ADDIS ABABA UNIVERSITY
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DETERMINANTS OF UNMET NEED FOR CONTRACEPTION AMONG CURRENTLY MARRIED COUPLES IN WEST *BELESSA WOREDA*, NORTH GONDAR OF AMHARA, ETHIOPIA.

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NEGA MIHRET

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Determinants of Unmet Need for Contraception Among Currently Married Couples in West Belessa Woreda, North Gondar Amhara Region

By

Nega Mihret Alazbih

Institute of Population Studies
College of Development Studies

Approved by the Examining Board

Dr. Terefe Degefa Chairman, Department Graduate Committee	Signature
Dr. Assefa Hailemariam Advisor	Signature
Dr. Charles Teller External Examiner	Signature
Dr. Terefe Degefa Internal Examiner	Signature

This Manuscript is in Memorials of:

- **My Father ;**

  Ato Mihret Alazbih Wonidm

  Died on; January 23, 2004

And,

- **My Brother ;**

  Ato Melkie Amsalu Arega

  Died on ; May 20, 2006

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Acronyms

CSA=	Central Statistical Agency
DHS=	Demographic and Health Survey
FGAE=	Family Guidance Association of Ethiopia
FP=	Family Planning
KAP=	Knowledge Attitude and Practice
MCH=	Maternal and Child Health
NGO=	Non Governmental Organization
TFR=	Total Fertility Rate
UN=	United Nations
WFS=	World Fertility Survey
WHO=	World Health Organization
ADA=	Amhara Development Association
CPR=	Contraceptive Prevalence Rate
FDG=	Focus Group Discussion

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Abstract

The objective of the study was to examine the underlying factors of unmet need for contraception among currently married couples in West Belessa Woreda. A community based cross sectional study was made. A multistage sampling procedure was carried out to interview 662 couples in the study area. The study was designed in such a way that the various demographic, socioeconomic and family planning variables have effects on unmet need for contraception. Demographic, socioeconomic and family planning variables were used as explanatory variables and the dependent variable is unmet need for contraception. In order to examine, then, the effect of these variables, the study utilized both descriptive and multi-variate analytical techniques.

The results indicated that around 31% of wives and 17% of husbands have not known any family planning method. 51% of wives and 18% of husbands knew utmost two methods, and 18.3% of wives and 66% of husbands knew at least three contraceptive methods. Around 65% of wives and 53% of husbands have never discussed with partners issues concerning family planning. It is also indicated that 69% of wives and 56.4% of husbands have never discussed about family planning methods with health extension workers. 31% of wives and 43.6% of husbands have discussed with health extension workers at least once in the past three months about contraceptive methods. Concerning the need status for contraception, 39.5 and 47 percent of women and men have unmet need for contraception, and 29 and 28.5 percent of women and men have met their need respectively. The minimum and maximum couples' unmet needs for contraception were found to be 29.5 and 57.5 percent respectively. According to the result of logistic regression, among the variables, number of living children, spousal communication and discussion with health extension workers about family planning methods were found to be significantly affecting couples unmet need for contraception.

It is therefore, recommended that raising the status of women through education, promoting communication between couples and discussion with health extension workers about family planning are the prime importance to erode barriers to use contraceptive methods.

Chapter One

1 Introduction

1.1 Background of the study

Until the mid 1990s, birth rates had remained high in the developing world since deliberate birth control to limit family size was practiced by only a small minority of couples (Bongaarts et al, 1990). However, by using data from the United Nations, the same author depicted that the trends of total fertility rate in developing countries, as a whole, has declined from 6.1 births per woman during 1960-65 to 4.2 during 1980-85. This substantial decline in fertility was highly attributable to the large decline in East Asia, Latin America and South Asia, where fertility reached 2.4, 4.1 and 4.6 births per woman respectively (Bongaarts et al 1990).

In contrast, fertility in Africa (declined from 6.6 during 1960-65 to 6.3 during 1980-85), particularly in sub-Saharan Africa (from 6.7 to 6.6 births per woman in the same period) remained nearly unchanged as it is the last world region to experience a decline in fertility (Bongaarts et al, 1990, Meekers 1991).

In Ethiopia, total fertility rate did not show any marked decline between the mid 1950s and mid 1980s (UN, 2001).Since the late 1980s the fertility rate began to decline from 6.4 children per woman in 1990(CSA, 1993) to 5.9 births in the 2000 EDHS, and it further declined to 5.4 in 2005 (CSA and ORC Macro, 2005).

Studies have shown that the proximate determinant of fertility, particularly modern contraceptive use is a primary determinant of fertility in developing countries (Mauldin and Ross, 1989). The fertility declines revealed above, though vary in region, are largely attributable to the rapid increase in contraceptive use (Bongaarts et al, 1990).

Studies conducted in developing countries have shown that rate of contraceptive prevalence rose from 9% in the early 1960s to 51% in 1990(Fathalla, 1994). During the

same period it has been also stated that contraceptive prevalence has increased in East Asia (from 13% to 70%) and Latin America (from 14% to 60%). But in Africa the change is insignificant (from 5% to 17%) and it has not produced a significant impact on fertility (Bonqaarts et al. 1990, Fathalla, 1994).

In Ethiopia, modern contraception was introduced in 1966 by Family Guidance Association of Ethiopia (FGAE) which is a non-governmental and non-profit organization, established to provide information, counseling and clinical services to families who want to space the birth of their children (Antenane, 1997).Before 1980, family planning services were not provided in government health facilities. Until recently, FGAE was the only NGO offering family planning information and services (Assefa et al, 2006). The same author further stated that the 1980 council of Ministers directive to integrate family planning as part of the Maternal and Child Health care (MCH) program of the Ministry of Health created same favorable environment to strengthen and expand family planning services in the country. At present, family planning services are provided through government and NGO service outlets, including hospitals, health centers, health posts, and community based distribution and social marketing.

Although the services have been provided for a prolonged time, contraceptive prevalence has not reached a level whereby it will have an impact on fertility. This was mainly attributed to the service delivery system, which was carried out through the network of general health facilities that are available mostly in urban or semi-urban communities, the bulk of the rural population remained without access to family planning services (Assefa et al, 2006). The recent EDHS conducted in 2005 revealed that contraceptive prevalence was only 15 %(47% in urban and 11% in rural areas) (CSA and ORC Macro, 2005).

Because of the low prevalence level of contraception in developing countries, unwanted births are increasing. For instance, estimates of unwanted fertility in Peru between 1982 and 1987 revealed that more than one third of all births were reported as unwanted, i.e. from the total fertility rate of 4.5, 36 percent were unwanted births (Westoff et al, 1989).

These unwanted births would never have occurred if their conception had been avoided by the practice of contraception that has a direct effect on fertility. In other words, women exposed to unwanted births are not practicing contraception in accordance with their reproductive preferences for spacing and limiting. This group of women is considered as having unmet need for contraception (the discrepancy between an expressed fertility goals and contraceptive practice) (Casterline et al, 1997).

The concept of unmet need evolved in the 1960s when data from surveys of contraceptive knowledge, attitude and practice (KAP) showed that a considerable number of women were not using contraceptives despite their desire to space and stop childbearing. (Omwago and Khasakhala, 2006, Bangaarts, 1991). Substantial data from World Fertility Survey (WFS), Contraceptive Prevalence Survey (CPS) and Demographic and Health Survey (DHS) helped to refine the concept further (Westoff, 1988, Westoft and Bankole, 1995, Casterline and Sinding, 2000, Ngom, 1997).

These early studies of unmet need, however, focused mainly on married women due to a number of factors that include the fact that women had been the central focus of research since they were more directly involved in reproduction, methods for women were more developed and that as opposed to men, they were more motivated to adopt contraception (Omwago and Khasakhala, 2006). However, these studies don't tell us whether the practice of family planning is by the support, cooperation and agreement of both partners. Just as the women has been central in family planning, so should the man, since he may fail to give consent for such practice ,or fail to cooperate in using methods. Therefore, using women's data to make conclusion on unmet need status of couples may be misleading.

Nafis Sadik in her study indicated that there are at least 350 million couples worldwide, who do not have access to the full range of modern contraceptive methods. Of these, about 120 million would use the method now to delay or stop having children if services were available (Sadik, 1994).

A study conducted in Kenya indicated that about 17% of couples were having unmet need for contraception (Omwago and Khasakhala, 2006). The result of this study has also shown that the level of unmet need for couples was much lower than that of married women or men separately, which is 24 and 23 percent respectively. This indicates that incorporating men in the estimation of unmet need is important in reducing the level of unmet need.

It should be remembered, however, that recently, there was an estimated 105.2 million married women in developing countries who have unmet need for contraception (55.4 million for spacing and 49.8 million for limiting).From this, sub Saharan Africa constitutes 24 million (22% of the total)(Ross and Winfrey,2002). In Ethiopia, it is estimated that 34% of married women had unmet need, of which 20% for spacing and 14% for limiting (CSA and ORC Macro, 2005).

The same study indicated that in *Amhara* region, the prevalence of unmet need among married women is high, though declining from 41% in 2000 to 30% in 2005. In 2000, it was the highest among the region in Ethiopia, but is placed third next to *Oromiya* (41%) and SNNP (37%) in 2005. The rate of contraceptive prevalence of the region increased from 7.7% in 2000 to 16% in 2005, whereas the proportion of total demand satisfied increases from 15% in 2000 to 35% in 2005 (CSA and ORC Macro, 2005).

1.2 Statement of the problem

Everyday, more than 400,000 conceptions take place around the world, of which about half are deliberate while the other half is unintentional (Potts, 2000, cited in Omwago and Khasakhala, 2006). In population with high unmet need, because the preference for fewer children is increasing, the level of unwanted fertility is rising (Westoff and Bankole, 1995). This high level of unwanted fertility leads to high fertility and population growth rate that remain a significant impediment to development.

In many developing countries, the increase in population size coupled with low technological development contributed to deforestation, soil degradation and species loss.

In other words, to support more people more food should be produced. To produce more food more resources are required in food production, which causes depletion of natural resources (Preston, 1994).

On the other extreme, in many cases, the fertility pattern of a population can affect the maternal and child health. Ramalingasulami (1994) suggested that high risk of maternal and child mortality and morbidity is associated with unwanted pregnancies, i.e., too early, too many, too often, and too late pregnancies. The same author further stated the factors that are exerting a marked influence on the health of mother and children. These factors are: timing and spacing of pregnancies, age at marriage and age at first birth, the number of pregnancies, and frequent childbearing and consequent displacement of the older sibling from the mother's breast.

A woman conceiving while under 15 years of age and over the age of 35 is five times more likely to die than a woman who conceives in her twenties(Ramalingaswami, 1994). The same author suggested that about 500.000 women lose their lives every year during pregnancy and labor, of these 99% of the deaths occur in developing countries).In Ethiopia, the maternal mortality ratio is among the highest in the world(673 deaths per 100,000 live births(CSA and ORC Macro,2005)). It is here that the disparity between developed and developing countries is greatest than for any other human development indicator. Young women who become pregnant are often at risk of obstructed labor that causes fistula, as they are not yet physically grown to their pelvic size.

Abortion is another indicator of unmet need for contraception. It is common among women who have the experience of unwanted pregnancy. Worldwide, 40-60 million abortions are estimated to be performed annually, of which half of it is believed to be illegal and unsafe that exposes women to the risk of pregnancy related illness and even death. (Sanstrom, 1993, Cited in, Ramalingaswami, 1994).

In addition to this, women with unmet need, because of pregnancy and childbearing burden, may also fail to be what they want to be. They are less likely to improve their

own lives through education, participation in economic activities and other opportunities, which could cause reduction in economic productivity over the entire life of the individual.

On the other hand, infant and child mortality is very high among women with unmet need. The chances of survival for the new born are increased as the birth interval increases. Ramalingaswami (1994) in his study suggested that spacing pregnancies by two years reduces child mortality by 20 percent. In Ethiopia infant and under five mortality rates are estimated at 77 and 123 deaths per 1000 live births respectively (CSA and ORC Macro,2005).

Researches indicated that infant death has a J-Shape distribution by birth order (Davanzo et al, 1983). This means high death rates of first born is due to detrimental biological effects of the mother such as maternal age where as those of higher birth order is due to behavioral reasons related with the possible care to be given to the child.

In order to limit the fertility rate by preventing all unwanted births, it is necessary to identify the factors associated with low contraceptive prevalence among those who have the knowledge and positive attitude to regulate their fertility. Thus, the purpose of this study is to identify and understand the determinants of unmet need for contraception in West *Belessa Woreda.*

1.3 Objective of the Study

- **General objective**

The main objective of this study is to examine the determinants of unmet need for contraception among currently married couples in West *Belessa Woreda*

- **Specific Objectives**

1 to assess the level of unmet need for contraception among married couples

2 to identify factors that contribute to unmet need for contraception among married couples in the study area.

3 to examine the attitude of husbands and wives towards the use of contraceptive methods.

4 to suggest possible interventions that could reduce number of married couples with unmet need.

1.4 Hypotheses of the Study

1 women's education is negatively associated with unmet need for contraception.

2 the level of unmet need for contraception increases with increasing number of living children in the household.

3 frequent discussion of women with Health Extension workers about family planning decreases the likelihood of unmet need.

4 frequent spousal communications on family planning issues negatively affects unmet need for contraception.

1.5. Significance of the study

Many studies on unmet need have focused on women based, with some inferences made for men and couples. However, reproductive decisions are not made by women alone. In other words, the ideal family size measures rely on reports of women who have little say in fertility decision making. In contrast, this study examines couple's unmet need for contraception by using the married couple as the unit of analysis rather than the individual man or woman. This may help to understand the attitude of spouses to space or stop childbearing. This is because the desire for and timing of additional children and contraceptive practice are influenced by extra individual factors, such as ability to communicate, lack of knowledge, societal disapproval and husbands approval (Ngom. 1997).

The identification of possible factors that determine the practice of contraceptives in the area will have greater input to program managers for designing programs, proper implementation and evaluation of their contribution regarding family planning and maternal health issues In addition, findings of the study may help in addressing several

health related problems that may occur due to pregnancies before age 20 or after age 35, such as low birth weight, malnutrition, slower physical growth and development.

Although some efforts have been made in the past to study the prevalence of unmet need and its correlates in Ethiopia, such study has not been conducted in the study area. Even at regional level, a study (Mekides, 2003) conducted in *Amhara* region identified factors that contribute for unmet need for contraception based on only women's response which did not consider men and couples. However, this study attempted to find out determinants of unmet need for contraception focusing on couples or currently married men and women in their reproductive age who have demand for contraception but not using any method of family planning.

Therefore, the study has attempted to suggest interventions to be designed in order to address couples with unmet need by identifying socio-economic, demographic and family planning factors that determine couples use or nonuse of contraceptive methods.

1.6 Review of Related Literature

1.6.1 Socio- Economic Factors

1.6.1.1 Education

Education is one of the variables with the most pervasive impacts on fertility preference and behavior of couples. Educated couples are more likely to know about contraceptive methods and to be more confident in approaching service providers than women with no education. Education helps to have better access to family planning services.

A study conducted in Kenya has shown that unmet need among couples seemed to decline with increasing education (Omwago and Khasakhala, 2006) This study further stated that couple who are more educated can afford to buy contraceptives, are more likely to reside in the urban areas where contraceptives are more accessible, are more informed about the available methods and are more likely to prefer small families than

their less educated counterparts. As a result, those with no education had the greatest unmet need.

Another study conducted on married men, in urban areas of Nigeria ,revealed that the desire for more children is high across all educational levels , but men with no education are the most likely to desire more children(Odumosu et al,1998). Omwago and Khasakhala(2006) also found that husband's education became insignificant when both husbands and wives education were put in the same model, to reduce couples unmet need.

The Ethiopian 2005 DHS showed that the contraceptive prevalence rate increases with educational attainment, i.e. it increases from 10% among women with no education to 53% among those with secondary and higher education. The same study revealed that women with no education are twice more likely to have unmet need for contraception than women with secondary and higher level of education (CSA and ORC Macro, 2005).

Recent studies in *Amhara* regional state using the 2000 Ethiopian DHS suggested that among women with no formal education and who have demand for contraception, 89% have unmet need and among those with secondary or higher education and who have demand for contraception, only 19.2% have unmet need for contraception (Mekides, 2003).

1.6.1.2 Place of Residence

The potential demand for contraception differs by place of residence. It is suggested that the larger proportion of potential spacers and limiters are residing in rural areas, as there would be poor means of transportation and less access to a range of family planning services than couples in urban areas. Due to this, the contraceptive prevalence rate in rural areas tends to be very low.

A study conducted in Kenya confirmed that couples in rural areas have greater total unmet need than their urban counterparts. This is because, they would have better access

to different contraceptives and are more informed about the available methods (Omwago and Khasakhala, 2006).

The Ethiopian 2005 DHS suggested that contraceptive prevalence is more than four times higher in urban areas (47%) than in rural areas (11%). And the unmet need for contraception among women in rural areas is higher (36%) than in urban areas (17%). Mekides (2003) also depicted that in *Amhara* region among women with demand for family planning and who reside in rural areas, 89% had unmet need and in urban areas out of the total women who had demand for contraception, only 37% had unmet need .

1.6.2 Demographic Factors

1.6.2.1 Age of spouses

Age of couples is an important determinant of contraceptive use. A study on couples unmet need show that husbands and wives who were in the age group of 35+ had the highest total unmet need for contraception (Omwago and Khasakhala 2006). Another study conducted on married men in urban areas indicated that the desire for more children is observed to decline with increased age except at age 60 and above that experiences a slight increase (Odumosu et al,1998).

Studies have revealed that most old women have unmet need for limiting whereas most young women have unmet need for spacing. The reason behind is that young women still want to have more children but want to space and old women have achieved their desired family size and thus want to stop child bearing. Ethiopian DHS (2005) depicted the trend of unmet need for spacing is decreasing with age while the reverse is the case for limiting. The result further showed that unmet need for contraception remains relatively high at all ages except for age group 45-49 that it falls sharply, may be attributed to the value attached to children at older age.

1.6.2.2 Number of living children

The number of living children is one of the factors for demand for contraceptive methods. Large number of living children encourages couples to space or limit the fertility. That means the likelihood of wanting no more children increases with the actual number of living children. Omwago and Khasakhala (2006) in their study indicated that couples who have more children are more likely to have unmet need than the ones who have fewer children or none at all. Studies conducted in Latin American countries suggested that 22% of women with one child want no more children and 60% of women with two children want no more children (Westoff and Bankole, 1995).

1.6.3 Family Planning Factors

1.6.3.1 Knowledge of Contraception

Lack of knowledge is an important cause for non-use. Couples are considered to have acceptable knowledge of method if they can describe whether they have ever heard of a method that a couple can use to delay or avoid pregnancy, but does not imply respondents knowledge on how it is used, its main side effects. and where it can be obtained. Studies conducted in 13 countries by using DHS data depicted that the most important reasons for non use are lack of knowledge (Bongaarts and Bruce, 1995).

1.6.3.2 Availability and Access of Family Planning Methods

In order to adopt any contraceptive method a couple should have access to it. There would be a direct relationship between the availability of the method and the prevalence of its use. A study conducted in 10 countries suggested that contraceptive prevalence declines as distance to family planning facilities lengthens (Bongaarts and Bruce, 1995). On the other hand. it indicates that the level of unmet need rises as distance from the source of contraceptive methods increases.

1.6.3.3 Objections from Spouse

For many married couples objections to contraceptive use from their partners would be a sufficient reason not to practice contraception despite their desire to do. By using DHS

data, a study conducted in Sudan revealed that among women who have unmet need, 44% of their husbands disapproved the use of contraceptive methods (Bongaarts and Bruce, 1995).

Many studies suggest that husband's desire for more children is the main reason for the objection. If a husband wants more children but the wife does not, there would be a disagreement on the practice of contraception. For instance, in Ghana among women who want to stop childbearing, 46% of their husbands want more children (Ghana Statistical Service /Institute of Development Research, 1989, cited in Bongaarts and Bruce, 1995). And according to the 1993 KDHS (cited in Ngom, 1997) among Kenyan women with unmet need for contraception 39% of their husbands have no demand for family planning. In contrast, wives' disapproval is not an important reason for not using contraception. A study conducted in urban areas of Nigeria revealed that only 1.3% of the total married men who have unmet need reported wives disapproval as the main reason not to use contraceptive methods (Odumosu et al,1998)

1.6.3.4 Spousal Communication

Communication helps to spread new information from one group to another. Spousal communication regarding issues about family size and contraceptive use has an important influence on the prevalence of unmet need for contraception. Couples who discuss such issues are more likely to have met need than those who do not. For instance, studies conducted in six selected sub- Saharan countries show that 68 percent of women who report that their husbands disapprove for use of contraception have never discussed about family planning issue with them (Bongaarts and Bruce, 1995)

To sum up, since 1960s, survey data have indicated that substantial proportions of women who have wanted to stop or delay childbearing have not practiced contraception in developing countries. The traditional interpretation, that these women lack access to contraceptive supplies and services, has led in turn to an emphasis on expanding family planning programs. However, there are other principal reasons, in addition to this, for

nonuse that have highlighted by researchers like, lack of knowledge, fear of side effects, and social and familial disapproval(Bongaarts and Bruce,1991) as revised above.

Ethiopia is one of the developing countries in which unmet need prevalence remains high. It is suggested that factors such as lack of knowledge of family planning, lack of access to services and the negative attitude towards family planning (women's, husbands and others attitude) are responsible for the prevalence of high unmet need in the country(Assefa et al.2006).

However, most of the factors reviewed above are based on women's response, which did not basically consider the attitude of men towards contraception. The purpose of this study is, thus, to explore the factors that are responsible for the high prevalence of unmet need in the couple based approach.

1.7 Theoretical and Conceptual Framework

1.7.1 Theoretical Basis of Unmet Need

Why does unmet need exist? Bhushan (1997, p.19) summarized theories that explain the existence of unmet need as follows.

*1 **The microeconomic framework**, which views reproductive responses through the calculus of optimizing behavior, has been a major tool for the analysis of fertility behavior for the last three decades. Microeconomic analysis assumes that couples have perfect, or complete and accurate information about the benefits from and the costs of both children and contraception. Under the basic assumptions of this framework, couples decide to have an additional child only when the net benefits from having the child or the difference between the future streams of benefits and costs are positive and greater than those of alternative investments. Therefore, conventional economic analyses conclude that unwanted fertility cannot exist in any significant measure because the cost of avoiding a child is extremely small relative to the cost of having and rearing a child.*

2 *The other theory suggests that the existence of unmet need is related to* ***perceived cost of contraception.*** *The perception of costs associated with contraceptive use depends upon the characteristics of a couple and their community. A person's intention to behave in a particular way and his/her behavior depends upon two sets of factors: personal and social influences. Personal factors include the individual's own positive or negative evaluation of the behavior, while social influence is the effect of other individuals' attitudes on one's behavior. Consequently, the perceived costs of contraception may differ. A relatively high perceived cost of contraception may lead to unmet need. Even if a woman wanted to prevent a next pregnancy, she would use contraceptives only if the disutility from using contraceptives were less than the welfare gain in avoiding the pregnancy. Thus, the perceived costs of fertility regulation may play an important role in reproductive decision-making.*

According to Bhushan (1997) regarding contraception, there are three categories of costs (categories of perceived cost of contraception).

1- Costs related to availability (geographical and physical, qualitative and cognitive aspects of availability)

2- Cost related to health concerns and fear of side effects (discontinuation, fear of side effects among never users)

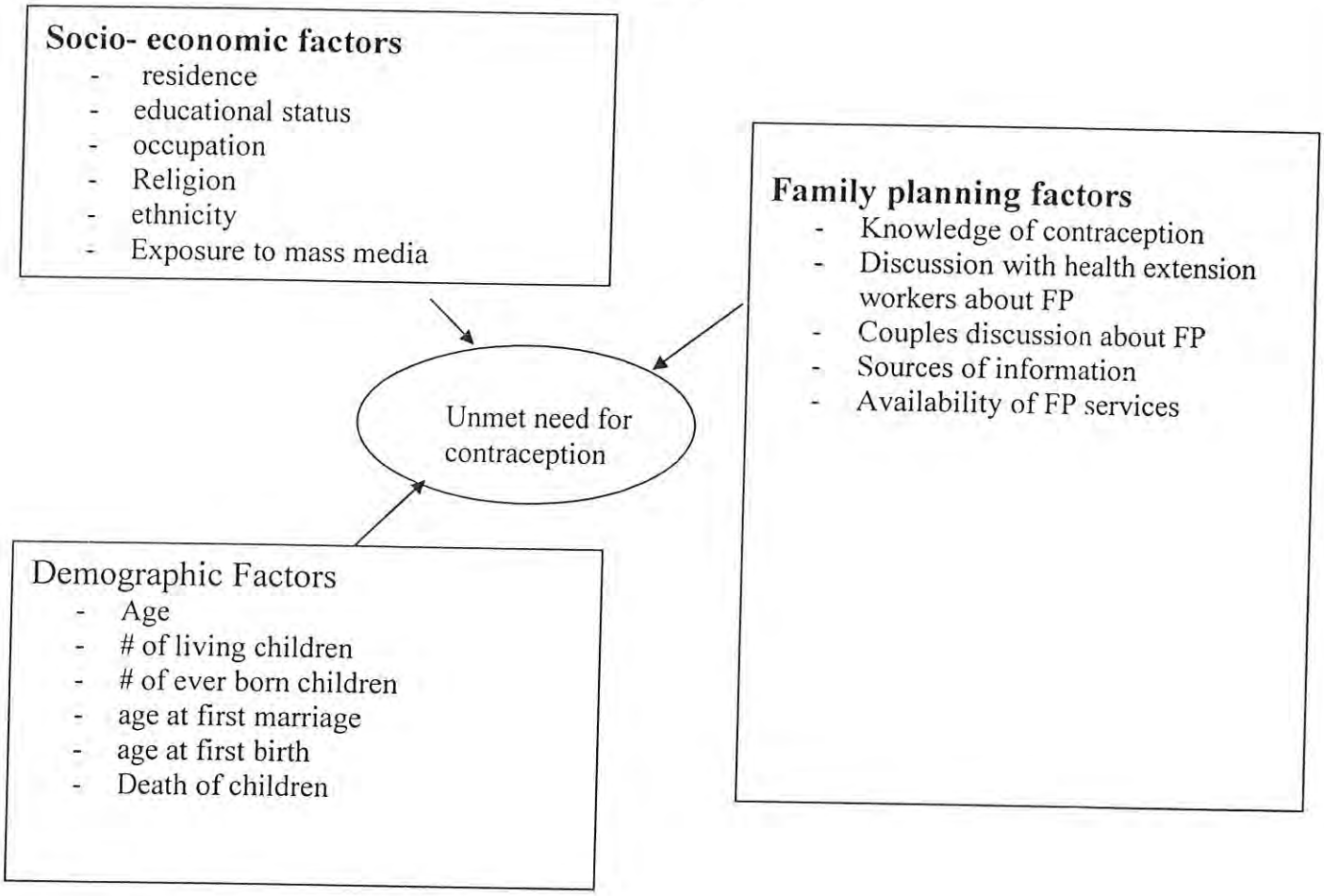
3- Cost related to social, cultural and familial disapproval of family planning (disapproval of family, religion and customs)

Therefore, thinking that nonmonetary costs may actually be a much bigger deterrent to contraceptive use than monetary costs, this paper focuses on the second theory (perceived cost of contraception).

1.7.2 Conceptual Framework

The framework is conceptualized by using two groups of variables, i.e., the dependent and independent variables. The independent variables are those that influence unmet need for contraception (dependent variable) which include Demographic, socio-economic and family planning factors

Figure1. The Conceptual Framework of the study



- Source; modified from Bhushan (1997)

- This analytical framework is used for both husbands and wives level analysis.

Chapter Two

2. Data and Methodology

2.1 Profile of the Study Area

West *Belessa woreda* is found in North *Gondar* Zone of *Amhara* Regional State. In the *woreda* there are a total of 30 urban and rural kebeles and about 79 sub-kebeles (*Gotts*).

According to the *Amhara* Regional State Bureau of Finance and Economic Development (ARSBFED), the population of West *Belessa woreda* was estimated at about 151,370 in 2004, of which female population accounts 73354 (49 %). The female population, within the reproductive age (15-49) accounts 46% of the total female population. The population is characterized by Young age structure (under 15 years of age) which accounts 46% of the total population, and only 2.5% of the population was aged 65 years and over (ARSBFED, 2004).

2.2 Study Design

A community based cross sectional survey was conducted among currently married couples living in the study area. A multi-stage stratified sampling technique has been employed for the selection of the sampling units (couples). In the study area, there are one urban and 29 rural kebeles. From the total kebeles (30 kebeles), eight kebeles, one from urban, and seven from rural, were selected. After the *woreda* has been stratified in to two strata (urban and rural), *Arbaya* town (the only urban kebele) was selected purposefully. Then from four sub-kebeles in the town, one sub-kebele was selected by using simple random sampling method. On the other hand, seven kebeles such as *Abeye Abei-tera, Kalai, Talla, Jandab, Aiseg*, and *Gond-ebrarag* were selected from 29 rural kebeles by using simple random sampling method. These seven kebeles have 2-3 sub-kebeles each. Then seven sub- kebeles (*gotts*)(one from each) were selected by the same method. Finally, on the basis of the sampling frame of household in each sub-kebele, currently married couples or married men and women within reproductive age and whose husband was living in the study area were selected from the selected eight sub-kebeles by

systematic sampling method. A list of households was obtained from the kebeles' administration office. The sample size is allocated to each enumeration area (sub-kebeles) based on the proportion to the size of the enumeration area.

2.3 Sample size Determination

In the determination of the sample size for the study, unmet need for contraception among currently married couples in the study area is the variable taken into consideration. The sample size was determined based on the estimate of the prevalence of unmet need for contraception among currently married women in *Amhara* region which is 30%(CSA, and ORC macro,2005),i.e., the population proportion of currently married couples who have unmet need for contraception(p) in the study area is assumed to be 30%. And the error to be tolerated in this study is taken to be 0.05, fixing the level of confidence interval at 95% and power at 80%, the sample size (n) is determined by the following formula (Woodward, 1992).

$$n = \frac{\left[Z_{\alpha/2} + Z_{\beta}\right]^2 p(1-p)}{e^2} = \frac{[1.96+0.84]^2 \times 0.3 \times 0.7}{0.05^2} \approx 659$$ and 5% for non response (33), in total n=692.

$Z_{\alpha/2}$ = the standard normal value corresponding to the desired level of confidence, 95% which corresponds to the value 1.96. Where α is the risk of a type I error (failing to accept the null hypothesis-*false positive*) usually equal to 0.05.

Z_{β} = the standard normal value corresponding to the desired level of confidence, which corresponds to the value 0.84. Where β is the risk of a type II error (failing to reject the null hypothesis-*false negative*) taken as the value 0.20.

e^2 = the effect size defined by the alternative hypothesis (the existing difference), 5% is accepted.

Power of the study: is equal to 1-β, which is the probability of obtaining a statistically significant *P* value, if a true difference exists that is equal to the effect size

defined by the alternative hypothesis. Since $\beta = 0.20$ the power of the study is equal to 80% (0.80).

Accordingly, 692 questionnaires were prepared and distributed. Out of these, 662 eligible couple respondents were interviewed. Non-response and absentees accounted for the remaining 30(4.3%).

Table 1 Distribution of Couples with Reproductive age of Wives in the sampled kebeles, West *Belessa Woreda*, 2008.

Kebele (urban/rural)	Sub-kebele *(gott)*	Household	Household sampled	Household interviewed
Arbaya (urban)	Addis sefer	331	109	107
Aiseg (rural)	Woneba	254	82	77
Abeye(rural)	Dirka	263	85	85
Abeytera(rural)	Abey-tera	261	85	85
Talla(rural)	Talla	266	86	86
Jandab(rural)	Jandab	262	85	85
Kallai(rural)	Kallai	244	79	61
Gond-ebrarag (rural)	Ebrarag	250	81	76
Total		2,131	692	662

***Source*; Field survey, 2008.**

2.4. Data sources and instruments

The current study is entirely based on primary data. Both quantitative (structured questionnaires) and qualitative (FGDs) methods were used. Questionnaires were administered to currently married couples or currently married men and women with their reproductive age (15-49). Information from FGDs was used to complement the findings from the quantitative survey. FGDs were conducted in three selected groups i.e. one from males in *Arbaya* kebele, two from females (One from younger women(15-29) in *Aiseg* kebele, and One from older women(30-49) in *Kallai* kebele). Participants in the discussions were recruited to represent the socio-economic and cultural compositions of the targeted population. Each FGD consists of 8-10 participants.

Enumeration was carried out by female and male high school graduates who were trained for three days about the purpose of the study and the content of the questionnaire. Female data collectors interviewed wives and males interviewed husbands to overcome the socio-cultural factors that could be a barrier to make free communication on issues related to reproductive health matters with opposite sexes

2.5. Ethical considerations

The present study has got official approval from Institute of Population Studies, Addis Ababa University. All respondents were asked for verbal informed consent before participation. The study participants were informed about the purpose of the study. They were also informed as they can skip questions that they do not want to answer fully or partly. After assuring the confidential nature of the response (the anonymity of the information provided by them) and obtaining informed consent from the study subject, the questionnaire was filled with strict privacy. Even husband and wife were asked in separate places.

2.6 Data Quality Assurance

The quality of data was ensured through proper training of data collectors and pre-testing of the questionnaire, close supervision of data collectors and getting immediate feedback, checking each of completed questionnaires daily. Daily information exchange to correct problems during the course of data collection. All collected data were checked for completeness, accuracy , and consistency by the principal investigator every day. Any thing which was unclear was corrected and communicated to the data collectors on the next day.

2.7 Method of Data Analysis

In analyzing the data, appropriate statistical tools were employed to test the findings. Both bivariate and multivariate analysis techniques were employed .At the bivariate stage, Chi-square test was used in order to identify the important explanatory variables. At the multivariate stage, logistic regression was used to determine the relative importance of a set of predictive variables.

2.8 Limitation of the study

- Since the analysis included only currently married couples, the results may not be inferable to all women and men
- The variables "age at first marriage" and "age at first birth" are not included in the model because a very high proportion of the respondents did not report their age.
- There could be information bias that wives may give wrong answer about current use of contraception deliberately, because of being suspicious of their answers to be passed over to their husbands. So this would under estimate the contraceptive prevalence in the area
- The total unmet need is not specified by spacers and limiters, because of the reducing effect of the size of cases, as there are couples whose unmet need type (spacer or limiter) are not the same.

2.9 Definition of Concepts

- **Women with unmet need**:-these group of women include (i) those women who are neither pregnant nor amenorrheic but fecund women and who want to space or limit their fertility but are not using contraceptive methods, (ii) those pregnant women whose pregnancy was mistimed or unwanted at the time when they became pregnant and (iii) all amenorrheic women whose last birth was mistimed or unwanted.
- **Met Need for contraception**:- refers to those currently married women who want to space births or limit the number of children and are using contraceptive methods to avoid unwanted or mistimed pregnancies.
- **Fecund women**:-refers to women who have physiological capacity to reproduce (Bongaarts and Potter, 1983).
- **Postpartum amenorrhea**: refers to the interval between child birth and resumption of menstruation, a period during which a woman is temporarily infecund (Bongaarts and Potter, 1983).
- **Couple** male and female who are in marital relationship or union.
- **Maximum couples unmet need** couples in which at least one spouse report not using modern contraceptive methods in spite of expressed demand for spacing or limiting childbirth (Ngom, 1997).
- **Minimum couples unmet need** couples in which both spouses want to space or limit births but are not using any contraceptive methods.
- **Housewife**_ women whose main occupation is caring for her family and running the household, who does not have regular paid work out side home
- **Zone-** Government administration hierarchy next to regional state.
- ***Woreda-*** Government administrative hierarchy that exists between kebele and zone.
- **Kebele-**the lowest Government administrative hierarchy that exists next to woreda.
- **Sub-kebele (*Gott*)**- the sub- division of kebele.

2.10. Problem Encountered

Some kind of gossip or heresy was perpetrated by few hooligans in one of the sample kebele in the study area known as *Kallai.* This was some thing against the data collection process in which they seemingly reflected the reproductive health questions as some kind of obscene implications which would repel the respondents from entertaining the questions. When this problem was encountered an appeal was made to the chief administrator of the *woreda,* who was actually positive about the objectives of the survey. In the end, the *woreda* administrator took measure and gave directives in writing to the kebele administrator to resolve the problem and the data collection process to continue. After five days of interruption the work was resumed.

2.11. Organization of the study

This study is organized in five chapters. The first chapter presents the background, statement of the problem, review of the literature, analytical framework, significance, objective and hypothesis of the study. Chapter two discussed data and methods, that includes profile of the study, study design, sample size determination, data sources and instrument, and method of data analysis. Chapter three presents the background characteristics of the study population which include socio economic, demographic and family planning characteristics of the population. Chapter four presents the analysis of determinants of unmet need for contraception that includes the examination of the association of each explanatory variable with unmet need (bi-variate analysis) and multivariate analysis to examine the relative importance of variables that affect couples unmet need. Chapter five presents summary of main findings, conclusion and recommendations.

Chapter Three

3. Background Characteristics of the Study Population

This chapter deals with the background characteristics of the 662 couples in West *Belessa Woreda.* It includes socio-economic factors such as religion, education, residence, occupation, ethnicity and exposure to mass media as well as demographic factors like, age, number of living children, number of ever born children, age at first marriage, age at first birth and number of dead children. Family planning factors like knowledge, attitude towards family planning and discussion with partner and health extension workers are also included in this chapter.

3.1. Socio-Economic Characteristics

The socio economic background characteristics of all respondents as presented in Table2 shows that the majority of couples (84%) were rural residents and Orthodox Christians (97.9%). In terms of education, wives were less educated than husbands; with approximately 92% of wives and 74% of husbands had no formal education. About 5% of wives and 22% of husbands have primary school education, and around 3.4% of wives and 4% of husbands had secondary and above education. Regarding their occupation, the majority of wives (87%) and husbands (88%) were housewives and farmers respectively. Only 1.8% of wives and 3.3% of husbands were employed in government sectors. As far as the exposure to mass media is concerned, more than half of the respondents in both sexes had no exposure to media (radio and television). This means, 58% of wives and 55% of husbands had no exposure to media, while 37% of wives and 41% of husbands had the exposure to radio. It is also illustrated that around 4% of wives and husbands each had the exposure to both radio and television.

Table 2: Percentage distribution of currently married men and women by reported socio-economic characteristics, West ***Belessa Woreda***, 2008.

Socio-economic characteristics	Women		Men	
	No	%	No	%
Place of residence				
Urban	107	16.2	107	16.2
Rural	555	83.8	555	83.8
Education				
Illiterate	601	90.8	393	59.4
Read and write	6	0.9	96	14.5
1 – 8	33	5	147	22.2
9 – 12	15	2.3	13	2
12+	7	1.1	13	2
Religion				
Orthodox	648	97.9	648	97.9
Others	14	2.1	14	2.1
Occupation				
No work	71	10.7	3	0.5
Farmer	-	-	580	87.5
House wife	575	86.9	-	-
Merchant	2	0.3	41	6.2
Daily laborer	2	0.3	16	2.4
Government employee	12	1.8	22	3.3
Ethnicity				
Amhara	660	99.7	661	99.8
Others	2	0.3	1	0.2
Exposure to media				
No exposure	389	58.3	366	55.3
Exposure to radio	245	37	269	40.6
Exposure to Radio and TV	28	4.2	27	4.1

***Source*; Field survey, 2008.**

3.2. Demographic Characteristics

As far as the demographic background characteristic of respondents is concerned, Table 3 illustrates that marriage is relatively early in wives. 97% of wives and 37% of husbands married before the age of 20. Only 3% of women married after the age of 19. About 44% and 19% of husbands married in the age group between 20-24 and 25 and above respectively. The table also indicates that 30% of wives and 7% of husbands were in the age group 15-24, and 52% of wives and 43% of husbands were in the age group 25-34. It is also indicated that 18% of wives and 50% of husbands were found in the age 35 and above.

Table 3 also depicts that 12.1% of wives and 11% of husbands did not give birth at all. 41.5% of wives and 41.2% of husbands had 1-3 ever born children and 46.4% of wives and 48% of husbands had four or more ever born children. In table 3, one can easily understand that 12.4% of wives and 11.2% of husbands had no living children. 48.5% of wives and 48.6% of husbands had 1 to 3 living children and 39.1% wives and 40.2% of husbands had four or more living children. It is also illustrated in the table that about 26.4% of wives and 26% of husband had one or more children died. Regarding age at birth, around 73% and 25% of wives gave birth to their first child with in age before 20 and between 20 and 24 respectively. About 47% and 50% of husbands gave birth to their first child when their age was between 20-24 and 25 and above. The current reproductive status of women is illustrated in table 3. About 10.4% and 10.6% of women were currently pregnant and amenorrheic (who gave birth in the last six months) respectively. The rest, 79% were neither of the two.

Table 3: Percentage distribution of currently married men, and women by reported demographic characteristics, west ***Belessa Woreda***, 2008

Demographic Characteristics	Women		Men	
	No	%	No	%
Age				
15 – 24	191	29.6	46	7
25 – 34	338	52.3	282	43
35+	117	18.1	328	50
Age at first marriage				
< 15	237	48	14	2.8
15 – 19	240	48.6	174	34.3
20 – 24	13	2.6	224	44.2
25+	4	0.8	95	18.7
Age at first birth				
< 15	67	16.5	-	-
15 – 19	228	56	12	3.4
20 – 24	100	24.6	165	46.9
25+	12	2.9	175	49.7
Number of living children				
None	82	12.4	74	11.2
1 – 3	321	48.5	322	48.6
≥ 4	259	39.1	266	40.2
Number of ever born children				
None	80	12.1	71	10.7
1 – 3	275	41.5	273	41.2
≥ 4	307	46.4	318	48
Number of dead children				
0	487	73.6	490	74
1	95	14.4	84	12.7
> 1	80	12.0	88	13.3
Current Reproductive status				
Pregnant	69	10.4	-	-
Amenorrheic	70	10.6	-	-
neither	523	79	-	-

***Source*; Field survey, 2008.**

3.3. Family Planning Characteristics

Knowledge of the method here simply means that a respondent has heard of it, but it does not imply respondent knows of how to use it or knows where to obtain the service. As a result, around 31% of wives and 17% of husbands have not heard of any family planning method. 51% of wives and 18% of husbands knew utmost two methods, and 18.3% of wives and 66% of husbands knew at least three contraceptive methods. From this, one can understand that husbands knew a wide range of methods than wives. Regarding the knowledge of places where family planning services are provided, 31% of wives and 17% of husbands did not know any place where to obtain. 64% of wives and 44% of husbands knew utmost two places and 5% of wives and 39% of husbands knew at least three places as to where contraceptive services are provided (table – 4).

Table 4 illustrates that wives and husbands who approved the use of contraceptive methods in order to avoid unwanted or mistimed pregnancy were about 81% and 91% respectively. It is also revealed in the table that around 65% of wives and 53% of husbands have never discussed with partners issues concerning family planning. 22% of wives and 19% of husbands have discussed utmost two time and the rest, 13% of wives and 28% of husbands have discussed at least three times in the past 6 months with their partners about contraceptive methods.

Table 4 also indicates that 69% of wives and 56.4% of husbands have never discussed with health extension workers about family planning methods. 31% of wives and 43.6% of husbands have discussed at least once in the past three months with health extension workers about contraceptive methods. As indicated in Table 4, the main source of information about contraceptive methods was health extension workers, which account for 50.3% for wives and 64% for husbands. This clearly shows that the role of health extension workers as a source of information for family planning is useful and in which case may affect the level of knowledge of potential users. Regarding the attitude towards contraceptives, 68% of wives and 91.2% of husbands reported that they had the intention to know more about contraceptive methods.

Respondents were also asked as to whether they had any accessible site as a source of contraceptive methods. Health stations and health posts were the most accessible sites in that 44.5% of wives and 76.5 of husband, and 78.2% of wives and 94.7% of husbands reported as source of methods respectively. As one can understand from the above figures, the availability of health posts in each kebele in the study area, made the potential users more accessible to contraceptive methods.

Table 4: Percentage of currently married men and women by reported Knowledge and attitude of FP, west ***Belessa Woreda***, 2008.

Characteristics	Women		Men	
	No	%	No	%
Knowledge of FP				
Do not know	204	30.8	112	16.9
Know utmost two	337	50.9	116	17.5
Know at least three	121	18.3	434	65.6
Knowledge of places FP services provided				
Do not know	204	30.8	112	16.9
Utmost two places	422	63.8	292	44.1
At least three places	36	5.4	258	39
Discussion of FP with partner				
Never discussed	426	64.6	349	52.7
One or two times	147	22.3	124	18.7
Greater than 2 times	86	13.1	189	28.5
Approval of FP				
Approve	535	80.8	599	90.5
Disapprove	127	19.2	63	9.5
Discussion of FP with health extension workers				
Never discussed	452	69	372	56.4
Discussed at least once	203	31	288	43.6
Source of information about contraceptives *				
Health extension workers	333	50.3	424	64
Radio	143	21.6	356	53.8
Television	28	4.2	141	21.3
Friends	78	11.8	282	42.6
News paper	6	0.9	179	27
Spouse	20	3	181	27.3
School	8	1.2	154	23.3
Intention to know more about contraceptives				
Yes	448	67.7	604	91.2
No	214	32.3	58	8.8
Sources of contraceptive methods *				
Hospital	30	7.1	245	46.8
Health station	188	44.5	401	76.5
Health post	330	78.2	496	94.7
Shop	6	1.4	197	37.6
Pharmacy	12	2.8	223	42.6
ADA RH project center	10	2.4	127	24.2

ADA RH=Amhara Development association Reproductive Health project.

* Multiple responses.

***Source*; Field survey,2008.**

As it is illustrated in Table 5, 39.7% of wives and 1.7% of husbands were ever users of contraceptive methods, and 29% of wives (23.8% for spacing and 5.2% for limiting) and 0.5% of husbands (both for spacing) were currently practicing contraceptive methods.

In the same table, it is also illustrated that 29.5% of wives and 54.8% of husbands who were not currently practicing contraception had the intention to use contraceptive methods. Those non-users of contraceptives were asked to list down number of reasons that hindered them from the practice of certain contraceptive methods. Findings show that the desire for more children was 63.8% for wives and 64.7% for husbands. The health concern was 23.8% for wives and 36.6% for husbands. Regarding side effects, 10.7% for wives and 37.5% for husbands; while lack of knowledge was 22.4% for wives and 31% for husbands. Concerning spousal disapproval 15.7% was for wives and 12.1% for husbands respectively. These were, therefore, the main reasons for not practicing contraceptive methods.

In Table 6, the need status of women, men and couples are illustrated. According to the illustration, 29% of women have met their need, 39.5% of them had unmet need and 31.5% of them were neither of the two. The need status of men is also indicated as 28.5%,47% and 24.5% met need ,unmet need and otherwise respectively. The minimum and maximum couple unmet need were 29.5% and 57.5% respectively.

Table 5: Percentage of currently married wives and husbands by intention to use modern contraceptive methods, West *Belessa Woreda*, 2008

Characteristics	Women		Men	
	No	%	No	%
Ever use of any modern contraceptive method	263	39.7	11	1.7
Yes	399	60.3	651	98.3
No				
Current use of modern contraceptives	187	29	3	0.5
For spacing	153	23.8	3	0.5
For limiting	34	5.2	-	-
Intend to use contraceptive methods				
Yes	195	29.5	360	54.8
No	254	38.4	297	45.2
Reasons not intend to use contraception *				
Side effect	46	10.7	248	37.5
Health concern	102	23.8	242	36.6
Lack of knowledge	96	22.4	205	31
No preferred method	44	10.3	193	29.2
Spousal disapproval	67	15.7	80	12.1
Religion prohibition	47	11	60	9.1
Family disapproval	10	2.3	71	10.7
Death of child	22	5.1	59	8.9
Desire more children	273	63.8	428	64.7

* Multiple responses

***Source*; Field survey, 2008.**

Table-6 Percentage Distribution of Currently Married Couples, Men and Women, by Reported Need Status, West ***Belessa woreda***, 2008.

characteristics	**Number**	**Percent**
Need status of women		
-met need	187	29
-unmet need	254	39.5
-indifferent	203	31.5
Need status of men		
-Met need	184	28.5
-unmet need	304	47
-indifferent	158	24.5
Minimum couple unmet need		
-yes	186	29.5
- no	444	70.5
Maximum couple unmet need		
-yes	374	57.5
-no	277	42.5

***Source*; Field survey, 2008.**

Chapter Four

4. Determinants of Unmet Need for contraception

This chapter presents the bi-variate and multivariate analysis of couple's unmet need for contraception by socioeconomic, demographic and family planning variables. In this study, couples unmet need refers to couples (wives and husbands combined) who want no more children or want to delay at least two years before the birth of another child, but are not practicing contraception. Accordingly, in the current study, it is found that the proportion of couples in which both partners who wanted to limit/space birth but were not practicing any contraception (couple unmet need) was 29.5%.

4.1 Bi-variate Analysis

4.1.1 Unmet Need and Socio economic characteristics

Residence: As it is illustrated in Table 7, among couples those who were residing in rural areas, 30.3% have unmet and about 26% of urban dwellers have unmet need for contraception. The result implies that respondents who were residing in urban areas have lesser unmet need that may be due to the higher contraceptive prevalence (46% in urban and 29% in rural areas). The availability of services and better awareness about contraceptives may have contributed to higher contraceptive prevalence and lower unmet need in urban areas. The focus group discussion conducted in Aiseg kebele supported the above explanation. Participants responded that pills, Depo provera and condom are the only accessible methods which are available in the health post in the kebele. According to the discussants, other methods such as IUD, Norplant and other modern methods are provided in urban areas far away. Moreover, the discussants explained that there is no transportation facility to go and obtain the service at the nearest town. One of the discussants in Kallai kebele also *said **I need to use irreversible contraceptive methods, not to have more children, but the health center, found in the woreda, referred me to Godar town (on average 70 kilometers away from their residence) but I do not have money for transportation and other expenses.***

Education:-It is shown in the same table that the level of unmet need varies with the educational level of respondents. Among women whose education was below primary, 30.2% have unmet need and those whose education was at least primary, 22.2% have unmet need for contraception. With regard to the educational level of husbands, among those with no schooling, 29% have unmet need, and of those whose education was primary or above 32% have unmet need for contraception. It is expected that respondents with better education have lower unmet need may be due to the indirect effect of education on contraceptive use through knowledge of contraceptives and awareness to the source of supply (Mekides, 2003). However, the current study shows the reveres. This may be the fact that the type of job they engaged may not have the exposure to increase their awareness about family planning; though they have better education (only 3.3% of men are employed in government sectors).

Occupation:-Table7 reveals that 30.4% of husbands who were participating in agricultural activities and 23.5% of husbands who engaged in non agricultural activities (merchant, government employee) have unmet need for contraception. Concerning women's occupation, among wives who were working at home (housewife) and among those who were working away from home 30.7% and 17% have unmet need respectively. The result indicates that husbands engaged in non agricultural activities and wives working out side home have lesser unmet need. This may be due to the fact that they are assumed to be more educated, more exposed to the out side world and have knowledge of modern contraceptive methods. Hence, they are expected to be users of contraception more likely than their counterparts.

Exposure to mass media: it is also one of the variables that affect couples potential demand for family planning. Couples who have been exposed to various mass media such as radio and television are less likely to have unmet need than those who have not been exposured. Studies conducted in Amhara region revealed that among married women not exposed to media, 88.9% have unmet need and among those who had exposure to media, 67.6% have unmet need (Mekides 2003). However, the current result shows that 29% of women who had no exposure to media and 32% of women who had exposure to media have unmet need respectively. The same trends have been observed for men i.e. 28% of husbands who had no exposure to media and 31% of husbands who had exposure to

4.1.2 Unmet Need and Demographic Characteristics

Age:-Table 8 shows that husbands who were in the <25 age group and wives who were between 25-34 age group had the highest unmet need for contraception. However, unmet need fluctuated with both husbands and wives age.

Age at first marriage:-It is generally accepted that early marriage lengthens the reproductive span in which conception can occur. As a result age at first marriage has the influence on the level of unmet need. Table 8 depicts that the level of unmet need decreases with increase of women age at first marriage. The level of unmet need was 36.3% while the age at firs marriage was less than 15 and it was 20.2% while the age at first marriage of women was greater than or equal to 15. The bi-variat result indicates that women's age at first marriage is significantly associated with couple unmet need (P<0.001).

Age at first birth:-the same Table 8 illustrates that unmet need is higher among women who gave birth in the early age. Among women who gave birth in the age group less than 15, 50% have unmet need, among those who gave birth in the age group between 15 and 19, 35.6% have unmet need and those who gave birth in the 20+ age group, 13.2% have unmet need for contraception. The result indicates that the level of unmet need decreases with increasing age of women at first birth. Hence, in this bi-variate analysis, age of women at first birth is found to be a strong determinants of couple's unmet need (P<.001). The result suggests that women who gave birth at an early age might achieve the desired number of children that they want to have at an early age than those who gave birth in the latter ages. As a result unmet need would be higher among women who gave birth in the early age. One of the young discussants in Aiseg kebele said ***I married early and gave birth to my first child when I was 16 and now I have four children. Before a year I knew nothing about contraceptives but now thanks to the health extension workers I know various types of methods and where to obtain. As a result I am ready to use in the near future because I achieved the number of children I want to have.***

Children ever born and living children:-All respondents (husbands and wives) were asked about the number of children ever born and living children in the household. However, little difference has been observed among wives and husbands. As s result the

4.1.2 Unmet Need and Demographic Characteristics

Age:-Table 8 shows that husbands who were in the <25 age group and wives who were between 25-34 age group had the highest unmet need for contraception. However, unmet need fluctuated with both husbands and wives age.

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Children ever born and living children:-All respondents (husbands and wives) were asked about the number of children ever born and living children in the household. However, little difference has been observed among wives and husbands. As s result the

investigator checked the reported numbers given by both wives and husbands in some selected households. And hence, number of children reported by wives has been found to be included in the household. In case of husbands, they reported children who were born from divorced wives and were not currently living with them. Hence, it is believed that children who are living in the household have an influence on unmet need for contraception. Due to this, the number reported by wives is used throughout the analysis.

As it is illustrated in Table 8 among couples with no ever born child, 21.3% have unmet need, among those who had 1-4 ever born children, 27.3% have unmet need and those who had five and above ever born children, 37.2% have unmet need for contraception. Concerning the number of living children, among couples who had no living child in the household, 22% have unmet need, among those who had 1 to 4 living children, 29.6% have unmet need and among those who had five or above children, 33.8% have unmet need for contraception. It is found that the level of unmet need increases with the number of both ever born and living children in the household. The focus group discussion conducted among old women in *kallai* kebele supported the above idea. They suggested that they faced many problems like economic and health (mother's health) problems because of having many children in the household. One of the same discussants said, ***we could not satisfy our children's interest because of their number. They always are nagging my husband and me to fulfill all what they need, like their friends.***

Table 8 percentage distribution of couples who have unmet need, by Demographic characteristics, west *Belesa Woreda* 2008

Characteristics	Couples unmet need				
	Yes	No	Total		
	No (%)	No (%)	No (%)	X2	P. Value
Age of women					
< 25	85(28.9)	209(71.1)	294(100)		
25-34	69.(32.7)	142 (67.3)	211(100)		
35 +	32(28.8)	79 (71.2)	111(100)	0.957	0.62
Age of men					
< 25	14(31.8)	30(68.2)	44(100)		
25-34	78(28.9)	192(71.1)	270(100)		
35 +	93(30)	217(70)	310(100)	0.192	0.908
Age at first marriage (women)					
< 15	81(36.3)	142(63.7)	223(100)	15.275	0.000
≥ 15	50(20.2)	198(79.8)	248(100)		
Age at first birth (women)					
< 15	7 (50)	7 (50)	14(100)		
15-19	95(35.6)	172(64.4)	267 (100)	20.87	0.000
20+	14 (13.2)	92 (86.8)	106(100)		
Ever born children					
None	17(21.3)	63(78.8)	80(100)		
1-4	99(27.3)	263(72.7)	362(100)		
>4	70(37.2)	118(62.8)	188(100)	8.827	0.012
Number of living children					
None	18(22)	64(78)	82(100)		
1-4	120(29.6)	286(70.4)	406(100)		
>4	48(33.8)	94(66.2)	142(100)	3.510	0.173

***Source*; Field survey, 2008.**

4.1.3 Unmet need and family planning characteristics

4.1.3.1 Knowledge of contraceptive methods

As it is illustrated in the background part, knowledge of the method means that a respondent has heard of any method. Here, the discussion on knowledge about contraceptive methods is based on eight major methods such as pills, IUD, injectable, Norplant, condom, female sterilization, male sterilization and natural methods (abstinence and withdrawal). Table 9 shows that among women who did not know (hear) any method 40% have unmet need, among women who knew utmost two methods 27.7% have unmet need and those who knew at least three methods 16.9% have unmet need for contraception. The same trend is observed in husbands, 64.2%, 31% and 27% have unmet need among those who did not know any method, knew utmost who methods and knew at least three methods, respectively. It is observed that unmet need decreased with the increased number of method known to wife and husband. This may be because couples who know a number of methods are likely to become users of methods. One of the male discussants in *Arbaya* town said, ***we (my wife and me) know only condom, depo provera and pills. Thinking that condom may decrease satisfaction, still we did not use it. My wife tried to use the other two methods, but they are not suitable for her health. As a result, we stopped using because of fear of side effects and we are continuing to child bearing.***

4.1.3.2 Couples Discussion about contraceptives, Respondents were asked about discussion of family planning issues with spouses in the past six months. As a result, among couples who did not discussed at all, 42% have unmet need and couples who discussed at least once, 20.6% have unmet need for contraception. Open discussion between wives and husbands about the number of children they want to have and the use of contraceptives lead them to practice methods. As a result the level of unmet need become less. Focus group discussion conducted among males in *Arbaya* town revealed that discussion between couples about the number of children and types of contraceptive

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methods initiates them to use the methods. The discussion may help them to arrive in decision to use contraceptives.

4.1.3.3 Availability of family planning services, Regarding the availability of family planning services, respondents were asked the availability of centers in which services are provided in their surrounding. The availability of six major service providing centers such as hospitals, health stations, health posts, pharmacy, shop and *Amhara* Development Association (ADA) reproductive health center were asked. As illustrated in table 9, among respondents who did not have any access, 40% of wives and 35.3% of husbands have unmet need, and among those who had at least one service providing center, 23.5% of wives and 27.8% of husbands have unmet need for contraception. The result depicts that despite the tendency to use contraception, a very high percent of couples are not practicing family planning services.

4.1.3.4 Sources of information about contraceptives

Exposure to different channels of family planning information is one of the factors that have bearing on current use of contraception. Table 9 shows that 38.8% of wives and 35.7% of husbands who did not have any access of family planning information have unmet need and 25.2% of wives and 28.2% of husbands who had at least one channel of family planning information have unmet need for contraception.

4.1.3.5 Discussion of women with health extension workers

Table 9 depicts among wives who did not discuss with health extension workers, 35.4% have unmet need and among those who discussed with them about family planning issues 17% had unmet need for contraception. This implies that the role of health extension workers in bringing couples to beneficiaries of contraception is useful and decreased the level of unmet need. One of the discussants in *kallai* kebele *said, **I am uneducated and always working at home. I did not have any information about contraceptive methods. As a result I gave many births (she did not tell the number of children, because of***

cultural factors). However, after the health extension workers came to our kebele, they are giving information about the type of contraceptives, how to use and where to obtain services, at church, on different meetings and even at home in person. The discussion also helps us to avoid negative rumors about side effects of contraceptive methods. Due to this I reached on decision to use contraceptive methods.

4.1.3.6 Women's Ever use of contraceptives, Table 9 illustrates that among women who were not ever users of contraception, 44.3% have unmet need and among those ever users 7.2% have unmet need for contraception. It is because, ever users are familiar with contraceptive methods that makes easy to practice while they want to use any method.

Table 9 percentage of couples with unmet need, by knowledge and attitude of Family Planning methods, west ***Belesa Woreda***, 2008

Characteristics	Couples unmet need				
	Yes	NO	Total		
	No (%)	No (%)	No (%)	X2	P. Value
Ever use of modern contraceptives (women)					
Yes	18(7.2)	233(92.8)	251(100)	100.187	0.000
No	168(44.3)	211(55.7)	379(100)		
Knowledge of Contraceptives (women)					
Do not know	78(40.2)	116(59.8)	194(100)		
Know utmost two	88(27.7)	230(72.3)	318(100)	20.13	0.000
Know at least three	20(16.9)	98(83.1)	118(100)		
Knowledge of contraceptives (men)					
Do not know	39(64.2)	70(64.2)	109(100)		
Know utmost two	36(32.7)	74(67.3)	110(100)		
Know at least three	111(27)	300(73)	411(100)	3.844	0.146
Couples discussion					

- Not at all - At leas once	110(42) 76(20.6)	151(57.9) 293(79.4)	261(100) 369(100)	34.11	0.008
Discussion of women with health extension workers - never - at least once	150(35.4) 35(17)	274 (64.6) 164 (82.4)	424(100) 199(100)	20.53	0.000
Availability of services (women) - do not have - at least one	92(40) 94(23.5)	138(60) 306(76.5)	230(100) 400(100)	19.107	0.000
Availability of services (men) - do not have - at least one	48 (35.3) 138(27.9)	88 (64.7) 356(72.1)	136(150) 494 (100)	2.775	0.096
Women's source of information about contraceptives - do not have - at least one	78(38.8) 108(25.2)	123(61.2) 321 (74.8)	201(100) 429(100)	12.223	0.000
Men source of information about contraceptives - do not have - at least one	41(35..7) 145(28.2)	74(64.3) 370(71.8)	115(1000) 515(100)	2.539	0.111

***Source*; Field survey, 2008.**

4.2. Multi-variate Analysis

In the previous part of the chapter, the bi-variate analysis was carried out to examine the different effect of couple's characteristics on their unmet need for contraception. In other words, the chi-square test detected whether there is a significant association between two categorical variables, i.e., unmet need for contraception and various independent variables mentioned in the previous part of the chapter. Tables 7, 8 and 9 show that chi-

square tests of each predictor variables in relation to the outcome variable. However, chi-square test doesn't say anything about how strong that association might be (doesn't consider confounding effects). As a result logistic regression analysis is applied to identify the relative importance of the various independent variables (occupation, number of living children, education, knowledge of family planning methods, place of residence, discussion about family planning methods, (with partner and health extension workers), availability of family planning services and age of respondents) in relation with the dependent variable, unmet need for contraception. The goodness of fit test is performed to the model by using Hosmer and Lemeshow's goodness of fit test and the percentage is 69.5.

Results of logistic Regression Analysis

Logistic Regression Analysis shows that the significant variables are couple's number of living children, Discussion of women with health extension workers and couples discussion about family planning. In the model 609 unweighted cases were included in the analysis. The interpretation of those correlates of unmet need for contraception and possible explanation are discussed in the subsequent paragraphs.

4.2.1. Spousal Discussion about Family Planning and Unmet Need

Spousal communication is found to be strongly and negatively associated with couple's unmet need. Discussion about family planning in the past 6 months is categorized into two groups, those respondents who have never discussed about family planning with their spouses, and those respondents who discussed once or more in the past 6 months. The first group (those who have never discussed), is taken as a reference category. In Table 10, the odds ratio Exp (B) = 0.470 for those who discussed at least once, tell us that couples who discussed with their spouse about family planning at least once are 53% less likely to have unmet need than the reference category. The finding is consistent with the bi-variate analysis in the previous part of the chapter and the prior studies (Mekides, 2003, Omwago and Khasakhala, 2006) where unmet need decreases with increase in the frequency of couple's discussion (the hypothesis, frequent spousal communication on

family planning issues negatively affects couples unmet need for contraception is accepted).

4.2.2 Number of Living Children and Unmet Need

Number of living children has three categories, of which the last category (couple who have five or more children) was selected as a reference category for analysis. It is found that all categories have made a statistically significant contribution at p<o 0.05 to explain unmet need for family planning. Thus, couples who have no child are 69% less likely to have unmet need than the reference category and couples who have one to four children are 40% less likely to have unmet need for contraception than the reference category. However, the finding is not in line with the result in the bi-variate analysis. This may be because of the fact that other Confounding factors made the association insignificant in the bi-variate analysis. These findings are found to be conformal to the hypothesis, the level of unmet need increases with increasing number of living children.

4.2.3. Discussion of Women with Health Extension Workers and Unmet Need

Discussion with health extension workers about family planning is found to be strongly associated with couple's unmet need. Discussion with health extension workers about family planning in the past three months is categorized into two groups, those who have never discussed and those who discussed at least once in the past three months. The first group (those who have never discussed) is taken as a reference category. In Table 10,the odds ratio Exp (B) =0.563 for those who discussed at least once indicates that women who discussed with health extension workers about family planning at least once in the past three months are 44% less likely to have unmet need for contraception than the reference category. The findings are found to be conformal to the hypothesis (frequent discussion of women with health extension workers decrease the likelihood of unmet need) and bi-variate results at a statistically significant level of P<O.05.

4.3 Discussion of the Results

The results have shown that the level of unmet need for couples was much lower than that of married women or men separately, i.e. 29.5 percent as compared to 39.5 and 47 percent for women and men respectively. It is evident that incorporating men in the estimation of unmet need is important in reducing the level of unmet need for contraception in the study area. The unmet need for couples in West *Belessa Woreda* (29.5%) was much higher than that of developing countries like Kenya (16.5%)(Omwago and Khasakhala, 2006). It is also observed that unmet need among married women (39.5%) was much higher than that of prevailing in Ethiopia (34%) and *Amhara* region (30%) (CSA and ORC Macro,2005).

From the present study it appears that the likelihood of having unmet need increases with the number of living children. Couples who have more living children are more likely to have unmet need than those who have fewer children or none at all. The result is consistent with earlier studies (Sahelu, 2007). Omwago and Khasakhala (2006) also found unmet need to be high among couples with more living children. This possibly seems that couples are aware of the consequences of having many children both on the economy of the family and the health of mother.

Spousal communication is found to be strongly associated with couple's unmet need. Couples who made frequent discussion about family planning have lesser unmet need for contraception. This is due to the fact that husband-wife communication on matters pertaining to family planning and reproductive health provides an enabling environment for couples to implement their fertility desires and contraceptive needs. This is in line with previous studies conducted by mekides (2003).

Discussion of women with health extension workers about family planning was found to be one of the key factors in changing patterns of contraceptive use. The finding that discussion of women with health extension workers significantly and negatively affects the level of unmet need is of fundamental importance for future strategies. Discussion about reproductive health issues enhances the utilization of family planning services. The

health extension workers can help them find ways to deal with side effects or advice to different methods which lead them to be beneficiaries of services.

There is an obvious gap between knowledge and use of contraceptives among those who have positive attitudes towards family planning, particularly in husbands. Not all who know about contraceptives practice it. This is due to many reasons including, limited access to services, fear of side effects, health concern, spousal and familial disapproval, and religious prohibition. These groups need a more effective communication, consultation and advice in addition to making the service accessible.

Although socio economic and demographic factors were important in determining couples unmet need, majority of them proved rather insignificant, for example, residence, education, age and occupation. Residence and women's education have been shown in other studies as key factors that may determine the use of family planning methods. The same case applies with family planning factors such as knowledge of family planning methods and availability of services. These are also the main factors in prior studies that showed a negative influence on unmet need for contraception (Mekides, 2003).

Table 10 Results of logistic Regression Analyses on unmet need for contraception, west Bellesa Woreda, 2008

Variable	B`	S.E	Sig	Exp(B)
Number of living children				
▪ None	-1.178	0.373	0.002	0.308
▪ 1-4	-0.504	0.255	0.048	0.604
▪ >4(RC)	0.000	-	-	1.000
Discussion of women with Health extension workers				
▪ Never discussed (RC)	0.000	-	-	1.000
▪ at least once	-0.574	0.261	0.028	0.563
Availability of services (for women)				
▪ do not have (RC)	0.000	-	-	1.000
▪ at least one center	-0.253	0.397	0.523	0.776
Women education				
▪ No schooling (RC)	0.000	-	-	1.000
▪ Primary and above	-0.187	0.403	0.643	0.829
Spousal discussion				
▪ Not at all (RC)	0.000	-	-	1.000
▪ at least once	-0.755	0.223	0.001	0.470
Women occupation				
▪ House wife (RC)	0.000	-	-	1.000
▪ Others	0.405	0.451	0.370	0.667
Couples Residence				
▪ Urban (RC)	0.000	-	-	1.000
▪ Rural	0.341	0.440	0.438	1.407
Knowledge of family planning (women)				
▪ Do not know (RC)	0.000	-	-	1.000
▪ Know utmost two	-0.011	0.396	0.977	0.989
▪ Know at least three	-0.422	0.493	0.392	0.655
Age of women - <25 (RC0	0.000	-	-	1.000
- 25-34	0.196	0.220	0.372	1.216
- 35+	-0.337	0.293	0.250	0.714
Men occupation,				
. Farmer (RC)	0.000	-	-	1.000
.Others	-0.108	0.499	0.829	0.898

Note- RC- Reference category, P< 0.05 - significant

Source; **Field survey, 2008.**

Chapter- Five

5. Summary, Conclusions and Recommendations

5.1 Summary

The Objective of the study is to identify the most important, socio-economic, demographic and family planning factors that influence couples' unmet need for contraception in the northern part of Ethiopia a place known as West *Belessa Woreda.* The study was based on 662 randomly selected currently married couples with women of reproductive age.

In terms of residence, about 84% of couples were in rural areas. As far as religion is concerned, about 98% of couples belonged to the Ethiopian Orthodox Church. Regarding the occupation of respondents, the majority of wives (87%) and husbands (88%) were housewives and farmers respectively. Only 1.8% of wives and 3.3% of husbands were employed in government sectors. With respect to education, 92% of wives and 74% of husbands had no schooling. More than half of the respondents in both sexes (58.8% of wives, and 55.3% of husbands) had no exposure to mass media.

As far as age at first marriage is concerned, 97% of women married below the age of 20 and 63% of husbands married above age 19. 12.1% of wives and 11% of husbands didn't give birth at all. About 42% of wives and 41% of husbands had one to three EBC (ever born children), and 46.4% of wives and 48% of husbands had four or more EBC. Regarding number of living children, 48.5% of wives and 48.6% of husbands had 1-3 living children, and 39.1% wives and 40.2% of husbands had four or more living children. 73% of wives gave birth to their first child before age 20. Concerning the current reproductive status of women, 10.4% of them were pregnant, 10.6% of them are amenorrheic and 79% were neither of the two.

Concerning knowledge of family planning, 69% of wives and 84% of husbands have heard (known) at least one method. Regarding the knowledge of places where family planning services are provided, 31% of wives and 17% of husbands did not know any site where to obtain services. About 69% of wives and 83% of husbands knew at least one

place where services are provided. As far as the places which are accessible to the respondents as a source of contraceptive methods, Health stations and Health posts were the most accessible sites that about 45% of wives and 77% of husbands, and 78% of wives and 95% of husbands reported as a source for family planning methods respectively. Wives and husbands who approved the use of contraceptives in order to avoid unwanted or mistimed pregnancies were about 81% and 91% respectively. Around 65% of wives and 53% of husbands never discussed with partners concerning family planning issues. On the other hand, 69% of wives and 56.4% of husbands has never discussed with Health extension workers about family planning. However, Health extension workers were the main source of information about family planning which accounts 50.3% for wives and 64% for husbands. About 40% of wives and 1.7% of husbands were ever users of contraceptive methods, and 29% of wives and 0.5% of husbands were currently practicing contraceptive methods.

Around 30% of wives and 55% of husbands who were not currently practicing contraception had the intention to use contraceptive methods. Desire for more children, health concern, side effects, lack of knowledge and spousal disapproval were the most important factors that hindered non-users from the practice of certain contraceptive methods, which accounted 64%, 24%, 11%, 22.4%, and 16% for wives, and 65%, 37%, 38%, 31%, and 12% for husbands respectively. As far as the need status is concerned, 29% of wives and 28.5% of husbands, had met the need of contraceptive methods, and 39.5% of wives and 47% of husbands had unmet need. About 29.5% and 57.5% of couples had minimum and maximum unmet need for contraception respectively.

Unmet need varies by place of residence. In urban areas, 26% of couples and about 30% of couples who resided in rural areas had unmet need for contraception. Unmet need declined as the level of women education increase. Among women who had no formal education, 30% had unmet need and those whose education is at least primary, 22% had unmet need. But with respect to husbands' education, unmet need seems to the reverse, i.e. they have positive relationship. Among men with no formal education, 29% had unmet need and those with at least primary level, 32% had unmet need. With regard to

occupation of respondents, 30% of husbands who engaged in agricultural activities have unmet need, and among those who are participating in non agricultural activities, 24% have unmet need. Among women who were working at home, and those who are working away from home 31% and 17% have unmet need respectively.

In terms of exposure to mass media, among couples who had exposure to mass media, 29% of wives and 28% of husbands have unmet need, and among couples who had exposure to media, 32% of wives and 31% of husbands have unmet need. In many studies revealed that the exposed groups have lower unmet need than none exposed. However, the current study shows the reverse. This may be because; since majority of couples are illiterate they may not give due attention to family planning program transmitted though radio or television.

Concerning age at first marriage, the level of unmet need decreases with the increase of women's age at first marriage. Unmet need was 36.3% for women who got married before the age of 15 , and it is 20.2% for women who married after age 15.

The same trends have been observed with age at first birth i.e. unmet need increases with decrease of age at first birth. Among women who gave birth in the age group less than 15, 50% have unmet need, and among those who gave birth in the age group between 15-19, 35.6% have unmet need. It is also illustrated that among those who gave birth in the 20 and above age group, 13.2% have unmet need for contraception.

Regarding ever born and living children, it is found that the level of unmet need increases with number of ever born and living children. Among couples with no ever born child, 21.3% have unmet need, among those who had 1-4 children 27.3% have unmet need and among those who had five or more children 37.2% have unmet need for contraception. And among couples who had no living child, 22% have unmet need, among those who had 1-4 living children 29.6% have unmet need and among those who had five or more living children 33.8% have unmet need for contraception.

As far as discussion among spouses is concerned, the level of unmet need decreases with frequent discussion among spouses. Among couples who didn't discussed at all, 42% have unmet need and among those who discussed at least once. 20.6% have unmet need. Concerning the availability of centers in which services are provided, among respondents who had no any accessible center, 40% of wives and 35.3% of husbands have unmet need, and those who had at least one accessible service providing centers, 23.5% of wives and 27.9% of husbands have unmet need for contraception.

With respect to channels of family planning information, among couples who did not have any access to family planning information, 38.8% of wives and 35.7% of husbands have unmet need, and among those who had at least one channel, 25.2% of wives and 28.2% of husbands have unmet need for contraception. Regarding discussion with health extension workers, among women who did not discussed, 35.4% have unmet need and among those who discussed at least in the past three months, 17% have unmet need.

After fitting explanatory variables in the model to predict the change in unmet need for contraception of couples in Wes *Belessa Woreda*, the result of the logistic regression analysis showed that:

- Most of the variables have categories that have no statistically significant contribution to explain the dependent variable at $p< 0.05$ level.
- Some explanatory variables have categories that have made a statistically significant contribution at $p < 0.05$ level to explain the dependent variable.
- The analysis identified some variables as determinants of unmet need. These are: number of living children, couples discussion about family planning and discussion with health extensions workers about family planning.

The findings of multivariate analysis have confirmed the hypotheses that proposed as the number of living children increase, the level of unmet need increase, frequent discussion between couples and among women and health extension workers decrease the level of unmet need. The logistic findings do not conform to the hypothesis; women's education is negatively associated with unmet need.

5.2. Conclusions and Recommendations

The study set out to estimate the level of unmet need using a couple approach and to determine the significant factors affecting couple unmet need in west *Belessa woreda*, with particular focus on the extent to which socio-cultural, demographic and family planning factors exert independent influence on contraceptive use. The results have shown that the level of unmet need for couples (minimum couple unmet need) was much lower than that of married women or men separately, that is, 29.5 percent as compared to 39.5 and 47 percent for women and men, respectively.

From the present study it appears that discussion among couples about family planning issues has a significant effect on unmet need for contraception. Discussion among couples regarding family planning has paramount importance in cultures like ours where reproductive health issues are not discussed openly.

A frequent discussion of women with health extension workers about family planning issues is one of the factors that have an effect on unmet need. The finding indicated that the level of unmet need decreases as there is a frequent discussion among women and health extension workers. It indicates that discussion among them may possibly avoid the fear of side effects that are told but are not related with methods. In addition, it may help them to know a wide range of contraceptives.

Another conclusion that can be reached in this study is that number of living children in the household is one of the most important factors that positively influences couples unmet need. This possibly seems that couples are aware of the consequences of having many children both on the economy of a family and the health of a mother.

In general, the prevalence of high unmet need in the study area is an outcome of diverse constraints imposed on both women and men in their efforts to achieve their fertility

preferences and hence inability to practice contraception. This situation is the cause of high rates of unwanted fertility and population growth. In the current study, since the highest level of unmet need is observed for couples with less frequent discussion among spouses, large number of living children and less frequent communication among women and health extension workers, family planning programs should focus on these couples to meet their needs.

Based on the findings of the study, the following recommendations are forwarded.

- Since, majority of couples are still illiterate and under the influences of social and cultural factors in the study area, discussion of women with health extension workers about reproductive health issues are needed to enhance the utilization of family planning services. When providers/health extension workers guarantee from the outset that they will work with a client until she is satisfied with her method and then follow through on that promise, a client is likely to keep returning to those service delivery outlets. Through discussion, a provider can either help a client find ways to deal with side effects or advice her to a different method. Counseling can help client to feel positive about the method they selected and help them deal with any negative attitudes of spouses or others relatives. Open discussion about negative rumors can also help clients distinguish fact from fiction. A well designed follow up system for contacting clients will also benefit the individual client.

- Efforts should be made that family planning programs should include IEC scheme that can promote discussion between married couples since it enhances couples understanding of each other attitude towards family planning and hence raise contraceptive use. Good and active IEC programs will raise individual's or couples desire to use family planning services and adopt behavior to improve family planning and/or reproductive health services through; 1) provision of accurate information about services and outlet location; 2) reducing perceived barriers to service use(such as rumors and misconceptions); 3) broadening of awareness of the availability of services; 4) raised spousal communication, and 5)

encouraging people to assess their risky behavior. It can also avoid the major impediments for not using contraceptives among couples with unmet need such as lack of knowledge on various contraceptive methods, side effects, spousal and familial disapproval and religious prohibition.

- Expand access to family planning services in rural areas and improve contraceptive method mix.
- Efforts should be made in improving women's status through improving their access to education, particularly in rural areas where early marriage is still common (despite efforts being made to rise age at marriage), female educational participation is low and school dropout is high.
- Knowledge of men about contraceptives is very high contrary to practice which is very low. As a result there is a need to develop and implement program that encourage the involvement of men in family planning, improve family planning services for men, and make male contraceptive methods available and accessible at all level of the health facility.
- Finally, I suggest that the study area needs further research that improve the outcome of the present study by narrowing the gap of information that explained in the limitation part, and to identify the extent of unmet need for all sexually active women and men.

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Annex 1

Couples or wives and Husbands who are currently family planning users, ever users otherwise never users are asked. You should circle the right answer among the multiple choices

Part one:-demographic and socio economic characteristics

S.No	Questions	Choice of answer	Skip to question...
101	How old are you at your last birth day?	... years (in complete years)	
102	What is your religion?	1. orthodox 2. Islam 3. protestant 4. catholic 5. Other (specify).....	
103	What is your ethnicity?	1. Amhara 2. Tigrary 3. Oromo 4. Others (specify)	
104	Can you read and write?	1. yes 2. no ——→	Skip to question 107
105	Have you attended any formal education?	1. yes 2. no ——→	Skip to question 107
106	What is the highest grade you have attained	1.1-8 grade 2. 9-12 grade 3. 12and above	
107	Do you have any job?	1. yes 2.no ——→	Skip to question 109
108	What type of occupation you are currently engaged in?	1. house wife (for wife 2. merchant 3. daily laborere 4. house maid (for wife) 5. government employee 6. farmer (for husband) 7. others (specify)	

109	What is your monthly income?	1. ..... birr 2. I don't know exactly	
110	If you compare your monthly income with your neighbors, where you put your economic status?	1. very poor 2. poor 3. medium 4. rich 5. I can't say 6. no response	
111	Do you have radio or TV in your house?	1. radio only 2. TV only 3. both radio and TV 4. non	

Part Two: Reproductive History

S. No	Questions	response	Skip to question
201	At what age did you first got married?	1. at the age of ..... 2. I do not remember	
202	Have you (your wife) ever been pregnant?	1. yes 2. no →	Skip to question 205
203	How old were you when you (your wife) first got pregnant?	1. ----- years	
204	Have you ever given birth?	1. yes 2. no →	Skip to question 208
205	Do you want to have a child in the future	1. yes 2. no →	Skip to question 225
206	After what time would you like to have a child?	1. <=2 years 2. >2 years	
207	How many children would you like to have in your life?	1. enter no..... →	Skip to question 225
208	How many children have you ever born during your life?	1. son 2. daughter 3. total ----	
209	How many living children do you have?	1. son 2. daughter 3. total	
210	How old were you when your first child was born	1. ------ years 2. I do not know exactly	
211	If you could go back to the time you did not have children and could choose of children to have in your whole life, how many could that be?	1. enter no ----- 2. I did not decide	
212	Are you (is your wife) pregnant now?	1. yes 2. no → 3. I am not sure →	Skip to question 217 Skip to question 217
213	How much longer have you waited between the previous birth and present pregnancy?	1. ------- months	

214	Is the pregnancy wanted now, wanted later or not wanted at all?	1. wanted now 2. wanted later 3. not wanted at all	
215	After the child you are expecting now, would you like to have another child or not to have any more children?	1.have a child 2. have no more children 3. not yet decided	 → Skip to question 222 → Skip to question 222
216	How long would you like to wait before the birth of another child?	1. ≤ 2 years 2. ≥ 2 years 3. not yet decide	→ Skip to question 222 → Skip to question 222 → Skip to question 222
217	How much loner have you waited between the last and the previous birth?	1. ------- months	
218	How much longer have you waited since the last birth?	1. -------- month (s)	→ Skip to question 220 if it is greater than 6 months.
219	At the time of you become pregnant, did you want to become pregnant then, wait until later or not want to have any more children at all?	1. wanted then 2. wanted later 3. not wanted at all	→ Skip to question 222 → Skip to question 222 → Skip to question 222
220	Do you want to have another child or not to have any more children at all?	1. have a child 2. have a children 3. not yet decided	 → Skip to question 222 → Skip to question 222
221	How long would you like to wait before the birth of another	1. ≤ 2 years 2. ≥ 2 years 3. not yet decide	
222	Have you ever had a pregnancy that was aborted (induced abortion)?	1. yes 2. no	 → Skip to question 225
223	How many times did you perform it?	1. Write no	
224	Through what way the induced abortion was ended up?	1. medical personnel 2. traditional method 3. Other.....	

225	Would you intend to use modern contraceptive methods?	1. yes 2. no → Skip to question 227 3. not yet decided → Skip to question 227			
226	Which method would you like to use?		Yes	no	
		1. pills	1	2	Skip to question 301
		2. implant /Norplant/	1	2	
		3. inject able	1	2	
		4. IUD	1	2	
		5. condom	1	2	
		6. male sterilization	1	2	
		7. female sterilization	1	2	
		8. natural methods (abstinence, withdrawal)	1	2	
		9. other	1	2	
227	What are the reasons that made you not to use modern contraceptive methods to avoid the pregnancy from happening?		Yes	No	
		1. fear of side effects	1	2	
		2. health concerns	1	2	
		3. not aware of contraceptive	1	2	
		4. no preferred method	1	2	
		5. little pregnancy risk	1	2	
		6. husband disapproval	1	2	
		7. contraceptive method	1	2	
		8. cost of method	1	2	
		9. infrequent sex	1	2	
		10. religion prohibition	1	2	
		11. breast feeding	1	2	
		12. familial opposition	1	2	
		13. death of children	1	2	
		14. distance form the source	1	2	

Part three; knowledge about contraception

301	Have you ever heard of family planning methods that women or men can use to avoid pregnancy?	1. yes 2. no →	Skip to question 307	
302	Which of the following methods do you know about?		Yes	no
		1. pill	1	2
		2. IUCD	1	2
		3. inject able	1	2
		4. implant (Norplant)	1	2
		5. condom	1	2
		6. female sterilization	1	2
		7. male sterilization	1	2
		8. natural method	1	2
		9. others (specify)	1	2
303	What is your source of information about family planning		Yes	no
		1. health extension workers	1	2
		2. radio	1	2
		3. TV	1	2
		4. friends	1	2
		5. news papers	1	2
		6. husband	1	2
		7. school	1	2
		8. other, specify	1	2
304	Do you know the place where modern contraceptive methods could be obtained?	1. yes 2. no →	Skip to question 306	
305	If you know where the methods are obtained, where is the main place that you or others are able to get modern contraceptive?		Yes	no
		1. hospital	1	2
		2. health center	1	2
		3. health /past/	1	2
		4. shop	1	2
		5. ADA.RA project center	1	2
		6. pharmacy/drug vendor	1	2

306	Which advantage of contraceptive methods do you know?	1. avoid unwanted pregnancy 2. regulation of period 3. to limit family size 4. to prevent STI 5. other specify	Yes no 1 2 1 2 1 2 1 2 1 2
307	Do you approve or disapprove of couples who contact with the health extension workers?	1. approve 2. disapprove	
308	Have you ever contacted and discussed about contraception with the health extension workers? With in the last three months?	1. yes 2. no →	Skip to question 310
309	If you have contacted, how many times did you contact them in a month in person?	1. once 2. twice 3. more than twice	
310	What is your husband's (wife's) attitude towards the communication between you and the health extension workers?	1 approve 2 disapprove 3 do not know	

Part four: Attitude towards contraceptive methods

401	Would you like to know more about contraceptive method?	1. yes 2. no	
402	Do you approve or disapprove of couples using a method of family planning?	1. approve 2. disapprove	
403	Have you discussed about contraception with your partner within the last six months?	1. yes 2. no →	Skip to question 405
404	If you discussed, how many times have you discussed	1. once 2. twice 3. three times 4. greater than 3 times	
405	What is your husband's (wife) attitude to wards contraceptive methods?	1. approve 2. disapprove 3. do not know	
406	Does your husband (wife) know whether you are using or not using any contraceptive?	1. yes he does know 2. no he doesn't know 3. I am not sure	
407	Do you know if your husband (wife) is using or not using any modern contraceptive?	1. yes 2. no 3. I am not sure	

Part five: practice of modern contraceptive methods

501	Have you ever used modern contraceptives?	1. yes 2. no →	Skip to question 507
502	How many living children did you have at the time you started to use the method	1. Son .... 2. Daughter..... 3. Total.....	Skip to question 507 if pregnant or amenorrheic
503	Are you currently using modern contraceptive methods	1. yes 2. no →	Skip to question 507
504	Which method are you using now?		Yes / no
		1. pill	1 / 2
		2. implant (Norplant)	1 / 2
		3. indictable	1 / 2
		4. IUD	1 / 2
		5. condom	1 / 2
		6. female sterilization	1 / 2
		7. male sterilization	1 / 2
		8. natural method	1 / 2
		9. others (specify)	1 / 2
505	For what purpose are you using the methods?	1spacing 2limiting	
506	What is the availability of method if you want to change other methods form the source you belong to?	1. easily available 2. not easily available 3. don't know	
507	What are the major problems (side effects) associated with the method you are using?	....	

508	Would you say that using contraception is mainly your dictions or your husband's diction or did you both decide together?	1. mainly respondent's 2. manly husband 3. joint decision 4. other	
509	How long would it take to reach to the source of contraceptive methods?	1..... hours 2. I do not know	
510	How costly the method is?	1.cheap 2.reasonable 1. expensive 2. do not know	

Part six; Issues Raised on the Focus Group Discussion

1 What do you know about family planning methods?

2 What do you think about the advantages and disadvantages of using any family planning methods?

3 Are you against or pro on family planning methods?

4 What is your opinion on long-term contraceptive methods like male/female sterilization and others?

5 Some couples have more number of children than they ever wanted. What could be the reason do you think?

6 What is the advantage of having few numbers of children through out one's life?

7 What is the attitude of husbands/wives towards family planning?

Declaration

The thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have been duly acknowledged.

Nega Mihret — Student

Signature

21/07/08 — Date

I confirm that this thesis has been submitted with my approval as the supervisor of the same.

Dr. Assefa H/Mariam — Advisor

Signature

21/07/08 — Date