

**IDENTIFYING FACTORS ASSOCIATED WITH THE DIFFERENCE
BETWEEN SIDAMA DEVELOPMENT PROGRAM AND FAMILY
GUIDANCE ASSOCIATION OF ETHIOPIA SUPPORTED CBD
PROGRAMS IN CONTRACEPTIVE PREVALENCE RATE, SIDAMA
ZONE, SNNPR.**

By:

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***Identifying Factors Associated With the Difference in
Contraceptive prevalence Rate between the SDP and FGAE
supported CBD project areas***

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Abbreviations

AAU	Addis Ababa University
AIDS	Acquired Immuno- Deficiency Syndrom
CBD	Community-Based Distribution
CFS	Community and Fertility Survey
CMR	Child Mortality Rate
CSA	Central Statistical Authority
CPR	Contraceptive Prevalence Rate
DCH	Department of Community Health
ECA	Economic Commission for Africa
EPHA	Ethiopian Public health Association
EPHTI	Ethiopian Public Health Training Initiative
EPI	Expanded Program on Immunization
FHI	Family Health International
FGAE	Family Guidance Association of Ethiopia
FHD	Family Health Department
FOM	Faculty of Medicine
FP	Family Planning
HC	Health Center
HIV	Human Immune- Deficiency Virus
HP	Health Post
HS	Health Station
IMR	Infant Mortality Rate
MCH	Maternal and Child Health

MOH	Ministry of Health
NGO	Non Governmental Organization
OAU	Organization of African Unity
PA	Peasant Association
RHB	Regional Health Bureau
SDP	Sidama Development Program
SNNPR	South Nations Nationals and People's Region
STI	Sexual Transmitted Infection
TFR	Total Fertility Rate
TOT	Training of Trainers
UNFPA	United Nations Population Fund
USAID	United States Aid for International Development
ZHD	Zonal Health Department

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Abstract

A comparative cross-sectional study was conducted in Sidama Zone, SNNPR to identify reasons for the difference in contraceptive prevalence rate between the Sidama Development Program (SDP) and Family Guidance Association of Ethiopia (FGAE) supported CBD projects.

Multi-stage sampling was employed to identify the study woredas. A total of 1058 reproductive age group women were interviewed from both project areas. Six hundred ninety eight from SDP and 360 from FGAE site were selected proportionate to population size. Households were selected from respective peasant associations using systematic sampling and woman from household selected randomly. Eight FGDs and four in-depth interviews were conducted in two project areas. Key informants and discussants were selected based on convenience and their position in the institution or community to participate in the study.

Contraceptive prevalence rates were 40.7% and 51.6 % in SDP and FGAE areas, respectively. This showed significant difference between the two project areas (p-value, 0.01). Knowledge of at least one contraceptive method was also significantly different between the two areas with (p-value <0.01). Ninety three percent of SDP and 97% of the FGAE areas mentioned at least one modern contraceptive method.

More women in FGAE (37%) than in SDP area 29.5% experienced contraceptive use-discontinuation. The main reasons were desire for more children followed by health related problems. Perception about the quality of FP services given by the CBD agents showed significant difference between the two project areas, particularly for possibility of getting method of their choice (OR=0.23(0.07,0.61)), information given about how to take the contraceptives (OR=0.18(0.07,0.49)) and methods that prevent HIV/AIDS (OR=0.54(0.30,0.94)). Standardized initial training and regular subsequent refresher training with occasional incentives given to the CBD agents showed significant association with variation in success of the agents' performances and contraceptive prevalence rate in two project areas.

The study concluded that variation in the CBD agents training, level of motivation and supervision given contributed for the difference in CPR. Therefore, it is recommended that sustained motivation of CBD agents, training and supervision (with using the successful model) in both areas is imperative. In addition, cost-effectiveness analysis research is recommended in order to identify the relative cost-effectiveness of the CBD projects.

Introduction

The recent demographic trends suggest that the world is experiencing rapid population change with subsequent short doubling time. Although fertility has fallen worldwide from about five children per couple to about three since 1960s, annual population growth in the 1990s is still approximately 80- 85 million people, equivalent to adding a country the size of Germany to the world's population each year (1, 2).

The 1998 United Nations Population projections portray a future world population between 7.7 and 11.2 billion by the mid- 21st century, an increase over our current total of 6 billion (3). The problem of the population is not simply a problem of numbers, but it is a problem of human welfare and development (4). Even with declining birth rates; by the middle of this century at least two billion people will live in the countries where water shortage may constrain food production and economic development (3).

Most of this growth is occurring in developing nations where fertility rates remain high (1). Accordingly, Africa faces a major population explosion in the near future. Africa's population, which was estimated at 257 million in 1960, had increased to 482 million by 1983. In 1993 population of the continent was estimated at 682 million. The average growth rate during the decade was 3.2 percent, the highest among third world regions. It is estimated that the regional share of the world population will increase from 12% in 1990 to 18% in the year 2025. Even under the medium variant of population projections by (ECA), a 2.8 percent annual growth would bring the total population to 997 million by the year 2008 (4).

Especially, sub-Saharan Africa, has more to do with a combination of cultural and socio economic factors which determine the attitude and behavior of people towards procreation. The high incidence of fertility at least reflects that reproduction starts at young ages, age at first marriage is early, and contraceptives are not being used widely and effectively (5).

As a step towards addressing population problems, family planning programs have been in place for more than thirty years in many regions of the world. The program helps developing countries address the issue of rapid population growth. In addition, it plays a crucial role in reducing poverty and improving living conditions. Individuals and families benefit and communities and nations are strengthened. Moreover, it helps to moderate high fertility (for instance, forty percent of fertility decline is achieved through it), fill the unmet needs for contraception, reduce the number of unwanted pregnancies, improve child survival and decrease maternal mortality by preventing and/or delaying pregnancy among high risk women (1). Moreover, FP service addresses issues related with safe motherhood goal attainment. It helps to reduce unwanted pregnancies by improving people's access to high quality, client oriented and gender sensitive information and services that offer a range of methods appropriate for different people at different stages in their lives (6).

Family planning has been successful in filling unmet need by helping women in developing countries overcome obstacles to the use of contraception. In developing world between 1969 and 1990, the average number of children per woman declined by two- and a-half and fertility has continued to decline. Nonetheless, the world's population is still growing and continues to do so

for decades to come. The pace of the growth could be moderated by commitment to two broad family planning policies: focus on unmet need and enhanced program effectiveness (7).

In order to increase access to family planning services (CBD) programs were originated in Asia in 1960s and spread through out Asia and Latin America in the 1970s and 1980s. They were introduced in sub Saharan Africa during the 1980s and 1990s. The program reduces the cost to contraception, there by extending use among clients who seek contraceptives but will not use services that are confined to clinical settings (8)

In Ethiopia the concept of family planning has been promoted since 1966, by the initiation of concerned volunteers who established the (FGAE). In 1980 'MCH' coordinating office was established under the departments of MOH, and began to be fully functional in 1983. After 10 years of its establishment, it has been recognized as Family Health Department (FHD) having four teams under it, one of which is the family planning team. Family planning activities under MOH are largely conducted as a series of country programs funded by UNFPA. To date four country programs have been undertaken and the fifth one is to be started (9).

In spite of long history and substantial and partially successful efforts to reduce population growth in Ethiopia, the population increases over decade from 42.6 million in 1984 to 53.5 in 1994. The current population of the country is estimated to be 67,220 million with the annual population growth rate of 2.7 % (10). In contrary, the CPR remains very low (8.19%) with high TFR of 5.9. (10,11). With the concern to the situations, the government of Ethiopia adopted the National Population Policy in April 1993, with the primary objectives to harmonize the rate of

population growth with socio economic development so as to achieve a high level of welfare. More specifically the population policy targeted a reduction in the total fertility rate from 7.7 children per woman in 1990 to 4 children per woman in 2015 and an increase in contraceptive prevalence rate from 4 percent in 1990 to 44 percent in 2015 (12).

The infant, child and under five-mortality rate of the area are still high. According to CSA's analytical report, 1996, the infant and child mortality rates were estimated at 88 and 124 per 1000 live births, respectively (13). Though accurate data pertaining to maternal mortality were not available, the number of women with high-risk fertility behavior is high in Sidama Zone. For instance, 37.2% of births took place after an interval of two years or less, 19.5% of births occurred among high-risk group of mothers (< 18 or > 34 years of age) and 32.7% of women in the reproductive age group had more than four births (14).

The 1997 CFS (Community and Fertility Survey) report also revealed that the Zonal fertility rate of 6.18 was the highest in the Region. The regional fertility rate is 5.8 children per woman. Though 68.2% of the surveyed women had knowledge about family planning methods, the CPR was only 11%. The total demand for the contraceptive use was 58% of which only 38% was met (15).

Two years ago large scale CBD program was initiated through the support of Sidama Development Program (SDP) in the zone. Prior to the initiation of the program, the CPR was 11% and the intended target was to raise this CPR to 35% after two years time. However, after two years of implementation of the program, the CPR has only increased to be 20%. The CPR in FGAE project areas however is relatively higher (35%) than the SDP project area (15).

Some of the factors that might have contributed to the lower CPR else where been: lack of community participation in CBD selection; most of the CBD agents being male; low motivation of the CBD agents; misconceptions and rumors about contraception; lack of method mix; opposition of religious leaders; male opposition; poor referral system; poor supervision; inadequate supply of contraceptive commodities and client's inability to pay (16).

Literature Review

The intrinsic relation of family planning with health, social and economical development has been emphasized in recent years. To have sustainable development and quality of life, planning and managing family size is imperative. The provision of appropriate information about family planning and making it accessible, available and affordable is equally important. The literature review, hence, touched the relation ship between family planning and fertility, factors that affects the success of service provision and contraceptive prevalence rate, the quality issue and various strategies of providing family planning services.

Concepts of Family Planning

Family planning: FP is a broad concept. A scientific group of the World Health Organization (WHO) explained that family planning includes the following concepts:

- Avoiding unwanted and to bring about wanted pregnancies;
- Makes decisions on the number of children wanted;
- Determining or regulating the interval between pregnancies
- Controlling the time of pregnancy in relation to the age of the parents
- Making sure that the number of children wanted is what can be appropriately taken care of (17).

The family planning program is developed with various rationales

- A ‘ health’ rationale of the linkage that exist between fertility patterns and reproductive and maternal health as well as the health and well-being of the child.
- A ‘ demographic’ rationale emerged in response concerning the

detrimental effect of rapid population growth on socio-economic development.

- A 'human right ' rationale noted that parents had a basic human rights to decide freely and responsibly, the number and spacing of their children. Advocates of women's rights have further reinforced the human right rationale (18).

Benefits of family planning program

Family planning plays a crucial role in reducing poverty and improving living conditions. It enhances the quality of life by reducing infant mortality, improving maternal health and alleviating pressure on governments to meet social and economical needs through planned wanted pregnancies and preventing unwanted pregnancies. Individuals and family benefits community and nations are strengthened (1, 19).

Barrier to the utilization of modern contraceptives

Although for many areas geographical access to service remains to be a major problem, others such as; lack of knowledge, fear of side effects, social and family disapproval desire for more children, lack of husband wife communication about family planning, low women's status and poor quality of services. Programs are likely to be most successful when they reach beyond the convention boundaries of services provision to influence and alter cultural and social factors to limit voluntary contraceptive use (20,21).

To attain this, programs of community- based distribution of contraceptives have been carried out in many developing countries. Barriers to the CBD expansion in sub Saharan Africa include medical conservatism, policy inertia, bureaucratic inertia (lack of commitment to the program)

and operational uncertainty regarding training, supervision, workers recruitment and deployment in the absence of practical pilot demonstrations.

In Ethiopia, reasons for contraceptive non-use in both health institution and CBD areas do not appear to differ from those documented elsewhere (22, 23, and 24).

Quality of Family Planning service

Throughout the world, the quality of family planning services was found to influence utilization. It is frequently stated in the literature that improving the quality of care serves individuals better and indirectly decrease fertility by increasing acceptance, continuation and prevalence of contraception (25, 26). Early family planning literatures discussed quality largely with regard to clinical operation (24). This approach neglected the interpersonal dimension of care, and suggested that high quality means sophisticated, expensive equipment. However, now a day quality of service mean that, within private and commercial programs, where clients provide all or partial cost recovery, the law of the market place suggest that better service at the right price will attract more clients. Within publicly supported programs both clinic and community based, it is likely that improvements in quality of service will result in greater initial acceptance and more sustained use (24, 25).

If quality of service going to rank alongside quantity of services as an indicator of program performance the "classical" clinical dimensions of quality of care and the subjective interpersonal aspects must be brought together in a simple and generally agreed up on framework. Bruce has selected six elements of FP program that together constitute quality. These are: choice of methods, information given to users, technical competence, interpersonal relations,

follows up or continuity mechanisms and appropriate constellation of services. These elements reflect six aspects of services that clients experience as critical (24).

Study conducted in Kenya to assess the quality of family planning service delivery revealed that service quality is identified in terms of the characteristics of health facility, provider-client interactions and cost and proximities of facilities. The quality of service received by clients is influenced by government program policies, practices at service delivery point and interaction between the provider and client (27).

A situational analysis of family planning services in Ethiopia in health facilities under MOH, assessment of quality of care in Addis Ababa health institutions have revealed some drawbacks related to quality of care; such as limited choice of method, insufficient information given to clients about the available methods, their side effects and their management, lack of privacy during counseling and examination as well as lack of follow up mechanisms (26). In contrast to this, a study carried out by the same author to assess quality of family planning service of FGAE head quarter's clinic as perceived by the client was found to be good and no major constraints were identified (28).

Likewise the thesis report conducted in eastern Shoa indicated that the contraceptive prevalence was higher in area where having higher quality service such as provision of information to the clients, discussion with the clients about method related problem functional referral system and others than lower quality services (9).

Sustainability of family planning services

Sustainability of a program could be defined as the capacity of the program to continue its activities over the long term despite changes in its environment. Sustainability is affected by various factors such as (29):

- The degree of involvement of beneficiary in initiating and executing (i.e., their identification with the ownership of the program).
- The level of commitment of the beneficiaries in terms of their own resources.
- Community needs for family planning services; the CBD program.
- Support from others (sectors collaboration, house holds etc.)
- The ability to adapt to changes in the socio economic and the political environment. There are four levels of sustainability identified by different authors in the field; these are International, National, Organizational and service/ community level. It is beyond the scope of this study to assess all levels (29).

Study conducted in Ethiopia showed that, the high proportion of contraceptive use discontinuation in former CBD project area compared to the CBD area actively working now.

This difference was attributable to the service cessation in the former CBD project area (9).

The institution based family planning services remained inaccessible for the majority of people who might otherwise be motivated to use contraceptives (30). Efforts to improve the acceptability and the efficacy of family planning programs often focus on developing convenient, non-clinical community based services.

Early research demonstrate that CBD was feasible, effective, safe and important to success at the national level in several Asian and Latin American countries suggesting that contraception was in demand and that non clinical community distribution was feasible and acceptable to local population (31). Wide spread commitment to expanding non-clinical family planning programs is based on assumptions about the efficacy and appropriateness of the various operational strategies (31).

The CBD

Family planning programs often augment clinical services with social marketing, satellite clinics, employer based programs, private sectors, and other forms of family planning outreaches such as home visitation by trained distribution agents.” Community Based Distribution” (CBD) refers to programs of non-clinical family planning services approach that the community organization, structure, and institutions to promote the use of safe and simple contraceptive technologies (32,33).

CBD is a complex concept, involving varied operational designs. Nonetheless, a common underlying assumptions guide all CBD initiatives:

- Offering family planning services at non-clinical community locations expands the acceptability and convenience of contraceptives and reduces the costs of contraception, thereby extending use among clientele who seek contraceptives but will not use services that are confined to clinical setting (30,34).

Essential feature of CBD program

1. Community residents that are not health professionals deliver supplies and services.

2. The programs deliver services to each community or each household, and don't depend on clinical attendance.
3. CBD workers operates relatively autonomously, with out day-to-day supervision.
4. Many diagnostic, screening and record keeping procedure, although desirable, are omitted, because they are not practical for community workers (35).

CBD assumptions

1. As CBD programs have developed throughout Africa, various assumptions have guided their operational design and presumed consequences (36). The conventional view sees CBD as a single strategy that addresses the problem of family planning inaccessibility under the assumption that a lack of convenient access to contraceptives represents the primary barrier to the practice of family planning. According to this view, inaccessibility constrains method adoption and use, rather than societal barriers such as a woman's belief that her husband disapproves of contraception.
2. Assumptions about the efficacy of CBD in Africa were derived largely from the legacies of CBD in other region (37). Community-based distribution programs originated in Asia in the 1960s with projects in Indonesia, Korea, Taiwan, and Thailand that led to a proliferation of the strategy through out Asian and Latin America in the 1970s and 1980s (8).
3. Early research demonstrated that CBD was feasible, effective, safe and important to success at national level in several Asian and Latin American countries, suggesting that contraception was in demand and that non-clinical community distribution was feasible and acceptable to local population (37).

CBD in sub- Saharan Africa

CBD program have expanded in sub Saharan Africa over the two decades. A review of 93 developing countries in 1984 concluded that CBD was functioning in 34 countries around the world, seven programs of which were operating in sub-Saharan Africa (30). Countries with CBD coverage of less than 21 % of their catchments areas considered having “weak” effort, where as those in which CBD programs cover 21 % or more of all areas are considered “strong” (30). Where the CBD was weak in the 1980s, program was constrained by medical conservatism, policy inertia, bureaucratic inertia, and operational uncertainty in Africa (36). By 1996 CBD programs begun in six additional countries (Benin, Central Africa Republic, Malawi, Mali Sudan, and Uganda). In all, 20 countries in Africa had at least one initiative in the five years from 1994 to 1998. Four countries have strong national CBD program (Kenya, Zimbabwe, Benin and Mali)(30).

In Ethiopia, unlike some African countries, the CBD program has been started very late. Through out the country, the CBD program has been implemented by NGOs, such as FGAE took the pioneering position and others like GTZ which significantly contributing for the expansion of the program. To a limited extent the public sectors initiated to conduct the CBD program. Recently, the CBRH programs are designed to bring Reproductive Health (RH) services to the community by utilizing community members as service delivery agent. Evaluations of CBD-FP projects of the FGAE various part of the country have shown notable changes in awareness about contraception, attitude towards FP and contraception use (16, 20, 38, and 39).

Impact of CBD

The main purpose of the CBD program is to provide information and appropriate contraceptives and referrals to men and women of reproductive age and to advice on other aspects of RH aspects such as HIV/AIDS/STI, and safe motherhood.

The impacts of the CBD program usually are examined on the following ways (40):

- Proportions hearing about, knowing of and talking to the CBD agents;
- Proportions receiving primary information about family planning from a CBD agent;
- Proportions of ever-user and current users who used a method provided by a CBD agents or referred by a CBD agent;
- Proportions desiring more children;
- Proportions of non-users who site non-biological reasons for non-use;
- Proportions receiving counseling from a CBD agents on a non-FP topics
- Unmet need for contraception
- CPR
- TFR.

The greatest strength of CBD is its potential to involve communities and foster male approval of family planning, thereby having impact on spousal communication and unmet need. One experimental study in Mali demonstrated that CBD increased spousal communication more than other family planning program components were able to. Thus the impact of CBD on contraceptive use has been established, but the more general causal basis for this impact is poorly understood. A recent study conducted in Mali demonstrated that CBD had an impact on

contraceptive knowledge and contraceptive use. In this particular condition the contraceptive knowledge and CPR raised from 1% to 31% and 10% to 99%, respectively (41).

In the Gambia, CBD through traditional social institutions increased contraceptive prevalence by 10 percent among women most likely to practice contraception (42). In Kenya the use of traditional health practitioners as CBD agents increased contraceptive prevalence to 40 % (higher than the national average, 27%) (43). Survey response suggests that CBD informs many couples about family planning in Kenya and that CBD may, therefore, contribute incrementally to contraceptive use (43). Moreover, statistical analysis has been completed suggesting that CBD program in Kenya have accelerated a demographic transition that was initiated by social and economic forces (44, 45). Two experimental studies in Ghana have demonstrated an impact on contraceptive use, that it increased access to FP for rural, lower total fertility rate (TFR) by 0.4. CBD services reportedly tripled contraceptive acceptance rate. (46,47). An ongoing Burkina Faso experiment has produced preliminary evidence that CBD doubled contraceptive prevalence from 4% to 8 % in rural district, and further effects may be found as this continues (48).

Studies demonstrating CBD effects have been conducted in settings of lower contraceptive prevalence. Statistics from Kenya and Zimbabwe suggests that rigorous national CBD efforts have provided substantial proportions of the contraceptive supplies and services that are furnished to couples in those countries (48). The timing of the CBD efforts in Kenya was associated with subsequent increase in method use (45).

Although ultimately research may demonstrate that CBD affects fertility, African demographic transitions are likely to be different from such transitions in other parts of the world where contraceptives are primarily used to limit births (50). They will probably be more gradual often women of all ages rather than only those older women who have reached their desired parity. The role of CBD in this unique region is unknown (51).

How ever, CBD can help couples with unmet need for family by mitigate monetary costs of the contraceptives in several ways (52,53):

- By placing services in convenient locations; by offsetting social costs of fertility regulation through offering information and services in a manner that dissipates familial barriers or other opposition to family planning.
- By averting psychological costs of contraception through counseling recorrect misinformation; and by reducing health costs of side effects with treatment and follow up services In contrast to the above findings, CBD programs in Africa provide strategic contrast that merit review. The role of CBD in producing the rising contraceptive prevalence rate has been the subject of considerable discussion and debate, however (54, 55, and 56).

Studies conducted in Ethiopia have shown that CBD programs significantly contributed to raise contraceptive knowledge, attitude and subsequent use. For instance, study conducted in East Shoa indicated that the proportion of ever and current contraceptive users were higher in the CBD project area than non-CBD areas. The contraceptive prevalence rate for current use was 43.4% and 7.6% for the CBD and non-CBD areas respectively. The contraceptive knowledge

and attitudes and service utilization were also found to be higher in the successful CBRH project in rural part of Northwest Ethiopia). Similarly, the study conducted in Central Tigray also revealed that the CPR for current use was higher in the CBD area than the non-CBD area with a prevalence of 14.4% and 4.4% , respectively (9,39,57,58). In line with this in the study Zone, prior to the initiation of the program, the CPR was 11% and the intended target was to raise this CPR to 35% after two years time. However, after two years of implementation of the program, the CPR has only increased to be 20%. The CPR in FGAE project areas however is relatively higher (35%) than the SDP project area (14).

Factors accounting for variance in CBD performance

The analysis of program performance based on CBD outputs indicated that agents who were provided with a monthly allowance perform better than those provided with non-monetary incentives. In addition, the programs providing their agents with some non-monetary incentives performed better than the program that didnot provide any incentives (59).

A combination of factors affected CBD output and contributed to CBD motivation or lack of it. The main among these were monetary and non-monetary incentives, an effective managements and supervision system coupled with strong community support and participation in CBD activities. In addition, income generating activities and non-monetary benefit such as prestige community recognition accrued from CBD work play a significant role in motivating CBD agents and subsequently affecting their out put and job satisfaction. High community participation in the management of CBD activities coupled with income generating activities (which benefit not only the CBD agents but in some cases their community members) partly explained the high-level job satisfaction among CBD agents. Factors that can be said to explain

the high output for CBD agents are time spent on the CBD activities and program's efficient supervision (60).

The variation in the range of activities and services provided by CBD agents is expected to affect FP per CBD agent. Agents providing integrated services have higher FP outputs per agent than providing FP only. For instance, a comparison of program output per CBD agent indicates that the program whose agents provide a wider range of services have higher FP output per CBD agent than the one which provides few services. CBD agents reported that, offering a wider range of services provides them with a better standing in their communities. Agents not providing MCH and STD/HIV information and referral services expressed a need to receive training for a broader range of services (9, 51, and 60).

Rationale of the study

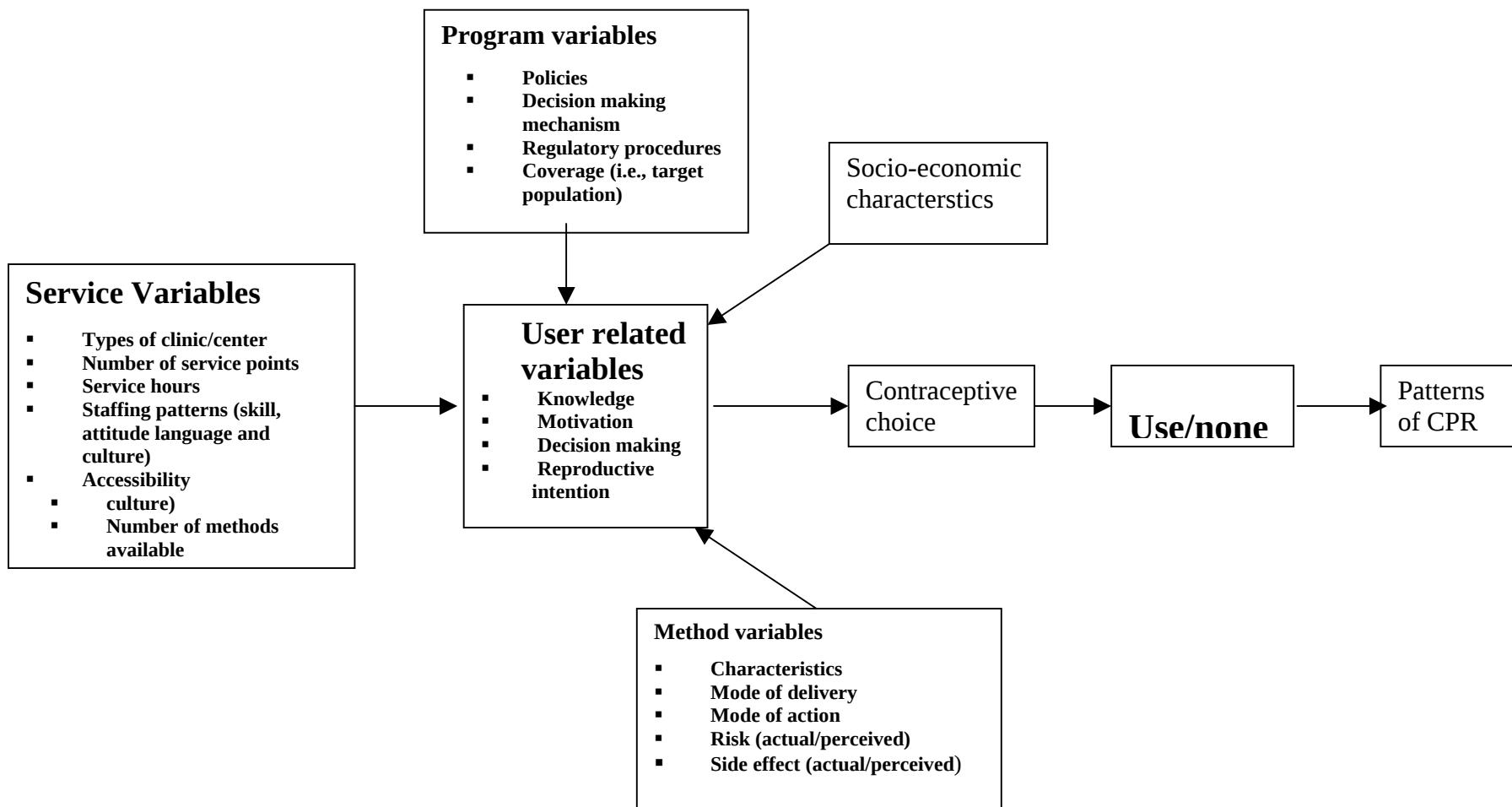
Since there is a difference in contraceptive prevalence rate in the two functional Community - Based Distribution programs for family planning in Sidama Zone, it is crucial to know reasons for this difference. Though few studies conducted in the country on the CBD programs, none of them compared the two functional but with different modalities. This study, therefore, is aimed to identify such factors for the observed difference in CPR between the two actively functioning projects. The finding of this study will help health planners, managers and service providers to intervene accordingly by restructuring and modifying the program in the subsequent phases

Study question

What factors contributed for the differences in contraceptive prevalence rate?

Fig 1. Conceptual Framework for the study of contraceptive use dynamics

Adapted from Trussel and Kost 1987, for a contraceptive review of methodological issues in the measurement of contraceptive failure & use continuation



Objectives

General objective

The general objective of the study is to identify Factors Associated with the Difference in contraceptive prevalence rate between SDP and FGAE supported CBD project areas of Sidama Zone, SNNPR.

Specific objectives

- Identify socio demographic and economic factors for the differences in contraceptive prevalence rates.
- Compare the levels of knowledge and attitudes of the clients towards family planning services in the two project areas.
- Compare the utilization of family planning services by the target groups in the two CBD project areas.
- Assess the level of assistance given for the family planning program (CBD) by both projects.

Methodology and materials

Study area and population

This study was conducted in Sidama Zone, which is one among the 13 zones in the Southern Nations Nationalities and People's Regional Government (SNNPRG). It is located in southeastern part of the region bordering in northeast and east the Oromiya Region, south Gedeo Zone and in the west Wolaita Zone. Awassa, the capital of the zone as well as the region, is situated 275 kms south of Addis Ababa on the main high way to Moyale, Kenya. According to the Zonal Health Department, the zone has a total of 2,549,280 people of which 1,295,937 (50.84%) are males and 1, 253,343(49.16%) are females. Women of the reproductive age group are estimated to be 605,708 (23.8%) of the total population (61).

Out of the total population, 2,347,950 (92.1%) are rural and 201,330(7.9%) are urban dwellers. The average population density is 332-persons/ sq. km. The major ethnicities of the zone are Sidama, which composes of 88.6%, followed by Amhara, Oromo, Wolaita and others. Administratively the zone is divided in to 10 woredas and forty urban kebeles and 536 peasant associations (PA). All of these woredas are accessible by all-weather roads, seven woredas have telephone services, and the remaining three are being served by rural radio communication (61).

The climatic condition of the zone is divided in to "Dega" (highland), "Woinadega" (middle land) and "Qola" (low land). Majority of the zone is covered by woinadega, which is 54 percent. Similar to other rural zones of Ethiopia, the economic situation is based on both subsistence and in addition they produce cash crop.

In the zone there is one hospital, 16 health centers, 54 health stations, 29 private clinics, 137 rural drug vendors, 3 drug distributors 13 pharmacies, 6 drug stores. The governmental health institutions provide services by using a total of 637 health professionals of various categories. Accordingly, the physician to population ratio of the zone is 1:79,665 and the nurse to population ratio is 1: 10,238 that is much higher when compared with the national ratio, (physician 1: 47,836 and nurse 1: 8461). In support to the government health services, there are some non-governmental organizations engaged in providing health services in the zone (Annex 9).

Study design

This study utilized both quantitative and qualitative method of data collections. A community based comparative cross-sectional survey was employed for the quantitative study, and qualitative information collected from focus group discussion and in-depth interview of key informants complemented the quantitative data.

I. Cross-sectional

The cross-sectional survey enabled the investigation of factors that determine the occurrence of certain characteristics or outcomes. In this study the particular outcome of interest is the identification of the reasons for the different contraceptive prevalence rates in the two project areas (SDP and FGAE).

Source population

The source population for this study was women in the reproductive age group (15-49years) who reside in the seven woredas of the Zone included under the CBD program (SDP and FGAE project area).

Study population

The study population was all women in the reproductive age group residing in the selected peasant association of study woredas. The selection was based on simple random sampling techniques.

Sample size determination

Assumptions

- Prevalence of contraceptive use rate for SDP project area = 20%.
- Prevalence of contraception use rate for FGAE area = 35%
- Design effect of 2, to take into account two levels of stratification: by SDP and FGAE areas and by urban and rural.
- The power of the study to detect any difference between the two project areas, 90%
- The level of confidence, $\alpha = 0.05$, to conclude that the difference in CPR between the two projects
- r , the population allocation ratio = 2 : 1 based on the proportion of the population of the two project areas, i.e. the SDP project areas population is 1,424,028 and the FGAE project areas is 822,079. The actual ratio is 1.74 : 1 but by rounding to the nearest decimal place it became 2 : 1.

$$n, \text{ for each sample} = \frac{[Z_{\alpha/2} \sqrt{(1+1/r) p(1-p) + Z_{\beta} \sqrt{p_1(1-p_1) + p_2(1-p_2)}}]^2}{(p_1-p_2)^2}$$

Where,

$Z_{\alpha/2}$ = value of the standard normal distribution curve corresponding to level of significance
alpha 0.05=1.96

Power= Z_{β} = value of the standard normal corresponding to 90%

P (pooled population proportion) = $\frac{p_1(n_1)+p_2(n_2)}{n_1+n_2}$

$$n_1+n_2$$

$$r = n_1/n_2$$

n_1 , Sample for FGAE project areas = 150

n_2 , Sample for SDP project areas = 300

Then assuming a non-response rate of **20%** and a design effect of **2**, the final sample size is **1080**.

Sampling Technique

A multistage sampling technique was employed to select woredas and kebeles. Family planning services in Sidama Zone are being provided by various organizations. Of the total 10 Woredas, seven are providing community based family planning services in addition to the routine institution based services. Family Guidance Association of Ethiopia (FGAE) and Sidama

Development Program (SDP) are the two non-governmental organizations supporting the CBD programs. Family Guidance Association of Ethiopia (FGAE) provides services in two Woredas namely Awassa Zuria and Dale. The Sidama Development Program (SDP) supported CBD family planning services are being provided in the five woredas namely Aletawondo, Dara, Hula, Bensa and Shebedino. Based on the number of women in the reproductive age in the seven woredas the ratio of women served by SDP and women served by FGAE is 1.74: 1. Accordingly, 2 woredas (Aletawondo and Shebedino) from SDP and Dale woreda from FGAE project sites were selected randomly.

Among 79 peasant associations found in Shebedino woreda 18 peasant associations and of the total peasant associations found in Aleta wondo woreda 20 peasant associations were included in SDP supported CBD project. Eighteen peasant associations in Dale woreda were included in the FGAE supported CBD projects. From each woreda, one-third of the peasant associations were enrolled randomly. Households from each peasant association were selected using systematic random sampling. One woman from each house hold was selected by lottery method. In events ,where the eligible woman was absent in the selected house, the woman in the next house were selected.

The detailed sampling scheme is shown in figure 2.

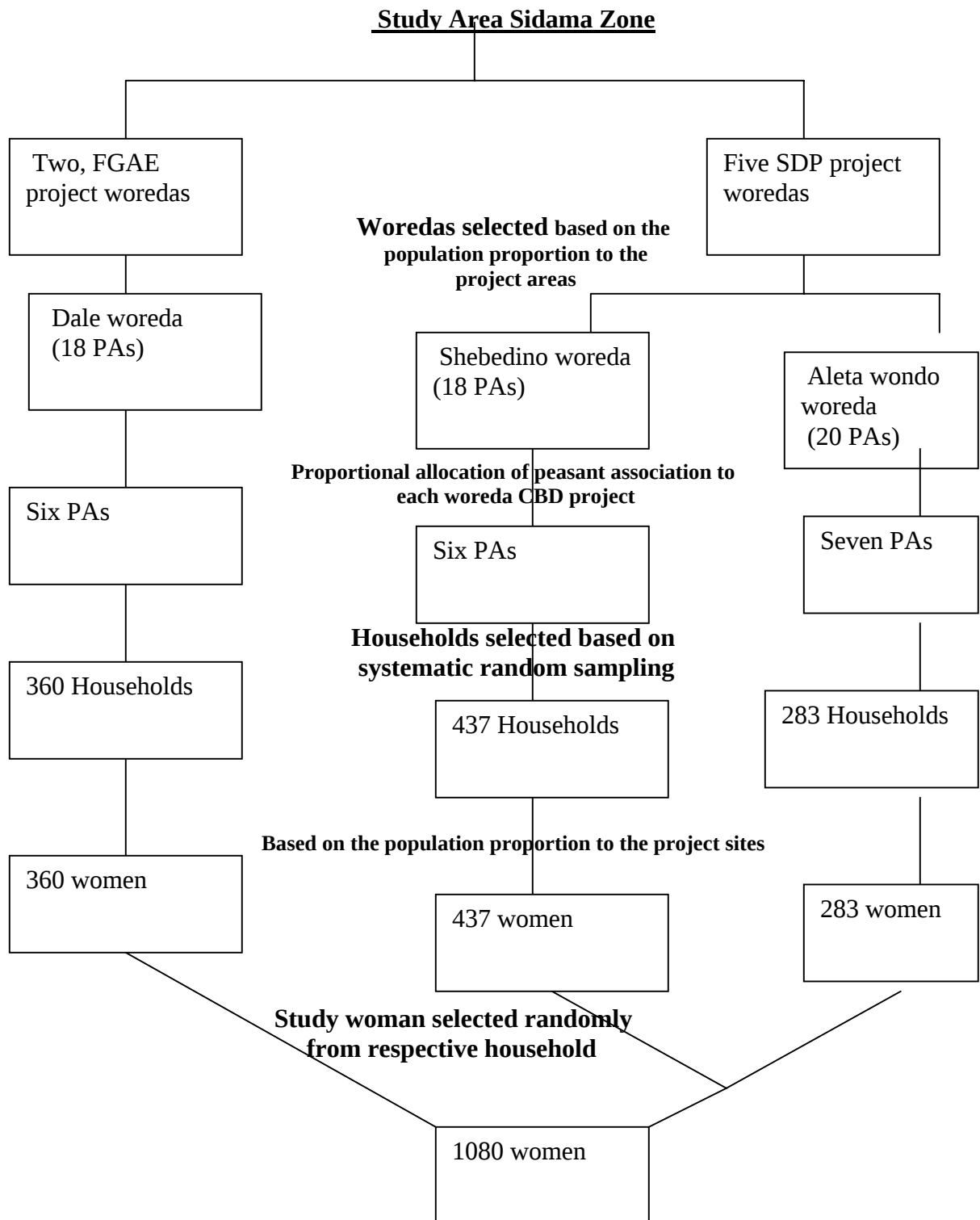


Fig.2, Study Architecture for sampling method

Eligibility criteria

Those women aged between 15-49 and the permanent residences of that peasant association were eligible.

Methods of data collection

Data were collected using a structured questionnaire that included socio-demographic reproductive knowledge and attitude towards FP variables. Trained interviewers who speak Sidamigna and completed grade 12 collected the data.

II. The qualitative part of the study

Focus group discussion

This method is considered for the study as it is assumed to increase interaction between participants and information would come out spontaneously. It also generates new ideas, and identifies differences in views. Therefore, this study utilized FGD in order to explore and obtain information from health service managers at woreda level, family planning service providers in health institutions (health centers, health stations and health posts), and community based distributors. In addition, community and religious leaders participated in the discussion in order to obtain opinion **for contraceptive utilization patterns**.

In-depth interview

Key informants for family planning services such as district health managers were interviewed using in-depth interview technique to generate detail information for the reasons that lower the CPR in the Zone.

Sampling technique

A total of two woredas were considered from the two project areas for the qualitative study. From the selected study woredas, a total of eight focus group discussions were arranged in the following manner:

- From health institutions (HC, HS, HP) service providers two groups were selected. Arrangements were made to bring each group together to convenient place in order to facilitate the discussion.
- From each project area, one group of community leaders was selected.
- From each project area, one group of religious leaders was selected

- For each project area, one FGD was conducted for CBD agents.

Discussants from respective office, health institutions and communities were selected using non-probability (convenient) sampling method through **communication with woreda health office heads and other knowledgeable persons about the local situations**. In-depth interview was conducted by selecting knowledgeable people (service managers) from each project area woredas.

Eligibility criteria

Health service managers at the woreda levels and those health professionals working in the Health Centers (HC), Health Stations (HS) and Health Posts(HP) were included. With regard to the community leaders only those currently working as active leaders were included. The CBD agents currently providing services were included.

Methods of data collection

A semi structured interview guide was used to facilitate the discussions. The principal investigator with the support of trained note taker moderated all discussions. All discussions were tape-recorded. All discussants actively participated in the discussion.

Assurance of the data quality

To maintain the data quality:

- Questionnaire was prepared first in English then translated to Amharic and then back to English in order to ensure correct translation.
- The questionnaire was tested for its consistency coherence and completeness.
- The selection of data collectors was based on the ability to speak the local language, grade 12 educations and being female. .

- Training for Data collectors was given for three days, including one day of practical work. Feedback from the interviewers was incorporated to enrich the questionnaire and make more applicable to the local situations.
- The supervisors checked each each questionnair daily. Interview of missing and correction of in appropriate responses done.
- A pre-test in a community similar to the study population but different from the selected sample were conducted prior to the data collection.

Operational definition

- **CBD Program** - a community based distribution program for FP designed to reach the reproductive age group people who do not use clinical services.
- **CPR** - this will be by dividing the total number of users by the total number of women in the age group 15- 49 years multiplied by 100.
- **Method mix** – The number and type of contraceptive methods available for the clients.
- **Knowledge of family planning method** _ The capability to name one or more methods of contraception
- **Motivation** – the factor that cause, channel, and sustain the CBD agents performance
- **Performance** _ the performance of the CBD agent how well he/she does the community based distributions and the IEC and other reproductive activities to the client.
- **Sustainability** _ the ability of the CBD program to continue longer with the contribution of the community members.
- **Assistance** _ support, help given to the CBD agents by the community, health professional and program managers in order to effect the program.

Data requirement

1. Dependent variables

1. Contraceptive methods usage
 - Current use of modern contraceptives
 - Past use/ discontinuation

2. Independent variables

1. Family planning service providers (the CBD agents)

- Practice
- Motivation
- Selection criteria for CBD agents

2. Women in their reproductive age groups

- Socio demographic and economical factors
- Desired number of children
- Accessibility of the services
- Knowledge, attitude
- Perceived attitude of partners towards family planning services (as described by their wives)

3. Service management

- Management and supervision of CBD agents

Data analysis

Data were entered using EPI-INFO version 6, and analyzed using EPI-INFO version 6 and SPSS statistical program. Proportions, percentages utilized to describe some characteristics in the study. χ^2 -test and Odds ratio were used to measure the association of dependent and independent variables, whereas 95% CI and p-value were utilized to see statistical significance. Multiple logistic regression analysis was done in order to assess the effect of various explanatory variables on the current use of family planning services. The qualitative portion of the study (FGD) was analyzed by using qualitative analysis technique (62). The following steps were employed: relistenning to the tape recorders several times, recording field notes, checking and organizing, transcribing data, coding, conceptualizing, categorizing, indexing, reducing and finally writing the report by narrating the finding.

Ethical clearance

Ethical clearance was obtained from the Department of Community Health, Faculty of Medicine Addis Ababa University. Permission for the study was obtained from SNNPRG Health Bureau, Sidama Zonal Health Department, and the study woredas; the FGAE and SDP project offices. All the study participants were informed about the purpose of the study, their right to refuse, and assured confidentiality and informed verbal consent were obtained. Feedback of the study will be given to the respective organizations. The output of the study will benefit health managers planners, service providers and women of the reproductive age group by suggesting factors associated with the difference in contraceptive use and its prevalence.

Results

I. Quantitative data

In this study it was expected to interview a total of 1080 respondents from two CBD project areas (the SDP and FGAE). However, a total of 1058 reproductive age group women were interviewed. Six hundred ninety eight from the SDP and 360 respondents successfully attended the interview. There was 2% non-response rate found during the data collection.

Socio-demographic and economic characteristics

Relatively, high proportion of the study women, found in the age group between 25-29 yrs.

The mean age of the respondents in SDP site was 26.4 years with SD (7.3), whereas it was 25.6 SD (5.8) years under FGAE sites. The majority of respondents in both project areas are protestant by religion, which accounts about 85.1 % and 85.8 % in SDP and FGAE, respectively. As to the educational status, among the interviewed respondents more than half (54.3 %) in SDP project site and 40 % in FGAE site were illiterate. The majority of respondents in both project areas were housewife by occupation, (80.4 % and 86.4 % in SDP and FGAE, respectively).

Table 1. Socio demographic and economic variables representing the SDP and FGAE supported CBD project areas, Sidama Zone, November-December, 2002

Socio demographic characteristics	SDP N %	FGAE N %
Age		
15-19	128(18.34)	52(14.4)
20-24	136(19.5)	83(23)
25-29	185(26.5)	135(37.5)
30-34	118(19.9)	57(15.8)
35-39	83(11.9)	22(6.1)
40 ⁺	28(4.91)	11(3.14)
Mean $\pm$ SD	26.4 $\pm$ 7.3	25.6$\pm$5.8
Religion		
Orthodox	40(5.7)	22(6.1)
Catholic	30(4.3)	15(4.2)
Protestant	594(85.1)	309(85.8)
Others	36(4.9)	14(3.9)
Ethnicity		
Sidama	622(89.1)	327(90.8)
Amhara	48(6.9)	22(6.1)
Others	28(4.0)	11(3.1)
Education		
Illiterate	376(54.3)	144(40.0)
Read & write	138(19.8)	83(23.1)
Primary	142(20.3)	116(32.2)
Secondary ⁺	39(5.6)	17(4.8)
Occupation		
House wife	561(80.4)	311(86.4)
Merchant	37(5.3)	32(8.9)
Others	100(14.4)	17(4.7)
Martial status		
Married	617(88.4)	333(92.5)
Unmarried	81(11.6)	27(7.5)
Polygamy marriage		
Yes	82(13.3)	53(15.9)
No	535(86.7)	280(84.1)

Note: ⁺ = and above

Table1. cont.

Socio demographic characteristics	SDP		FGAE	
	N	%	N	%
Perceived economic status in comparison to the neighbor				
Very low		46(6.6)		25(6.9)
Low		217(31.1)		89(24.7)
Medium		417(59.7)		224(62.2)
High		18(2.6)		22(6.1)
Radio ownership				
Yes		227(32.5)		166(46.1)
No		471(67.5)		194(53.9)

Reproductive characteristics

Among the reproductive characteristics considered in this study; intention of pregnancy, age of first childbirth, desired number of children, first marital age, showed significant difference between two project areas (Table 2).

First marital age

Of the total 965 ever-married women interviewed in the study, majority of them were married at age below 20years. Nearly 92 percent in SDP and 97.1 percent in FGAE were married before their 20s. The mean age for their first marriage was 16.2 SD (2.2) and 15.7 SD (2.8) years in SDP and FGAE respectively indicating that they get married at their early age (Table 2).

Intended pregnancies and age of first child birth

The majority of respondents got pregnant based on their desire to be pregnant. Almost 90 % and 81.6 % in SDP and FGAE project areas respectively got pregnant with their intention to do so. Correspondingly to their early marital age, majority of the respondents have shown history of early childbirth. Eighty seven percent and 75 % in FGAE and SDP project areas respectively gave birth before their twenties (Table 2).

Desired number of children

The mean desired number of children in the SDP and FGAE supported project areas were 5 SD (1.6) and 5.6 SD (1.8), respectively. Similarly, mean for the desired male and female children number were 2.6 SD (1.0), 2.9 SD (1.2), 2.4 SD (1.1), 2.7 SD (1.1) in SDP and FGAE respectively were shown significant difference (table2).

Number of pregnancies

The mean number of pregnancies a woman had was found to be 4.4, SD (2.5) and 4.1, SD (2.3) in SDP and FGAE respectively. This difference was not statistically significant. Among the study subjects who had experienced unwanted pregnancies on average they had nearly 2 (SD=1.5) in SDP and 1.9 (SD=1) unwanted pregnancies. This didn't show statistically significant difference between the two project areas (table2).

Table.2 Reproductive characteristics representing FGAE and SDP projects areas Sidama Zone November- December 2002.

Reproductive characteristics	SDP N %	FGAE N %
First marital age		
10-14 Yrs	121(19.3)	65(19.2)
15-19	454(72.5)	264(77.9)
20 ⁺	51(8.3)	10(2.9)
Mean $\pm$ SD	16.2 $\pm$ 2.2	15.7 $\pm$ 2.8
Pregnancy history		
Yes	621(89.0)	331(91.9)
No	77(11.0)	29(8.1)
Number of pregnancies		
1-3	266(42.8)	153(46.2)
4-6	233(37.5)	126(38.1)
7 ⁺	122(19.6)	52(15.7)
Mean $\pm$ SD	4.4 $\pm$ 2.5	4.1 $\pm$ 2.3
Intention of Pregnancies		
Yes	557(89.7)	270(81.6)
No	64(10.3)	61(18.4)
Number of unwanted Pregnancies		
1-2	47(73.4)	45(73.8)
3-8	17(26.6)	16(22.2)
Mean $\pm$ SD	1.98 $\pm$ 1.5	1.9 $\pm$ 1.0
History of abortion		
Yes	125(20.1)	55(16.6)
No	496(79.9)	276(83.4)
Type of abortion		
Spontaneous	113(90.4)	44(80.0)
Induced	12(9.6)	11(20.0)
Current status of pregnancy.		
Yes	99(15.9)	52(15.7)
No	522(84.1)	279(84.3)

Note: ⁺ = and above

Table 2., continued

Reproductive characteristics	SDP N %	FGAE N %
Current desire of Pregnancy.		
Yes	81(81.8)	44(84.6)
No	18(18.2)	8(15.4)
History of child birth		
Yes	611(98.4)	320(96.7)
No	10(1.6)	11(3.3)
Age of first child birth		
10-14	60(9.80)	25(10.24)
15-19	397(64.8)	187(76.6)
20 ⁺	155(25.33)	32(13.11)
Desired number of children		
1-3	75(10.74)	12(4.9)
4-6	515(73.78)	153(62.2)
7 ⁺	108(15.50)	81(32.9)
Desired number of male children		
1-3	574(82.23)	171(69.5)
4-9	124(17.76)	75(30.5)
Desired number of female children		
1-3	602(87)	187(76)
4-9	90(13)	59(24)
Number of children alive now		
1-3	302(49.5)	118(48.4)
4-6	229(37.54)	97(39.8)
7 ⁺	79(12.95)	29(18.8)

Note: ⁺ = and above

Knowledge, Attitude and Practice of Family Planning

1. Knowledge

There was significant difference between the SDP and FGAE supported CBD project areas with regard to their knowledge (ever heard about it) of modern contraceptive methods, ($X^2 = 6.09, P < 0.05$). It was found that 93.1 % of the SDP and 97.2 % of the FGAE areas knew at least one modern contraceptive method. There was also a significant difference in their knowledge of specific modern contraceptive methods when the study subjects in SDP project area compared with those in FGAE project area (table 3 and 4). The most commonly known modern contraceptive method by the respondents was injectable followed by contraceptive pills in SDP project area, while pill is mostly known by FGAE project area followed by injectable hormone. Knowledge of other methods like condom, IUCD, and Norplant is higher in FGAE project area than the SDP project area (table 4). This study has shown significant difference for the knowledge of specific family planning methods in the two project areas ($X^2 = 188.27, P < 0.01$).

2. Attitude

Future intention of the respondents to use family planning method has shown statistically significant difference in between the two project areas ($\chi^2 = 6.46, P < 0.05$). Nearly, 87 % and 92 % of the respondents in SDP and FGAE areas respectively showed the intention to use contraceptive methods in the future. As to the attitude of the respondents towards family planning services, almost equal proportion (90.8 %) have shown positive attitude towards family planning service. No statistically significant difference was observed here. With regard to the perceived husband's attitude towards the utilization of contraceptives, there was significant

difference between the two project areas. Seventy five percent and 86.2% in the SDP and the FGAE respectively were found to have positive attitude towards contraceptive use. Concerning to couple's discussion about family planning methods, there was statistically significant difference between the two project areas ($\chi^2=54.83$, $P<0.01$). Forty four percent and 19.8 % of the respondents in SDP and FGAE respectively discussed with their partner about family planning methods within three months before the survey. Respondent's attitude in support of others utilization of contraceptives showed statistically significant difference between SDP and FGAE supported CBD project areas. Of the total respondents, 90 % and 96.4 % in SDP and FGAE project areas respectively were found to support other's contraceptive use.

3. Practice

The proportion of women who ever used modern contraceptive methods significantly differs between the two study project areas ($X^2=33.9$, $P<0.01$). It was found that 49.6 % of the SDP and 68.3 % of the FGAE project areas study women ever used modern contraceptive methods. Where as, 40.7 % and 51.6 % of women living in the respective study areas were current users of modern contraceptive methods. This showed statistically significant difference between the two study project areas (Table 3). There was no significant difference observed in their use of specific modern contraceptive methods by the women between the studies areas, however, injectable hormone was the most frequently used MCM followed by oral contraceptive pills. Sixty two percent of the SDP and 72.4 % of the FGAE areas current contraceptive users were using injectable, while 39.6 % of the SDP and 56.9 % of FGAE areas were using oral contraceptive pills.

Table.3: Percent distribution about family planning knowledge at SDP and FGAE supported CBD project areas, Sidama Zone November-December,2002

Family planning knowledge status	SDP N %	FGAE N %	x²	P-value
Ever heard at least one method:	N=698	N=360		
Yes	654(93.7)	350(97.2)	6.09	0.01*
No	44(6.3)	10(2.8)		
Specific types of contraceptive known:				
Natural methods	9(1.4)	22(6.3)	186	0.01*
Pills	469(71.6)	333(95.1)		
Injectable	489(74.8)	328(93.7)		
Implant	45(6.9)	141(40.3)		
Loop	16(2.4)	66(18.9)		
Others	14(2.2)	82(23.5)		
Source of information	99(15.1)	108(30.9)	88.4	0.01*
Radio	226(34.6)	116(33.1)		
Health institution	213(32.6)	183(52.3)		
CBD agents	17(2.6)	43(12.3)		
Husband	267(40.8)	135(38.6)		
School	44(6.7)	10(2.9)		
News letter	69(10.6)	12(2.3)		
Others				

NB. Numerator for specific contraceptive knowledge and sources of information for family planning is greater than the denominator because more than one answers could be given by the respondents

*= Significant difference

Table 4. Comparison of knowledge, attitude and practice of family planning services between SDP and FGAE supported CBD project areas, Sidama Zone, 2002

Variable	SDP N (%)	FGAE N (%)	x²	p-value
Knowledge of modern contraceptive methods:	N=698	N=360		
Know	654(93.7)	350(97.2)	6.09	0.01*
Don't know	44(6.3)	10(2.8)		
Knowledge of specific methods:				
Natural method	9(1.4)	22(6.3)	188.27	0.01*
Pills	468(71.6)	333(95.1)		
Injectables	489(74.8)	328(93.7)		
Condom	11(1.7)	57(16.3)		
IUCD	16(2.4)	66(18.9)		
Norplant	45(6.9)	141(40.3)		
Others	3(.5)	27(7.8)		
Future intention to use:				
Intended to use	605(86.7)	331(91.9)	6.46	0.01*
Did not intent	93(13.3)	29(8.1)		
Ever use of MCM				
Ever used	346(49.6)	246(68.3)	33.9	0.01*
Never used	352(50.4)	144(31.7)		
Current use of MCM				
Users	244(40.7)	159(51.6)	9.76	0.01*
Non-users	355(59.3)	149(48.4)		
Current use of specific MCM				
Pills	137(39.6)	140(56.9)	3.71	0.148
Injectables	215(62.1)	178(72.4)		
IUCD	12(3.5)	7(2.8)		
Others	18(5.2)	8(3.2)		
Respondent's attitude to FP				
Positive	633(90.7)	327(90.8)	0.01	0.938
Negative	65(9.3)	33(9.2)		

*Note: *= significant difference*

Table 4. Continued

Variable	SDP N (%)	FGAE N (%)	x²	p-value
Respondent's attitude in support of other client's acceptance of FP methods				
Yes	628(90.0)	347(96.4)	13.52	0.01*
No	70(10)	13(3.6)		
Husband knowledge of his partner's contraceptive use				
Knows	313(90.5)	227(92.3)	0.59	0.443
Does not know	33(9.5)	19(7.7)		
Perceived husband's attitude towards contraceptive use				
Positive	463(75.0)	287(86.2)	16.15	0.01*
Negative	154(25)	46(13.8)		
Length of duration for contraceptive acceptance				
1-11 months	37(15)	94(27.2)	31.85	0.01*
1-3 yrs	130(52.8)	203(50.8)		
4 and above	79(32.2)	49(14)		
Mean $\pm$ SD	2.8 $\pm$ 2.0	1.9 $\pm$ 1.6		

Note: *= significant difference

Reasons for modern contraceptive methods non-use

Among the reasons mentioned for non-use of modern contraceptive methods by the respondent women, no reason was found to be significantly different between the two study project areas. However, among the stated reasons for non-use, need for more child was found to be greater that is, 32.4 percent of the SDP and 26.3 percent of the FGAE study areas. Lack of information about family planning was the second mostly mentioned reason for non-use in FGAE study area with 22.8 percent. The second reason for non-use in SDP study area was the absence of sexual partner, which accounted for 27.6 percents. Others like lack of confidence on the methods influence of others and medical problems were also among the reasons for contraceptives non-use (Table 5).

Reasons for contraceptives use discontinuation

Among the respondent women in the study area, 29.4% and 36.5% in SDP and FGAE respectively experienced contraceptive use discontinuation. From the reasons for discontinuation, desire for more children is an out standing (58.3 % and 65.5% in SDP and FGAE, respectively), followed by health problems. Significant difference was observed between the two project areas in this regard (Table, 5).

Table 5. Comparison of reasons for contraceptive non-use and use-discontinuation between SDP and FGAE supported CBD projects Sidzma Zone, November-december,2002

Variable	SDP		FGAE		X ²	P-value
	N	%	N	%		
Reasons for contraceptive use discontinuation	N=100		N=89			
Desire to bear more child	57	(57)	66	(74)	7.95	0.02*
Health problem	28	(28)	15	(17)		
Others	15	(15)	8	(9)		
Reasons for MCM non-use	N=349		N=117			
Lack of information	77	(22)	26	(22.2)	10.88	0.144
Need for more child	114	(32.7)	30	(25.6)		
Other's influence	10	(2.9)	5	(4.3)		
Medical problem	12	(3.4)	7	(6)		
Lack of confidence on methods	8	(2.3)	5	(4.3)		
Absence of sexual partner	97	(27.8)	24	(20.5)		
Others	31	(8.9)	20	(17.1)		

Note: *= significant difference

Quality of family planning services

Statistically significant difference was observed between the SDP and the FGAE supported CBD project areas for quality of service in possibility of getting method of choice, how to take contraceptive methods, methods that prevent STD/HIV, methods other than chosen, about experience of method related problems (Table 6). Others like, information given to about method related problems, contraindication to the modern contraceptive methods, what to do if method related problems arise, next appointment to receive the method, experience to ask the service providers about contraceptive related problems arise, did not show significant difference between the two project areas (Table 6).

Table. 6 Comparison of contraceptive user's view about the quality of family planning services between SDP and FGAE supported CBD projects Sidama Zone, November-December, 2002

Variable	SDP N	FGAE N	X²	P-value
Possibility of getting method of choice	N=346	N=246		
Yes	317	241	10.69	(0.01)**
No	29	5		
Information given to the client by the CBD	N=88	N=114		
<i>How to take the contraceptive methods:</i>				
Yes	65	107	15.63	(0.00)**
No	23	7		
<i>About method related problem</i>				
Yes	54	85	2.04	(0.15)
No	34	35		
<i>Contraindication:</i>				
Yes	52	85	3.10	(0.80)
No	36	35		
<i>What to do if method related problem arise:</i>				
Yes	53	86	2.98	(0.08)
No	35	34		
<i>Method that prevents STD/HIV:</i>				
Yes	45	79	4.53	(0.03)**
No	43	41		
<i>Other than the method chosen:</i>				
Yes	45	85	8.36	(0.003)**
No	43	35		
<i>Next appointment,</i>				
Yes	81	110	0.01	(0.9)
No	7	10		
Experience of method related problem :	N=346	N=246		
Yes	92	27	21.8	(.00)**
No	254	219		

Note: **= significant difference

Table 6 continued

Variable	SDP N	%	FGAE N	%	X ²	P-value
Experience to ask the CBD agents about contraceptive related problems:						
Yes	49		10		2.18	(0.13)
No	43		17			
Reasons for not asking CBD agents about problems						
<i>The agent did not give time for discussion:</i>						
Yes	13		5		0.00	(0.95)
No	30		12			
<i>Absence of trust on the ability of the agent:</i>						
Yes	9		6		1.32	(0.25)
No	34		11			
<i>The agent seemed busy:</i>						
Yes	17		5		0.53	(0.47)
No	26		12			
<i>The agent is not in friendly way:</i>						
Yes	18		5		0.79	(0.38)
No	25		12			

Note: **= significant difference,

Access to family Planning Services

Accessibility of family planning services is among the reasons that affect the family planning service utilization. Among the accessibility characteristics assessed in this study, free contraceptive provision showed statistically significant difference between the SDP and FGAE supported CBD project areas (Table 7). In contrary, service inaccessibility due to lack of money and experience of any method shortage were found to show no significant difference between the two study project areas. Where as, among the reasons mentioned by the respondent women about contraceptive inaccessibility; the reason that they could not mention spcifically showed significant difference between the two project areas. Others like limited method mix, lack of information and health problems were not shown any significant difference (Table 7).

Table 7 Comparison of contraceptive users view about access of family planning service between SDP and FGAE supported CBD project areas, Sidama Zone, November-December,2002

Variable	SDP		FGAE		X²	P-value
	N	%	N	%		
Contraceptive provision free						
Yes	297	(85.8)	59	(24)	229.1	(0.00)*
No	49	(14.2)	187	(76)	1*	
Inaccessibility due to lack of money						
Yes	6	(12.2)	10	(5.3)	2.91	(0.09)
No	43	(87.8)	177	(94.7)		
Reasons for contraceptive Inaccessibility						
Limited method	7	(31.8)	27	(79.4)	15.49	(0.01)
lack of information	3	(13.6)	3	(8.8)		
Health problem	4	(18.2)	3	(8.8)		
Unknown	8	(36.4)	1	(2.9)		
Any method shortage						
Yes	23	(6.6)	12	(4.9)	0.81	(0.36)
No	323	(93.4)	234	(95.1)		

Note: 1= reference, *= significant association*

Determinants of contraceptive use

Stratified analysis between SDP and FGAE project areas was carried out to see the association between the independent variables with the current contraceptive use in the two study project areas. Among the socio-demographic and economic variables assessed in this study; age (15-19), occupation (house wife), marital status, perceived economic status in comparison with the neighbors and ownership of radio were positively associated with current contraceptive use in both study project areas. Similarly, among the reproductive characteristics only history of childbirth, desired number of children and number of living children were positively associated with the current contraceptive use. In addition, the desire to and current alive male children were also positively associated with current contraceptive use (table 8 and 9).

Table 8. Stratified analysis for comparison of socio-demographic and economic variables with outcome (current contraceptive use) variable between SDP and FGAE supported CBD projects in Sidama Zone, November- December

Socio demographic characteristics	SDP		Crude OR	FGAE		Crude OR	Adjusted OR
	Use	No use		Use	No use		
Age	N=244	N =355		N =159	N=149		
15-19	15	91	0.41(0.25,0.94)	9	35	0.45(0.19,1.1)	0.38(0.17,0.83)*
20-24	51	66	1.91(0.86,4.3)	40	23	2.09(0.49,9.1)	1.93(0.98,3.90)
25-29	81	80	2.49 (1.16,5.43)	66	53	1.49(0.38,6.0)	2.21(1.14,4.27)*
30-34	47	50	2.31(1.02,5.3)	29	24	1.45(0.33,6.4)	2.06(1.02,4.18)*
35-39	37	36	2.53(1.1,6.0)	10	8	1.5(0.26,8.9)	2.26(1.07,4.54)*
40 ⁺ *	13	32	1*	5	6	1*	
Religion							
Orthodox	18	19	1.89(0.60,6.0)	11	9	0.87(0.16,4.7)	1.46(0.59,3.65)
Catholic	10	14	1.43(0.39,5.22)	7	6	0.83(0.13,5.39)	1.19(.43,3.32)
Protestant	207	304	1.36(0.57,1.35)	134	129	0.74(0.20,2.7)	1.12(0.55,2.27)
Others*	9	18	1*	7	5	1*	
Ethnicity							
Sidama	213	318	1.63(0.62,4.4)	142	136	0.84(0.18,3.67)	1.33(.61,2.92)
Amhara	24	20	2.91(0.90,9.71)	12	9	1.07(0.17,6.18)	2.14(.83,5.59)
Others*	7	17	1*	5	4	1*	
Education							
Illiterate	134	183	0.73(0.35,1.54)	64	64	0.60(0.18,1.93)	1.02(0.71,1.46)
Read write	42	73	0.58(0.25,1.31)	38	29	0.81(0.22,2.72)	0.64(.32,1.25)
Primary	50	81	0.62(0.28,1.38)	47	50	0.56(0.17,1.86)	0.60(.31,1.15)
Secondary ⁺ *	18	18	1*	10	6	1*	

Note: += and above, 1*= reference, *= significant association

Table 8 continued

Socio demographic characteristics	SDP		Crude OR	FGAE		Crude OR	Adjusted OR
	Use	Nouse		Use	No use		
Occupation							
House wife	217	263	3.0(1.70,5.33)	144	117	18.46(2.51,380)	3.70(2.19,6.5)*
Merchant	8	23	1.26(0.44,3.58)	14	17	12.4(1.37,282)	2.26(.91,4.61)
Others*	19	69	1*	1	15	1*	
Marital status							
Married	239	280	12.8(4.88,36.53)	158	123	33.4(4.74,670.6)	15.81(6.75,41.39)*
Unmarried	5	75	1*	1	26	1*	
Polygamous marriage							
Yes	32	35	1.08(0.63,1.86)	18	29	0.45(0.23,0.90)	0.77(.50,1.16)
No	207	245	1*	140	102	1*	
Perceived economic status in comparison to the neighbour							
Very low	11	34	0.49(0.12,1.98)	9	16	0.41(0.10,1.64)	0.44(0.17,1.16)
Low	49	125	0.59(0.58,1.98)	32	45	0.52(0.17,1.59)	0.55(0.25,1.22)
Medium	178	187	1.43(0.45,4.62)	107	80	0.97(0.34,2.76)	1.16(0.55,2.46)
High*	6	9	1*	11	8	1*	
Radio ownership							
Yes	102	96	1.94(1.35,2.78)	82	60	1.58(0.98,2.25)	1.52(1.15,2.02)
No	142	259	1*	77	89	1*	

Note: 1*= reference, * significant association

Table 9 Stratified analyses for comparison of reproductive variables with outcome variable (current contraceptive use) between SDP and FGAE supported CBD projects in Sidama Zone, November-December, 2002

Reproductive characteristics	SDP User	Nonuser	Crude OR	FGAE User	Non user	Crude OR	Adjusted OR
First marital age	N=242	N=285		N=159	N=128		
10-14	42	59	0.71(0.32,1.58)	29	29	0.50(0.06,3.57)	0.67(0.32,1.40)
15-19	180	206	0.87(0.43,1.76)	126	97	0.65(0.08,4.23)	0.84(0.44,1.61)
20 ⁺	20	20	1*	4	2	1*	
Pregnancy history	N=356	N=352		N=246	N=114		
Yes	346	275	9.69(4.75,20.31)	245	86	79.8(1.34,1560)	13.75(7.91,30.99)
No	10	77	1*	1	28	1*	
Number of pregnancies	N=244	N=278		N=159	N=139		
1-3	154	197	0.78(0.16,3.78)	107	90	0.59(0.02,8.53)	0.73(0.19,2.27)
4-6	86	77	1.12(0.23,5.54)	50	48	0.52(0.02,7.69)	0.91(0.23,3.48)
7 ⁺ *	4	4	1*	2	1	1*	
Intention of current pregnancy	N=56	N=43		N=32	N=20		
Yes	46	35	1.05(0.33,3.28)	27	17	0.95(0.15,5.51)	1.02(0.40,2.60)
No	10	8	1*	5	3	1*	
Number of unwanted pregnancies	N=22	N=59		N=26	N=29		
1-2	15	50	0.39(0.11,1.40)	19	21	1.03(0.27,3.98)	1.0(.48,2.08)
3-8	7	9	1*	7	8	1*	

Table 9 continued

History of child birth	N=347	N=275		N=245	N=86		
Yes	346	265	13.06(1.72,274)	244	76	32.1(4.1,681)	19.73(4.83,140.35)
No	1	10	1*	1	10	1*	
Age of first child birth	N=244	N=278		N=159	N=119		
10-14	23	27	0.79(0.39,1.69)	16	11	1.18(0.39,3.61)	0.90(.50,1.62)
15-19	154	189	0.75(0.49,1.15)	122	91	1.09(0.51,2.29)	0.84(.58,1.21)
20 ⁺	67	62	1*	21	17	1*	
Desired number of children	N=244	N=355		N=159	N=119		
1-3	22	36	0.60(0.29,1.23)	16	11	1.18(0.39,3.61)	0.74(.41,1.33)
4-6	175	273	0.63(0.39,1.01)	122	91	1.09(.5,2.29,2.29)	0.74(.48,1.09)
7 ⁺	47	46	1*	21	17	1*	
Male	N=244	N= 355		N=159	N=149		
1-3	182	314	0.38(0.24,0.61)	109	107	0.86(0.51,1.44)	0.55(.39,0.76)
4-9	62	41	1*	50	42	1*	
Female	N=230	N=353		N=159	N=149		
1-3	209	304	1.09(0.65,1.81)	117	116	0.79(0.45,1.38)	0.94(.55,1.56)
4-9	31	49	1*	42	33	1*	
Number of Children alive now	N=243	N=278		N=158	N=119		
1-3	102	159	0.52(0.30,0.90)	129	51	0.82(0.36,1.84)	0.60(.36,0.91)
4-6	100	86	0.94(0.53,1.67)	114	57	0.65(0.28,1.45)	0.82(0.52,0.82)
7 ⁺ *	41	33	1*	34	11	1*	

Logistic Regression Analysis

Step forward logistic regression analysis was carried out for socio-demographic, reproductive knowledge and attitude towards family planning services and site of the projects to control for possible confounder and detect the relative effect of the selected variables on the dependent variable. Among the mentioned explanatory variables computed, only husband's knowledge about spousal contraceptive utilization showed statistically significant association with contraceptive use, where as the number of living male children showed protective effect ($OR=0.4(0.22,0.72)$)(table 10). Others such as possession of radio, discussion between couple about FP, intension to use FP services and CBD project areas, which showed significant association in stratified analysis for current contraceptive use, did not show significant association in the logistic regression.

Table 10: Logistic regression analysis of selected explanatory variables with current modern contraceptive use in Sidama Zone, November- December, 2002

Variable	User	Non-user	Exp (Adjusted OR and 95% CI)
Possession of radio			
Yes	184(54.1)	156(45.9)	1.457(0.971, 2.186)
No	219(38.6)	348(61.4)	
Husband's knowledge about contraceptive use			
Yes	379(70.3)	160(29.7)	2.23(1.12,4.63)
No	23(44.2)	29(55.8)	
Discussion about FP between couple			
Yes	219(75.3)	72(24.7)	1.46(0.92, 2.32)
No	177(61.2)	112(38.8)	
Intention to use FP services			
Yes	398(68.4)	184(31.6)	4.14(0.97, 17.57)
No	4(40)	6(60)	
Number of living children			
1-3	283(49.3)	291(50.7)	0.393 (0.215, 0.719)
4-9	76(63.9)	43(36.1)	

Qualitative data

Focus group discussion

All discussant health professionals agreed on the rapid population growth in their respective woreda. One discussant from Shebedino mentioned, “before a year Shebedino was one woreda, but recently it has divided in to two woredas, this is an indication for the rapid population growth.” Among the discussant from Dale woreda, one also emphasized the alarming population growth of his woreda. He said that the woreda population number surpasses what they use statistically. The situation is evidenced that when they go for polio campaign with consideration of the number of under five based on the statistics they have, but actually they get more than what they planned.

All discussants expressed the socio-demographic, economic and health related problems in relation to population growth in both the study project areas. They mentioned that uncontrolled population growth contributed to the extreme decrease in the size of arable land, hence reduction in agricultural production. More over, there are numerous problems related in this regards. Parents cannot provide proper nutrition, send to school, and provide cloths and other life necessities. It has further worsened the living status of one family, neighbor, community and the nation. Due to reduction in arable land, searching for agricultural land end up in clearing the already affected forests. Aforestation further aggravates the ecological situation of the area. One discussant also mentioned “ the effect of population is more than to be mentioned by words.” He elaborated that; it is new event to see the street boys at Yirgalem town, which indicates the rural urban migration. Furthermore, there were social conflicts due to agricultural landmark, increasing numbers of joblessness, theft and other socioeconomic crisis.

However, few of the CBD agents mentioned the modest population growth change and decrease in the total fertility rate.

Knowledge about Institution Organization and Programs that render FP services

All the discussants mentioned that health institutions such as health centers, health stations health posts, and Yirgalem hospital are providing the services. Additionally, the community- based distribution agents provide reproductive health with emphasis to family planning services.

Perception about the CBD agents and program functionality

Concerning the selection of the CBD agents, some of the discussants expressed that the selection of agents were conducted based on the set criteria. The woreda health office sent list of criteria to the respective peasant association through the woreda administrative council. In each peasant association, selection was done with participation of community members. Issues of volunteerism, and competence to perform the activities were respected. Few of the discussants mentioned that the community leaders alone did the selection. The training of agents was conducted in different perspectives. The training of the agents at SDP project areas was conducted by the Zonal Health Department in collaboration with the respective woreda health office.

As most of the discussants mentioned, the quality of training was adequate for their level especially at the FGAE project area, however small proportion of the discussants expressed their reservation on the quality of training given. They justified that the trainer on the SDP project area did not get training of trainers (TOT) and were not experienced in the provision of such training. Furthermore, they added the inadequacy of practical training and demonstration sessions. In contrary the training in the FGAE project area is better than the SDP project area. In the later site trainers were trained on the TOT and the training they provided to the CBD agents

mainly focused on their task. During the training the trainee got chance to do field visit. Supervision of the CBD agents under SDP project area was being conducted very occasionally by the woreda health professionals. Where as, the health personnel at the health station, conducted supervision on monthly base during the EPI outreach. The personnel in the health station did not use checklist during the supervision. Where as, the supervision under the FGAE project area was on going, regular. They used a permanent CBD project supervisor who employed for this purpose. They have pre-prepared checklist that assess the performance of the agents and provide on going training simultaneously. Refreshment trainings were given to the CBD agents 2-3 days every three-month base in both project areas formerly but since the beginning of 2002, it has been conducted at FGAE site only.

Perception of the CBD program contribution by the health professionals

All discussant health professionals in both project areas strongly agree and appreciate the effect of community-based distributors to the expansion of family planning services. They acknowledged that the agents share the work burden of the health professionals through provision of health education on reproductive matters and dispensing contraceptive pills and condom. They also refer cases, which need referrals for better services.

Problems encountered in relation to the CBD program

All the discussants share the existence of problems with the CBD program. At the inception of the program the main problem was community resistance towards the CBD program. One discussant forwarded his previous experience of community resistance and discouragement by saying " the fellow who makes woman infertile is coming." Gradually, this problem was solved. Current problems of the program include: shortage of budget to effect refresher training, conduct

supervision, remunerate the CBD agents, inadequate community participation and lack of government commitment.

Knowledge of family planning

Except health professionals, all other categories of discussants shared their ideas, experiences and understandings about family planning program. They mentioned that family planning means; having the number of children the couple needed at the time when they want to have. Some of them stated that it is a means to space pregnancies, limit family size in relation to socio-economic capacity. They also mentioned that it is a means to build healthy and happy family community and nation.

Reasons for the establishment of CBD program

Most of the discussants mentioned the reasons for the establishment of the program as follows. Before the establishment of the CBD program, the services were limited to static health institution. AS the result, services were out of the reach of the majority of the local community members. The programs were established to provide information on family planning program, making the service accessible to the out of reach communities. Accessibility of service increases awareness to the service creates demand of the service and finally increases service utilization. Few discussants mentioned that the CBD program increase client comfort and security by decreasing social and geographical distance.

Support provided to the CBD program

Most of the discussants in four focus group discussions mentioned that community leaders religious leaders and community members participate in the CBD programs in varying degree.

The community leaders involved in the program from the time of agent selection. Subsequently, he/she collaborates the program with other peasant association activities. The leaders provide with support letter to implement everywhere in their respective peasant association. Some times the community leaders directly involve in transmitting information on issues related with family planning. They orient church leaders and other community organization to support the program.

At the inception of the program, most religious institutions were resistant to the concept of family planning and the CBD agents. Through persistent and gradual discussions, now the church leaders started to participate in the CBD programs. They allow the CBD agents to teach about family planning in the church congregation. They orient their members to follow the information given and utilize the services.

Discussants also shared their experiences about the general community participation and support to the CBD program and the agents. In this regard, the community participation revealed that they show willingness to use the service and accept the program.

Perception of community support to the CBD program

Some of the religious and community leaders mentioned that the support given to the agents and program were not adequate. The CBD agents are performing demanding tasks but lack of clear direction and inadequate information, refrained the community from provision of adequate support.

Mechanism to sustain the CBD program

Majority of the discussants were not aware of the voluntary base performance of the CBD agents. Most of them considered that the agents were performing their tasks with permanent

payment. Some of the community residents try to compare the living standard of the agents with them selves. It was a wonderful issue that some of the community leaders them selves don't know the volunteer service provision of the agents. The discussants agreed that purely voluntary base activities would be at risk of cessation and doubtful to meet its objective. One discussant elaborated this by saying, "the CBD agents are human being who has their family and other life responsibility, and their own life demands that they need some compensation for their effort."

Another discussant also mentioned that there is a gap in understanding about the patterns how the agents function in their respective community. During the discussion it was found that all the discussants whole-heartedly internalize the difficult task the agents perform and their benefit of the program to the community members.

Suggestion to sustain the CBD program

The entire discussant group suggested that for sustainability of the CBD program, motivation and remuneration of the CBD agents is of paramount importance. Without such motivation the life span of the program will be short. There fore, strong government commitment and community participation are of primary importance.

In-depth Interview

Four persons involved in the in-depth interview conducted in the selected project areas. In-depth interview involved woreda health managers, SDP health desk head and FGAE, Yirgalem branch head. The interview included main themes that aimed to explore the patterns of the CBD functionality, the support given by the local community, government and funding agencies and sustainability issues of the program.

The interview result indicated that in both project areas the reasons for the project establishment were intention to increase access to family planning services through improving client comfort and providing privacy. In addition, the CBD program was expected to win the socio-cultural geographical and psychological barriers.

With the above aim the program and projects established in 1998 and 1996 under SDP and FGAE, respectively. To accomplish the program of CBD, agents were selected based on the criteria set at higher level. The CBD agents included both female and male workers. Their selection was done by the local community leaders in consultation with respected people, youth, and women representatives, in their respective peasant association of the project areas. The role of the woreda health offices SDP and FGAE in the selection of the agents includes discussing the importance of the CBD program and the selection of agents with respective local governmental authorities and community members. More over, these organizations had the responsibilities to follow the selection of agents with account to the selection criteria.

Training

In-depth interview discussion revealed that the training time allotted to the agents in the SDP project area was very short; where as the FGAE site it found to be adequate. The subsequent refresher training under SDP had discontinued since the middle of 2002. The refresher training is actively given under the FGAE site. The Zonal health department, woreda health office, facilitates training in collaboration with SDP and FGAE. The trained trainer in the FGAE site utilizing standardized manual prepared for this purpose gave the actual training. Where as, health professionals who hadn't taken such training of trainers gave the training under SDP.

Supervision

Through the discussions, it was found that there was difference in the approach of the CBD program supervisions. In SDP project area the health assistant in the closer health station to the CBD project peasant association conduct supervision on monthly bases during EPI outreach. Where as, in FGAE site there was a trained nurse supervisor who conducts the supervision. There were observed difference on how they conduct supervision. The health assistant in the SDP site did not have checklist during the supervision while the FGAE site supervisor uses check list prepared in addressing the tasks of the CBD agents. Feed back was being given to the agents during supervision The FGAE supervisors provide ongoing training during the supervision.

Patterns of CBD agent's functionality and level of their motivation

CBD is a community based distribution program of family planning services where the community members have an obligation to work on the volunteer bases. With recognition of the above concept selection of the agents accomplished and they have been performing their duties.

How ever, the effectiveness of any program depends on the motivation and courage of agents who carry it out. In this regard, the FGAE provide a uniform yearly, transport allowance during monthly review meeting and perdiem of 30.00 Birr at the same time. Very recently they started to provide bicycle for some of the agents. More over, contraceptives under FGAE project sold for minimal charge and 60 % of that was given to the agents. In contrary, the agents in the SDP site perform solely on voluntary bases. They collect contraceptive methods from the governmental health institutions and provide to the clients freely. Such difference in the pattern of their performances made the agents to behave differently. The agents under the FGAE were found to be strongly motivated and courageous while that of the SDP were not.

Concerning the primary responsible body for the projects in two areas, FGAE at local, regional and federal level followed by the respective government authorities, where as in SDP sites government health organizations are the primary one followed by the SDP.

Types of service CBD agents offer

In both project areas the agents provide similar services. These includes provision of health education on reproductive matters with emphasis to family planning, dispense pills and condom and refer clients who need other methods of contraceptives than provided by the agents. A referral service for family planning services is more functional in FGAE sites than the SDP, that the FGAE site sends the client who need injectable to the monthly outreach site for EPI program. Moreover they send those who need other procedure like loop insertion surgical implant to Apposto clinic and Yirgalem hospital. The CBD agents provide services by moving from house to house, at outreach site during EPI out reach, and as stationary base for some of the clients.

Problems encountered and issue of sustainability

Voluntary service provision usually faces some sort of problems particularly difficult to manage. Despite the efforts made at every level, the CBD program in SDP project area faces a lot of problems. To mention some of the problems: absence of budget, demotivated CBD agents and high rate of dropout and failure to provide refresher training as previously. The FGAE project had faced strong community resistance towards the program especially by the religious leaders at beginning of the program. Motivation of the agents even under FGAE is to be considered systematically.

As mentioned by the discussants, in both project areas sustainability of the CBD project is of crucial concern. The sustainability of the project would depend on the strong governmental commitment, active participation of community, maintained support of the funding agencies and motivation of the CBD agents and the beneficiary. In this regard, both project areas community leaders have been showing active participation in the CBD program. They provide support letter for the agents to perform their activities anywhere in the community setting. Some times they directly involve in provision of the health information in collaboration with the agents. So far, there were no separate budget for the SDP project area but they have plan to do so in future by discussing with the SDP manager, Zonal health department and woreda administrative council. With regard to the FGAE, currently the budget is already allocated by the FGAE of the Region, but to make it sustainable the community participation and government commitment is of paramount important. Creating strong desire to family planning service utilization is another supportive way to sustain the program.

Discussions

With the main objective of identifying factors associated with the difference in contraceptive prevalence rate, the study assessed socio-demographic, reproductive and knowledge, attitude towards current contraceptive utilization, patterns of quality of services provided by the CBD agents, the accessibility and patterns how the CBD agents perform their activities.

It is believed that in many instances, the socio-demographic factors affect the family planning services utilization and contraceptive prevalence rate and the CBD performances (44). In line with this the study subjects showed differences in some of the socio-demographic variables between the two project areas. Education, occupation, marital status and possession of the radio of the respondents were among the assessed variables, which showed significant differences between the two project areas.

One of the main anticipated contributions of the CBD agents is to increase the quantity and quality of knowledge of contraceptive methods as a means of assessing increased adoption and reduced discontinuation of use. This study has revealed significant differences in the knowledge of modern contraceptives methods between SDP (93.7%) and FGAE (97.2%) supported CBD project areas. The Finding for SDP area is similar with findings of similar study in South Gondar (92.2%) and higher than other studies in Eastern Shoa (89.1%), Central Tigray (89%). The knowledge at FGAE project area is the highest of the similar studies conducted in the country (9,38,39,57), but nearly similar with the finding in Mali (99%) and Kenya 97% (41,57). The observed difference in knowledge of the respondents to FP is partly attributed to the better literacy rate, possession of the radio and performance of the CBD agents at the FGAE than the

SDP project site. For example, possession of radio was significantly different between the SDP and FGAE project areas. It is true that access to the information and the capacity to posse sources of information, can influence the beneficiary to practice contraceptives better than their counter part. In this regard about 46.1% of the respondents at FGAE site and 32.5% at the SDP site had informed that they possess radio at their homes. Relatively, the higher proportion of respondents' possession of radio at FGAE site might have contributed to the increased knowledge of the respondents for family planning than the SDP site.

Like most of the study findings in the country and else where, pill (95.1%) was the most widely known modern contraceptive method followed by injectable hormone (93.7%) for FGAE project area (9, 38, 39, 40, 58). Where as, knowledge of the specific contraceptive methods in SDP project area is higher for injectable hormone. This shows that an increasing interest of clients towards injectable hormones. Knowledge of other methods like condom, IUCD and Norplant was higher in FGAE supported area when compared to SDP area. This finding indicated that there were better method mix and or wider scope of CBD agents' knowledge in provision of information about available methods. This is further evidenced by both the focus group discussion and in-depth interview. The agents in the FGAE project area were exposed for better initial and subsequent training and supervision than the agents at the SDP project site in which they update their knowledge to the wider scope of reproductive health services.

Significant difference was observed about the sources of information for family planning between the two project areas. School, CBD agents and Health Institutions were the leading sources of information for FP services followed by radio, husband, neighbors and newsletter. In this regard, 32.6 % and 52.3 % of the respondents in SDP and FGAE, respectively got

information about family planning primarily from the CBD agents. The result of this study is higher than the study findings in Northwest Ethiopia (9.4%) and Kenya (13.1%) (39,63). This difference might be due to the variation in the level of motivation and performance of the CBD agents between the two project areas. This is supported by the FGD and in-depth interview that the motivated agents at FGAE site performed better than the agents at SDP. Likewise, the FGAE site agents had frequently contacted their clients and provided more information on family planning.

Attitude towards family planning services utilization in this study was not found different between the two study project areas. Nearly equal proportion (90.8%) of the study women showed positive attitude to FP service utilization. This result is slightly higher than the previous studies conducted in central Tigray (87.3%) and Eastern Shoa CBD project (85.2%) (9, 57). Discussion between couple about contraceptive use is among the proxy indicators for service utilization. In the study, statistically significant difference was observed between two computing CBD project areas. The finding of this study was found to be similar with the finding in North and South Gondar but extremely less than the studies in Kenya (16, 64). The highest level of positive attitude is in line with the finding of focus group discussions and in-depth interview that people in both project areas showed extreme worryness about population growth and its adverse consequences. More over, the existence of the CBD program in both project areas attributed to the recent higher level of positive attitude of the community to wards FP (9, 57).

The perceived husband's attitude to his spousal contraceptive utilization revealed significant difference between the SDP and FGAE project areas. The finding in this study is lower than study in the Central Tigray (57). The reasons for the difference could be the difference in the

level of awareness to family planning that in turn was due to difference in the level of education, possession of radio and CBD performance.

In order to know the demand for family planning, future intention to use modern contraceptive methods was assessed. Nearly equal proportion (73.6% and 74.7%) of women in the reproductive age group who knew but never used modern contraceptive in SDP and FGAE project areas intended to use FP in the future. The finding is somewhat similar with the study in Eastern Shoa and Jimma but lower than Central Tigray. Therefore, this clearly shows the existence of significant demand for FP services in both project areas of Sidama Zone. In line with this, the FGD result also explained that significant proportions of women in the reproductive age group are not using modern contraceptives due to various reasons (9, 58).

History of contraceptive ever use was found to show statistically significant difference between the two project areas. It was higher in the FGAE project area (68.3%) than (49.6%) in SDP area. The finding in this study is inline with the results of similar studies in the country and out side the country (9, 34, 41, 57, and 58). This difference is also attributable to the difference in the pattern of CBD performances and the life span of the project.

The difference in contraceptive prevalence rate between the two project areas would be attributed to their difference in project life span, aspects of CBD motivation and support given by the funding agencies. This is further justified by the qualitative study both in FGD and in-depth interview that the observed difference on contraceptive prevalence rate was attributed to this difference in their level of motivation and incentives they received. The agents at FGAE site tend to recruit more clients as they get significant amount of share from contraceptive charge. This

finding is similar with that of Tanzania, where the program variation in their approach contributed to difference in their success and performance of the agents. This was elaborated that paid agents performed better than non-paid and agents that got non-monetary incentives preformed better than that did not get any incentives.

Consequently, Current use of MCM, 40.7 % and 51.6% in SDP and FGAE project areas respectively showed significant difference. The finding for SDP project area is similar with the finding in East Shoa, Zimbabwe, Mali, but the result for the FGAE is higher when compared with the similar findings in the country but equal with that of Kenya and Turkey (9, 45, and 57). The rate in both project areas were extremely higher than the national figure 8% according to the DHS, 2000, and 17.2% health and health related indicator of MOH for the year 2001/2002(10,12). The relatively higher level of the CPR in both project areas is partly attributed to the presence of functional CBD program, other family planning services provision outlets by the governmental, NGOs and Church based health institutions in the Zone.

Unlike the previous studies in the country, more than half of the study women are currently using injectable hormone followed by oral contraceptive pill. The finding showed the increasing preference of clients for the injectable methods due to perceived convenience and better compliance of the method. Further more, it is an indication that the FGAE project area expanded the scope of services to the EPI outreach sites where they provide injectable hormone. Additionally, this is attributed to the improved referral systems of the clients to other method of contraceptives given by the CBD agents (9, 12, 49, and 64).

The use continuation of contraceptive methods in FGAE project area was higher than the SDP area. Eight five percent of FGAE and 64.8 % of SDP areas ever users of their method used their contraceptives for at least one year. The finding of this study is higher than other similar studies conducted in rural health center in Ethiopia and Eastern Shoa community based distribution program (9). How ever, the finding is nearly similar with the finding in six rural areas of developing countries based on Demographic and Health Survey (12) data, which revealed that 60-75% of pill users, used it at least for one year.

Quality of services has significant role in increasing access and contraceptive utilization. Pertaining to the quality of services given by the CBD agents in the two project areas, significant differences were observed in: how to take contraceptives, methods that prevent HIV/AIDS and STI, availability of contraceptive methods other than client recently taking and experience of method related problems. The likely of getting methods of their choice was slightly better in the FGAE project area than the SDP site. It also revealed that the CBD agents in the FGAE site provided better information to the clients about how to take contraceptive methods and method that prevent STD/HIV than the SDP site (9,65,66). On the other hand, the client experience of method related problem is more likely mentioned in SDP project area than the FGAE project area. Others assessed but not showed significant differences include; information given about the contraceptive side effects, contraindications, what to be done if contraceptive s related problems arise and about the next appointment.

The observed difference is attributable to the better performance in the FGAE area as complemented by the FGD and in-depth interview. As it is indicated in the discussion, both

initial and subsequent refresher training provision was markedly different. In the FGAE project area, trained trainers gave training and there was regular refresher training every three months. In contrary, the refresher training in SDP was discontinued since the middle of 2002. Trained trainer did not give even the initial training and the duration given for practical training was inadequate.

Supervision was being conducted by the trained nurse supervisor on regular basis in the FGAE site where as, non-trained health assistant in the near by health station occasionally conduct the supervision in sites under the SDP. Another major difference was identified with regard to the agents' motivation and incentives provided. The CBD agents at FGAE project area get incentives such as 30.ET.Birr and transport allowance during monthly review meeting. They sale contraceptive methods for a minimum price and sixty percent of the sale were provided for them. Additionally, they got annual uniform. Where as, agents at the SDP site didn't have any form of incentive except that they freely dispense the contraceptive methods they collected from the governmental health institution. The difference on the pattern of incentive provision created difference on the level of their motivation and dropout rate that in turn affected the level and quality of their performances (15,43,63,65,66).

Accessibility of FP services in most case affect contraceptive utilization. Community Based Distribution program was started in Ethiopia with the aim to enhancing outlets for contraceptive provision. It was evidenced that the CBD program has been contributing significantly to the increment of contraceptive prevalence. Similarly, 46% and 25.4% of the ever-contraceptive users received their methods from the CBD agents in FGAE and SPD project areas, respectively. In

line with, accessibility to the contraceptive utilization in this study showed significant difference between the two project areas. Eighty-six percent and 24% of the SDP and the FGAE supported CBD project areas; the study women obtained contraceptive method freely. The high proportion of free provision of contraceptive methods in SDP sites did not reveal any significant contribution for the difference in contraceptive prevalence rate. It is further supported by that very few (5.8%) of the clients in FGAE site mentioned about failure to get contraceptive methods due to lack of money. Both FGD and in-depth interview supported this finding in that the CBD agents provided service by moving from house to house. The provision of bicycle and other incentives in FGAE sites further enhanced the house-to-house visit and increased recruitment of more clients than the SDP.

Strength and Limitation of the study

I Strength

The strength to be mentioned in this study includes:

- ◆ The utilization of both quantitative and qualitative research methods and comparison made between the two CBD project areas in the rural part of the Zone where 92.1% of the population reside;
- ◆ The consideration of design effect and non-response rate during sample size determination to maximize sample size in order to improve validity of the study;
- ◆ Inclusion of all reproductive age group women irrespective of their marital status to see the pattern of contraceptive utilization.

II. Limitation

The limitation of the study includes:

- ◆ The very nature of cross-sectional study, its failure to indicate which comes first, the “hen or the egg dilemma”, which is the case also in this study;
- ◆ Inability to include the urban disadvantaged group due to the absence of the CBD project in the Urban setting of the Zone;
- ◆ Limited coverage of the CBD project in the selected study woredas,(nearly one-third of the peasant association of the woredas)

Conclusion

The study assessed important determinant variables on FP services in order to identify which of the mentioned factors are responsible for the observed difference of contraceptive prevalence rate between the two project areas. In addition, the extent of support given to the CBD agents and the available mechanism to sustain the CBD project was assessed. Based on the findings, the study concludes that:

- Access to information as measured by possession of radio and educational status of the women significantly contributed to awareness towards FP services.
- Difference in CPR between the two project areas is attributed due to variation in the quality of services, accessibility of FP and level of knowledge and attitude of the women of reproductive age group.
- Inadequate community participation and awareness about CBD program functionality were among the main factors affecting success of the program.
- Variation in the quality of both initial and subsequent refresher training of the CBD agents and supervision of the CBD program were strongly related with the difference in performances of the agents.
- Provision of incentives to motivate the CBD agents in the FGAE supported CBD project and absence of such provision in the SDP site contributed for the difference in contraceptive prevalence rate.

Recommendation

Based on the above finding and conclusions for sustained contraceptive utilization and CBD program, the study recommends:

- The CBD agents should be motivated through provision of occasional incentives and regular refreshment training
- Strengthen regular and continues supervision by trained supervisors.
- Provide clear direction and information for the community members about the functionality of the CBD program
- Collaborate activities and increase the extent of community participation in CBD program.
- Increase the scope of the CBD programs by integrating other RH activities.
- Use the experience of FGAE project in the SDP area in order to increase and maintain the service utilization (provision of incentives, continues and regular refresher training, conducting regular supervision by trained person).
- Conduct cost-effectivness analysis to identify the relative effectiveness of the CBD program in two project areas.

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Annex 1, English version questionnaire for survey

DEPARTMENT OF COMMUNITY HEALTH FACULTY OF MEDICINE ADDIS ABABA UNIVERSITY

QUESTIONNAIRE to identify reasons for the difference in the CPR in the CBD project areas of the Sidama Zone.

Identification

Woreda _____ Kebele/Peasant association _____

House no. _____ Code No. _____

Verbal consent form before conducting interview

Greeting

Hello, I am _____. I am working in the research team of Addis Ababa University in collaboration with Ethiopian Public Health Association (EPHA) and Family Health International (FHI). I would like to ask you a few questions about family planning and your modern contraceptive practices. This will help us to improve the CBD programs and service provided to you based on your answer to our questions. Your name will not be written in this form and will never be used in connection with any information you tell us. All information given by you will be kept strictly confidential. Your participation is voluntary and you are not obliged to answer any questions you do not wish to answer. However, your honest answers to the questions will help us in identifying the reasons for the differences in contraceptives prevalence rate, hence to improve the family planning services particularly, the CBD programs. Do I have your permission to continue?

If yes, continue.

Date of interview _____

Interviewer's name _____ Signature _____

Supervisor's name _____ Signature _____

Section I Socio demographic and economical characteristics

No	Question	Possible answers	Code
Q101	What is your age?	_____ Years	
Q102	What is your religion?	1. Orthodox 2. Catholic 3. Protestant 4. Muslim 5. Others, specify	
Q103	What is your ethnicity?	1. Sidama 2. Amhara 3. Oromo 4. Wolaita 5. Gedeo 6. Kambata 7. Hadia 8. Gurage 9. Others, specify	
Q104	What is your level of education?	1. Illiterate 2. Can read and write 3. Primary school completed 4. Secondary school completed 5. Tertiary level	
Q105	What is your current marital status?	1. Married 2. Single 3. Divorced 4. Widowed	
Q106	Does your husband have another wife/wives	1. Yes 2. No	
Q107	What is your occupation?	1. Housewife 2. Merchant 3. Civil servant 4. Daily laborer 5. Farmer 6. Student 7. Others, specify----- -----	

Q108	What is your monthly income?	1. <100.00/m 2. 100.00- 300.00/m 3. 301.00 –600.00 4. >600.00/m 5. Not clearly known
Q109	Do you have radio in your house?	1. Yes 2. No
Q110	When you compare your monthly income with your neighbors how do you rate your income?	1. Very low 2. Low 3. Medium 4. High

Section II Reproductive characteristics

No	Question	Possible answers	Code
Q201	When you first got married?	_____ Years	
Q202	Have you ever been pregnant?	1. Yes 2. No⇒ skip to ques.no.212	
Q203	How many times have you been pregnant?	_____ times	
Q204	Were all your pregnancies wanted?	1. Yes 2. No	
Q205	If not, to ques. 204 how many pregnancies were unwanted?	_____Pregnancy	
Q206	Have you ever-experienced abortion?	1. Yes 2. No ⇒ skip to ques.no.208	
Q207	If yes to question no. 204 what type of abortion you had?	1. Habitual 2. Induced (criminal) 3. Induced (therapeutic)	
Q208	Are you pregnant now?	1. Yes 2. No→ skip to ques. no.210	
Q209	If yes to question no.206, is this wanted?	1. Yes 2. No	
Q210	Have you ever given birth to a child?	1. Yes 2. No → skip to ques.no.212	
Q211	What is your age at first birth?	_____ Years	
Q212	How many children do you intend to have?	_____ Sons _____ Daughters _____ Total	
Q213	How many living children do you have now?	_____ Sons _____ Daughters rs _____ Total	

Section III. Family planning knowledge			
S.no.	Question	Possible answers	Code
Q301	Have you ever heard about family planning?	1. Yes 2. No⇒ skip to ques. no.403	
Q302	If, yes to ques.301 from where do you usually hear about FP from?	1. Radio 2. Television 3. Health institution 4. CBD agents 5. Husband 6. Other family members 7. Neighbors 8. School 9. Newsletter/leaflet 10. Others ----- --- --	
Q302	What methods of FP do you know?	1. Natural family planning methods 2. Pills 3. Injectables 4. Implant 5. IUCD 6. Tubal ligation 7. Vasectomy 8. Condom 9. Foam 10. Others,specify -----	
Q304	Does your husband/partner know whether you are taking contraceptives?	1. Yes 2. No ⇒ Skip to # 407	
Section iv. Attitudes towards family planning			
Q401	Do you support the idea of family planning?	1. Yes 2. No	
Q402	In the past three months have you had chance to discuss about family planning with your partner?	1. Yes 2. No	
Q403	Do you intend to use any method of FP?	1. Yes 2. No	

Q405	Does your partner/ husband support your use of modern contraceptive method?	1. Yes 2. No
Q406	If your answer to ques.405 is no, what the reasons do you think?	1. Need for more child 2. Fear for the side effect of the drug 3. For unknown reasons
Q407	Do you support if your friends or relatives seek your advice to use FP- methods?	1. Yes 2. No
Q408	What is your future intention with regard to contraceptive usage?	1. Plan to use 2. No plan to use

Section V.
Family planning
practice

Q501	Have you ever used any modern contraceptive methods?	1. Yes 2. No →skip to ques. no.524
Q502	Are you using modern contraceptive methods now?	1. Yes 2. No
Q503	If yes to questions no. 501 and 502 what types of modern contraceptive methods are/ were you using	1. Pills 2. Injectables 3. IUCD 4. Implant 5. Tubal ligation 6. Condom 7. Foam 8. Others, specify ----- ---
Q504	At the time when you started to use contraceptives, did you get your own choice of methods	1. Yes 2. No
Q505	If your answer to ques. no. 504 is no, which method was your choice?	1. Pills 2. Injectables 3. IUCD 4. Implant 5. Tubal ligation 6. Condom 7. Foam 8. Others, specify ----- ---

Q507	Where do you get the contraceptives?	1. Hospital 2. Health center 3. Health station 4. FGAE clinic 5. CBD agents 6. Others, specify ----- -----
Q508	If the CBD agent is the source for the provision of your contraceptives, has she/he informed you about _____? (Read all options).	Yes No 1.how to use the methods, 1 2 2.side effects of the method, 1 2 3..contra-indication of the methods 1 2 4.what to do methods related problems arise 1 2 5.methods which protect against STD/HIV 1 2 6..methods of contraceptives other than the one you are using now 1 2 7.. next appointment orally/written 1 2
Q509	Is the contraceptive provision free?	1. Yes 2. No
Q510	If not free, for instance how much do you pay for each cycle?	One cycle of Oc costs _____Birr One packet of condom costs _____Birr
Q511	Have you ever failed to take your contraceptives due to lack of money to buy it?	1. Yes 2. No
Q512	Do you have an access to get your own choice of contraceptives?	1. Yes 2. No

Q513	If your answer to question no. 512 is no, what reasons do you think?	1. Limited method mix 2. Lack of information about various methods 3. Restriction due to medical reasons 4. For unknown reasons
Q514	How long have you been using the contraceptive methods?	_____ Months/Years
Q515	While you use contraceptives have you had any method related problem?	1. Yes 2. No
Q516	If yes to quest.no.515, did you seek for any advise from the service provider, the CBD agent?	1. Yes 2. No

Q517	If not to quest no.145, why not?	1. CBD agents did not give chance to raise concern 2. Lack of confidence on the skill of CBD agents 3. Too short time is spent with 4. Service provider is not friendly 5. Others, specify _____	Yes	No
Q518	Have you ever used more than one method?	1. Yes		
Q519	If yes, from which method to which method have you switched?	2. No ⇒ skip to ques. no.521 From _____ to _____		
Q520	What was /were the reason/s for your switching?	1. Side effect 2. Inconvenience 3. Unavailability of the previous method 4. Others, specify _____		
Q521	Have you experienced shortage of the method when you need it?	1. Yes		
Q522	While taking contraceptives have you ever discontinued in between?	2. No		
Q523	If your answer is yes to ques. no.522, what are the reasons for contraceptive use discontinuation?	1. Yes 2. No		
Q524	If you have never been using contraceptive methods, what are the reasons You think?	1. Desire to become pregnant 2. Fear of infertility 3. Fear of side effects, specify 4. Husband's objection 5. Lack of method of choice 6. No services in near by 7. Rumors about effects of contraceptive methods 8. Absence of sexual partner 9. Others, specify _____ 1. Ignorance 2. Influence of others 3. Need of additional child 4. Fear of side effects 5. Medical problems 6. Spousal disapproval 7. Lack of method of choice 8. Inaccessibility 9. Others, specify ---- -----		

Annex 2 Amharic version questionnaire

በአዲስ አበባ ዩኒቨርሲቲ
ህክምና ፋኩሊቲ
የህብረተሰብ ጤና ትምህርት ክፍል

ይህ መጠይቅ በሲዳማ ዞን ውስጥ የሚገኙ ተሳታፊዎችን የቤተሰብ መምሪያ ማህበርና የሲዳማ ልማት ፕሮግራም የሚያካሂዱትን ህብረተሰብ መሰረት ያደረገ የወሊድ መቆጣጠሪያ ዜደ አሰራራዊነትና ሽፋን በሁለቱ ፕሮጀክቶች አካባቢ የሚታየውን ልዩነትና መንስኤ ለማጥናት የተዘጋጀ ነው።

መለያ

ወረዳ _____ ቀበሌ/ገበረ ማህበር _____
የቤት ቁጥር _____ የመጠይቁ መለያ ቁጥር _____

ቃለ መጠይቁን ከማድረግ በፊት የተሳታፊዎችን ፈቃደኝነትን መጠየቂያ ቅፅ፤

ሰላምታ፤ እንደምን አሉ? እኔ አቶ/ወሮ ወራት _____ እባላለሁ።

እዚህ የመጣሁት ይህንን ጥናት የሚያካሂዱት የአዲስ አበባ ዩኒቨርሲቲ% የኢትዮጵያ ጤና አጠባበቅ ማህበርና አለምአቀፍ የቤተሰብ ጤና ድርጅት ቡድን አባል ሆኜ ነው።

ከእኔ በመቀጠል የቤተሰብ ምጣኔና የወለድ ቁጥጥርን በተመለከተ የተወሰኑ ጥያቄዎችን ልጠይቆት እወዳለሁ። ከእርስዎ የሚገኘው መልስ በሀገራችን ለሚከናወነው የጤና አገልግሎት መሻሻል የበኩሉን እገዛ ከመኖሩም ሌላ የቤተሰብ ምጣኔ አገልግሎት ከሚሰጥባቸው መንገዶች አንዱ የሆነውን ህብረተሰብአቀፍ የቤተሰብ ምጣኔ አገልግሎት የማስራጨት መንገድን ያለውን ድክመትና ጥንካሬ መስተካከል ሚገባቸውን ነጥቦችን ለይተው በማወቅ እርምጃ ለመውሰድ ይጠቅማል።

ከእርስዎ የሚናገሩባቸውን ማሻሻያዎች መልስ በምስጢር እንጠብቃለን። ከዚህ ጥናት ጋር በተያያዘ በማንኛውም ቦታና ጊዜ ስምዎ እንደማይመዘገብና አንደማይጠቀስ ልንገልጽ እንወዳለን። በጥናቱ የሚናገሩት የርስዎን ሙሉ ፈቃደኝነትን ስናገኝ ብቻ ነው። በመጠይቁ ሂደት ለመመለስ የማይፈልጉትን ጥያቄዎችን ያለመመለስ መብትዎ የተጠበቀ ነው።

በመጠይቁ ለመሳተፍ ፈቃደኛ ነዎት?

አዎን _____ይቀጥላል

የለም _____ወደ ሌላ ተጠያቂ ቤት መሸጋገር

የጠያቂው ስም _____ ፊርማ _____

መጠይቁ የተሞላበት ቀን _____

የተቆጣጣሪ ስም _____ ፊርማ _____

ክፍል አንድ፤ ማህበራዊ ስነ ህዝባዊና ኢኮኖሚያዊ ገጽታዎችን በሚመለከት

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ
101	እድሜዎ ስንት ነው፤	----- አመት	
102	የትኛው ሃይማኖት ተከታይ ነዎት፤	1. ኦርቶዶክስ 2. ካቶልክ 3. ፕሮቴስታንት 4. ሙስሊም 5. ሌላ ካለ ይጠቀስ -----	
103	የትኛው ብሄር/ብሄረ ሰብ ተወላጅ ነዎት፤	1. ሲዳማ 6. ካምባታ 2. አማራ 7. ሃዲያ 3. ኦሮሞ 8. ጉራጌ 4. ወላይታ 9. ሌሎች ካሉ 5. ጌዲኦ ይጥቀሱ -----	
104	የትምህርት ደረጃዎ	1. መፃፍና ማንበብ የማይችል 2. መፃፍና ማንበብ ብቻ 3. የመጀመሪያ ደረጃ ት/ት ያጠናቀቀ 4. ሁለተኛ ደረጃ ት/ት ያጠናቀቀ 5. ከፍተኛ ደረጃ ት/ት ያጠናቀቀ	
105	የጋብቻዎ ሁኔታ	1. ያገባ 2. ያላገባ 3. ባል የሞተባት 4. ፈት	
106	ባሌቤትዎ ሌላ ሚስት አላቸው፤	1. አዎን 2. የለም	
107	ስራዎ ምንድነው፤	1. የቤት እመቤት 2. ነጋዴ 3. የመንግስት ሰራተኛ 4. የቀን ሰራተኛ 5. ገበሬ 6. የግል ድርጅት ሰራተኛ 7. ተማሪ 8. ሌላ ካለ ይጠቀስ-----	
108	የወር ገቢዎ በአማካይ ስንት ነው፤	1. በወር ከመቶ ብር ያነሰ 2. በወር ከመቶ እስከ ሶስት መቶ ብር 3. በወር ከሶስት እስከ ስድስት መቶ 4. በወር ከስድስት መቶ ብር በላይ 5. በትክክል አይታወቅም	
109	የወር ገቢዎ ከጎረቤትዎ	1. በጣም ዝቅተኛ	

- | | | |
|-----|--------------|---------|
| | ጋር ሲያመዛዝኑ | 2. ዝቅተኛ |
| | በየትኛው ደረጃ ነው | 3. መካከኛ |
| | የሚመደቡት? | 4. ከፍተኛ |
| 110 | እቤትዎ ውስጥ ሬድዮ | 1. አዎን |
| | አለዎት? | 2. የለም |

ክፍል ሁለት፤ የስነ ተዋልዶ ሁኔታ በሚመለከት

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ኮድ
201	አግብተው ከሆነ መጀመሪያ ጋብቻ የፈፀሙት በስንት አመት እድሜ ነበር፤	-----አመት	
202	አርግዘው ያዉቃሉ፤	1 አዎን የለም ⇒ወደ ተ. ቁ 212 ይሻገሩ	
203	አርግዘው የሚያውቁ ከሆነ ስንት ጊዜ ነው ያረዝሱት፤	-----ጊዜ	
204	አርግዘው የሚያውቁ ከሆነ ሁሉም እርግዝና በፍላጎት ነበር፤	1 አዎን 2 የለም	
205	ያልተፈለገ እርግዝና ከነበረ ስንት እርግዝና ያልተፈለገ ነበር ፤	-----እርግዝና	
206	ከዚህ በፊት አስወርዶት ያዉቃል፤	1 አዎን 2 የለም	
207	አስወርዶት የሚያውቅ ከሆነ ምን አይነት ውርጃ ነበር፤	1 በራሱ ጊዜ የሚመጣ 2 ህገወጥ ውርጃ በሰው 3 በህኪም ትእዛዝ ለህክምና	
208	አሁን ነፍሰ ጡር ኖት፤	1 አዎን 2 የለም ⇒ወደ ተ.ቁ 210 ይሻገሩ	
209	ነፍሰ ጡር ከሆኑ ፈልገው ነው ያረዝሱት፤	1 አዎን 2 የለም	
210	ልጅ ወልደው ያዉቃሉ፤	1 አዎን 2 የለም ⇒ወደ ተ.ቁ 212 ይሻገሩ	
211	ልጅ ወልደው ከሆነ የመጀመሪያ ልጅ በስንት አመት እድሜ ነበር የወለዱት፤	-----አመት	
212	ስንተ ልጆች እንዲኖሩት ነው የሚፈልጉት፤	-----ወንድ -----ሴት -----ጠቅላላ	
213	ባሁኑ ጊዜ ስንት ልጆች በህይወት አሉ፤	-----ወንድ -----ሴት	

ክፍል ሶስት፤ የቤተሰብ ምጣኔ (የወሊድ ቁጥጥር) ግንዛቤ በሚመለከት

ተቁ	ጥያቄ	አማራጭ መልሶች	ኮድ
301	ስለ ቤተሰብ ምጣኔ ሰምተዉ ያዉቃሉ፤	1 አዎን 2 የለም ⇒ወደ ተ.ቁ 401 ይሻገሩ	
302	ስለ ቤተሰብ ምጣኔ ሰምተዉ ከሆነ ከየት ወይም ከማን ነዉ የሰሙት፤	1 በሬድዮ 2 በቴሌቪዥን 3 ከጤና ተቋማት 4 ከስነ ተዋልዶ ና ቤተሰብ ምጣኔ ጤና ተጠሪ 5 ከባሌቤቴ 6 ከሌሎች የቤተሰብ አባላት 7 ከጎረቤት 8 ከትምርት ቤት 9 ጋዜጣ ወይም ሌሎች በራሪ ጽህፎችን በማንበብ 10 ከሌሎች ምንጮች-----	
303	የትኛዉን የወሊድ ቁጥጥር ዘዴን ያዉቃሉ?	1. ተፈጥሮአዊ የወሊድ ቁጥጥር ዘዴ 2. በአፍ የሚዋጥ ክኒን (ፕልስ) 3. በመረፌ የሚሰጥ 4. በክንድ የሚቀበር 5. በማህጸን የሚቀመጥ (ሉፕ) 6. የሴት ማህጸን አሸነፍ ማስቋጠር 7. የወንድ ዘር መተላለፍያ ቧንቧ ማስቋጠር 8. ኮንዶም 9. አረፋማ ክኒን 10. ሌላ ካለ ይጥቀስ-----	
304	የወሊድ መቆጣጠሪያ ዘዴን ተጠቃሚ ከሆኑ ባለቤትዎ እንዴትሚውስዱ ያዉቃሉ?	1 አዎን 2 የለም ⇒ወደ ተ. ቁ 407 ይሻገሩ	
ክፍል አራት፤ ስለ ቤተሰብ ምጣኔ ያለዉን አመለካከት በሚመለከት			
401	የቤተሰብ ምጣኔ (የወሊድ መቆጣጠሪያ ዘዴ) መዉሰድን ይደግፋሉ፤	1 አዎን 2 የለም	
402	ባለፈዉ ሶስት ወር ዉስጥ ከባለቤትዎ ጋር ስለ ቤተሰብ	1 አዎን 2 የለም	

ምጣኔ ተወያይተዉ ያዉቃሉ፤

403	የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም ይፈልጋሉ፤	1 አዎን 2 የለም
404	ከላይ በተራ ቁጥር 129 ለተጠየቀዉ ጥያቄ መልስዎ አዎን ከሆነ የትኛዉን የወሊድ መቆጣጠሪያ ዘዴን ለመጠቀም ይፈልጋሉ?	1. ተፈጥሮአዊ የወለድ ቁጥጥር ዘዴ 2. በአፍ የሚዋጥ ክኒን (ፕልስ) 3. በመረፌ የሚሰጥ 4. በክንድ የሚቀበር 5. በማህጸን የሚቀመጥ (ሉፕ) 6. የሴት ማህጸን አሸነፉ ማስቋጠር 7. ወንድ ዘር መተላለፍያ ባንባ ማስቋጠር 8. ኮንዶም 9. አረፋማ ክኒን 10. ሌላ ካለ ይጥቀሱ- ----- ---
405	ባሌቤትዎ የእርስዎን የወሊድ መቆጣጠሪያ ዘዴን መወሰድ ይደግፋሉ?	1 አዎን 2 የለም
406	ለጥያቄ ቁጥር 155 መልስዎ የለም ከሆነ ምክንያቱ ምንድነዉ?	1 ብዙ ልጅ መወለድ ስለሚፈልግ 2 የባሌቤቴን ጤና ይጎዳል ብለዉ ስለሚያስብ 3 ላልታወቀ ምክንያት 1 አዎን 2 የለም
407	ዘመድ ወይንም ሉደኛ የወሊድ መቆጣጠሪያ ዘዴን ለመጠቀም ፈልገዉ ቢያማክሮት ይደግፋሉ?	1 አዎን 2 የለም

ክፍል አምስት፤ ቤተሰብ ምጣኔን አጠቃቀም በሚመለከት

501	ዘመናዊ የወሊድ መግጠሪያን ተጠቅመው ያዉቃሉ?	1. አዎን 2. የለም ⇒ወደ ተ. ቀ 524
502	በአሁኑ ሰዓት የወሊድ መቆጣጠሪያን ይወስዳሉ?	ይሻገሩ 1 አዎን 2 የለም
503	ለጥያቄ ተራ ቁጥር 131 ና 132 መልስዎ አዎን ከሆነ የትኛውን ዘመናዊ የወሊድ መቆጣጠሪያን ወስደዉ ያዉቃሉ?	1 በአፍ የሚዋጥ ክኒን (ፕልስ) 2 በመረፌ የሚሰጥ 3 በክንድ የሚቀበር 4 በማህጸን የሚቀመጥ (ሉፕ) 5 የሴት ማህጸን አሸንዳ ማስቋጠር 5 ኮንዶም 6 አረፋማ ክኒን 8 ሌላ ካለ ይጠቀስ-
504	የወሊድ መቆጣጠሪያን ለመጀመሪያ ጊዜ ሲወስዱ ምርጫዎ ተጠብቆሎታል	1 አዎን 2 የለም
505	ከላይ ለጥያቄ ተ ቁ 134 መልስዎ የለም ካሉ ምርጫዎ የትኛውን የወሊድ መቆጣጠሪያ ዘዴ ነበር?	1 በአፍ የሚዋጥ ክኒን (ፕልስ) 2 በመረፌ የሚሰጥ 3 በክንድ የሚቀበር 4 በማህጸን የሚቀመጥ (ሉፕ) 5 የሴት ማህጸን አሸንዳ ማስቋጠር 6 ኮንዶም 7 አረፋማ ክኒን 8 ሌላ ካለ ይጠቀስ-----
506	የወሊድ መቆጣጠሪያን ተጠቅመው ከሆነ ለምን አላማ ነዉ የተጠቀሙት?	1 ልፅ አራርቆ ለመውለድ 2 የቤተሰብ ቁጥር ለመወሰን 3 ለህክምና 4 ሌሎች ምክንያቶች ካሉ

507	የወሊድ መቆጣጠሪያን ከየት ነዉ. የወሰዱት/የምወስዱት?	ይጠቀሱ -----			
		1	ከሆስፒታል		
		2	ከጤናጣቢያ		
		3	ከመንግስት ክሊኒክ		
		4	መንግስታዊ ካልሆኑ ክሊኒኮች		
		5	ከግል ክሊኒኮች		
		6	ከስነ ተዋልዶ ና ቤተሰብ ምጣኔ ጤና ተጠሪ		
7	ሌላ ካለ ይጠቀስ -----				

508	የስነ ተዋልዶና የቤተሰብ ምጣኔ ጤና ተጠሪ የወሊድ መቆጣጠሪያ ሰጥቶት ከሆነ የሚከተሉትን ነጥቦች ነግሮታል?(እያንዳንዱ ምርጫ ይነበብ)	<u>አዎን</u> <u>የለም</u>			
		1	የወሊድ መቆጣጠሪያ ዘዴ እንዴት እንደሚሰራ.....	1	2
		2	የወሊድ መቆጣጠሪያ ዘዴን እንዴት መውሰድ እንዳለበት...1		2
		3	የወሊድ መቆጣጠሪያ ዘዴ የሚያስክትለውን ችግር	1	2
		4	የወሊድ መቆጣጠሪያ ዘዴ እንዳይወሰድ የሚከለክሉትን ሁኔታዎችን	1	2
		5	የወሊድ መቆጣጠሪያ ዘዴ ሲወሰድ ችግር በያስከትል ምን መደረግ እንዳለበት	1	2
		6	ከወሊድ መቆጣጠሪያ ዘዴዎች የአባላዘር በሽታዎችን ኤችአይቭን ጨምሮ የትኛዉ መከላከል እንደ ሚችል	1	2
		7	እሁን ከሚወስድ የወሊድ መቆጣጠሪያ ዘዴ ሌላ	1	2
		8	ስለ ቀጣይ ቀጠሮ በጽሁፍ ወይም በቃል	1	2
		509	የወሊድ መቆጣጠሪያ ዘዴን በነጻ ነዉ. የሚያግኙት?	1	አዎን
2	የለም				
510	የወሊድ መቆጣጠሪያ ዘዴን በግE የሚያገኙ. ከሆነ ለሚጠቀሙት ዘዴ ምን ያህል ከፍለዋል?	1	የአንድ ወር ፕልስ -----ብር/ሳንትም		
		2	አንድ ፓኬት ኮንዶም -----ብር/ ሳንትም		
511	በገንዘብ እጥረት ምክንያት የወሊድ መቆጣጠሪያ ዘዴን	1	አዎን		
		2	የለም		

	ያልወሰዱበት አጋጣሚ ነበር?			
512	አሁን የሚፈልጉትን የወሊድ መቆጣጠሪያ አይነት ለማግኘት የሚያስችል ሁኔታ በአቅራቢያዎ አለን?	1 አዎን 2 የለም		
513	ከላይ በተቁጥር 142 ለተጠቀሰው ጥያቄ የለም ከሆነ ምክንያቱ ምንድነው?	1 የወሊድ መቆጣጠሪያ ዘዴዎች በአይነት ውስን መሆን 3 የተለያዩ ዘዴዎች ስለመኖራቸው ግንዛቤ አለመኖር 4 አንዳንድ የወሊድ መቆጣጠሪያ ዘዴዎችን በጤንነት ችግር ምክንያት መውሰድ አለመቻል 4 ባልታወቀ ምክንያት		
514	የወሊድ መቆጣጠሪያ ዘዴ ወስዶ ከሆነ ለምን ያህል ጊዜ ነበር የውሰዱት?	----- ወር/አመት		
515	የወሊድ መቆጣጠሪያ በሚወስዱበት ጊዜ ከመቆጣጠያ ጋር የተያያዘ ችግር አጋጥሞዎታል?	1 አዎን 2 የለም		
516	ከወሊድ መቆጣጠሪያ ጋር በተያያዘ ችግር አጋጥሞዎት ከሆነ ከስነ ተዋልዶና ቤተሰብ ምጣኔ ጤና ተጠሪ ምክር ጠይቋል?	1 አዎን 2 የለም		
517	ከወሊድ መቆጣጠሪያ ጋር በተያያዘ ችግር አጋጥሞት ከስነ ተዋልዶና ቤተሰብ ምጣኔ ጤና ተጠሪ ምክር ያልጠየቁ ከሆነ ምክንያቱ ምንድነው? (እያንዳንዱ ምርጫ ይነበብ)	አዎን የለም 1 የስነ ተዋልዶና ቤተሰብ ምጣኔ ጤና ተጠሪ ችግሩን ለመወያየት ጊዜ ባለመስጠት .1 2 2 በስነ ተዋልዶና ቤተሰብ ምጣኔ ጤና ተጠሪው ችሎታ ሙሉ እምነት ባለመኖሩ1 2 3 የስነ ተዋልዶና ቤተሰብ ምጣኔ ጤና ተጠሪው በጣም አጭር በሆነ ጊዜ ስለምያናግረኝ.....1 2 4 የስነ ተዋልዶና ቤተሰብ ምጣኔ ጤና ተጠሪው በጥሩ ሁኔታ ስለማያናግር 1 2 5 ሌሎች ካሉ ይጠቀሱ-----		

518	ከአንድ በላይ የወሊድ መቆጣጠሪያ ዘዴን ወስድዉ ያዉቃሉ?	1 አዎን 2 የለም ⇒ወደ ተ. ቀ 521 ይሻገሩ
519	ከላይ በተቁጥር 148 ለተጠየቀዉ ጥያቄ መልስዎ አዎን ከሆነ ከየትኛዉ ዘዴ ወደ የትኛዉ ዘዴ ነዉ የቀየሩት?	ከ ----- ወደ -----
520	የወሊድ መቆጣጠሪያ ዘዴ ቀያይረዉ የተጠቁሙ ከሆነ በምን ምክንያት ነበር ለመቀየር የፈለጉት?	1 መድሃኒቱ ባስከትለዉ ያልተፈለገ ዉጤት 2 መጀመሪያ ስወሰድ የነበረዉ ዘዴ ባለመኖሩ 3 የወሊድ መቆጣጠሪያ ዘዴ የማይመች በመሆኑ 4 ሌላ ምክንያት ካለ ይጠቀስ -----
521	የወሊድ መቆጣጠሪያ ዘዴን ተጠቃሚ ከሆኑ በሚጠቅሙበት ወቅት የወሊድ መቆጣጠሪያ ዘዴ እጥረት አጋጥሞት ያዉቃል?	1 አዎን 2 የለም
522	ከዚህ በፊት የወሊድ መቆጣጠሪያ እየወሰዱ በመካከል አቋርጠዉ ያዉቃሉ?	1 አዎን 2 የለም
523	ለጥያቄ ቁጥር 152 መልስዎ አዎን ከሆነ ምክንያቱ ምንድነዉ?	1 ማርገዝ ስለምፈልግ 2 መካን እንዳያደርግ ፍራቻ 3 መከላከያዉ ችግር ያስከትላል በሚል ፍራቻ 4 በጤና ችግር ምክንያት 5 በአቅራቢያዉ የሚፈለግ አገልግሎት አለመኖር 6 በባሌቤቴ አለመስማማት 7 ባል ወይም ሌላ የትዳር ሊደኛ አለመኖር 8 ስለ መከላከያዉ በሚወራ መጥፎ ወሬ 9 ሌሎች ካሉ ይጠቀሱ -----

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ከዚህ በፊት ማንኛውንም
የወሊድ መቆጣጠሪያ
ዘዴን ተጠቅመው
የማያውቁ ከሆኑ
ምንድነው ምክንያቱ?

1. ስለሁኔታው ግንዛቤ አለመኖር
2. ተጨማሪ ልጆችን ስለምፈልግ
3. በሌሎች ሰዎች ተፅዕኖ ምክንያት
4. የሚፈለገው መከላከያ ዐይነት
ባለመገኘቱ
5. በጤንነት ችግር ምክንያት
6. በመድሃኒቱ ላይ ጥርጣሬ ስላለ
7. ሌሎች ካሉ ይጠቀሱ -----

Annex 3

Interview guide, for FGD with health workers (who are responsible for supporting and supervising CBD agents).

Theme 1. Introduction

Thank you for coming to this session, your presence is very important.

(Description; what a focus group what it like an opinion survey, but very general, broad questions).

Purpose: We will be discussing your reaction/perception and experience about the impact of family planning services in this area in general and CBD program in particular.

- All your ideas, comments and suggestions are of great interest for us.
- There is no right or wrong answers, all comments both positive and negative, are welcome.
- Please disagree one another when necessary. We would like to have many points of view

Ask each participant to introduce him/her self

- Name,
 - Some thing about one's self, position, work or residential experiences and others as desired.
1. To begin with, how do you see the population growth pattern and total fertility in your area?
 2. Currently there are various methods and strategies to harmonize the population growth with one's nation developmental aspect. What strategies for providing family planning services do you know?
 - What do you know about the CBD programs?
 3. One of the factors to maintain the service quality is close supervision and refreshing training given to the providers. In this regard:
 - How do you supervise the CBD agents (frequency, on service and off service training, motivation and encouragement).
 5. What is your opinion to sustain the CBD program?

Interview guide for FGD with the CBD agents

1. What do you know about population and population growth of your locality?
2. When I mention the term “ family planning” What is the first thing that comes to your mind? (Take what you get and probe)
3. Currently there are organizations providing family planning services in various parts of the countries.
4. Where from the people in your area get health services?
5. What are the mechanisms that the community helps each other?

Interview guide for FGD with Community and Religious Leaders

1. What do you know about population and population growth of your locality?
2. What do you know about family planning?
3. Currently there are organizations providing family planning services in various parts of the countries.
4. Where from the people in your area get health services?
5. What are the mechanisms that the community helps each other?

Annex 4

Guide line for individual in-depth interview questionnaire format for district managers family health experts and family planning program coordinator to identify reasons for the difference in the contraceptive prevalence rate (CPR) in CBD project areas.

This questionnaire format is to be used by an expert interviewer who wishes to get required in- depth information on issues of interest by interviewing an individual believed to be a resource person.

Introduction

- Introduce your self and purpose of the interview.
- Ask for permission to tape and record the interview in any form including the reason for doing so.
- Be sure whether the permission is obtained or not

Theme one

General

The CBD project in our catchment's area is providing family planning services.

1. What are the reasons to establish this program?

Tell us your opinion, understanding

2. How long is it since its establishment?

Theme two

Main body

3. Who are the CBD agents in your project area/ catchment's areas?
4. How the agents selected?
5. What is your opinion about the training of the CBD agents?
6. How do you see the supervision patterns for the CBD agents and the program?
7. In what manner does the CBD agents provide the services?
8. How do you see the courage of the CBD agents?

9. How the CBD program function?

Theme three

Closing part

10. What problems do you come across the CBD programs?

11. What mechanism do you have to sustain the project?

12. What mechanisms do you have to solve any uncertainty?

Thank you for your willingness and patience to accomplish the discussion.

Annex 5 Summary Tables for FGD
FGD I Health professional

Theme	SDP	FGAE
Knowledge of CBD project functionality	Selected by community leaders some times in consultation with community members, initial training was adequate, misses subsequent refresher training	Selected mostly by the community leaders, short duration of training consistent and regular refresher training, and supervision by trained supervisor
Problems encountered with CBD program	Motivational, lack of budget	Lack of governmental and community commitment and lack of budget
Mechanisms to sustain the CBD project	Sustainability depends on adequate budget allocation, agent motivation and community and government commitment, Fund raising	Sustainability depends on adequate budget allocation, agent motivation and community and government commitment, Fund raising

FGD-II Religious Leaders

Theme	SDP	FGAE
Reasons for the establishment of the CBD program	Increase access, create demand and provide services	Increase access, improve comfort, increase service utilization
Support given to the CBD agents	Collaborate CBD activities, coordinate, Provide letter of support, show acceptance	Collaborate CBD activities, coordinate, Provide letter of support, show acceptance
Perception of community support	Inadequate, lack of clear vision, few opponents, ignorance	Acceptance of the program, show willingness, collaborative work, provides transport fee in few cases
CBD selection	Based on criteria, some times leaders alone select, mostly in consultation the community members	Based on criteria, some times leaders alone select, mostly in consultation the community members
Perception of the CBD work	Strong acceptance of the program and helpfulness of their duty to the community	Strong acceptance of the program and helpfulness of their duty to the community
Community mechanism to deal with uncertainty	Organization in to homogeneous group, contribute money and labour idea to solve the problem	Organization in to homogeneous group, contribute money and labour idea to solve the problem
Perception of the functionality of the CBD agents	Most said that provide voluntary service few said occasional payment	Most said that provide voluntary service few said occasional payment

FGD III Community Leaders

Theme	SDP	FGAE
Reasons for the establishment of the CBD program	Increase access, acceptability and contraceptive use	Increase access acceptability create demand and increase contraceptive utilization
Role of community in the CBD program	Participate in CBD agents selection, collaborate their activities, provide support letter	Support, willingness facilitate their duties participate in CBD agents selection follow their performances
Mechanism to sustain the CBD program	Local community does not have economical capacity to support, recommended the government to allocate budget for the program, make the service chargeable motivate the agents	Contribution of money from local community is difficult, needs communication at different level, decision at higher level for sustainability

FGD IV. CBD agents

Theme	SDP	FGAE
Reasons for the establishment of CBD program	Increase access, create demand, increase service utilization	Increase access, create demand, increase service utilization
Strategy of service provision	House to house visit, static at the agents house, in outreach site for EPI, and mass gatherings	House to house visit, static at the agents house, in outreach site for EPI, and mass gatherings
Training	Seems inadequate, needs additional training, no refreshment training	Initial and subsequent training were sufficient to effect their tasks.
Support given by the community	Leaders work in close collaboration, facilitates the CBD agent's duties, the community showed acceptance of the services, no monetary or related support	Leaders work in close collaboration, facilitates the CBD agent's duties, the community showed acceptance of the services, no monetary or related support

Annex 6
In-depth interview summary table

Theme	SDP	FGAE
Reasons for the establishment of CBD program	Increase access, create demand provide privacy, and confidence increase interest, increase CPR increase client comfort wean social and cultural barrier	Increase access, create demand increase CPR increase client comfort wean social and cultural barrier
Duration of the establishment	1998	In 1991 population concern project and in 1996 the current vision 2000 project were established
Selection of the agents	The local community leaders in collaboration with the community members and the local governmental agencies and the funding agencies	The local community leaders in collaboration with the community members and the local governmental agencies and the funding agencies
Training	For new agents time seems short, manual was used no refresher training recently	Sufficient time allotted, both practical and conceptual, continual refresher training, have curriculum and manual trainers have got TOT, and standardized
Supervision	Inadequate, no permanent staff regularly conducting the supervision, checklist not regularly used	Trained nurse supervisor conducted supervision on regular base using checklist and provide feedback and training at the same time.
CBD functionality	Work purely on voluntary base, get supplies from governmental health institution provide for clients freely	Have occasional incentives sale contraceptives for minimum charge , get 60% of the sale money, get transport allowance
Motivation of the agents	Seems not motivated, they have no incentives	Are highly motivated
Strategies	House to house, static and outreach	House to house, static and outreach
Responsible body	Government health organization and institution primarily and the SDP	FGAE at local regional and federal level are the primary responsible and the government health organizations
Problem encountered	Sustainability problem shortage of budget lack of motivation	Community resistance at the very beginning

Annex 7

Health Related NGOs Active in the Zone

NGO	Location of Activity	Description of Activity
1. Sidama Development Program (Irish Aid)	All woredas of the Zone	- Health facilities (HF) construction and rehabilitation - Improving transport and facilities - Availability of essential drugs and equipment - Community based Programs (seven woredas) - Short and long term training - HIV/AIDS prevention - Spring protection - Operation Research
2. Family Guidance Association of Ethiopia (FGAE)	Awassa and Dale	- Family Planning - MCH Program - Male Clinic - Health Education - HIV/AIDS prevention
3. Marie Stopes	Awassa	- Family Planning - MCH Program - Curative Services - HIV/AIDS prevention
4. Catholic church	Awassa, Boricha, Hulla, Aleta Wondo	- Curative Services - Public health services (Bushulo)
5. Mekane Yesus Church	Aleta Wondo, Hulla, Arbegona and Bensa	- Curative services - FP and MCH - Immunization
6. Kale-Hiwot	Aleta Wondo	- Curative services - MCH services - Immunization
7. Philadelphia Mission	Awassa	- Curative Service - Immunization - Nutrition - ANC/PNC - FP
8. Mary Joy	Awassa	- HIV/AIDS prevention

Annex 8

Sidama Zonal Map

DECLARATION

I, the undersigned, declare that this is my original work, has never been presented in this or any other University and that all the source materials used for the thesis have been duly acknowledged.

Name _____

Signature _____

Place _____

Date of Submission _____

This thesis has been submitted for examination with my approval as a University advisor.

Name _____

Signature _____