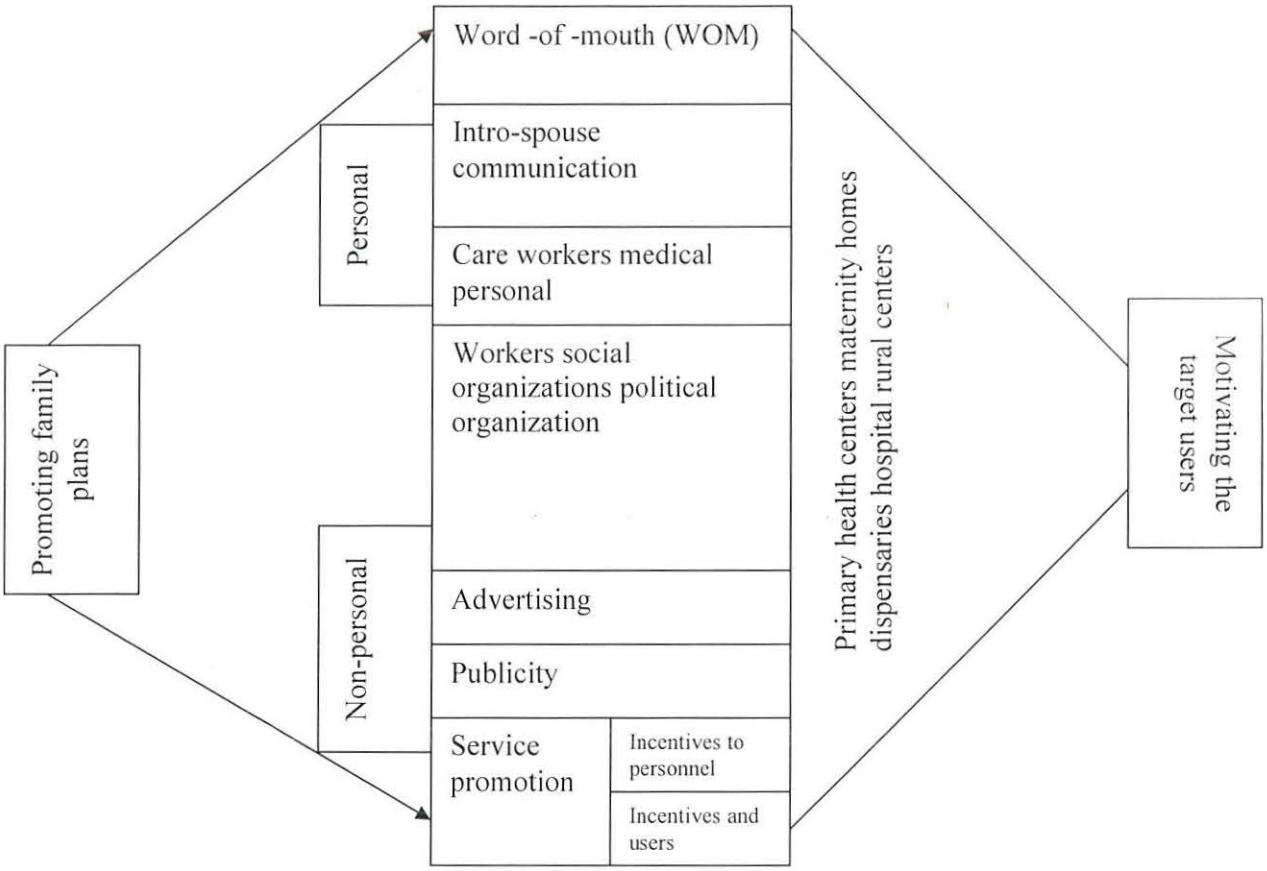

Figure 3. Family Planning Promotion Model (Source: Jha, 2005)

2.13.1 Effective Communication Strategies

To promote and sustain healthy behavior, strategic communication programs use a systematic process to develop and carry out communication activities, drawing on behavioral theory. They also use a mix of mass media, interpersonal, and Community-based communication channels.

2.13.2 Contraceptive Security

Successful programs provide contraceptive security: They ensure that people are Able to choose, obtain, and use high-quality contraceptives whenever they want them. The "seven Cs" that contribute to contraceptive security are: contextual Factors, commitment, capital, capacity, coordination, commodities, and clients.

2.13.3 Client-Centered Care

Programs should plan and implement services with clients' needs in mind. When Clients receive services that are tailored to their needs; they are more likely to find a Suitable contraceptive method and to continue using family planning.

2.13.4 Easy Access to Services

Offering family planning services through multiple channels, such as clinics and Retail outlets, helps clients to obtain services easily. Ensuring easy access also entails removing unnecessary medical barriers.

2.13.5 Affordable Services

Targeting subsidies to low-income users while shifting users who can afford to pay from the public sector to the private sector keeps services affordable for all clients. It also contributes to the financial sustainability of programs.

2.13.6 Appropriate Integration of Services

Integrating services, such as family planning with HIV care and prevention or with maternal and child health care, can address a wider range of health needs conveniently for clients. It also can be more efficient for programs.

2.13.7 Work for Supportive Policies

Showing howfamily planning contributes to developmentgoals makes the case for continued support forfamily planning programs.

2.13.8 Coordinate

When governments, donor agencies, and implementing partners work together, they streamline efforts and avoidduplication .

2.13.9 Build a High-performing Staff

Programs can keep workers motivated and on the job by creating a good working environment, matching skills with tasks, and rewarding a job well done .

2.13.10 Secure Adequate Budget, Use it Well

Spendingwisely, doing more with less, and fi nding waysto recover costs can help ensure fi nancial sustainability .

2.13.11 Base Decisions on Evidence

Research, monitoring, and evaluation yield important information to guide decision-making, and they need not be expensive .

2.13.12 Lead Strongly, Manage Well

Strong leadership helps programs navigate change. Good management solves operational problem .

CHAPTER THREE

RESEARCH METHODOLOGY

Based on the objective of the study, research methodology was applied for preparing instruments of data collection, sampling and data analysis. This chapter deals with the specific steps followed while collecting data, sample selection, and ethical grounds maintained in accomplishing research objectives.

3. Research Design and Methods

3.1 The Study Area

The study was conducted at MSIE which is located in Addis Ababa. MSIE delivers its services **in four branches of Addis Ababa**. From this four branches the student researcher selected Arada branch of Addis Ababa due to the high number of clients are receiving the service of MSIE in that specific branch.

3.2 Research Design

The major objective of this study is to assess the social marketing practices of MSIE, related to FP/RH and its influence in bringing behavioral change on the part of customers/clients. By following explorative and descriptive approaches, the study targets FP/RH service clients/users of the MSIE. Thereafter, the extent of MSIE practices to improve its client awareness and knowledge about FP/RH, as provided by the organization, was seen in association with changing behavioral patterns (practices). According to Malthora (2007), descriptive research under taken in order ot address social issues related to child are, drug abuse, reproductive health, family planning, hunger and poverty. Therefore, the study was conducted through the implementation of explorative and descriptive research to address social marketing issues.

3.3 Population and Sampling

The sample population for the study comprised of two types of respondents-FP/RH clients/users and the MSIE managerial staff. The major focus/target group of the study include females (age 15-49) approached to receive FP/RH services (clients) at Arada branch

of MSIE. Keeping the nature of clients and staff MSIE maintains, non-probability sampling approach was used in contacting target units (respondents) of the study. However, considerations were made to randomize the selection of respondents based on their age, marital status (married or unmarried), and occupational level. Therefore, the final data collection was administered for about a month, while maintaining sudden visits (both in the morning and afternoons) to the center, to avoid selection biasness up to some extent.

The sample size of the research is 250, drawn from the total estimated annual population of 15,000 (as declared by the organization under study) receiving the FP/RH services at Arada branch. All the respondents were contacted when they were appeared at the center for receiving services, and reached by the student researcher personally.

3.4 Sources and Instrument of Data Collection

Both primary and secondary sources were explored to obtain the data relevant for the study.

3.4.1 Primary Data

3.4.1.1 Questionnaire

The main instrument used in this study was a questionnaire, initially prepared in English and then translated to Amharic (Local) language, with the help of professional translators. The instrument is divided into three sections based on the subject of the questions **(Appendix I and II).** The First part comprises of 9 choice items, designed to assess the back ground/socio-demographic status of the target audience (users of FP/RH of MSIE), while the **second part** contains 3 questions to determine the usage/methods of FP/RH by the clients and the awareness creation about FP//RH.

The third part of the questionnaire comprises scale items reflecting social marketing mix and the behavioral change. All the statements under this section were placed on a 5-point Likert type scale, while asking the respondents to report their level of agreement (5-strongly agree and 1-strongly disagree) associated with each of the statement. Furthermore, the respondents were required to report on their beliefs from the past about the concept and use of family planning and related methods (contraceptives in practice/use.)

3.4.1.2 Interview

Finally, an interview was designed in English (structured questions) for the concerned management staff, whose task is directly linked with providing/facilitating the FP/RH services/programs in the MSIE. It was also carried out in order to cross check and enrich the information gathered through the questionnaires. The interview comprises of 13 questions **(Appendix III).**

3.4.2 Secondary Data

Secondary sources were explored to gather reviews from different published documents, reliable online archives like JSTOR and Emerald, books, and other publications related to the study area. These secondary data sources were also used in designing the instrument for primary data collection (questionnaire and interview).

3.5 Data Collection Procedure

All the clients visiting Arada branch for FP/RH services, were invited by the researcher to participate in the study, by briefing them about the rationale and benefits of the present research. Furthermore, based on the convenience of respondents accepted the invitation of participation in the study, selection was made by the student researcher, and questionnaires were handed-over. For the managerial staff at MSIE, the researcher first asked the chief and the main manager to identify those managerial members who have direct concern to the programs/services of MSIE. In all case, the users of MSIE FP/RH program were provided with a brief explanation about the study, and asked to fill out the questionnaire individually, besides, they were assured that their response would be kept in strict confidence, and would never be revealed to any third party.

3.6 Data Analysis Approach

Before administrating the questionnaire for final study, a pilot testing of the instrument was carried out with 30 respondents, to obtain the valuable insight in designing and updating the instrument on language and content part. From the 30 distributed questionnaires 27 were returned and completely filled. According to the pilot study result, 13 questions were discarded from the Likert scale part of the questionnaires because they have scored below 0.5 when factor analysis was carried out. Finally, the questionnaire comprises only 60 questions

which were distributed for the final study. To analyze the data obtained through questionnaires, descriptive analysis together with chi-square and correlation analysis were employed.

All the analysis was performed by SPSS 13 windows version (statistics package for social science). **Descriptive analysis (percentage and mean value)** were used to analysis respondents general profile and the Likert scale type questions respectively. Before finding the mean value, the average value of each Likert scale type question was analyzed by using transform analysis method and the mean value was assigned to each seven dimension of Likert scale type questions. Factors affecting family planning and contraceptive use were obtained and their association was identified with a behavioral profile of the respondents about FP/RH through **chi-square** analysis method. **Correlation** analysis method was also employed to observe direction and relation ship that was found in the Likert type questions which were categorized in to 7 dimensions.

3.7 Ethical consideration

All the research process starting from finding of secondary data source up to the final analysis of the data were taken place with due follow up of the department of business education. To visit different libraries and social marketing organizations (Government organization and NGOs) the student researcher was supported by formal letters which were prepared by the business education department. And also to distribute the questionnaires and to conduct interview those formal letters were given to responsible management units of the MSIE.

CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

Data collected, by following the methodology as presented in the last chapter, were exposed to various statistical analyses to generate the results inline with research objectives. This chapter explores the techniques used in computing the general profile of the respondents of the organization, social marketing trends, marketing mixes, perception, and attitude/beliefs of FP/RH customers by using the descriptive, chi-square, mean value and correlation analysis.

4.1 Descriptive Analysis

Descriptive statistics were applied to summarize percentages of the respondents on different back ground characteristics.

Table 1: Response on the age and number of children

Characteristics	Variables	Percent (%)
Age of respondents	15-20	24
	21-25	53
	26-30	13
	31-35	7
	36-40	3
	>40	0
Number of children	0	74
	1	10
	2	13
	3-5	2
	>5	1

Source: Survey Data

With regard to age, almost half of the respondents, (53%) were found on the age group 21-25, while one fourth of the respondents (24%) 15-20, (13%) were 26-30, the other (7%) were 31-35 and the remaining (3%) of the respondents were found on the age group 36-40. But, there were no respondents in the age group which is greater than 40. This implies the majority of the respondents were in the age category/group of 21-25, this result shows that, most of the users of FP/RH are those individuals who are on the age of high fertility. With regard to the number of children, almost three-fourth (74%) of study respondents were responded as having no children, and this implies the majority of the respondents have no children due to their awareness about controlling pregnancy and the rest have at least one, which is: (13%) had two children, (10%) had only one child, (2%) respondents have children between 3-5, the rest of the respondents (1%) have children more than 5 (Table 1)

Table 2: Response on education and marital status

Characteristics	Variables	Percent (%)
Education	No schooling	4
	Primary	11
	$10^{th}/12^{th}$	39
	Diploma/1^{st} degree	44
	Masters and above	2
Marital Status	Single	61
	Married	32
	Divorced	4
	Other	3

Source: Survey Data

Regarding the education background of the respondents, (44%) of the study respondents were completed their diploma/first degree followed by the second largest respondents (39%) were 10th/12th grade complete, next (11%) were attended primary school, the remaining (4%) were not attended schooling and the rest (2%) were educated in the level masters degree and above. This result implies more educated women, make appropriate fertility decisions well in advance in the course of their marital life and tend to go for early contraceptive adoption.

Moreover, marital status of women looks to have some effect on the use of contraception as expected the highest number of the respondents, (61%) were single (not married), while the (32%) were married, the remaining (4%) of the respondents divorced, others respondents (3%) were widowed. This implies that more than half of the respondents who use contraceptives were single (not married) to avoid unwanted pregnancy (Table 2).

Table 3: Response on the variables duration of marriage and occupation

Characteristics	Variables	Percent (%)
Duration of Marriage	<2	13
	3-7	6
	8-12	12
	13-17	8
	>17	1
Occupation	Government	19
	Private organization employee	49
	Students	25
	Others	7

Source: Survey Data

According to Table 2, from the total percent of respondents, only (32%) were married and the rest were reported as unmarried. And according to Table 3, regarding the duration of their marriage, most (13%) of the study respondents from the married were experienced less than two years of marriage duration followed by (12%) who were having a marriage experience for 8-12 years and (8%) of the respondents were stayed 13-17 years under marriage , (6%) of the respondents were between 3-7 the rest (1%)of the respondents were above 17 years marriage duration.

According to the data (Table 2), Unmarried women have the highest prevalence of the usage of FP/RH products/services while, married women were less prevalence for using the contraceptives (FP/RH) products/services. This may be seen as an implication as unmarried women do not want having a child before marriage. Table 3, also shows work status

(Occupation) of respondents and almost half (49%) of women employed in private organizations, while, (19%) Government employees, the remaining (25%) were students; the rest (7%) respondents do not have permanent occupation that helps them for generating income. This study implies, women working outside home reported the highest population from the total respondents who are using and being aware about family planning programs.

Table 4: Response on monthly income, religion and ethnicity

Characteristics	Variables	Percent (%)
Monthly Income(ETB)	<200	18
	201-500	24
	501-1000	28
	1001-2000	15
	>2000	15
Religion	Christian	90
	Muslim	8
	Others	2
Ethnicity	Amhara	44
	Tigre	17
	Oromo	31
	Gurage	8
	Other	0

Source: Survey Data

Regarding the wealth (income) of the women the about one fourth of study subjects (28%) have an income above 500 ETB, (24%), 201-500 ETB, (18%) below 200 ETB, (15%) 1001-2000 ETB, and the rest (15%) earn monthly income above 2000 ETB . Concerning religion the great number of respondents (90%) were Christians while the rest (8%) were Muslims the other respondents (1%) were reported as being followers of traditional belief. Regarding to the ethnicity nearly half (44%) of the respondents, were Amahra, while the second highest (31%) were Oromo, the remaining respondents (17%) were Tigre and the rest

(8%) were Gurage. This implies among the respondents who are using contraceptives Amharas and Oromo's were having the dominant share.

Table 5: Awareness, Contraceptive Types and Purposes for Use

Characteristics	Variables	%
Promotional tools that the client be aware of MSIE FP/RH program	News paper	11
	Television	25
	Friends/relatives	77
	Community-based communication	45
	Broacher/Pamphlets	19
	Other	3
Contraceptives approach's/methods used by clients	Pills	36
	IUD	14
	Injectable	22
	Condom	24
	Sterilization Male/Female	1
	Nor Plants	3
	Others	0
Purpose/idea behind the usage of FP/RH	To limit the family	77
	To prevent Sexual Transmitted	22
	To have an interval between births	52
	To avoid unwanted pregnancy	72
	To stop delivery births	22
	Others	4

Source: Survey Data

Regarding the promotional tools accessed by respondents which can help them to be aware about FP/RH service of MSIE, Table 5, reported that above three fourth (77%) of the respondents have got information about FP/RH from friends/relatives, while (45%) from

community-based communication, followed by (25%) of the clients who received information from TV advertising and others (19%) from broachers/pamphlets and the rest respondents (11%) from news paper, (6%) receives information from radio. As the results of the analysis shows, most of the clients get informed about FP/RH from their friends/relatives and this shows that clients of MSIE are more dependable on the information of their friends /relatives rather than following other promotional tools.

Regarding contraceptive approach/method used by clients of MSIE (36%) of the respondents used pills while, (24%) used condoms, (22%) used injectabeles, (14%) used IUD, (3%) Norplant and (1%) of the study subject used sterilization. The result of the analysis showed that the majority of the respondents used pills and condoms; this might be due to the reason that, the majority of the respondents were not married, and they are not willing to use the long term contraceptive method.

Concerning the purpose/idea behind the usage of FP/RH, when the respondents were required to fill more than one choice/option at a time they were responded as follows: more than three fourth of the respondents (77%) use FP/RH to limit the family size, (72%) to avoid un wanted pregnancy, (52%) of the respondents responded to have an interval between births, the rest of the respondents use FP/RH to stop delivering births, the remaining (22%) to prevent sexual transmitted diseases, while, (4%) use FP/RH for their economic reasons. As the study result shows, the highest number of the respondents has knowledge/awareness about FP/RH to limit birth. While the second highest number of the respondents also use FP/RH to avoid unwanted pregnancy. This analysis implies the highest number of the respondents/clients agree by the objective of the MSIE children by choice not by chance (Table 5).

4. 2. Chi-Square Analysis of the Respondents

Table 6, shows the Socio-Demographic and methods of contraceptive usage by using Chi-square analysis to show the association between methods of contraceptive offered by MSIE with various socio-demographic characteristics of the respondents. The chi- square statistical analysis does not tell us the relative contribution or net effect of each variable, but only can indicate the existence of association. Once the chi-square result in presented, the differential of each variables is discussed thoroughly in order to have a clear understanding.

Table 6: Results of Chi -square Statistical Significance Test between Selected Socio-Demographic Characteristics and Types of Contraceptives used.

Age of the respondents	Methods/Approach of contraceptive usages						$\chi 2$ value	Chi-square significance
	Pills	IUD	Inject able	Condom	Sterilization Female	Nor plants		
15-20	12	4	3	3	0	2	**38.243**	**0.008**
21-25	17	5	12	17	1	1		
26-30	2	3	5	3	0	0		
31-35	3	2	2	0	0	0		
36-40	2	0	0	0	0	1		
>40	0	0	0	0	0	0		
Number of children							**225.096**	**0.000**
0	27	9	15	20	0	3		
1	6	1	1	2	0	0		
2	3	4	5	1	0	0		
5-3	0	0	1	1	0	0		
>5	0	0	0	0	1	0		
Education								
No schooling	1	1	2	0	0	0	**127.829**	**0.000**
Primary	2	1	4	3	0	1		
!0th/12th com.	19	5	8	6	0	1		
Diploma/Degree	14	7	7	15	0	1		
Masters & above	0	0	1	0	1	0		
Marital status								
Single	24	6	13	15	1	2	**22.622**	**0.092**
Married	11	8	6	6	0	1		
Divorced	1	0	1	2	0	0		
Others	0	0	2	1	0	0		
Occupation								
Government Employee	7	4	2	5	0	1	**26.146**	**0.161**
Private Employee	16	6	13	12	0	2		
Student	11	4	4	5	1	0		
Other	2	1	2	2	0	0		

Source: Survey Data

Regarding the association between age of respondents and methods of contraceptive used by the respondents there exists a significant association between the two variables ($\chi 2$= 38.243, p <0.05). From the total age categories, the majority of the respondents who use FP/RH lie on the age group 21-25. This implies this age is the very critical determinants of the chi-square test because, the respondents are found in high fertility age, they exposed themselves to various usages of contraceptives methods than the rest age groups.

The table also indicates that from all type of contraceptive devices, high numbers of respondents prefer pills than other contraceptive methods. This may be due to the reason that pills is more suitable and comfortable for the respondents to control birth because, it may be easily available, affordable, accessible and used/applied with out the support of any health care service providers.

With regard to the association between number of children and methods of contraceptive usage, the chi-square results shows that there is a statistical high significant association between the above variables ($\chi 2 = 225.096$, $P < 0.001$). When we compare respondents who have children with those of respondents who do not have, most of the users of contraceptives were applied by those respondents who do not have any child. This implies that, the respondents use contraceptive device due to the reason that, they do not engage themselves in to marriage or other family responsibilities and they use different contraceptive methods to avoid unwanted pregnancy.

Table 6 depicts that there is strong association between educational statuses of respondents with their usage of contraceptive devices. As indicated in the chi-square test, the two variables were found to have strong /significant relationship, because the value of cross tabulation shows ($\chi 2 = 127.829$, $p < 0.001$). In addition to this, strong association between educational level of respondents and usage of contraceptives shows that from the total users of contraceptives majority of them are completed their diploma/first degree program. This indicate that, majority of the users of contraceptive were women who attend the formal education, because from the total respondents only (4%) are illiterate or not attend any school. This may be largely explained by the fact that educated women are more knowledgeable about the appropriateness and importance of usage of contraceptive device than women who are not educated (illiterate).

As presented in table 6, the computed chi-square showed no significance association between marital statuses and method of contraceptive usage. ($\chi 2 = 22.622$). Regarding the item on usage of contraceptives and marital status there is no any significance association between the two variables, whether respondents married or unmarried it does not have any influence on their application of contraceptive, this is may be both married and unmarried women have equal access to the usage of contraceptive method and awareness to protect unwanted pregnancy. Furthermore, chi-square test revealed, there is insignificant association between occupational status of respondents and contraceptive methods they applied ($\chi 2 = 26.146$). This

shows that occupation of respondents (whether they have job or not) could not interfere on the usage of contraceptives. Table 6 also portrays, even though large numbers of respondents were employees of private organizations this does not have any implication as far as the usage of contraceptive methods concerned. Finally, this study shows using FP/RH methods were applied equally by both employed and unemployed women.

4.3 Responses on the Scale Items

The scale items (48) were converted in to 7 dimensions. For the research purpose the total mean value of each dimension was take in to account. Some times the value which is below the mean average value was described by the student research along with that of the total mean value. To measure the mean value of each dimension the "5" scale were converted to "3" mean categories, "1" represent strongly disagree and disagree, "2" represents neutral (neither agree nor disagree), "3" represents strongly agree and agree. Thus the score below "2" for the items under the 7 dimensions, "1" stating about respondents were disagree/dissatisfied with the specific dimension (questions), and scores mean or average which is above "2" describes respondents agreement the question of each dimension the middle point which is "2" implies, respondents do not know or want to say any thing about the question or dimension rather they want to be neutral.

Table 7: Clients' Response on Product/Service and Experience of MSIE

Dimension	Items	Mean	Standard Deviation
PRODUCT/SERVICE/EXPERIENCE(PRS)		**2.45**	**0.402**
	PRS1	2.72	0.651
	PRS2	2.58	0.753
	PRS3	2.36	0.833
	PRS4	2.54	0.742
	PRS5	2.38	0.774
	PRS6	2.14	0.874
	PRS7	2.41	0.778

Source: Survey Data

Regarding product/service and experience of MSIE, users assigned the average mean value (2.45). This implies that clients were agreed up on the questions which are listed in the first dimension. Because clients are approaching to agreement with the existence of FP/RH program of MSIE (2.72), their interest in adopting FP/RH methods of MSIE (2.58) ,delivery of beneficial FP/RH products through MSIE (2.36), providing a right to avoid unwanted pregnancy (2.54), about the provision quality of FP/RH product /service (2.38), respondents also gives more than the mean value for the question of waiting longer time to obtain the product, service of MSIE (2.14) and respondents gave (2.41) for the questions about delivering of product/service of MSIE that best suit their requirements/needs. It can be inferred from table 7 respondents are satisfied by the products/services and experience of FP/RH, even though, they wait longer period of time to obtain FP/RH service /products from MSIE .

Table 8: Perception of Respondents towards Service Providers of MSIE

Dimension	Items	Mean	Standard Deviation
PERCEPTION (PER)		**2.153**	**0.289**
	PER1	2.58	0.766
	PER2	2.5	0.783
	PER3	2.29	0.806
	PER4	2.54	0.729
	PER5	2.38	0.787
	PER6	2.48	0.757
	PER7	2.38	0.824
	PER8	2.53	0.687
	PER9	1.81	0.41
	PER10	2.53	0.715
	PER11	2.2	0.777

Source: Survey Data

Regarding respondents' perception about MSIE program the response level approached (2.153), i.e. customers have a positive perception about service providers knowledge and program of MSIE. Like, questions related to service providers, knowledge about FP/RH product/service (2.54), satisfying need and requirement of the clients (2.29), service providers respect to the privacy of their client (2.38), the guidance of the service providers about the contraceptive methods, benefits and side effects they assigned a mean value less than 2 (1.81). This shows respondents could not get appropriate advice/guidance about MSIE products benefit or side effects. With regarding to other perception questions like creating responsibility towards a society, to maintain a small families (2.58), to improve quality life of women (2.5), insuring equal participation, from both husband and wife (2.38) respondents assigned higher mean value for showing their agreement.

Finally, a respondent reported their perception towards MSIE effort in involving a community to take active part in FP/RH program (2.48), provision of modern FP/RH service (2.53), the operating hours of its clinic or health centers (2.53) and weather running a special program for under-served groups (2.2). All this results shows respondents have a positive perception towards the activities of MSIE for the provision of its product/service. From this we can infer that the respondents perceive the cooperation and respect of MSIE service providers in a positive way but, they perceive the guidance of MSIE service providers towards creating awareness about the benefits and side effects of contraceptive methods negatively. Due to this customers could not choose the right contraceptive method which may be preferable and suitable for them and due to this reason they may relied on word of mouth communication even with individuals without related profession.

Table 9, illustrate the attitude/belief of respondents on the over all MSIE product/service. The average mean is (2.153). In the case of questions that using contraceptive reduces sexual power (1.8), customers' hesitation to the suitability of MSIE contraceptive (1.99) and users' belief that contraceptive damage the naturalness of sexual intercourse (1.61). All the above three questions have a mean value less than the average (2) this indicates that, customers were not gave their agreement to the questions. From the result we can infer that respondent's belief MSIE FP/RH product/service does not decrease/reduce their sexual power/intercourse. And they also believe that FP/RH methods do not avoid the naturalness of sexual intercourse and they are suitable for them to be used. Concerning the belief of respondents on creating interest in adopting FP/RH methods (2.43), becoming happy with the behavior of health

center workers (2.46), receiving advice or services now than the past time (2.54), knowing about contraceptive use in the modern age (2.79), customers believes in postponing the increasing number of family size until the person is ready to take responsibility (2.71) and clients wish/plan to continuous the usage of MSIE product/service (2.56).

Table 9: Respondents Beliefs/Attitudes towards MSIE Service Providers

Dimension	Items	Mean	Standard Deviation
ATTITUDE/BELIEF(AB)		**2.321**	**0.263**
	AB1	1.8	0.885
	AB2	2.43	0.818
	AB3	2.46	0.782
	AB4	1.99	0.88
	AB5	2.54	0.656
	AB6	2.79	0.59
	AB7	1.61	0.489
	AB8	2.71	0.639
	AB9	2.56	0.793

Source: Survey Data

These result reflects customers have a positive attitude or belief for the service providers' behavior, getting more knowledge now than in the past and for continuing usage of FP/RH in their life .

With regard to Table 10, which deals with socio-cultural view, respondents were asked about four questions and their responses are presented as follows. The total mean value assigned by the responds was (2.53). Respondents view to a questions about FP/RH service of MSIE are culturally accepted (2.05), female based method are successful than men oriented (2.54) and the equal provision of FP/RH service for both married and unmarried females (2.5). This implies cultures as well as status of marriage (married or unmarried) do not influence contraceptive usage of clients of MSIE.

Table 10: Socio- Cultural Stand of Respondents

Dimension	Items	Mean	Standard Deviation
SOCIO-CULTURE(SC)		**2.253**	**0.407**
	SC1	2.05	0.912
	SC2	1.85	0.7
	SC3	2.54	0.715
	SC4	2.5	0.743

Source: Survey Data

Concerning the question about their religion's influence on accepting/rejecting the concept of FP/RH, it was reported that major respondents put a mean value (1.85), which is below average (2) , This indicates that respondents were not influenced by their religion because it do not have any interference (influence) on accepting/rejecting the concept of FP/RH methods.

Table 11: Affordability (Price) of MSIE FP/RH Products

Dimension	Items	Mean	Standard Deviation
PRICE (PR)		**2.253**	**0.507**
	PR1	2.03	0.879
	PR2	2.43	0.78
	PR3	2.3	0.857

Source: Survey Data

Table 11 shows that, respondents view about the price of MSIE products. On this table three questions were included and the total mean for those three questions was (2.253). With regard to individual price related questions like, price of contraceptive largely affects the decision of customers (2.03), customer usage of FP/RH service of MSIE for economic reason (2.43), and MSIE offers FP/RH products at low cost (2.3). The mean value that were given for all three individuals question and one general dimension were above average (2). This indicates that price of contraceptive do not affect the decision of the users to use or not to use FP/RH

products. In other words, the price of the MSIE products/services is affordable at a lower cost i.e FP/RH products of MSIE are provided by considering the purchasing power of people. This is one of the main goals (objectives) of social marketing to the needy. According to UNAIDS condom social marketing (2000), social marketing should be practiced to make health related information and product/services easily available and affordable to low income people and those at risk.

Table 12: Convenience and Location of MSIE

Dimension	Items	Mean	Standard Deviation
PLACE (PL)		**2.403**	**0.512**
	PL1	2.25	0.781
	PL2	2.44	0.685
	PL3	2.52	0.743

Source: Survey Data

Concerning to one of marketing mix dimension (place) customers was asked to respond for three questions. The total average mean value respondents assigned for the dimension (2.403) and the respective mean value for each question were as follows. Responses for the questions MSIE maintain wide net work of clinic-based and non-clinic based service delivery respondents signed a mean value (2.25), about the availability of MSIE service throughout its own health clinic (2.44), and as to the convenience of the service centers location (2.52). The possible reason for this, MSIE provides its service/product at a convenience place which is suitable (comfortable) to the clients because, the study area is situated at the center of Addis Ababa and convenient for transportation availability. Due to this, customers responded their agreements positively for MSIE place convenience and reach ability.

Response of Promotional Tools for Implementation MSIE Service/Products

Regarding promotional tools that MSIE uses for creating awareness on the part of its clients about its product/service, respondents asked 11 questions. For all this questions the respondents' total mean value was (2.383).

Concerning questions about the application or usage of various communication media like the use of magazines, printing materials, (2.48), about usage of community-based communication and informal groups discussion(2.61), promotion of it's service through all its communication facilities (3,71). This implies MSIE uses various promotional tools for promoting its program and products because, customers' scores more mean value that imply their agreement. For questions knowing FP/RH services/products of MSIE respondents assigned a mean value (1.66) it is below the mean value. This indicate even through the MSIE uses various communication/promotion tools users are more dependent on the information gathered from their peer/relatives or community-based discussion rather than the formal MSIE communication tools like, TV, Radio, Magazines, Broachers and others different medias.

Table 13: Promotional Tools for Implementation MSIE Service/Products

Dimensions	Items	Mean	Standard Deviation
PROMOTION(PRO)		**2.383**	**0.317**
	PRO1	2.39	0.813
	PRO2	1.66	0.477
	PRO3	2.43	0.83
	PRO4	2.48	0.743
	PRO5	2.61	0.693
	PRO6	3.71	1.11
	PRO7	2.36	0.821
	PRO8	2.46	0.756
	PRO9	1.81	0.893
	PRO10	2.46	0.782
	PRO11	1.85	0.855

Source: Survey Data

Also, respondents were reported as mean value below 2 (average) that is (1.8) about the existence of negative word-of-mouth communication about MSIE product/service. This implies respondents do not agree on the existence of bad word-of–mouth communication

through out the society (the society do not communicate negative ideas/information about the MSIE product and service) i.e. MSIE delivers products/services which are acceptable by the community.

With respect to the questions like MSIE continuously engage itself in creating awareness (2.39), to encourage other people to take FP/RH service (2.43) , making clients clear on various myths about FP/RH (2.46), MSIE communication using contraceptives prevents STD's (2.46) and promotes the idea of contraceptive than usage of abortion (2.36). Due to the above results the users of MSIE FP/RH do have an agreement on MSIE promotion towards creating awareness for its clients and to change their behavior on various myths about the idea of contraceptives. Regarding the poor/bad impression of local medias the mean value assigned (1.85). This shows the disagreement of respondents to this specific question. i.e clients believe that MSIE has a good impression on the eyes of local medias.

4.4 Correlation Analysis

Correlation table used to express the directions and relation ship of variables (between -1 and +1). The table also helps to gain understanding as to the strength of the relation ship that exists between variables.

Table 14: Correlation Analysis

	PRS	PER	AB	SC	PR	PL	PRO
PRS	1						
PER	.614**	1					
AB	.525**	.457**	1				
SC	.247**	.290**	.145**	1			
PR	.241**	.289**	.454**	.310**	1		
PL	.222**	.239**	.162*	.049	.257**	1	
PRO	.471**	.535**	.553**	.134	.470**	.353**	1

Source: Survey Data

** Correlation is significant at the 0.001 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Note: PRS – Product/Service and Experience, PER – Perception, AB- Attitude/belief, SC- Socio-cultural view, PR- Price, PL- Place, PRO, Promotion.

Table 14 reveals the simple bi- variate correlation that exists between variables. It is shown in the table, product/service /experience of MSIE and customer's perceptions were found to be significantly and positively correlated ($p< 0.001$) with attitude/Belief and socio-cultural view of respondents and price, place promotion mix of MSIE programs.

There is also a significant association between the individual product/service dimensions with the rest of six social marketing dimensions. This was reported from higher to lower perception of clients (0.614) promotion (0.471), Attitude/ Belief (0.425), Socio-cultural view (0.248). Price, (0.241), Place (O.222). On the other hand place that MSIE provides its service was found to be insignificantly associated with the socio-cultural view of the respondents. ($r= 0.049$). Although the place dimension of the table have relation ship with attitude/behavior of the respondents it is significant at $p<0.05$ ($r= 0.162*$). In addition to this the promotion tools of MSIE did not have association with the socio-cultural view of the respondents ($r= 0.134$). The rational behind the result implied that, the respondents' socio-cultural background /view did not have significant influence in launching or designing promotional programs. Further more place/convenient location of receiving FP/RH products do not have relation ship with the socio-cultural profile of the respondents. This shows that, weather respondents have various beliefs/attitudes they can receive product/service of FP/RH at the place where it is found.

4.5 Interview result of MSIE Management units

As it was found from the interviewed management unit of MSIE, the organization applies the commercial marketing mixes (4p's) for addressing its objectives. And as the interviewee stated that, FP/RH products of MSIE are highly qualified and given by those of service providers who are well experienced in the provision of FP/RH service. MSIE frequently uses the printed promotional media like pamphlets, magazines, news papers, brochures and community-based peer group/relatives discussion for as their main promotional tools. This information also supported by the questions data found in Table 5.

MSIE maintains different partners to secured funds from donors such as UK, European Union (EU) ComiRlief, USAID/AID, Pathfinder International, Family Health International, Christian Relief and Development Association (CRDA) and World Bank. The priority or major objective of MSIE is to develop cost effective projects to deliver those services (FP/RH) that meet the local needs. To up-grade its experiences MSIE also works in

collaboration with various international communities to get practical expertise advice or technical assistance in FP/RH programs/service. The organizations not only receive expertise assistance it also provides world wide consultancy and technical assistance to governments multilateral and bilateral organizations, NGO and other private sectors.

As the management unit said that, MSIE established its own guidelines to communicate about FP/RH with the society members. This guild line is written in pamphlets and brochures to make clear awareness of the clients. As mentioned by management unit the key component of MSIE, social marketing program is more focused on those FP/RH product /services followed by promotional programs. These two social marketing components help or play a great role in the prevention of unwanted pregnancy, STDs and to create space between births.

Finally the program coordinator said, MSIE FP/RH program is designed to create brand awareness, to get acceptance among users, to provide orientations, trainings about the importance of FP/RH usage, to bring behavioral change , and make them clear and to provide them right on their choice .

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Based on the analysis carried out and the findings reported, this chapter presents the summary conclusion and recommendation.

5.1 Summary

The study was conducted to explore the social marketing practice of MSIE in specific to the program of FP/RH. The study also attempted on the female users of FP/RH (both married and unmarried) among aged group 15-49 in the Arada Branch of MSIE Addis Ababa region.

This study was devoted to examine basic socio-demographic and cultural status of respondents and the social marketing mixes of the organization on the usage of contraceptives methods in order to measure the overall behavioral change of clients in that specific area.

In order to gain sufficient insight about social marketing practice of MSIE various related literature were reviewed. The review of related literature, thus, later served as for developing data gathering tools (questionnaire having seven dimensions and interview that was conducted with the management unit of social marketing of MSIE.

The methodology section which consists of (data source, data collection, data organization and analysis) is one of the most important parts of the study. A questionnaire consisting of 12 general items and 48 Likert-scale statements were developed and used to elicit the required information from the respondents. Also the interview was conducted with three management unit of MSIE to get information about the FP/RH social marketing program. About 250 respondents were selected by using non probability sampling particularly accidental sampling technique but the analysis of the study was made based on 200 returned questionnaire from the total 250 distributed questionnaires.

Percentage method was used to analysis the general back ground of the respondents (age, education and marital status, number of children, occupation, income, religion and ethnicity. Correlation analysis was used to show the direction of the relationship that exists among the dimension found in the second section of the questionnaire (likert type) (product /service and experience, perception, attitude/behavior, socio-cultural view, price, place, and promotion).

And the mean value of the dimension were also found by using descriptive analysis to determine the agreement or disagreement level of the respondents for each (7) dimensions to measure the knowledge/ awareness level of respondents towards FP/RH program of MSIE . Finally chi-square method was implemented in order to see the association which is found between the socio demographic characteristic of the respondents with the usage of various contraceptive methods offered by MSIE.

As the study indicates among all the demographic variables included in the study age of women and their educational status have a significant influence on contraceptive usage. It is observed that women in the age group of 21-25 years have a higher contraceptive usage than the other age group, this is because the high reproductive/fertility stage of women, and also their need to avoid unwanted pregnancy. As shown in the analysis the education status of the respondents is also the other significant factor that influence the usage of FP/RH because 44% of the respondents were educated (attend their diploma and first degree program).

Regarding the access of promotional tools most of the respondents (77%) get information about FP/RH from their friends and relatives. This indicates that respondents prefer information delivered through their relatives and friends than through other promotional tools.

The cross tabulation results of the analysis reveled that the number of children and methods of contraceptives applied by clients showed strong/significant association. Large number of FP/RH users (74%) was not having any child. This shows that having a child or not do not influence the usage of contraceptive of respondents because majority of the respondents do not have children. Beside of this, marital status of the respondents does not have any association with the method of contraceptive used by clients. As seen from Table 2 (61%) of users were unmarried. Based on this the marital status of women do not have a significant influence up on the usage of various contraceptive methods.

Result from the mean/descriptive analysis about the product/service and experience dimension shows respondents favors the FP/RH products/services of MSIE because; they assigned a mean value more than average for all products related questions. But with regard to the dimension of belief/attitude the respondents were not provide their agreement on the belief that contraceptive reduces the sexual power of the users and damage the naturalness of sexual intercourse.

In the correlation analysis, it was revealed that the socio-cultural view of respondents did not maintained a significant influence on the place/location where the product is available and on the promotional tools used by MSIE to communicate with the target audience because as shown in Table 14, value for those (place and promotion dimensions) were r=0.049, and r=0.134, respectively.

Correlation analysis also reveled that; price of FP/RH of MSIE does not have an influence on the usage of respondents. This indicates that MSIE provides its FP/RH products at a lower price.

5.2 Conclusion

The objective of the study was to examine and assess the development and implementation of social marketing mixes at MSIE. It was intended to evaluate the performance of the social marketing practice of MSIE with respect to bringing altitudinal and behavioral changes towards its customers/clients.

On the bases of objectives, data collection and analysis made the following conclusion were drawn.

Conclusion drawn from the general profile of respondents showed as:-

- It is believed that age and educational status of respondents are great determinant factors that influence usage of FP/RH program than the other general profile of the respondents.
- As shown in the chi-square analysis, large number of respondents who used FP/RH methods from MSIE does not have children. This implies respondents who were single or unmarried were also users of FP/RH for controlling births before marriage.
- Results founded from the analysis shows that there is no relationship between marital status of respondents and usage of contraceptives methods. This shows that, the FP/RH products/services of MSIE are delivered for both married and unmarried women with out any pre-determined criteria.
- Based on the promotional tools used by MSIE to influence the behavior of clients, majority of the respondents were not followed message transmitted through mass

media, rather clients depend on the message which is delivered from peer groups/relatives and community –based. This shows that MSIE information delivered through those mass media could not reached the appropriate target audience.

- From the seven (7) dimensions results found from the mean analysis respondents were agreed by the MSIE FP/RH product/service. This indicates that, they are satisfied with the product/service of MSIE. i.e., MSIE provide FP/RH service/product in its own clinic/ health centers which is acceptable and comfortable by the users.

- Concerning result that has been found from the correlation analysis socio-cultural view of respondents did not have any association with place dimension. Although, the subject of this study have various socio-cultural view, this did not influence clients for the selection of place/convenient for receiving FP/RH product/service of the MSIE.

- Regarding price of FP/RH products/service of MSIE it does not have any significant influence on the usage pattern of respondents. This is due to the MSIE social marketing program is directed to provide the product/ service at a lower cost to people in the society.

- To explore the MSIE service providers, guidance and counseling service that were given to the respondents, subjects were not get adequate/sufficient guidance as to the benefit and disadvantages of various FP/RH products available in the clinic. Due to this respondent did not get awareness and knowledge about the overall FP/RH program by the employees even if the management have a concern of having well experienced staff capable to support the program of MSIE.

5.3 Recommendations

Based on the above summary and conclusion, valuable recommendations were made by the student researcher.

- To change behavior of clients that is the main objective of MSIE, promotional mix that MSIE uses should be directed to the needs and requirements of the clients. In other words in order to get the required behavioral change from the target audience, MSIE should direct its promotional program according to the need of the target audience.

- To reach the large number of the audience MSIE need to give a big attention by emphasis on community-based (CBD), peer group communication and relatives than other promotional mixes to get the needed result that is behavioral change on the part of it's clients because majority of respondents prefer CBD promotion than the rest of promotional tools.

- MSIE should work highly to improve the status of its service provider employees because, these employees have direct contact with clients to provide service according to their needs, they are expected to treat and create impact on the service clients properly. More over, MSIE should use the different types of mechanisms to accomplish its objectives. One of the methods is providing training for the service providers of MSIE to improve their knowledge about customer handling/ treatment by increasing the transparency between customers and service providers.

- Service providers of MSIE needs to have adequate knowledge about all FP/RH products/service with their advantage and disadvantage to serve their customers effectively.

- MSIE is also expected to provide appropriate information to the clients by considering their needs and choices to provide the products/services as per clients' requirements and to gain /achieve behavioral change from the side of clients.

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Appendix I

Addis Ababa University

Faculty of Business Education

Marketing Management Education Program

A Survey for Assessing Family Planning Practices of MSIE from Social Marketing Perspective

Dear respondent,

My name is Genet Tafesse, MA-Marketing graduating student of AAU. Given below are the statements about the concept and practice of family planning service at MSIE, from Social marketing perspective, upon which your opinion/experience is to be scored. This information will be used solely for academic purpose and all the responses will be treated in strict confidentiality. In advance, I thank you very much.

Section I: General Profile. Kindly select the option that best represent you by making a tick (√) mark.

1. Age (in years): A) 15-20 B) 21-25 C) 26-30 D) 31-35 E) 36-40 F) 41+
2. Number of Children: A) 0 B) 1 C) 2 D) 3-5 E) above 5
3. Education: A) No schooling B) Primary C) $10^{th}/12^{th}$ D) Diploma/1^{st} degree E) Masters & above
4. Marital Status: A) Single B) Married C) Divorced D) Other (pl. specify) _____
5. If you are married, when did you get marry? _____.
6. Occupation: A) Government Employee B) Private Organization Employee C) Student D) Other _____
7. Monthly Income (in ETB): A) Less than 200 B) 201-500 C) 501-1000 D) 1001-2000 E) above 2000
8. Religion: A) Christian (pl. specify)_____ B) Islam/Muslim C) Other (pl. specify) _____
9. Ethnicity: A) Amhara B) Tigre C) Oromo D) Gurage E) Other (pl. specify) _____
10. How did you come to know about MSIE family planning services? (you can select more than one choice)

    A) Newspaper adv. B) Television adv. C) Friends/Relatives D) Community based communication

    E) Broacher/Pamphlets F) Other (pl. specify) _____
11. To maintain the gap between two births, which of the following approaches/methods MSIE use(?)

A) Pills B) IUD C) Injectables D) Condom E) Sterilization (Male/Female)

F) Norplant G) Other (pl. specify)

12. Which of the following do you think is/are the basic purpose/idea behind family planning? **(N.B. you can choose more than one options).**

A) To limit the family B) To prevent sexual transmitted disease C) To have an interval between births D) To avoid unwanted pregnancy E) To stop delivering births F) Other (pl. specify)_____

Section II: Social Marketing & Family Planning. Based on your experience of family planning services and contraceptives that you received from MSIE, please make a tick mark (√) showing your level of agreement with each of the following statement, ranging from **Strongly Agree** to **Strongly Disagree**.

No	Statements/Items	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	Product/Service/Experience (PRS)					
1	I better know the existence of FP/RH programs with MSIE, now than in the past					
2	I become interested in adopting FP/RH methods/contraceptives through MSIE programs					
3	MSIE programs/services deliver more benefits than disadvantages to the users of contraceptives for FP/RH					
4	MSIE provides me a right to avoid unwanted pregnancy					
5	MSIE provides high quality FP/RH services					
6	I have to wait for a longer period of time to obtain/get FP/RH services from MSIE					
7	MSIE delivers the FP/RH service that best suits to my requirements/needs					
	Perception (PER)					
8	MSIE presents/deals in FP/RH to make us more responsible towards society while maintaining small families					
9	MSIE provides/FP/RH services to improve quality of life of women while safeguarding the reproductive right					
10	Health service providers at MSIE know my needs/requirements of FP/RH					
11	Service providers at MSIE are knowledgeable about FP/RH products/services					
12	MSIE ensures equal participation/cooperation from the couple/(both the husband and wife) obtaining FP/RH services					

13	MSIE advices different communities to take active part in FP/RH programs as considering their social responsibility					
14	MSIE service providers respect the privacy of their clients who obtain or participates in FP/RH services					
15	MSIE provides modern FP/RH services to its clients/customers					
16	Service providers at MSIE guide all the customers on various modern methods/contraceptives for FP/RH with their benefits and side effects (if any)					
17	Operating hours of MSIE clinics/health centers are convenient to its users of FP/RH					
18	MSIE runs special programs on FP/RH for marginalized/underserved groups					
	Attitude/Beliefs (AB)					
19	I believe that using contraceptives for FP/RH will reduce sexual power/fertility in future					
20	MSIE made me interested in adopting FP/RH methods/contraceptives					
21	I feel happy with the behavior of health-center workers in MSIE					
22	I hesitate to use contraceptives for FP/RH because they are not suitable to me					
23	I favor FP/RH advices/services of MSIE by now, than in the past time, considering no negative effects on the health					
24	It is good to know as much as possible about FP/RH and contraceptives use in the modern age/time					
25	I believe that contraceptives ruin naturalness of sexual intercourse					
26	It is better to postpone increasing family-size(more children) until a person is ready to take the responsibility					
27	I wish to continue using FP/RH services of MSIEW					
	Socio-cultural View (SC)					
28	FP/RH services provided by MSIE are culturally accepted					

29	Religion has a major influence on accepting/rejecting the concept of FP/RH					
30	Female based methods of FF/RH are more successful than men oriented					
31	MSIE offers FF/RH services, equally, for both married and unmarried females					
	Price (PR)					
32	The price of contraceptives at MSIE largely affects my decision to use FP/RH					
33	I am using FP/RH services of MSIE for economic reasons					
34	MSIE offers low cost FP/RH services to poor people					
	Place (PL)					
35	MSIE maintains a wide network of clinic-based and non-clinic FP/RH service delivery outlets					
36	All MSIE programs/services related to FP/RH are available through its own health clinics					
37	MSIE offers FP/RH programs/services at convenient locations					
	Promotion (PRO)					
38	MSIE continuously engages itself in creating awareness of FP/RH through various promotional activities					
39	I came to know about various contraceptive to be used for F/RH from MSIE					
40	I encourage other people women to rake FP/RH services from MSIE					
41	MSIE uses magazines and various print materials to inform/promote its FP/RH programs to the potential users/clients					
42	MSIE uses community-based communication and informal groups to make aware the people about FP/RH practices					
43	MSIE promotes the idea of FP/RH through all its communications facilitated through various media					
44	MSIE promotes more the idea of contraceptives uses for FP/RH than abortion					

45	MSIE communication made me clear on various myths about FP/RH					
46	There exists a negative word-of-mouth communication about FP/RH services offered by MSIE					
47	MSIE suggests/communicates that using contraceptives prevents STDs along with FP/RH					
48	Local media(paper/electronic) has a poor/bad impression					

Appendix II

በአዲስ አበባ ዩኒቨርስቲ
የድህረ ምረቃ ፕሮግራም
የቢዝነስ ኢዱኬሽን ትምህርት ክፍል
ማርኬቲንግ ማኔጅመንት ኢዱኬሽን

የ ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ አተገባበር ከማህበራዊ ግብይት አንፃር በመገምገም የተከናወነ ጥናት

ውድ መላሽ

እኔ የአዲስ አበባ ዩኒቨርሲቲ የማርኬቲንግ ማኔጅመንት የማስተርስ ተመራቂ ተማሪ ስሆን ከዚህ በታች የቀረቡት መጠይቆች የሜሪስቶፕስ ኢንተርናሽናል ኢትዮጵያ ስለሚያከናውናቸው የቤተሰብ ምጣኔ ተግባራት/ስነ ተዋልዶ ጤና ፅንስ ሀሳብና አሰራሮች ከማህበራዊ ግብይት አንፃር ምን እንደሚመስሉ ለማጥናት የቀረቡ መጠይቆች ናቸው። እርስዎ የሚሰጡት አስተያየቶች/ያለዎት ተሞክሮ ያመዘገባል። ይህ መረጃ በጥቅም ላይ የሚውለው ለትምህርታዊ አላማ ብቻ ሲሆን ሁሉም መልሶች በሚስጥር የሚያዙ ናቸው። እባክዎ ለእያንዳንዱ ጥያቄ ያለዎትን ልባዊ/ትክክለኛ አስተያየት ያስፍሩ። በዚህ መጠየቅ ተሳታፊ በመሆንዎ አስቀድሜ አመሰግንዎታለሁ። (✓) ይህንን ምልክት በማስቀመጥ ስለራስዎ ምላሽን ይስጡ።

ማሳሰቢያ፡ ስም መፃፍ አያስፈልግም

ክፍል 1. አጠቃላይ መረጃዎች

1. ዕድሜ (አመታት) ሀ. 15-20 ለ. 21-25 ሐ. 26-30 መ. 31-35
   ሠ. 36-40 ረ. 41+
2. የልጅዎችዎ ብዛት ሀ. 0 ለ. 1 ሐ. 2 መ. 3-5 ሠ. ከ5 በላይ
3. የትምህርት ደረጃ ሀ. አልተማርኩም ለ. የመጀመሪያ ደረጃ ት/ቤት ተማሪ ነኝ
   ሐ. 10ኛ/12ኛ ክፍል አጠናቅቄያለሁ መ. ዲፕሎማ/የመጀመሪያ ዲግሪ አለኝ
   ሠ. ማስተርስ እና ከዚያ በላይ አለኝ
4. የጋብቻ ሁኔታ ሀ. አላገባሁም ለ. አግብቻለሁ ሐ. ፈትቻለሁ
   መ. ሌላ
5. አግብተው ከሆነ ያገቡት መቼ ነው? _____
6. ስራ ሀ. የመንግስት ተቀጣሪ ለ. የግል ድርጅት ተቀጣሪ
   ሐ. ተማሪ መ. ሌላ ካለ _____

7. ወርሀዊ ደመወዝ (በኢትዮጵያ ብር)፡ ሀ. ከ200 ብር በታች ለ. ከ201-500
ሐ. 501-1000 መ. 1001-2000 ሠ. ከ2000 በላይ

8. ሀይማኖት፡ ሀ. ክርስቲያን (በግልጽ ያስቀምጡ) _____
ለ. እስላም/ሙስሊም ሐ. ሌላ ካለ (በግልጽ ያስቀምጡ)_____

9. ብሔር፡ ሀ. አማራ ለ. ትግሬ ሐ. ኦሮሞ መ. ጉራጌ
ሠ. ሌላ ካለ (በግልጽ ያስቀምጡ)_____

10.ስለ ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ አገልግሎቶች እንዴት ሊያውቁ ቻሉ? (ከአንድ መልስ በላይ መስጠት ይችላሉ)፡፡
ሀ. በጋዜጣ ማስታወቂያ ለ. በቴሌቪዥን ማስታወቂያ ሐ. ከጓደኞቹ/ዘመዶቹ
መ. ከማህበረሰብ ጋር የሚደረግ ግንኙነት ሠ. ብሮሸር/በራሪ ወረቀቶች
ረ. ሌላ ካለ (በግልጽ ያስቀምጡ)_____

11.በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ከሚሰጡት የወሊድ መከላከያ አገልግሎቶች ውስጥ ልጆችን አራርቆ ለመውለድ የምትጠቀሚው የትኛውን ዘዴ ነው?
ሀ. እንክብሎች /ፒልስ/ ለ. አይዩዲ (ሉፕ) ሐ. በክንድ የሚወጋ
መ. ኮንዶም
ሠ. የሴት የዘር ፍሬን ማስቋጠር (ስቴራላይዜሽን) ረ. በክንድ የሚቀበር (ኖር ፕላንት)

12. ከሚከተሉት መካከል የቤተሰብ ምጣኔ አላማ የትኛው ነው ብለው ያስባሉ? (አስታውሱ ከአንድ በላይ መልሶችን መስጠት ይችላሉ)፡፡
ሀ. የቤተሰብ ቁጥርን ለመመጠን
ለ. በግብረስጋ ግንኙነት የሚተላለፉ በሽታዎችን ለመከላከል
ሐ. እያራራቁ ለመውለድ መ. ያልተፈለገ እርግዝናን ለመከላከል
ሠ. መውለድን ለማቆም ረ. ሌላ (በግልጽ ያስቀምጡ)_____

ክፍል 2. የማህበራዊ ግብይት እና የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና የሚመለከቱ መረጃዎች፡-

ከሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ከሚያገኙት የቤተሰብ ምጣኔ አገልግሎት እና የወሊድ መቆጣጠሪያዎች ተሞክሮ በመነሳት እባክዎ ለሚከተሉት ጥያቄዎች **እጅግ እስማማለሁ** ከሚለው ጀምሮ እስከ **እጅግ አልስማማም** እስከሚሉት ምርጫዎች (✓) ምልክት በማድረግ መልስ ይስጡ፡፡

ቁጥር	መጠይቆች	እጅግ እስማማለሁ	እስማማለሁ	መልስ የለም	አልስማማም	እጅግ አልስማማም
1	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና ፕሮግራሞች ስለመኖራቸው ቀድሜ ከነበረኝ እውቀት የተሻለ አሁን አለኝ፡፡					
2	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት የሚሰጠው ተጠቃሚዎቹን ጥቂት የቤተሰብ አባላትን ይዘን ለማህበረሰቡ ኃላፊነት የሚሰማን ዜጎች እንድንሆን ለማገዝ ነው፡፡					
3	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ አገልግሎት/የስነተዋልዶ ጤና እንክብካቤ/የወሊድ መከላከያ ዘዴዎች የመጠቀም ፍላጎት አለኝ፡፡					
4	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶች የሴቶችን የመውለድ መብቶቻቸውን እንዲያስጠብቁና የአኗኗር ዘይቤያቸውን እንዲያሻሽሉ ይረዳል፡፡					
5	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የተለያዩ የማስታወቂያ ተግባራትን በማከናወን ማህበረሰቡ ስለ ቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት ንቃተ ህሊናው (ግንዛቤው) ከፍ እንዲል ሳያቋርጥ ይሰራል፡፡					
6	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ያሉ የጤና አገልግሎት አቅራቢዎች የእኔን የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት ፍላጎቶች ይረዳሉ፡፡					
7	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚገኙ የአገልግሎት አቅራቢዎች ስለቤተሰብ ምጣኔ/የስነ ተዋልዶ ጤና አቅርቦቶች/አገልግሎቶች እውቀት አላቸው፡፡					
8	ስለቤተሰብ ምጣኔ እና ስለስነተዋልዶ ጤና እንክብካቤ ጥቅም ላይ የሚውሉትን የተለያዩ የወሊድ መከላከያ ዘዴዎችን በተመለከተ ለመጀመሪያ ጊዜ ያወቁት ከሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ነው፡፡					
9	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ፕሮግራሞች/አገልግሎቶች ለቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ የወሊድ መከላከያ ተጠቃሚዎች ላይ ከሚያስከትሉት ጉዳት የበለጠ ጥቅም አላቸው፡፡					
10	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ጥንዶች (ባልና ሚስት) የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎትን ለማግኘት እኩል ተሣትፎ/መስማማት እንዳለባቸው ያሳውቃል/ያምናል፡፡					
11	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የተለያዩ					

	ማህበረሰቦችን በቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ ፕሮግራሞች ማህበረሰባዊ ግዴታዎቻቸውን ለመወጣት እንደሆነ በማሰብ ንቁ ተሣትፎ ማድረግ እንዳለባቸው ይመክራል፡፡					
12	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚሰጡ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎቶች በባህላችን ተቀባይነት አላቸው፡፡					
13	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ያልተፈለገ እርግዝናን ለመከላከል መብቴን እንድጠቀም አገልግሎትን ያቀርብልኛል፡፡					
14	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የአገልግሎት አቅራቢዎች በቤተሰብ ምጣኔ/ስነተዋልዶ ጤና አገልግሎቶች የሚሳተፉ ደንበኞቻቸውን ሚስጢሮች ይጠብቃሉ/ያከብራሉ፡፡					
15	ሌሎች ሰዎችን/ሴቶችን በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ በሚሰጡ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶች እንዲሣተፉ አበረታታቸዋለሁ፡፡					
16	የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶችን መቆጣጠሪያዎችን መጠቀም ለወደፊቱ የወሲብ ፍላጎት/ልጅ የመውለድ ብቃትን እንደሚቀንስ አምናለሁ፡፡					
17	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት ዘዴዎች/የወሊድ መቆጣጠሪያዎችን እንድጠቀም ፍላጎትን አሳድሮብኛል፡፡					
18	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ በሚገኙ የጤና ማዕከል ሰራተኞች ባህሪያት/አቀባበል ደስተኛ ነኝ፡፡					
19	የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎቶችና የወሊድ መከላከያዎችን ለመጠቀም አቅማማለሁ፤ ምክንያቱም ለእኔ ተስማሚ ስላልሆኑ ነው፡፡					
20	በአሁኑ ጊዜ በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚሰጡ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ ምክሮችን/አገልግሎቶችን ከዚህ በፊት ይሰጡ ከነበሩት ይልቅ የተሻሉ ናቸው ብዬ አስባለሁ፤ ምክንያቱም በጤናዬ ላይ ምንም አሉታዊ ውጤቶች የሏቸውም፡፡					
21	በዚህ አሁን ባለንበት የስልጣኔ ዘመን በጥቅም ላይ ስለዋሉ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት ዘዴዎች እና የወሊድ መከላከያዎች በተቻለ መጠን ማወቅ አስፈላጊ ነው፡፡					
22	እስከዛሬ ድረስ ሀይማኖት የቤተሰብ ምጣኔ/ስነተዋልዶ ጤና አገልግሎቶችን ጽንሰ ሀሳብ በመቀበል/ፈቃደኛ ባለመሆን ላይ ከፍተኛ ተጽእኖ አሳቸው፡፡					
23	የወሊድ መከላከያዎች የወሲባዊ ግንኙነትን ተፈጥሮአዊነት/ፍላጎት እንደሚያጠፉ አምናለሁ፡፡					
24	አንድ የቤተሰብ አስተዳደር የቤተሰብ መጠን/የልጆች ቁጥርን ከመጨመሩ በፊት ኃላፊነቱን ለመወጣት በመጀመሪያ ዝግጁ መሆን አለበት፡፡					

25	በሴቶች ላይ ያተኮሩ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና ዘዴዎች በወንዶች ላይ ካተኮሩት ይልቅ በተሻለ መልኩ ስኬታማ ናቸው፡፡					
26	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ከፍተኛ ጥራት ያለው የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶችን ያቀርባል፡፡					
27	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ለደንበኞቹ ዘመናዊ የሆነ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት ያቀርባል፡፡					
28	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚገኙ አገልግሎት ሰጪዎች ሁሉንም ደንበኞቻቸውን ስለተለያዩ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶች ዘመናዊ ዘዴዎች/የወሊድ መከላከያዎች ከጥቅሞቻቸው እና ከሚያስከትሉት ጉዳት ጋር መመሪያን/ግንዛቤን ይሰጣሉ፡፡					
29	ከሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚገኙ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎቶችን ለማግኘት ለረጅም ጊዜ ተራ እጠብቃለሁ፡፡					
30	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚሰጣቸው የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎቶች ከእኔ ፍላጎት ጋር የሚጣጣሙ ናቸው፡፡					
31	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶችን ላገቡ እና ላላገቡ ሴቶች በእኩልነት ይሰጣል፡፡					
32	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የስነተዋልዶና የቤተሰብ ምጣኔ አገልግሎቶች ዋጋ የአገልግሎቱ ተጠቃሚ ላለመሆን ተጽእኖ ፈጥሮብኛል፡፡					
33	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ክሊኒኮች/የጤና ማዕከላት አገልግሎት የሚሰጡባቸው ሰአታት ለቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶች ለሚጠቀሙ የህብረተሰብ ክፍሎች አመቺ ናቸው፡፡					
34	የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎቶችን የምጠቀመው ኢኮኖሚያዊ ጠቀሜታ ስላላቸው ነው፡፡					
35	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ በዝቅተኛ ኑሮ ደረጃ ለሚኖሩ ማህበረሰብን በአነስተኛ ዋጋ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶችን ያቀርባል፡፡					
36	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ በክሊኒክ ላይ መሰረት ያደረጉና ያላደረጉ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎት መስጫ ዘዴዎች ሰፊ ግንኙነት አለው፡፡					
37	ሁሉም ከቤተሰብ ምጣኔ/ስነተዋልዶ ጤና ጋር ግንኙነት ያላቸው የሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ፕሮግራሞች/አገልግሎቶች የሚሰጡት በራሱ ክሊኒኮች በኩል ነው፡፡					

38	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚያቀርባቸው የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና ፕሮግራሞች/አገልግሎቶች የሚሰጡት ለተጠቃሚው አመቺ በሆነ ስፍራዎች ነው።					
39	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ መጽሔቶችን እና የተለያዩ የህትመት ማቴሪያሎችን በመጠቀም ተጠቃሚ/ደንበኞች ሊሆኑ የሚችሉትን የማህበረሰብ ክፍሎች ስለቤተሰብ ምጣኔ/የስነተዋልዶ ጤና ፕሮግራሞቹ ያሣውቃል/ያስተዋውቃል።					
40	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ማህበረሰብ ተኮር የሆኑ እና በጓደኝነት ላይ የተመሰረተ ግንኙነት ዘዴዎችን በመጠቀም ስለቤተሰብ ምጣኔ ወይም ስነተዋልዶ አገልግሎት እውቀትን እንዲያገኙ ያደርጋል።					
41	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አላማዎቹን በተለያዩ የመገናኛ ብዙሀን ዘዴዎች በመጠቀም ያስተዋውቃል።					
42	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ጽንስን ከማስወገድ ይልቅ የቤተሰብ ምጣኔ/ስነተዋልዶ ጤና የወሊድ መከላከያዎችን የመጠቀም አማራጭ ሀሳብን በይበልጥ ያራምዳል።					
43	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚያከናውናቸው የግንኙነት ስራዎች ስለቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ አገልግሎቶች የነበሩኝን የተለያዩ ጥርጣሬዎች እንዳስወግድ እረድቶኛል።					
44	በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ስለሚሰጡ የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶች ጥሩ ያልሆኑ ነገሮች ሲነገሩ ሰምቻለሁ።					
45	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የወሊድ መቆጣጠሪያ ዘዴዎችን መጠቀም ከቤተሰብ ምጣኔ/የስነተዋልዶ ጤና እንክብካቤ በተጨማሪ በግብረስጋ ግንኙነት የሚተላለፉ በሽታዎችን ለመከላከል እንደሚጠቅም ያስተምራል/ያስረዳል።					
46	የሀገር ውስጥ የህዝብ መገናኛ ዘዴዎች/ህትመት/ ኤሌክትሮኒክ ማሰራጫዎች ስለሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ ስነተዋልዶና የቤተሰብ ምጣኔ አገልግሎቶች/ፕሮግራሞች ጥሩ ያልሆነ አመለካከት አላቸው።					
47	ሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ በቤተሰብ ምጣኔ/የስነተዋልዶ ጤና ዙሪያ አገልግሎቱን የማግኘት ዕድል ለሌላቸው ክፍሎች ልዩ ፕሮግራም አለው።					
48	እኔ በሜሪ ስቶፕስ ኢንተርናሽናል ኢትዮጵያ የሚቀርቡትን የቤተሰብ ምጣኔ/የስነተዋልዶ ጤና አገልግሎቶችን መጠቀሜን ለመቀጠል እፈልጋለሁ።					

Appendix III

Addis Ababa University

Faculty of Business Education

Marketing Management Education Program

These questions are prepared to conduct an interview with the representative (Management Unit) of MARIE STOPS INTERNATIONAL ETHIOPIA (MSIE). I thank the interviewees in advance for their cooperation.

1. What are the key components of social marketing program of (MSIE)
2. What are the roles of (MSIE) in the prevention of unwanted pregnancies/STDS?
3. What are your target customers for FP/RH programs?
4. How the organizations create the product awareness, availability and affordability?
5. What commercial marketing techniques do you use to raise brand awareness, promote the product and services by encourage healthier behavior as a result of purchase and correct use of contraceptive?
6. How do you create acceptance among individuals of contraceptives for FP/RH?
7. What kind of promotional materials do you use in your contraceptive social marketing program?
8. Which media or mix of Medias do you frequently use to promote appropriate of contraceptive brands?
9. To what extent do you believes that FP/RH is helpful and importance for all in the society to show them responsible?
10. Do you have any partners regarding to work social marketing program of FP/RH?
11. What kind of policy does your organization uses to apply its FP/RH program?
12. Does your organization works with different local publics like (MOH, Hospitals. clinic to Accomplish its objectives?
13. Does your organization help the nation in controlling population for development?

Appendix IV Result of correlation Analysis

Correlations

		PRS	PER	AB	SC	PR	PL	PRO
PRS	Pearson Correlation	1	.484(**)	.337(**)	.201(**)	.150(*)	.191(**)	.383(**)
	Sig. (2-tailed)		.000	.000	.004	.034	.007	.000
	N	200	200	200	200	200	200	200
PER	Pearson Correlation	.484(**)	1	.440(**)	.220(**)	.351(**)	.224(**)	.493(**)
	Sig. (2-tailed)	.000		.000	.002	.000	.001	.000
	N	200	200	200	200	200	200	200
AB	Pearson Correlation	.337(**)	.440(**)	1	.163(*)	.432(**)	.081	.503(**)
	Sig. (2-tailed)	.000	.000		.021	.000	.253	.000
	N	200	200	200	200	200	200	200
SC	Pearson Correlation	.201(**)	.220(**)	.163(*)	1	.351(**)	.106	.132
	Sig. (2-tailed)	.004	.002	.021		.000	.137	.062
	N	200	200	200	200	200	200	200
PR	Pearson Correlation	.150(*)	.351(**)	.432(**)	.351(**)	1	.177(*)	.459(**)
	Sig. (2-tailed)	.034	.000	.000	.000		.012	.000
	N	200	200	200	200	200	200	200
PL	Pearson Correlation	.191(**)	.224(**)	.081	.106	.177(*)	1	.315(**)
	Sig. (2-tailed)	.007	.001	.253	.137	.012		.000
	N	200	200	200	200	200	200	200
PRO	Pearson Correlation	.383(**)	.493(**)	.503(**)	.132	.459(**)	.315(**)	1
	Sig. (2-tailed)	.000	.000	.000	.062	.000	.000	
	N	200	200	200	200	200	200	200

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Appendix V Result of chi-square analysis

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Age of respondent * To maintain the Gap between the gap two births, which of the folowing approchs /methods MSIE uses	200	100.0%	0	.0%	200	100.0%

Age of respondent * To maintain the Gap between the gap two births, which of the folowing approchs /methods MSIE uses Crosstabulation

Count

		To maintain the Gap between the gap two births, which of the folowing approchs /methods MSIE uses						
		Pills	IUD	Injectables	Condom	Sterialization(Male/female	Norplant	Total
Age of respondent	15-20	24	8	6	6	0	4	48
	21-25	34	10	24	34	2	2	106
	26-30	4	6	10	6	0	0	26
	31-35	6	4	4	0	0	0	14
	36-40	4	0	0	2	0	0	6
Total		72	28	44	48	2	6	200

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	38.243(a)	20	.008
Likelihood Ratio	44.194	20	.001
Linear-by-Linear Association	.177	1	.674
N of Valid Cases	200		

a 18 cells (60.0%) have expected count less than 5. The minimum expected count is .06.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Number of childeren * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses	200	100.0%	0	.0%	200	100.0%

Number of children * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses Cross tabulation

Count

		To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses						
		Pills	IUD	Injectables	Condom	Sterilization(Male/female	Norplant	Total
Number of childeren	0	54	18	30	40	0	6	148
	1	12	2	2	4	0	0	20
	2	6	8	10	2	0	0	26
	3-5	0	0	2	2	0	0	4
	>5	0	0	0	0	2	0	2
Total		72	28	44	48	2	6	200

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	225.096(a)	20	.000
Likelihood Ratio	49.412	20	.000
Linear-by-Linear Association	.424	1	.515
N of Valid Cases	200		

a 22 cells (73.3%) have expected count less than 5. The minimum expected count is .02.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Education * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses	200	100.0%	0	.0%	200	100.0%

Education * To maintain the Gap between the gap two births, which of the folowing approchs /methods MSIE uses Cross tabulation

Count

		To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses						Total
		Pills	IUD	Injectables	Condom	Sterilization(Male/female	Norplant	
Education	No schooling	2	2	4	0	0	0	8
	Primary	4	2	8	6	0	2	22
	Tenth/Twelve's	38	10	16	12	0	2	78
	Diploma/first Degree	28	14	14	30	0	2	88
	Master and above	0	0	2	0	2	0	4
Total		72	28	44	48	2	6	200

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	127.829(a)	20	.000
Likelihood Ratio	48.406	20	.000
Linear-by-Linear Association	.695	1	.404
N of Valid Cases	200		

a 20 cells (66.7%) have expected count less than 5. The minimum expected count is .04.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Marital Status * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses	200	100.0%	0	.0%	200	100.0%

Marital Status * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses Cross tabulation

Count

		To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses						Total
		Pills	IUD	Injectables	Condom	Sterilization(M ale/female	Norplant	
Marital Status	Single	48	12	26	30	2	4	122
	Married	22	16	12	12	0	2	64
	Divorced	2	0	2	4	0	0	8
	Other(Pl.specfify)	0	0	4	2	0	0	6
Total		72	28	44	48	2	6	200

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.622(a)	15	.092
Likelihood Ratio	24.580	15	.056
Linear-by-Linear Association	1.020	1	.313
N of Valid Cases	200		

a 16 cells (66.7%) have expected count less than 5. The minimum expected count is .06.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Occupation * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses	200	100.0%	0	.0%	200	100.0%

Occupation * To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses Cross tabulation

Count

		To maintain the Gap between the gap two births, which of the following approaches /methods MSIE uses						Total
		Pills	IUD	Injectables	Condom	Sterilization(Male/ female	Norplant	
Occupation	Government employee	14	8	4	10	0	2	38
	Private organization Employee	32	12	26	24	0	4	98
	Student	22	8	8	10	2	0	50
	Other(pl.specfiy)	4	0	4	4	0	0	12
	6	0	0	2	0	0	0	2
Total		72	28	44	48	2	6	200

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	26.146(a)	20	.161
Likelihood Ratio	28.241	20	.104
Linear-by-Linear Association	.043	1	.836
N of Valid Cases	200		

a 18 cells (60.0%) have expected count less than 5. The minimum expected count is .02.

Declaration

I, the undersigned, declare that the thesis is my original work. I have carried it out independently except for the guidance and suggestions of the research supervisor. This study has not been submitted for any degree / diploma in this or any other university. It is offered here in partial fulfillment of the requirements of the degree of Master of Marketing Management Education.

Declared by: Genet Tafesse