

**ADDIS ABABA UNIVERSITY, FACULTY OF MEDICINE,
DEPARTMENT OF COMMUNITY HEALTH**

**DOES COMMUNITY BASED REPRODUCTIVE HEALTH
PROGRAM (CBRHP) IMPROVE WOMEN STATUS?**

**A COMPARATIVE STUDY BETWEEN CBRHP AND NON-
CBRHP AREAS, IN *BASSONAWORANA* DISTRICT**

NORTH SHOA ADMINISTRATIVE ZONE, AMHARA REGION

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**A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES
OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF
THE REQUIREMENT FOR THE DEGREE OF MASTER IN PUBLIC
HEALTH.**

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DEDICATION

**IN MEMORY OF MY BELOVED MOTHER W/O ELFINESH MINALU, WHO
WAS NEVER TIRED TO MENTOR HER FATHERLESS CHILDREN AND
WHOSE LOSS WAS VERY PAINFUL EXPERIENCE FOR ME.**

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WHILE MANY PEOPLE HAVE CONTRIBUTED TO THE TIMELY COMPLETION OF THIS THESIS I, HOWEVER, TAKE THE RESPONSIBILITY FOR ERRORS OR OMISSIONS.

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LIST OF ABBREVIATIONS

CBD-----COMMUNITY BASED DISTRIBUTION

CBRHA ---- COMMUNITY HEALTH REPRODUCTIVE HEALTH AGENT

CBRHPA--- COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM
AREAS

CPR-----CONTRACEPTIVE PREVALENCE RATE

CSA-----CENTRAL STATISTICAL AUTHORITY

DHS-----DEMOGRAPHIC AND HEALTH SURVEY

FP-----FAMILY PLANNING

ICPD-----INTERNATIONAL CONFERENCE ON POPULATION AND
DEVELOPMENT

IUCD-----INTRA-UTERINE CONTRACEPTIVE DEVICE

MCM-----MODERN CONTRACEPTIVE METHODS

MOH-----MINISTRY OF HEALTH

NCBRHPA---NONE- COMMUNITY BASED REPRODUCTIVE HEALTH
PROGRAM AREAS

NGO-----NON-GOVERNMENTAL ORGANIZATION

PI/E-----PATHFINDER INTERNATIONAL/ETHIOPIA

PPS-----PROBABILITY PROPORTIONATE TO SIZE

RH-----REPRODUCTIVE HEALTH

SRS-----SIMPLE RANDOM SAMPLING

STI/STD-----SEXUALLY TRANSMITTED INFECTION/DISEASES

TFR-----TOTAL FERTILITY RATE

VSC-----VOLUNTARY SURGICAL CONTRACEPTIVE

ABSTRACT

A COMPARATIVE CROSS SECTIONAL STUDY WAS CONDUCTED TO ASSESS WOMEN'S STATUS IN CBRHP AND NON-CBRHP AREAS IN BASSONAWORANA WOREDA OF AMHARA REGION. THE STUDY WAS CARRIED OUT IN TEN RURAL KEBELES IN THE WOREDA, FIVE KEBELES FROM EACH CBRHP AND NON-CBRHP AREAS. IN THE STUDY, A QUANTITATIVE METHOD WAS USED FOR DATA COLLECTION. A TOTAL OF 620 PARTICIPANTS WERE SELECTED USING A MULTISTAGE SAMPLING TECHNIQUE.

THE RESULT INDICATED THAT MEAN AGE OF MARRIAGE WAS 17.5 ± 3.1 IN CBRHP AREAS AND 17.1 ± 2.9 IN NONE CBRHP AREAS. THE MEAN AGE OF FIRST PREGNANCY IN THE PROGRAM AREA WAS 19.2 ± 3.5 AND 18.1 ± 4.4 IN NON PROGRAM AREAS. THE MEAN NUMBER OF CHILDREN IN THE PROGRAM AREAS WAS 3.1 ± 2.4 AND 4.1 ± 2.3 IN THE NON PROGRAM AREAS. THE CPR WAS FOUND TO BE 64.5% IN THE CBRHP AND 25.5 IN NONE CBRHP AREAS [OR=2.4, 95% CI=1.5, 3.8].

THE STUDY SHOWED THAT ABOUT 91% OF THE RESPONDENTS KNEW AT LEAST ONE MCM IN THE PROGRAM AREAS COMPARED TO 70.1% IN THE NON-PROGRAM AREAS; THE DIFFERENCE WAS STATISTICALLY SIGNIFICANT [OR (95%CI) =4.3(2.7, 6.7)]. SIMILARLY 64.8% OF WOMEN IN CBRHP AND 38.7% IN NONE CBRHP AREAS [OR =1.93, 95% CI=1.3, 2.8] USED AT LEAST ONE METHOD OF MODERN CONTRACEPTIVE IN THEIR LIFE.

DECISION MAKING ON BUYING /SELLING MAJOR HOUSEHOLD AND AGRICULTURAL ITEMS WERE MADE JOINTLY IN 74.4% OF THE RESPONDENTS IN CBRHP AREAS, WHILE ONLY 36.9% OF DECISIONS WERE MADE JOINTLY IN NONE CBRHP AREAS [OR=9.3, 95% CI=6.1, 14.4]. SIMILARLY DECISION ON SEEKING MEDICAL CARE WAS MADE JOINTLY IN 68.5% OF THE PROGRAM AREAS RESPONDENTS WHILE ONLY 41.1% OF THE RESPONDENTS DECIDED

JOINTLY IN NON-CBRHP AREAS [OR=9.9, 95% CI=6.1, 16.1]. IN THE NON-PROGRAM AREAS, HUSBANDS ALONE MADE THE MAJORITY OF DECISIONS [53.7%]

ABOUT SEVENTY EIGHT PERCENT AND 15.5 % OF THE WOMEN IN THE PROGRAM AREAS WERE THE DECISION MAKERS ON UTILIZATION OF MCM JOINTLY AND BY THE WIVES ALONE RESPECTIVELY. THE CORRESPONDING PROPORTIONS FOR THE NON PROJECT AREAS WERE 65 % AND 5.8 %. [OR=12.6, 95% CI=5.7, 28.3 AND OR=5.7, 95% CI=3.3, 10.1].

THE PERCEIVED STANDARD OF LIVING IN THE PAST FIVE YEARS WERE IMPROVED IN 38.9% OF THE RESPONDENTS IN PROGRAM AREA WHILE THE CORRESPONDING PROPORTION FOR THE NONE PROJECT AREA WAS ONLY 6.8%[OR =10.1, 95% CI=5.4, 18.9].

WITH THESE FINDINGS ONE CAN EASILY CONCLUDE THAT CBRH PROGRAM IMPROVES BOTH WOMEN AUTONOMY AND THEIR STATUS IN MANY REPRODUCTIVE HEALTH AND SOCIO-ECONOMIC ASPECTS. CIVIC ASSOCIATIONS LIKE WOMEN'S ASSOCIATIONS AND ORGANIZATIONS WORKING ON GENDER AND DEVELOPMENT CAN USE THE CBRH PROGRAM AS A STRATEGIC OPTION TO IMPROVE WOMEN STATUS. IMPLEMENTATION OF THE PROGRAM ALSO CONTRIBUTES FOR THE ATTAINMENT OF THE MILLENNIUM DEVELOPMENT GOALS [MDGS], PARTICULARLY FOR GOALS 3, 4, 5 AND 6. HENCE, WE RECOMMEND THAT CBRH PROGRAM HAS TO BE STRENGTHENED AND POLICY MAKERS/PROGRAM MANAGERS SHOULD PAY ATTENTION TO EXTEND THIS PROGRAM IN TO VILLAGES AND DISTRICTS OF THE COUNTRY.

INTRODUCTION

ETHIOPIA, THE SECOND MOST POPULOUS COUNTRY IN SUB-SAHARAN AFRICA HAS ONE OF THE HIGHEST FERTILITY RATE [5.9 CHILDREN PER WOMEN OF REPRODUCTIVE AGE], A LOW CONTRACEPTIVE PREVALENCE RATE, AND VERY HIGH INFANT MORTALITY.

IN ETHIOPIA, WOMEN OF CHILDBEARING AGE MAKE UP ONE FIFTH OF THE TOTAL POPULATION AND ABOUT 45% OF THE FEMALE POPULATION. IN THE COUNTRY, AS IN MOST AFRICAN COUNTRIES, WOMEN PLAY THE PRINCIPAL ROLES IN THE REARING OF CHILDREN AND THE MANAGEMENT OF FAMILY AFFAIRS. ON THE OTHER HAND THE HEALTH, ECONOMIC AND EMPOWERMENT STATUS OF THESE WOMEN REMAINS ONE OF THE POOREST IN THE WORLD. ACCORDING TO THE REPORT OF CSA, THE MATERNAL MORTALITY RATIO IN ETHIOPIA IS ESTIMATED AT 871, PER 100,000 LIVE BIRTHS, WHICH IS ONE OF THE HIGHEST IN SUB-SAHARAN AFRICA. POOR HEALTH AND NUTRITIONAL STATUS, INFECTIOUS DISEASES, HIGH WORKLOAD, EARLY MARRIAGE, PREGNANCY, INADEQUATE ACCESS TO AND UTILIZATION OF HEALTH SERVICES, AND THE LOW STATUS OF WOMEN IN THE SOCIETY ARE AMONG THE UNDERLYING CAUSES OF MATERNAL MORTALITY IN THE COUNTRY.

THE MAJORITY OF ETHIOPIAN WOMEN LIVE IN RURAL AREAS WHERE ACCESS TO MODERN HEALTH FACILITIES IS LIMITED. THEREFORE, THE

NATIONAL POPULATION AND HEALTH POLICIES CALL FOR A
DECENTRALIZATION OF THE HEALTH CARE SYSTEM. ^[1]

COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM (CBRHP) IS ONE
OF THE STRATEGIC OPTIONS IN INCREASING REPRODUCTIVE
HEALTH/FAMILY PLANNING SERVICES, ESPECIALLY, IN DEVELOPING
COUNTRIES LIKE ETHIOPIA.

THE MAJORITY OF OUR PEOPLE LIVE IN AREAS WHERE THE HEALTH
INFRASTRUCTURE IS POOR BOTH IN QUALITY AND QUANTITY. THIS
LIMITED HEALTH CARE SYSTEM CALLS FOR OTHER OPTIONS LIKE
TRAINING AND ASSIGNING OF COMMUNITY BASED REPRODUCTIVE
HEALTH AGENTS TO PROVIDE BASIC REPRODUCTIVE HEALTH CARE FOR
THE UNDER SERVED COMMUNITY.

AS SOME STUDIES IN OTHER COUNTRIES SHOW, BESIDES IMPROVING
REPRODUCTIVE HEALTH STATUS, SUCH PROGRAMS HAVE PLAYED
ROLES IN IMPROVING WOMEN DECISION MAKING AND SOCIO-
ECONOMIC STATUS. THE INFLUENCE OF WOMEN STATUS ON THEIR
REPRODUCTIVE BEHAVIOR WAS STUDIED IN SOUTH ETHIOPIA AND IT
DEMONSTRATED THAT THERE IS A LINK BETWEEN WOMEN'S
AUTONOMY AND REPRODUCTIVE BEHAVIOR. ON THE OTHER HAND, THE
MAIN OBJECTIVE OF THIS STUDY IS TO SHOW THE INFLUENCE OF
COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM IN WOMEN

STATUS, BY COMPARING CBRHP AND NON-CBRHP AREAS IN OUR
CONTEXT. ^[1,2]

COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM

IN THE EARLY 1960S, MOST FAMILY PLANNING PROGRAMS IN THE
DEVELOPING COUNTRIES WERE CLINIC BASED. THESE CLINICAL
ORIENTED FACILITIES, PRIMARILY LOCATED IN URBAN AREAS WERE
UNABLE TO SERVE THE MAJORITY WHO LIVED IN RURAL AREAS. IN AN
EFFORT TO ALLEVIATE THIS PROBLEM, MULTIPLE OF ALTERNATIVE
SERVICE DELIVERY SYSTEMS WERE INITIATED IN 1970S.AMONG THESE
ALTERNATIVE DELIVERY SYSTEMS, COMMUNITY BASED DISTRIBUTION
AND CONTRACEPTIVE SOCIAL MARKETING DESERVE MENTIONING. ^[2]

COMMUNITY BASED DISTRIBUTION PROGRAMS (CBD) WERE FIRST
INTRODUCED IN ASIA AND DEVELOPED FURTHER IN AFRICA AND LATIN
AMERICA. THE CBD PROGRAMS IN SUB-SAHARAN AFRICAN COUNTRIES
HAVE BEEN IMPLEMENTED FOR THE PAST THIRTY YEARS BASED ON
THE CONVICTION THAT PROVIDING CONTRACEPTIVE METHODS AT THE
COMMUNITY LEVEL INCREASES ACCESS TO AND ACCEPTABILITY OF
FAMILY PLANNING IN THE RURAL AND UNDESERVED COMMUNITIES
WHERE THE HEALTH CARE INFRASTRUCTURE IS WEAK.

COMMUNITY BASED REPRODUCTIVE HEALTH [CBRH] PROGRAM IN ETHIOPIA

ACROSS THE COUNTRY NON-GOVERNMENTAL, PRIVATE AND SOME DEVELOPMENT ORGANIZATIONS ARE INCREASINGLY SUPPLEMENTING THE DELIVERY OF FAMILY PLANNING AND OTHER REPRODUCTIVE HEALTH SERVICES. THE GOVERNMENT OF ETHIOPIA SUPPORTS THE IMPLEMENTATION OF COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM BASED ON THE PREMISE THAT THIS STRATEGY BRINGS SERVICES CLOSER TO THE UNDER SERVED COMMUNITIES WHO WOULD OTHERWISE BARELY ACCESS TO MODERN HEALTH SERVICES.

ACCORDING THE ASSESSMENT DONE BY THE MINISTRY OF HEALTH (MOH), ETHIOPIA 2004, THERE ARE 30 NGOS (NONE GOVERNMENTAL ORGANIZATIONS) WITH CBRH PROGRAMS IN SEVEN REGIONS COVERING 252 DISTRICTS. A TOTAL OF 12840 CBRH AGENTS ARE PROVIDING SERVICES THROUGH THESE NGOS. THERE WERE AN ESTIMATED 14,970,945 WOMEN OF REPRODUCTIVE AGE IN THOSE REGIONS WHERE THERE WERE ACTIVE CBRH PROGRAMS.

THIS STUDY TRIES TO EXPLORE REPRODUCTIVE HEALTH/ FAMILY PLANNING IN THE CONTEXT OF WOMEN'S LIVES -- THEIR PSYCHOSOCIAL WELL BEING, DOMESTIC LIVES, WORK LIVES, AND POSITION WITHIN THE COMMUNITY.

MANY STUDIES SHOW THAT WOMEN'S EDUCATION, ECONOMIC POSITION, HOUSEHOLD CHARACTERISTICS, AND SOCIAL STATUS INFLUENCE THE USE OF REPRODUCTIVE HEALTH SERVICES. IN CONTRAST, LITTLE IS KNOWN ABOUT THE OPPOSITE PERSPECTIVE—

HOW REPRODUCTIVE HEALTH SERVICES AFFECT OTHER ASPECTS OF WOMEN'S LIVES OR STATUS? THIS STUDY TRIES TO DEAL IN THIS PERSPECTIVE.

Literature Review

“REPRODUCTIVE HEALTH IS A STATE OF COMPLETE PHYSICAL, MENTAL AND SOCIAL WELL-BEING AND NOT MERELY THE ABSENCE OF DISEASE OR INFIRMITY, IN ALL MATTERS RELATED TO THE REPRODUCTIVE SYSTEM, ITS FUNCTIONS AND PROCESSES.”

REPRODUCTIVE HEALTH, THEREFORE, IMPLIES THAT PEOPLE ARE ABLE TO HAVE A SATISFYING AND SAFE SEX LIFE AND THAT THEY HAVE THE CAPABILITY TO REPRODUCE AND THE FREEDOM TO DECIDE IF, WHEN AND HOW OFTEN TO DO SO. IMPLICIT IN THIS LAST CONDITION IS THE RIGHTS OF MEN AND WOMEN TO BE INFORMED AND TO HAVE ACCESS TO SAFE, EFFECTIVE, AFFORDABLE AND ACCEPTABLE METHODS OF REPRODUCTIVE/ FAMILY PLANNING SERVICES OF THEIR CHOICE. IN LINE WITH THE ABOVE DEFINITION OF REPRODUCTIVE HEALTH, REPRODUCTIVE HEALTH CARE IS DEFINED AS THE CONSTELLATION OF METHODS, TECHNIQUES AND SERVICES THAT CONTRIBUTE TO REPRODUCTIVE HEALTH AND WELL BEING BY PREVENTING AND SOLVING REPRODUCTIVE HEALTH PROBLEMS. ^[3]

IN 1994, THE “INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT” (ICPD) WAS HELD IN CAIRO, EGYPT, AND IN 1995, THE “FOURTH WORLD CONFERENCE ON WOMEN” WAS HELD IN BEIJING, CHINA. BOTH CONFERENCES REAFFIRMED THE NEED FOR A CHANGE IN PERSPECTIVE -- THE NEED TO VIEW REPRODUCTIVE HEALTH/FAMILY PLANNING NOT AS AN END UNTO IT SELF, BUT AS MEANS TO HELP

WOMEN AND MEN IMPROVE THEIR HEALTH STATUS. REPRODUCTIVE HEALTH, IN TURN, WAS SEEN AS ESSENTIAL TO WOMEN'S EMPOWERMENT, AS DEFINED BY THE ICPD PROGRAM OF ACTION.

AT THE FOURTH WORLD CONFERENCE ON WOMEN, PARTICIPANTS REAFFIRMED THE ICPD'S RECOMMENDATION THAT FAMILY PLANNING BE PLACED IN THE CONTEXT OF REPRODUCTIVE HEALTH. THE BEIJING PROGRAM OF ACTION NOTED THAT "WOMEN ARE SUBJECT TO PARTICULAR HEALTH RISKS DUE TO INADEQUATE RESPONSIVENESS AND LACK OF SERVICES TO MEET HEALTH NEEDS RELATED TO SEXUALITY AND REPRODUCTION," AND THE DOCUMENT CALLED FOR THE MAINSTREAMING OF A GENDER PERSPECTIVE INTO ALL POLICIES AND PROGRAMS. THREE OTHER REPORTS CALLED FOR INCREASED ACCESS TO REPRODUCTIVE/ FAMILY PLANNING SERVICES, NOTING THAT CHOICES ABOUT CONTRACEPTIVES AND OTHER ASPECTS OF REPRODUCTIVE LIFE ARE ESSENTIAL TO HUMAN DIGNITY. ^[4]

GENERAL OVERVIEW OF WOMEN'S ROLE AND STATUS

IN EVERY CULTURE AND AS FAR BACK AS HISTORY RECORDS, WOMEN HAVE BEEN PLAYING INNUMERABLE ROLE IN BOTH PRODUCTIVE AND REPRODUCTIVE ASPECTS. IT WAS ALSO EVIDENT THAT THEY HAVE PRESTIGIOUS POSITION IN SIMPLE SOCIETIES WHERE DISCRIMINATION AND DOMINATION ON THE BASIS OF GENDER WAS MINIMAL.

IN SIMPLE SOCIETIES THE DIVISION OF AUTHORITY WITHIN THE HOME, BETWEEN THE HUSBAND AND WIFE TENDS TO BE RELATIVELY EQUAL WITHOUT A CLEAR DOMINATION BY THE HUSBAND. IN SUCH SOCIETIES WOMEN TEND NOT TO HAVE THEIR SOCIAL LIVES RESTRICTED TO

HOME BUT TO ENGAGE IN ACTIVITIES IN SOLDIERLY GROUPS WITH OTHER WOMEN IN COMMUNITY AT LARGE.

THE INTERNATIONAL ENCYCLOPEDIA OF SOCIAL SCIENCES HAS ALSO EXPLAINED ABOUT DIVISION OF LABOR IN PRIMITIVE SOCIETY “IN PRIMITIVE SOCIETY, THE WORKING FORCES ARE HARDLY DISTINGUISHABLE FROM THE TOTAL PRODUCTION. SINCE THE TECHNOLOGY IS BACKWARD, THE WHOLE POPULATION OF THE PRIMITIVE SOCIETY WAS ENGAGED IN THE COOPERATIVE TASKS OF PRODUCING NECESSITIES FOR SUBSISTENCE”. THIS INDICATES THAT WOMEN IN SIMPLE SOCIETIES HAVE PARTICIPATED EQUALLY FOR SUBSISTENCE ROLE AND HAVE RELATIVELY EQUAL STATUS WITH MEN. HOWEVER, SOME WRITERS HAVE ARGUED THAT THOUGH THE DEGREE AND COMPLEXITY VARY FROM SOCIETY TO SOCIETY, GENDER INEQUALITY HAS APPARENTLY EXISTED IN THE PRIMITIVE SOCIETY. OTHER WRITERS INDICATED THAT THERE ARE OR HAVE BEEN TRULY EGALITARIAN SOCIETIES IN WHICH WOMEN HAVE ACHIEVED CONSIDERABLE SOCIAL RECOGNITION AND POWER, BUT NON HAVE OBSERVED A SOCIETY IN WHICH WOMEN HAVE PUBLICLY RECOGNIZED POWER AND AUTHORITY SURPASSING THAT OF MAN. THIS SHOWS THE DOMINANCE OF MEN OVER WOMEN AND WOMEN’S SUBORDINATION. ^[5] THE STATUS OF WOMEN HAS BECOME FURTHER DEGRADED WHEN SOCIETY CHANGED FROM HUNTING AND GATHERING TO AGRICULTURE.

SOCIOLOGIST BAUD HAD INDICATED THE IMPACT ON THIS CHANGE ON THE STATUS OF WOMEN AS FOLLOWS:

THE SHIFT OF THE STATUS OF WOMEN FARMER MAY HAVE HAPPENED QUITE RAPIDLY. ONCE THERE WERE TWO MALE SPECIALIZATIONS RELATING TO AGRICULTURE: PLOUGHING AND THE CARE OF CATTLE. THIS SITUATION LEFT WOMEN WITH ALL THE SUBSIDIARY TASKS, INCLUDING WEEDING AND CARRYING WATER TO FIELDS. THESE NEW FIELDS WERE LARGER, SO WOMEN HAD TO WORK JUST AS MANY HOURS AS THEY DID BEFORE BUT NOW THEY WORKED AS MORE SECONDARY TASKS. THIS COULD CONTRIBUTE FURTHER TO THE EROSION OF THE STATUS OF WOMEN.

A SIMILAR SITUATION CAN ALSO HAPPEN IN COMPLEX PRE-INDUSTRIAL SOCIETIES IN WHICH WOMEN HAVE ACCESS TO EVERY THING THROUGH MEN. THIS UNDERMINES THEIR AUTHORITY AND STATUS, SO THAT, MEN HAVE FULL RIGHT TO EXERCISE THEIR AUTHORITY OVER WOMEN.

IN GENERAL, THE CHANGING OF SOCIETY FROM ONE FORM TO ANOTHER, FROM SIMPLE TO COMPLEX AND THEN TO MODERN, DID NOT POSITIVELY INFLUENCE THE STATUS OF WOMEN. WOMEN IN ALMOST ALL SOCIETIES HAVE LOWER STATUS COMPARED TO MEN. THIS IS BECAUSE OF THE SOCIALLY AND CULTURALLY CONSTRUCTED GENDER

INEQUALITY IN ALL SOCIETIES. THIS HISTORICAL PERSPECTIVE SHOWS THE UNIVERSAL SUBORDINATION AND DOMINATION OF WOMEN BY MEN. ^[5]

WOMEN'S DECISION MAKING POWER AND ACCESS TO RESOURCES

WOMEN'S DECISION- MAKING POWER VARY FROM SOCIETY TO SOCIETY AS WELL AS FROM CULTURE TO CULTURE. BUT IN GENERAL WOMEN HAVE LOWER DECISION-MAKING POWER THAN MEN DUE TO CULTURAL VALUES AND NORMS.

WOMEN ARE NOT ENCOURAGED TO MAKE PUBLIC AND FARM WORK DECISION IN MOST SOCIETIES AND CULTURES. LACK OF DECISION MAKING POWER HAS A CONSIDERABLE IMPACT ON THE STATUS OF WOMEN. WOMEN ARE NOT ENCOURAGED TO PARTICIPATE IN DECISION MAKING ON FAMILY OR COMMUNITY MATTERS. THIS COULD BE THE DIRECT RESULT OF CULTURAL, SOCIAL, ECONOMIC AND TRADITIONAL BELIEFS OF THE AREA WHERE THEY LIVE, AND ATTRIBUTED TO THEIR BEING INFERIOR IN THE SOCIETY.

GENDER INEQUALITY IN ACCESS TO RESOURCES IS ALSO REFLECTED IN MANY SOCIETIES. THE EXTENT OF GENDER INEQUALITY, DIFFERENCES

BETWEEN MEN AND WOMEN IN ACCESS TO REWARDS, RESOURCES, POSITIONS, RIGHTS AND PRIVILEGES –VARY FROM SOCIETY TO SOCIETY BUT IN GENERAL MEN HAVE GREATER ACCESS TO THE SOCIAL PREREQUISITES THAN WOMEN.

WOMEN HAVE LITTLE CONTROL OVER THE DIFFERENT RESOURCES. IN MANY AREAS, ALL RESOURCES ARE UNDER THE CONTROL OF HER HUSBAND, FATHER, BROTHERS, AND BROTHER IN LAW ETC. WOMEN IN MANY SOCIETIES, HAVE DISADVANTAGES IN ALMOST ALL AREA OF ACTIVITIES. THE CULTURE, TRADITION, NORMS AND THE LOCAL LAWS, INSTEAD OF WEAKENING THE SUBORDINATION OF WOMEN, THEY STRENGTHEN THE TRADITIONAL INFERIORITY OF WOMEN IN THE SOCIETY.

“IT IS THE UNFORTUNATE MAN WHO LOSES HIS COWS; THE FORTUNATE ONE LOSES HIS WIFE” [BENGALI PROVERB]

AS THE BENGALI PROVERB INDICATES, DESPITE WOMEN’S IMPORTANT ROLE IN MANAGING THE HOUSEHOLD AND CONTRIBUTING INCOME, MANY CULTURES VALUE WOMEN LESS THAN MEN OR EVEN CATTLE. THIS MAY BE MANIFESTED THROUGH LESS ACCESS TO FOOD, LIMITED EDUCATIONAL OPPORTUNITIES AND ACCESS TO HEALTH SERVICES, RESTRICTED MOBILITY, LACK OF PARTICIPATION IN DECISION MAKING, EXPECTATIONS OF LARGE FAMILIES AND SON PREFERENCE,

PROSTITUTION, FEMALE GENITAL MUTILATION, HEAVY WORK LOADS, PHYSICAL AND EMOTIONAL ABUSE, AND EARLY MARRIAGES. ^[6]

IN MANY CULTURES, WOMEN HAVE LIMITED ABILITY, IF ANY, TO INFLUENCE DECISION MAKING IN THE HOUSEHOLD. THIS IS CLOSELY ASSOCIATED WITH THEIR LOW STATUS IN THE FAMILY AND SOCIETY AS A WHOLE. THEY USUALLY NEED THEIR HUSBAND'S PERMISSION OR THAT OF OTHER MALE FAMILY MEMBERS BEFORE THEY CAN OBTAIN CARE. THE FOLLOWING TRUE STORY FROM "FAMILY HEALTH INTERNATIONAL NETWORK" ILLUSTRATES THIS SITUATION;

"FATIMA, 27, WHO LIVED IN A REMOTE YEMENI VILLAGE, DELIVERED HER SIXTH CHILD, BUT HER PLACENTA DID NOT FOLLOW. AN HOUR LATER SHE WAS BLEEDING HEAVILY. HER HUSBAND WAS AWAY AND SHE COULD NOT GO TO THE HOSPITAL WITHOUT THE PERMISSION OF A MALE RELATIVE. BY THE TIME HER UNCLE WAS FOUND AND FATIMA WAS CARRIED IN THE STRETCHER 15 KM TO THE NEAREST HIGHWAY, SHE WAS DEAD."

NOWADAYS, WOMEN STATUS BECOMES VERY IMPORTANT AGENDA TO EVERY NATION WORLDWIDE, PARTICULARLY IN AFRICA BECAUSE WOMEN ARE FOUND TO HAVE MANY DISADVANTAGES IN FAVOR OF MEN DUE TO THEIR LOW STATUS. IN ETHIOPIA, WOMEN GENERALLY DO

NOT HAVE POWER TO MAKE DECISIONS REGARDING THEIR OWN LIVES. THEY DON'T HAVE EQUAL RIGHT TO OWN LAND, THEY NEED THE CONSENT OF THEIR PARTNERS TO MAKE USE OF CONTRACEPTIVES AND EVEN TO SPACE OR LIMIT THEIR CHILDBIRTH, ETC.

THE UNIVERSAL DECLARATION OF HUMAN RIGHTS STATES THAT EVERY ONE HAS THE RIGHT TO TAKE PART IN THE GOVERNMENT OF HIS/HER COUNTRY, BUT THIS RIGHT IS NOT EXERCISED IN MANY PARTS OF OUR PLANET. THE EMPOWERMENT AND AUTONOMY OF WOMEN AND THE IMPROVEMENT OF WOMEN'S SOCIAL, ECONOMIC AND POLITICAL STATUS IS ESSENTIAL FOR THE ACHIEVEMENT OF BOTH TRANSPARENT AND ACCOUNTABLE GOVERNMENT AND ADMINISTRATION AND SUSTAINABLE DEVELOPMENT IN ALL AREAS OF LIFE.

POVERTY AND CULTURAL BELIEFS ABOUT THE ROLES AND VALUE OF WOMEN ALL CONSPIRE TO DEPRIVE FEMALES FROM INFANCY, OF THE VERY RESOURCES THEY NEED TO BE PRODUCTIVE MEMBERS OF SOCIETY, AND THUS ENGENDERING ECONOMIC DEPENDENCY ON MEN.

IT IS ALSO CLEAR THAT SOCIOECONOMIC IMBALANCES ARE PERPETUATED IN A MALE DOMINATED POLITICAL ARENA WHERE MALES DOMINATE POSITION OF POWER INCLUDING THE JUDICIARY.

THE IMPORTANCE OF EMPOWERMENT AND AUTONOMY OF WOMEN AND OF IMPROVEMENT IN THEIR POLITICAL, SOCIAL, ECONOMIC AND HEALTH STATUS IS EMPHASIZED BY A NUMBER OF INTERNATIONAL

HUMAN RIGHTS INSTRUMENTS. IMPROVING THE ECONOMIC STATUS OF WOMEN ENHANCES THEIR DECISION-MAKING CAPACITY AT ALL LEVELS AND IN ALL ASPECTS OF LIFE. THE DEVELOPMENT OF ANY SOCIETY MUST, THEREFORE, INCLUDE WOMEN IN ORDER TO BRING CHANGES IN SOCIAL AS WELL AS ECONOMIC DEVELOPMENT OF A COUNTRY.

REPRODUCTIVE HEALTH AND WOMEN STATUS

PEOPLES' VIEW OF REPRODUCTIVE HEALTH/FAMILY PLANNING [RH/FP] IS OF WIDE RANGE. THEY SEE REPRODUCTIVE HEALTH SERVICE AS ONE OF MANY ELEMENTS OF OVER ALL HEALTH, AND SEE HEALTH AS ONE ELEMENT OF QUALITY OF LIFE. WOMEN SAY HEALTH IS LINKED TO OTHER ASPECTS OF THEIR LIVES: TO THEIR FAMILIES, THEIR ECONOMIC CONDITIONS, AND THEIR GOALS AND VALUES. RH/FP EFFECTS ARE MULTIFACETED AND MULTIDIMENSIONAL. WOMEN MAY HAVE LONG HELD THIS BROAD PERSPECTIVE; HOWEVER, POLICY-MAKERS AND RESEARCHERS HAVE ONLY RECENTLY BEGUN TO ADOPT SIMILAR VIEWS AS THEY QUESTION WOMEN IN-DEPTH ABOUT THEIR PERCEPTIONS AND EXPERIENCES.

QUALITATIVE AND QUANTITATIVE DATA FROM DIFFERENT COUNTRIES SHOW THAT WOMEN GENERALLY BELIEVE CBRH/FP IS BENEFICIAL. FOR EXAMPLE, IN ZIMBABWE, WOMEN AND MEN SAID FAMILY PLANNING WAS AN IMPORTANT ELEMENT OF QUALITY OF LIFE. IN INDONESIA, COUPLES SAID FAMILY PLANNING OFFERED THEM A MEANS TO ACHIEVE FINANCIAL STABILITY AND HARMONY WITHIN THE HOME. WOMEN WHO USE REPRODUCTIVE HEALTH SERVICE SAY IT GIVES THEM FREEDOM TO PURSUE EDUCATION, JOBS AND OTHER OPPORTUNITIES, WHICH IMPROVES THEIR STATUS. ^[7, 8]

RH/FP AFFECTS NUMEROUS DOMAINS OF WOMEN'S LIVES

CBRH /FP PROGRAM IS OFTEN DISCUSSED IN TERMS OF ITS IMPACT ON WOMEN'S PHYSICAL HEALTH. HOWEVER, RESEARCHES INDICATE THAT WOMEN OFTEN VIEW FAMILY PLANNING IN BROADER TERMS, AS A LONG-TERM ACTIVITY THAT AFFECTS THE QUALITY OF THEIR PSYCHOSOCIAL HEALTH, THEIR DOMESTIC LIVES, THEIR ABILITY TO PARTICIPATE IN THE WORK FORCE, AND THEIR ABILITY TO JOIN IN COMMUNITY ACTIVITIES.

FOR SOME WOMEN, FAMILY PLANNING EXPERIENCES INCREASE THEIR SELF-ESTEEM AND AUTONOMY. A STUDY IN COCHABAMBA, BOLIVIA, FOUND THAT MODERN CONTRACEPTIVE USERS HAD HIGHER LEVELS OF SELF-DETERMINATION THAN NON-USERS AND ALSO WERE MORE SATISFIED WITH THEIR SEXUAL RELATIONSHIPS. ^[8]

SEVERAL STUDIES SUGGEST THAT CBRH /FP USE, LEAD TO IMPROVEMENTS IN COUPLE RELATIONSHIPS AND STABILITY AT HOME. IN ZIMBABWE, A WOMAN EXPLAINED THAT "WITHOUT FAMILY PLANNING AND THE CONSEQUENT CHILD SPACING AND LIMITATION, THERE IS NOT QUALITY OF LIFE. AS A WOMAN, YOU CANNOT GET ENOUGH TIME TO GIVE LOVE TO YOUR CHILDREN AND YOUR HUSBAND IF YOU HAVE MANY CHILDREN." _____IN MALI, WOMEN SAID THAT WITH SMALLER FAMILIES, THEY HAD MORE TIME TO DEVOTE TO THEIR HUSBANDS AND CHILDREN. AND IN INDONESIA, WHERE THE GOVERNMENT CBRH /FP PROGRAM HAS BEEN IN PLACE FOR MORE THAN TWO DECADES, COUPLES SAW CONTRACEPTIVE USE AS A SOURCE OF DOMESTIC TRANQUILITY. A WOMAN FROM NORTH SUMATRA SAID, "YES, PEOPLE ARE HAPPY WITH CBRH /FP PROGRAM. THEY SEE THAT THEIR FAMILY IS IN HARMONY, THEIR CHILDREN ARE BIG ENOUGH TO TAKE CARE OF THEMSELVES, WHILE THE MOTHER CAN TAKE CARE OF HERSELF."¹⁹¹

IN ONE STUDY, STUDY PARTICIPANTS SAID THAT REPRODUCTIVE HEALTH /CONTRACEPTIVE USE DEFINITELY AFFECTS THEIR ABILITY TO WORK AND GO TO SCHOOL. IN BRAZIL, ADOLESCENTS WHO SOUGHT TREATMENT FOR COMPLICATIONS FROM INDUCED ABORTIONS WERE NINE TIMES MORE LIKELY TO BE IN SCHOOL THAN ADOLESCENTS WHO CARRIED THEIR PREGNANCIES TO TERM. IN ZIMBABWE, FEMALE

STUDENTS WERE FREQUENTLY ASKED TO LEAVE SCHOOL IF THEY BECAME PREGNANT AND OFTEN DID NOT RETURN AFTER THE BIRTH OF A CHILD BECAUSE THEY WERE NO LONGER INTERESTED, HAD NO TIME, OR HAD NO MONEY.

WOMEN HAD MIXED VIEWS ABOUT WHETHER CBRH /FP PROGRAM HELPED OR HINDERED THEIR PARTICIPATION IN THE WORK FORCE. IN MALI, WOMEN SAID CBRH /FP PROGRAM WAS A WAY TO GAIN MORE TIME FOR WORK INSIDE AND OUTSIDE THE HOME. HOWEVER, FOR WOMEN IN BANGLADESH WHO EXPERIENCED SIDE EFFECTS, CONTRACEPTIVE USE WAS OFTEN SEEN AS A BARRIER TO WORK. ^[9]

IN SOME STUDIES, SUCH AS THOSE IN CHINA AND ZIMBABWE, WOMEN AND MEN SAID THAT CBRH /FP PROGRAM ENHANCED THEIR ABILITY TO EARN INCOME, AND THIS WAS VIEWED AS BENEFICIAL. IN THE PHILIPPINES, WOMEN SAID FAMILY PLANNING ALLOWED THEM TO WORK OUTSIDE THE HOME. HOWEVER, WITH LITTLE OR NO RELIEF FROM DOMESTIC CHORES, WOMEN DID NOT NECESSARILY SEE THIS OPPORTUNITY AS POSITIVE. WOMEN SPENT AN AVERAGE OF 46 HOURS PER WEEK WORKING OUTSIDE THE HOME --YET THEY ALSO SPENT AN AVERAGE OF 23 HOURS DOING HOUSEWORK. ^[10]

THE DUAL BURDEN OF DOMESTIC AND WORK ROLES WAS EVIDENT IN SOUTH KOREA. SINCE THE 1960S, WHEN THE GOVERNMENT IMPLEMENTED A NATIONWIDE FAMILY PLANNING PROGRAM THAT

ENCOURAGED COUPLES TO HAVE ONLY TWO CHILDREN, THE COUNTRY'S FERTILITY RATE HAS DECLINED. THE "FERTILITY REVOLUTION" HAS GIVEN WOMEN ADDITIONAL OPPORTUNITIES IN THE WORK PLACE, AND MEN HAVE BECOME MORE INVOLVED IN DOMESTIC CHORES. HOWEVER, THIS CHANGE HAS SOMETIMES LED TO FAMILY CONFLICT AND LOWER SELF-ESTEEM FOR WOMEN. MANY DROP OUT OF THE WORK FORCE AROUND THE TIME THEY MARRY OR HAVE THEIR FIRST CHILD BECAUSE THEIR DOMESTIC AND WORK RESPONSIBILITIES ARE TOO HEAVY. "I CAME OUT OF THE HOUSE AT DAWN, WENT TO SCHOOL AND TAUGHT MANY STUDENTS ALL DAY LONG," SAID ONE WOMAN. "TEACHING WAS A HARD-WORKING JOB. ...BUT EVEN AFTER I RETURNED HOME, MY LABOR DID NOT FINISH BECAUSE THE HOUSEWORK, WHICH IS ALWAYS A WIFE'S JOB, WAS LEFT UNDONE. ...IT WAS SO HARD; I COULDN'T HELP QUITTING THE JOB."^[11]

SOME WOMEN FELT CBRH /FP PROGRAM ALLOWED THEM TO PARTICIPATE IN FORMAL COMMUNITY ACTIVITIES, INCLUDING POLITICAL CAMPAIGNS. HOWEVER, MANY WOMEN, SUCH AS THOSE IN THE WESTERN VISAYAS IN THE PHILIPPINES, SAID THEIR INVOLVEMENT WAS LIMITED TO CERTAIN TYPES OF ACTIVITIES, SUCH AS RELIGIOUS ORGANIZATIONS. IN ZIMBABWE, FORMAL COMMUNITY PARTICIPATION INCREASED SLIGHTLY WITH PARITY; 5 TO 6 PERCENT OF WOMEN SAID THEY PARTICIPATED IN COMMUNITY ACTIVITIES AT THE TIME THEY

BECAME SEXUALLY ACTIVE, COMPARED WITH 10 TO 11 PERCENT PARTICIPATION AFTER THE BIRTH OF THE FOURTH CHILD. IT MAY BE THAT AS WOMEN'S STATUS INCREASES WITH MOTHERHOOD, IT BECOMES MORE ACCEPTABLE FOR WOMEN TO PLAY A ROLE OUTSIDE THE DOMESTIC SPHERE. NONETHELESS, WOMEN WHO PARTICIPATED IN FORMAL COMMUNITY ACTIVITIES EARLY IN LIFE TENDED TO CONTINUE COMMUNITY ACTIVITIES THROUGHOUT THEIR LIVES. ^[12, 23]

BENEFITS OF CBRH/FP PROGRAM TO WOMEN

MOST WOMEN AND MEN ARE CONVINCED THAT PRACTICING CBRH /FP PROGRAM AND HAVING SMALLER FAMILIES PROVIDE ECONOMIC AND HEALTH BENEFITS. ACROSS CULTURES, WOMEN AND MEN SURVEYED IDENTIFIED TWO MAIN BENEFITS OF CBRH /FP PROGRAM. SMALLER FAMILY SIZE LEADS TO INCREASED FAMILY INCOME, AND CONTRACEPTIVES GIVE WOMEN RESPITE FROM PREGNANCIES THAT ARE TOO CLOSELY SPACED. ^[12, 22]

IN CHINA, GENERATIONAL STUDIES INDICATED STARK CONTRASTS IN LIFE BEFORE AND AFTER FAMILY PLANNING. IN FOCUS GROUP DISCUSSIONS, WOMEN AND MEN DESCRIBED THE TIMES BEFORE FAMILY PLANNING AS DESPERATE AND BLEAK AND THE TIMES AFTER FAMILY PLANNING AS OPTIMISTIC. "MY PARENTS HAD EIGHT CHILDREN," ONE 56-YEAR-OLD WOMAN EXPLAINED. "MY FATHER DIED WHEN I WAS 20 -- THERE WAS NO MONEY FOR THE DOCTOR. SOME

SIBLINGS WERE GIVEN TO OTHER FAMILIES. HAVING TOO MANY CHILDREN -- NOT ONLY DO THE PARENTS SUFFER, BUT ALSO THE CHILDREN, WITH BAD NUTRITION AND BAD HOUSING CONDITIONS."

ANOTHER 60-YEAR-OLD WOMAN SPOKE OF HAVING SIX CHILDREN, FIVE OF WHOM SURVIVED. "AT HOME, WE HAD NOTHING TO EAT. IT IS HARD TO TALK ABOUT AND SAD TO RECALL." WHEN ASKED ABOUT THE RELATIONSHIP BETWEEN CBRH /FP PROGRAM AND VARIOUS ASPECTS OF THEIR LIVES, MORE THAN NINETY PERCENT OF SURVEY RESPONDENTS IN NORTH ANHUI AND SOUTH JIANGSU PROVINCES SAID FAMILY PLANNING HELPED THEM IN BECOMING HEALTHIER, EARN MORE INCOME, AND SPEND MORE TIME ON THEIR JOBS. "NOW OUR LIVES AND STATUS ARE IMPROVED," SAID ONE 34-YEAR-OLD WOMAN. "WE HAVE FEWER GYNECOLOGICAL DISEASES."^[13]

WORK/JOB OPPORTUNITIES

THE MOST COMPELLING EVIDENCE OF THE POSITIVE EFFECT OF CBRH /FP PROGRAM ON WOMEN'S EMPLOYMENT STATUS COMES FROM STUDIES IN THE PHILIPPINES. SECONDARY ANALYSIS OF DATA FROM THE 1983 CEBU LONGITUDINAL HEALTH AND NUTRITION SURVEY INDICATED THAT WOMEN WITH FEWER CHILDREN HAD GREATER INCREASES IN EARNINGS. MEAN CHANGE IN INCOME FOR WOMEN WITH NO SURVIVING CHILDREN BORN DURING THE STUDY INTERVAL (1983-91) WAS 2.3 TIMES HIGHER THAN THAT OF WOMEN WHO HAD GIVEN

BIRTH TO ONE OR MORE CHILDREN DURING THE SAME PERIOD. THE CHANGE IN INCOME IN PART REFLECTS AN INCREASE IN AVERAGE HOURS WORKED, ESPECIALLY FOR WOMEN IN THE INFORMAL SECTOR. PIECE WORKERS HAD THE LOWEST GAINS WHILE WAGE EARNERS IN THE FORMAL SECTOR HAD SUBSTANTIALLY HIGHER GAINS. THE NEGATIVE EFFECT OF CHILDBEARING ON INCOME WAS EXPLAINED BY LOWER WAGES AND FEWER WORK HOURS. ^[14]

ZIMBABWE STUDIES SUGGEST THAT THE TIMING OF CONTRACEPTIVE USE APPEARS TO INFLUENCE LATER EVENTS IN A WOMAN'S LIFE. A NATIONAL SURVEY OF ZIMBABWEAN WOMEN'S PARTICIPATION IN DEVELOPMENT FOUND THAT, WOMEN WHO HAD STARTED CONTRACEPTION EARLY IN THEIR REPRODUCTIVE LIVES WERE SIGNIFICANTLY MORE LIKELY TO BE WORKING AT THE TIME OF SURVEY. YET, THE STRONG TENDENCY FOR WOMEN TO DELAY FAMILY PLANNING UNTIL THEY HAVE HAD THEIR DESIRED NUMBER OF CHILDREN APPEARS TO PUT THEM AT A DISADVANTAGE IN THE COUNTRY'S HIGHLY COMPETITIVE JOB MARKET. ^[15]

IN ANOTHER STUDY, ZIMBABWEAN WOMEN AND MEN ASSOCIATED BOTH FAMILY PLANNING AND WOMEN'S PARTICIPATION IN THE LABOR FORCE WITH QUALITY OF LIFE, BUT IT WAS IMPORTANT FOR WOMEN TO PROVE THEIR FERTILITY BEFORE USING A CONTRACEPTIVE METHOD. SIMILARLY, IN-DEPTH INTERVIEWS WITH ZIMBABWEAN WOMEN WHO

HAD BEEN FORCED TO DROP OUT OF SCHOOL BECAUSE OF PREGNANCY DOCUMENTED THEIR REGRET THAT LACK OF KNOWLEDGE OF, OR ACCESS TO CBRH /FP PROGRAM HAD CUT THEM OFF FROM THE EDUCATION THEY NEEDED TO PURSUE CAREERS. ^[16]

THE STUDY PARTICIPANTS NOTED NUMEROUS BENEFITS OF FAMILY PLANNING, INCLUDING THE OPPORTUNITIES IT PROVIDED FOR WOMEN TO IMPROVE THEIR EDUCATION AND JOB SKILLS, TO ENHANCE THE FAMILY'S FINANCIAL SECURITY, OR TO IMPROVE THE WOMAN'S AUTONOMY AND SELF-ESTEEM. YET, THE IMPACT OF CBRH /FP PROGRAM ON WOMEN'S LIVES IS RESTRICTED BY THE SOCIAL, POLITICAL AND ECONOMIC CLIMATES IN WHICH THEY LIVE.

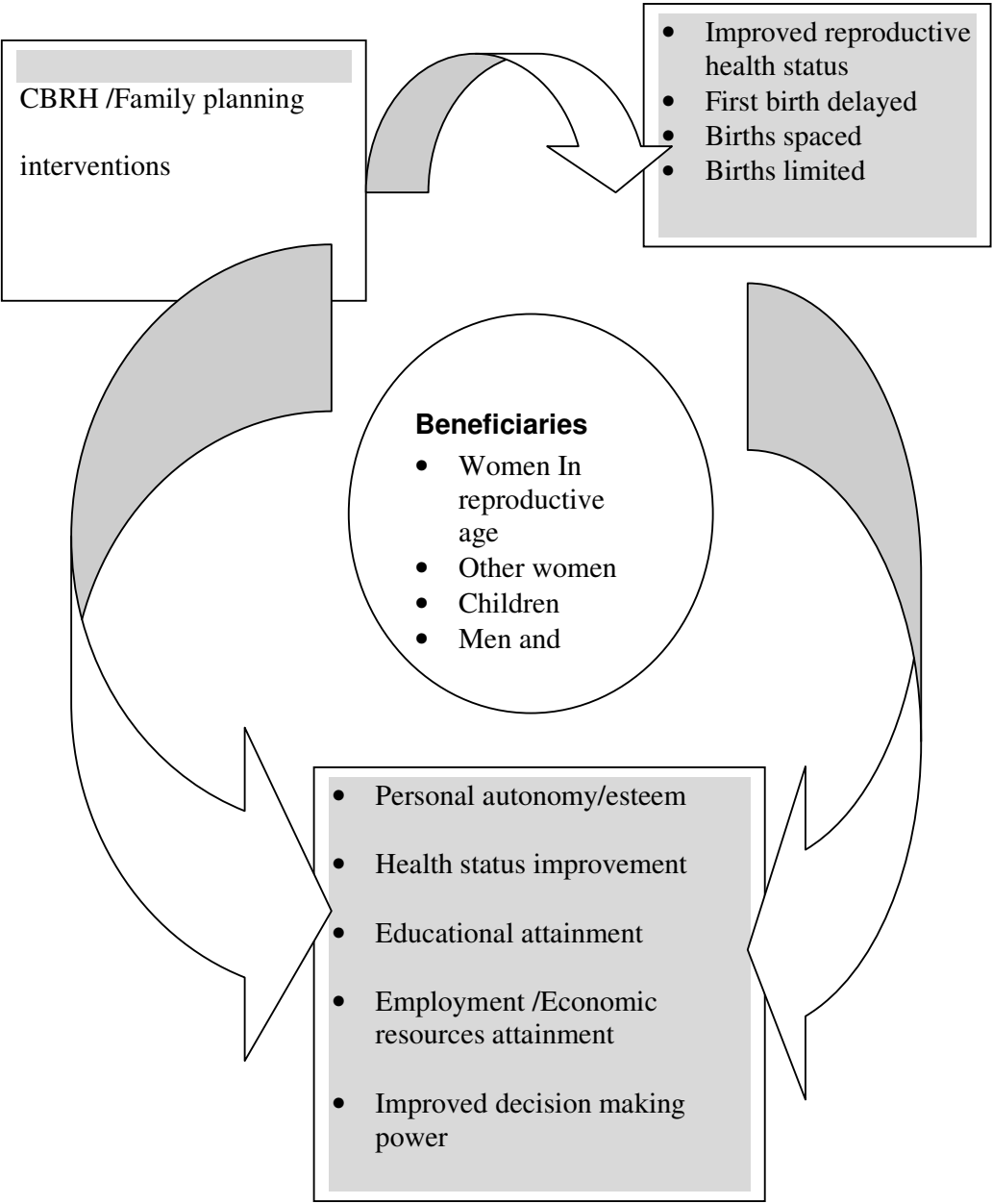
THE IMPACT OF HOUSEHOLD DELIVERY OF RH/FP SERVICES ON WOMEN STATUS

A STUDY WAS CONDUCTED IN BANGLADESH TO SHOW THE EFFECT OF RH/FP ON WOMEN STATUS. THE STUDY COMPARED WOMEN STATUS AT THE BEGINNING OF CBRH SERVICE IN 1988 WITH THE FINDINGS IN 1993, AFTER FIVE YEARS OF PROGRAM COMMENCEMENT. ACCORDING THE FINDING, AMONG 3783 CLIENTS AT THE BEGINNING THE PROGRAM, IN 1988, ALMOST ALL REPORTED HAVING PERMISSION TO VISIT PARENTS OR RELATIVES AND DECIDE ON OWN PROPERTY, OR BEING ABLE TO TAKE TRIPS AWAY FROM HOME. AFTER FIVE YEARS OF CBRHP

IMPLEMENTATION, IN 1993, MOST RESPONDENTS REPORTED THAT THERE WAS NO NEED OF ASKING PERMISSION TO LEAVE THE VILLAGE TO ATTEND A HEALTH CENTER OR TO SEE A MOVIE (91-92%), AND SAID THEY USUALLY DECIDED FAMILY SIZE AND TIMING OF BIRTHS (90-91%).^[17]

CONCEPTUAL FRAMEWORK OF THE STUDY

THE OVERALL EFFECT OF CBRH PROGRAM IN INCREASING WOMEN STATUS IS SUMMARIZED BY THE FOLLOWING FIGURE.



OBJECTIVE

GENERAL OBJECTIVE

To examine the effect of CBRH interventions on selected indicators of women empowerment

SPECIFIC OBJECTIVES

1. To compare the socio-economic autonomy of women in the CBRHP and non-CBRHP areas

2. To examine and compare level of involvement of women in decision making in the CBRHP and non-CBRHP areas

3. To assess knowledge & practice on MCM, and status of CPR in CBRHP & non-CBRHP areas

METHODS AND SUBJECTS

STUDY DESIGN

THE STUDY DESIGN IS A COMPARATIVE CROSS SECTIONAL STUDY COMPARING CBRHP AND NON-CBRHP AREAS WITH REGARD TO WOMEN STATUS .THE STUDY USED QUANTITATIVE METHOD AS A TOOL FOR DATA COLLECTION. A STRUCTURED QUESTIONNAIRE WAS EMPLOYED TO COLLECT DATA FROM THE STUDY POPULATION. THE STUDY AREAS WERE SELECTED USING INFORMATION OBTAINED FROM *WOREDA* AND ZONAL HEALTH OFFICES, WHICH ARE WORKING AS PARTNER WITH PATHFINDER INTERNATIONAL ETHIOPIA [PI/E] IN ITS CBRHP PROJECT. THE CRITERION USED TO IDENTIFY THE TWO-AREAS OF STUDY IS THE PRESENCE OR ABSENCE OF CBRH PROGRAM IN BOTH AREAS.

STUDY AREA

THE STUDY WAS CONDUCTED IN BASSONAWORANA DISTRICT, NORTH SHOA ZONE OF AMHARA REGION. THE DISTRICT IS ONE OF THE TWENTY DISTRICTS IN NORTH SHOA ADMINISTRATIVE ZONE. ACCORDING TO THE CENTRAL STATISTICAL AUTHORITY PROJECTION, THE TOTAL POPULATION OF THE DISTRICT FOR 2005 IS 145,430. ALMOST ALL THE DISTRICT POPULATION LIVES IN RURAL AREAS WHERE THERE IS SCARCE INFRASTRUCTURE OF ALL KIND. THE WOREDA IS DIVIDED IN

TO 29 VILLAGES, EACH HAVING THE LOWEST UNIT OF GOVERNMENTAL STRUCTURE. WITH REGARD TO HEALTH INFRASTRUCTURE; THE WOREDA HAS, ONE HEALTH CENTER, 20 HEALTH POSTS AND VARIOUS LEVEL HEALTH PROFESSIONALS INCLUDING 68 CBRHAS. THE POTENTIAL HEALTH SERVICE COVERAGE FOR THE DISTRICT IS 68%.

THIS DISTRICT IS SELECTED BECAUSE; THIS IS THE ONLY DISTRICT IN NORTH SHOA ZONE IN WHICH CBRH PROGRAM IS PARTIALLY COVERED BY PI/E IN COLLABORATION WITH THE ZONAL HEALTH DEPARTMENT. THIS MAKES CONVENIENT TO CONDUCT A COMPARATIVE STUDY IN BOTH PROGRAM COVERED AND NONE COVERED AREAS. TEN VILLAGES, FIVE FROM CBRHP AND ANOTHER FIVE FROM NCBRHP AREAS WERE SELECTED BASED ON PRESET CRITERIA USING INFORMATION OBTAINED FROM THE DISTRICT HEALTH OFFICE.

THE CBRHP PROGRAM STARTED IN THE DISTRICT IN 2001 AND OUT OF THE 29 KEBELES OF THE DISTRICT, THE PROGRAM WAS LAUNCHED IN 19 KEBELES .EIGHTY ONE COMMUNITY BASED REPRODUCTIVE HEALTH AGENTS WERE SELECTED BY THE COMMUNITY AND HAD BEEN TRAINED FOR 15 DAYS BASED ON THE CURRICULUM OF MINISTRY OF HEALTH. EACH CBRHA WAS RESPONSIBLE FOR HIS RESPECTIVE VILLAGE IN PROVIDING REPRODUCTIVE HEALTH SERVICE BOTH IN STATIC AND “HOUSE TO HOUSE” BASIS.

MEASUREMENT

WOMEN STATUS WAS MEASURED USING VARIOUS VARIABLES. IN THIS STUDY THE INDEPENDENT VARIABLES (EXPOSURE) ARE THE SOCIO-DEMOGRAPHIC VARIABLES SUCH AS AGE, SEX, EDUCATION AND MAJOR REPRODUCTIVE CHARACTERISTICS.

THE DEPENDENT (OUTCOME) VARIABLES ARE:

- DECISION MAKING POWER
- ECONOMIC IMPROVEMENT
- PUBLIC PARTICIPATION
- SOCIAL STATUS

STUDY POPULATION

THE STUDY POPULATION IS MARRIED WOMEN IN REPRODUCTIVE AGE GROUP RESIDING IN BOTH AREAS OF SELECTED KEBELES, AND THE STUDY WAS CONDUCTED FROM NOVEMBER 2005 THROUGH FEBRUARY 2006.

PROCEDURE OF SAMPLING

TO SELECT THE STUDY SUBJECTS DIFFERENT SAMPLING TECHNIQUES WERE USED. OUT OF THE 19 KEBELES OF THE CBRHP AND 9 KEBELES

NON-CBRHP AREAS, FIVE KEBELES FROM EACH WERE SELECTED FOR THE STUDY USING THE RANDOM SAMPLING METHOD. PROPORTIONAL ALLOCATION WAS USED TO DETERMINE THE NUMBER OF HOUSEHOLDS AND SYSTEMATIC RANDOM SAMPLING WAS USED TO LOCATE THE STUDY HOUSEHOLDS. IN EACH HOUSEHOLD, ONE MARRIED WOMEN IN REPRODUCTIVE AGE GROUP WAS ENROLLED AND INTERVIEWED IN THE STUDY .IN CASE IF THERE WERE MORE THAN ONE ELIGIBLE IN THE SAME HOUSEHOLD, ONE WAS SELECTED USING LOTTERY METHOD. IN CASE, IF THERE WAS NO ILLEGIBLE IN THE SELECTED HOUSEHOLD, THE NEXT NEAR HOUSEHOLD WAS TAKEN.

SAMPLE SIZE

THE ASSUMPTION MADE FOR THE SAMPLE SIZE CALCULATION WAS BASED ON THE STUDY AREA EXPERIENCE OF CBRHP PRACTICES AND WOMEN DECISION MAKING OF 49% [30]. A TWO-SIDED SIGNIFICANT LEVEL OF 0.05 AND POWER OF 80% WERE USED.

$$N \text{ (EACH GROUP)} = \frac{[Z_{1-\alpha/2} \sqrt{(1+1/R)P(1-P)} + Z_{1-B} \sqrt{P_1(1-P_1)+P_2(1-P_2)}]}{(P_2-P_1)}$$

KEY:

$$P \text{ (POPULATION PROPORTION)} = \frac{P_1+RP_2}{1+R}$$

P₁= WOMEN DECISION MAKING POWER IN CBRHP AREA [49%]

P_2 = WOMEN DECISION MAKING POWER IN NCBRHP AREA [32%]

$Z_{1-\alpha/2}$ = VALUE OF THE STANDARD NORMAL DISTRIBUTION AT SIGNIFICANT LEVEL OF

ALPHA 0.05

Z_{1-B} = VALUE OF THE STANDARD NORMAL DISTRIBUTION CORRESPONDING TO A POWER OF 80%

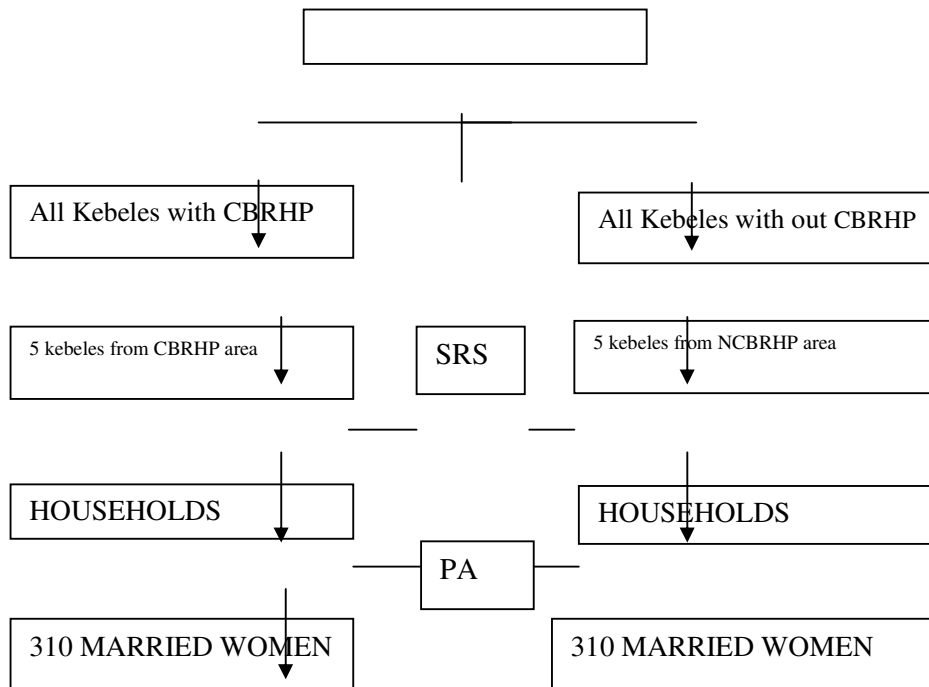
BASED ON THIS SAMPLE SIZE CALCULATION, INCLUDING THE DESIGN EFFECT OF 2 STAGES AND 10% LOSSES TO FOLLOW-UP/NONE RESPONSE RATE, THE STUDY SUBJECTS FOR EACH GROUP ARE 310.

SELECTION CRITERIA

CBRHP AREAS: THESE ARE KEBELES IN WHICH COMMUNITY BASED REPRODUCTIVE HEALTH SERVICES ARE PROVIDED BY TRAINED CBRHAS.

NON-CBRHP AREAS: THESE ARE KEBELES IN WHICH COMMUNITY BASED REPRODUCTIVE HEALTH SERVICES ARE NOT PROVIDED AND DO NOT HAVE TRAINED CBRHAS.

STUDY ARCHITECTURE



DATA COLLECTION

DATA WERE COLLECTED BY INTERVIEWING STUDY SUBJECTS USING STRUCTURED QUESTIONNAIRE. INFORMATION WAS COLLECTED

REGARDING THE STATUS OF WOMEN, BASED ON THE DHS MODEL QUESTIONNAIRE BY ADAPTING TO THE LOCAL CONDITION.

THE SURVEY WAS CONDUCTED IN REMOTE RURAL AREAS WITH DIFFICULT TERRAIN; MALE AND FEMALE DATA COLLECTORS WHO COMPLETED GRADE 12 WERE SELECTED AND TRAINED ON TECHNIQUES OF DATA COLLECTION FOR FOUR DAYS. FOR THE PURPOSE OF SUPERVISION, TWO HEALTH PROFESSIONALS WERE EMPLOYED AND TRAINING WAS GIVEN ON BASIC SUPERVISORY SKILLS.

THE QUESTIONNAIRE WAS INITIALLY PREPARED IN ENGLISH AND THEN WAS TRANSLATED IN TO AMHARIC AND BACK TO ENGLISH TO CHECK FOR CONSISTENCY. THE AMHARIC VERSION QUESTIONNAIRE WAS PRE-TESTED BEFORE THE BEGINNING OF ACTUAL DATA COLLECTION PROCESS IN OUTSIDE THE STUDY AREAS, AND APPROPRIATE CORRECTION WAS DONE.

QUALITY CONTROL

THE PRINCIPAL INVESTIGATOR AND THE SUPERVISORS CHECKED THE ACCURACY AND RELIABILITY OF THE DATA COLLECTION PROCESS. THEY WERE GIVING CLARIFICATIONS WHEN AMBIGUITY OCCURRED. DISCUSSIONS WERE HELD AMONG THE PRINCIPAL INVESTIGATOR, SUPERVISORS, AND DATA COLLECTORS, AS NECESSARY. BASED ON THE FEEDBACK FROM THE SUPERVISORS AND DATA COLLECTORS, IMMEDIATE CORRECTIVE MEASURES WERE TAKEN.

AN INTERVIEW GUIDE AND JOB DESCRIPTION MANUAL WAS PREPARED AND GIVEN TO DATA COLLECTORS.

DATA ENTRY AND ANALYSIS

THE DATA WERE CODED AND ENTERED TO EPI-INFO VERSION 6 AND ANALYZED USING THE SAME PACKAGE AND SPSS VERSION 11. TO SHOW MEASURES OF STRENGTH OF ASSOCIATIONS ODDS RATIO AND χ^2 TEST ARE USED. P-VALUE AND 95% CONFIDENCE INTERVAL WERE USED TO SEE STATISTICAL SIGNIFICANCE. LOGISTIC REGRESSION ANALYSIS WAS DONE TO MEASURE THE RELATIVE EFFECT OF SELECTED INDEPENDENT VARIABLES ON THE DEPENDENT VARIABLES.

ETHICAL CONSIDERATION

ETHICAL CLEARANCE AND APPROVAL WAS OBTAINED FROM THE DEPARTMENT OF COMMUNITY HEALTH, FACULTY OF MEDICINE, ADDIS ABABA UNIVERSITY. THE NECESSARY PERMISSION WAS OBTAINED FROM BASSONAWORANA ADMINISTRATIVE COUNCIL, BASSONAWORANA HEALTH OFFICE AND LOCAL ADMINISTRATIVE HIERARCHIES. INFORMED VERBAL CONSENT WAS OBTAINED FROM THE STUDY SUBJECTS AND CONFIDENTIALITY WAS ASSURED.

DISSEMINATION AND UTILIZATION OF RESULTS

THE STUDY FINDINGS WILL BE COMMUNICATED TO THOSE WHO NEED THE STUDY RESULTS FOR VARIOUS PURPOSES. GOVERNMENTAL AND NON-GOVERNMENTAL ORGANIZATIONS, INSTITUTIONS AND INDIVIDUALS THAT HAVE INTEREST ON THE SUBJECT MATTER WILL BE AMONG THE UTILIZERS OF THE FINDINGS. THE FINDINGS OF THE RESULTS CAN BE PUBLISHED IN SCIENTIFIC JOURNALS IF NEED BE.

OPERATIONAL DEFINITIONS

- *STATUS OF WOMEN* REFERS TO THE ECONOMIC AND SOCIAL FREEDOM ENJOYED BY WOMEN IN THE FAMILY
- *Condition of women* refers to women's practical or material needs and includes such things as education, health, food, water, fuel, improved technology, skills and wages.
- *The position of women*, is concerned with their status in society and is related to the underlying structures of subordination and inequality, especially as they determine the position of women with regard to that of men
- *Women's position in the household*: participation in decisions such as family size, use of household income, children's education, and labor force participation:

indicators of the potential for women's empowerment in household decision-making.

- *Women's position in the community*: participation in community and local political activities.
- *Empowerment* is “the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them”. It is important to mention that women's decision-making power and women's autonomy are two intrinsically linked dimensions of what is called women's empowerment.
- “*Status and decision-making power within the household.*” This dimension includes decisions on the allocation of resources within the household, control over money and purchases, and enhanced status in the family.
- *Women involvement in decision-making* is referred here to women's ability to express their opinion and involvement on family decision processes
- *Women's autonomy* is referred here to married women's capacity of taking initiatives and actions without asking for their partners' approval.
- *Agricultural supplies* referred to any agricultural equipment, or commercial, agricultural products or commodities, raised, grown or maintained at household level.
- *Household supplies* are referred here to any item or equipment for common domestic use at household level
- *Modern Contraceptives* are referred to methods that prevent conception through their chemical and mechanical effects.

RESULTS

1. SOCIO-DEMOGRAPHIC CHARACTERISTICS

A TOTAL OF 620 WOMEN IN REPRODUCTIVE AGE WERE INTERVIEWED, FROM WHICH EACH 310 RESPONDENTS WERE IN CBRHP [COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM] AND NCBRHP [NON-COMMUNITY BASED REPRODUCTIVE HEALTH PROGRAM] AREAS. THEIR BACKGROUND CHARACTERISTICS ARE PRESENTED IN TABLE 1.

THE AGE DISTRIBUTION OF BOTH GROUPS SHOWED A SIMILAR PATTERN, WITH MEAN AGE OF 32.4 ± 8.6 AND 30.9 ± 8.1 YEARS IN THE PROGRAM AND NON-PROGRAM AREAS RESPECTIVELY.

MAJORITY OF THE STUDY SUBJECTS IN BOTH AREAS WERE ORTHODOX CHRISTIANS, 98.7% AND 99.7% IN CBRH AND NCBRH AREAS RESPECTIVELY.

AS SHOWN IN TABLE 1, THE TWO GROUPS WERE COMPARABLE ON A NUMBER OF SOCIO-DEMOGRAPHIC CHARACTERISTICS SUCH AS ETHNICITY, EDUCATIONAL STATUS AND OCCUPATION. ON THESE VARIABLES NO STATISTICALLY SIGNIFICANT DIFFERENCES WERE OBSERVED.

2. REPRODUCTIVE CHARACTERISTICS

THE MEAN AGE OF MARRIAGE, IN PROGRAM AND NON-PROGRAM AREAS WAS 17.5 ± 3.1 AND 17.1 ± 2.9 YEARS RESPECTIVELY. WHILE, THE MEAN AGE OF BEARING THE FIRST CHILD WAS 19.2 ± 3.5 AND 18.1 ± 4.4 YEARS IN CBRHP AND NCBRHP AREAS RESPECTIVELY.

THE AVERAGE TOTAL BIRTHS PER WOMAN WERE 3.4 AND 4.3 CHILDREN FOR PROGRAM AND NON-PROGRAM AREAS RESPECTIVELY. THE AVERAGE NUMBER OF CHILDREN A WOMAN HAS CURRENTLY WAS FOUND TO BE 3.1 IN CBRHP AND 4.1 IN NON-CBRHP AREAS, AND THE DIFFERENCE IS STATISTICALLY INSIGNIFICANT. ON THE OTHER HAND

THE AVERAGE NUMBER OF PERSONS PER HOUSEHOLD IN PROGRAM AND NON PROGRAM AREAS WERE 4.3 AND 5.2 RESPECTIVELY.

Table 1, Socio-demographic characteristics of CBRHP and non-CBRHP areas, Bassonaworana Woreda, North Shoa zone, 2005/06

Variables	CBRHP area N [%]	NCBRHP area N [%]	OR [95% CI]	X²	P-value
	N=310[100]	N=310[100]			
1.Age					
15-19 years	10(3.2)	18(5.8)		8.4	0.212
20-24 "	53(17)	51(16.5)			
25-29 "	70(22.5)	76(24.6)			
30-34 "	45(14.5)	58(18.8)			
35-39 "	49(15.8)	41(13.3)			
40-44 "	42(13.5)	39(12.3)			
45-49 "	41(13.5)	27(8.7)			
Mean ± SD	32.4±8.63	30.9±8.1			
2.Religion					
Orthodox	306(98.7)	309(99.7)		4.9	0.172
Catholic	0(0)	1(0.3)			
Protestant	1(0.3)	0(0)			
Muslim	3(1)	0(0)			
3.Ethnicity					
Amhara	307(99.1)	308(99.4)		2.0	0.574
Oromo	2(0.6)	1(0.3)			
Tigre	1(0.3)	1(0.3)			

4.Education

Illiterate	198(64.1)	222(71.8)	4.8	0.090
Read & write	67(21.7)	48(15.5)		
Elementary & +	45(14.2)	40(12.6)		

Table 1(CONT.)

Variables	CBRHP area N [%]	NCBRHP area N [%]	OR [95% CI]	X²	P- value
	N=310[100]	N=310[100]			
5.Occupation					
House wife	281(90.7)	280(90.3)		2.2	0.701
Farmer	3(1.0)	2(0.6)			
Alcohol Seller	19(6.1)	24(7.8)			
Gov. employee	6(1.9)	4(1.3)			
Student	1(0.3)	0(0)			
6. Crop land avail.					
Yes	243(78.1)	272(88)	1.9(1.3,3.1)		
No	67(21.9)	38(12)			
7.Grow cash crop					
Yes	101(32.5)	30(9.7)	4.5(2.8,6.9)		
No	209(67.5)	280(90.3)			
8.Radio available					
Yes	218(70.1)	136(44)	2.9(2.1,4.2)		
No	92(29.9)	174(56)			

**Table 2, Reproductive characteristics of CBRHP and non-CBRHP areas,
Bassonaworana Woreda, North Shoa zone, 2005/06**

Variables	CBRHP area N[%]	NCBRHP area N[%]	X²	P-value
	N=310[100]	N=310[100]		
Age of marriage				
Below 15	40(12.9)	43(13.9)	1.2	0.784
15-19 years	195(63)	197(63.4)		
20-24 "	64(20.6)	61(19.7)		
25-29 "	11(3.5)	9(2.9)		
Mean ± SD	17.5 ± 3.1	17.1±2.9		
Age at first preg.				
Below 15 yrs.	9(3)	14(4.7)	2.4	0.671
15-19 years	168(51.5)	182(57.1)		
20-24 "	116(39.8)	101(33.8)		
25-29 "	17(5.7)	13(4.4)		
Mean ± SD	19.2±3.5	18.1±4.4		
Total No. of births.				
0	14(4.5)	20(6.5)	2.4	0.298
1-3	169(54.4)	152(48.9)		
≥4	127(41.1)	138(44.7)		
Mean ± SD	3.41±2.2	4.33±2.3		

Table 2 (CONT'D)

Variables	CBRHP area N[%]	NCBRHP area N[%]	X²	P-value
	N=310[100]	N=310[100]		
Total No. of currently surviving children				
0	14(4.5)	20(6.5)	1.9	0.382
1-3	178(57.3)	167(53.4)		
≥4	118(38.2)	123(39.8)		
Mean ± SD	3.11±2.4	4.12±2.3		
More children wanted				
0	228(73.6)	193(62.5)	4.2	0.0001
1-2	68(21.9)	51(16.2)		
3-4	9(2.9)	39(11.7)		
5-6	5(1.6)	17(5.9)		
>6	0(0)	10(3.7)		
Mean ± SD	1.91± 0.72	2.56± 1.3		
Hx of unwanted				

pregnancy

Yes	76(24.4)	148(48.7)	39.0	0.0001
No	234(75.6)	162(51.3)		

REGARDING DESIRE FOR ADDITIONAL CHILDREN, 73.6% AND 62.5% OF THE WOMEN IN PROGRAM AND NON-PROGRAM AREAS RESPECTIVELY REPORTED THAT THEY DIDN'T WANT TO HAVE ANY ADDITIONAL CHILDREN [$X^2=4.15, P=0.0001$].

AMONG THOSE WOMEN WHO HAD HISTORY OF PREGNANCY, 24.4% IN CBRHP AND 48.7% IN NON-CBRH AREAS HAD HISTORY OF UNWANTED PREGNANCIES [OR=0.345; 95%CI=0.244, 0.487]

3. CONTRACEPTIVE CHARACTERISTICS

IN THIS SECTION A COMPARISON WAS DONE ON WOMEN'S KNOWLEDGE AND UTILIZATION OF DIFFERENT FAMILY PLANNING METHODS BETWEEN THE PROGRAM AND NON-PROGRAM AREAS.

THE PROPORTION OF WOMEN WHO HEARD OF AT LEAST ONE FAMILY PLANNING METHOD WAS SIGNIFICANTLY HIGHER IN THE PROGRAM AREA [90.9%] THAN NON-PROGRAM AREA [70.1%] AND THE DIFFERENCE WAS STATISTICALLY SIGNIFICANT [OR=4.25; 95%CI=2.68,6.73]

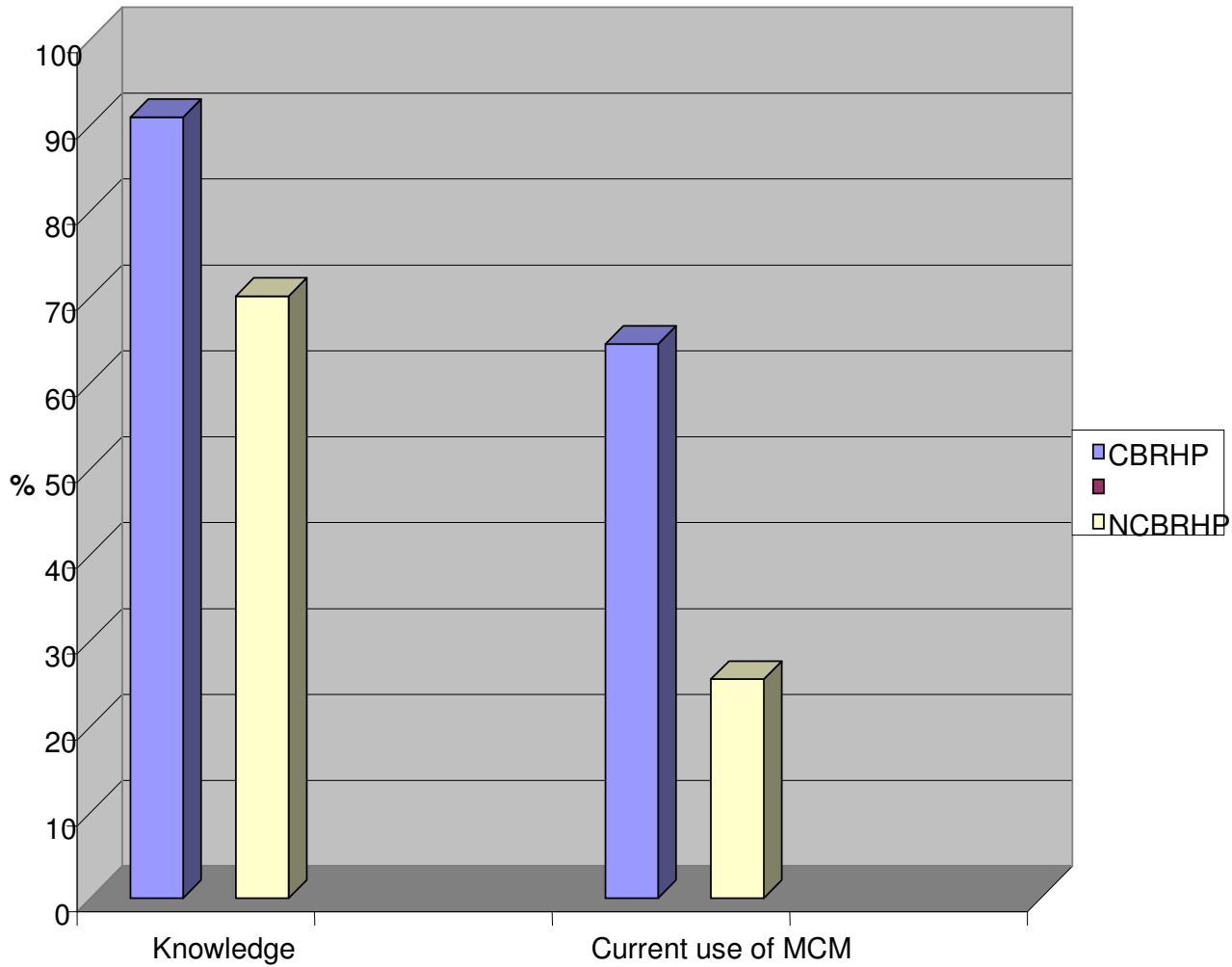
REGARDING THE KNOWLEDGE OF SPECIFIC CONTRACEPTIVE METHODS THE KNOWLEDGE FOR PILLS WAS 81.5% IN PROGRAM AREA AND 80.5%

IN NON-PROGRAM AREA. FOR THE INJECTABLES THE KNOWLEDGE WAS 94.6% AND 64.9% IN CBRHP AND NCBRHP AREAS, THE DIFFERENCE IS STATISTICALLY SIGNIFICANT [OR=11.7;95%CI=6.3,21.7]. WHILE FOR CONDOMS, IUCD, NORPLANT AND VOLUNTARY SURGICAL CONTRACEPTIVE [VSC] THE KNOWLEDGE WAS 52.5%, 42.1%,42.1%,AND 2.5% RESPECTIVELY FOR PROGRAM AREAS AND 29.8%, 1.4%,1.4%, AND 0.5%, RESPECTIVELY IN NON-PROGRAM AREAS.

REGARDING USE OF CONTRACEPTIVES METHODS, RESPONDENTS WHO EVER USE MODERN CONTRACEPTIVES METHODS [MCM] IN PROGRAM AREAS WERE 64.8% AND IN NON- PROGRAM AREAS 38.7% AND THE DIFFERENCE WAS STATISTICALLY SIGNIFICANT [OR=1.9; 95%CI=1.3,2.8].

THE CURRENT USE OF MCM, 64.5 %OF THE WOMEN IN CBRHA AND 25.5% IN NON-CBRHA AREAS ALSO SHOWED STATISTICALLY SIGNIFICANT DIFFERENCE [OR=2.3; 95%CI=1.4, 3.8].

Fig.1 Knowledge & current use of MCM in CBRHP & NCBRHP areas Bassonsworana woreda, North Shoa zone, 2005/06



THE MOST WIDELY USED CONTRACEPTIVES METHOD IN BOTH AREAS WERE INJECTABLES AND PILLS.

THE MAJORITY OF WOMEN WHO ARE CURRENTLY USING MCM ARE TAKING INJECTABLE [82.0%] AND [74.7%], FOLLOWED BY PILLS [16.5%] AND [22.8 %] IN PROGRAM AND NON-PROGRAM AREAS RESPECTIVELY. IN BOTH AREAS ONLY FIVE RESPONDENTS USED PERMANENT METHODS OF CONTRACEPTIVES AND IUCD.

THE MAJOR SOURCE OF CONTRACEPTIVES SUPPLY [64.1%] IN PROGRAM AREA ARE COMMUNITY BASED REPRODUCTIVE HEALTH AGENTS [CBRHA] WHILE 98.9% OF THE NON- PROGRAM AREA RESPONDENTS GOT THEIR SUPPLY FROM PUBLIC HEALTH INSTITUTIONS. RESPONDENTS WERE ALSO ASKED WHETHER THEY EVER GOT SERVICE BY CBRHAS IN THE PAST ONE-YEAR. AS EXPECTED, MAJORITY OF THE PROGRAM AREA RESPONDENTS [81.6%], GOT SERVICE BY CBRHAS AND ONLY 2.6% OF THE NON-CBRHP AREA RESPONDENTS GOT SERVICE BY THE AGENTS.

REGARDING CROPLAND OWNERSHIP OF THE RESPONDENTS, A SIGNIFICANT DIFFERENCE WAS SEEN IN PROGRAM AND NON-PROGRAM AREAS, 78.1% AND 88% IN CBRHP AND NCBRHP AREAS RESPECTIVELY [OR=1.9; 95%CI=1.3,3.1]. ON THE OTHER HAND, REGARDING AVAILABILITY OF CASH CROP, A SIGNIFICANT DIFFERENCE IS SEEN, 32.5% AND 9.7% IN PROGRAM AND NON PROGRAM AREAS RESPECTIVELY [OR=4.5; 95%CI=2.8, 6.9] (TABLE 1).

Table 3, Knowledge and practice of reproductive health service in CBRHP and non-CBRHP areas, Bassonaworana Woreda, North Shoa zone, 2005/06

Variables	CBRHP area N[%]	NCBRHP area N[%]	OR[95% CI]
	N=310[100]	N=310[100]	
Knowledge of MCM			
Yes	282(90.9)	211(70.1)	4.25(2.68,6.73)
No	28(9.1)	89(29.9)	1.0
Knowledge of specific MCM			
Pills			
Yes	230(81.5)	170(80.5)	1.19(0.8,1.9)
No	52(18.5)	41(19.5)	1.0
Injectable			
Yes	267(94.6)	137(64.9)	11.7(6.3,21.7)
No	15(5.4)	74(35.1)	1.0
Ever use of MCM			
Yes	201(64.8)	120(38.7)	1.9(1.3,2.8)
No	109(35.2)	190(61.3)	1.0
Ever use of specific MCM			

Pills			
Yes	65(32.3)	55(45.8)	1.8(1.1,2.9)
No	136(67.7)	65(54.2)	
Injectable			
Yes	161(80.1)	68(56.7)	3.2(1.9,5.2)
No	40(19.9)	52(43.3)	1.0

Table 3 (CONT'D)

Variables	CBRHP area N[%]	NCBRHP area N[%]	OR[95% CI]
	N=310[100]	N=310[100]	
Current use of MCM			
Yes	200(64.5)	79(25.5)	2.3(1.4,3.82)
No	110(35.5)	231(74.5)	
Current use of specific MCM			
Pills			
Yes	33(16.5)	18(22.8)	1.5(0.8,2.9)
No	167(83.5)	61(77.2)	1.0
Injectable			
Yes	164(82.0)	59(74.7)	2.4(1.5,3.8)
No	36(18.0)	20(25.3)	1.0
Source of contraceptive			
CBRHA	143(64.1)	0(0)	
Health facility	57(35.9)	77(98.9)	
Pharmacy	0(0)	2(1.1)	
Shop	0(0)	0(0)	

OWNERSHIP OF RADIO HAD SHOWN A SIGNIFICANT DIFFERENCE BETWEEN THE TWO AREAS WITH 70.1% IN PROGRAM AREA AND 44% IN NON-PROGRAM AREA [OR=2.9; 95%CI=2.1, 4.2]

4. DECISION MAKING AUTONOMY

WOMEN'S DECISION-MAKING AUTONOMY IS SIGNIFICANTLY ASSOCIATED WITH IMPLEMENTATION OF REPRODUCTIVE HEALTH PROGRAM. THE CONVENTIONAL FACTORS SUCH AS EDUCATION AND ECONOMIC STATUS THAT OFTEN DETERMINE THE STATUS OF WOMEN DO NOT VARY IN MOST OF THE STATUS INDICATORS OF THIS STUDY BETWEEN THE PROGRAM AND NON-PROGRAM AREAS, THUS, COULD NOT EXPLAIN THE OBSERVED DIFFERENCES.

TWO HUNDRED FORTY THREE [78.3%] AND 48[15.5%] OF THE WOMEN IN THE CBRHP AREAS SAID THAT DECISION MAKING IN FAMILY PLANNING [FP] HAD BEEN MADE JOINTLY AND BY THE WIVES ALONE RESPECTIVELY .THE CORRESPONDING PROPORTIONS FOR THE NON-PROJECT AREAS WERE 65 % AND 5.8 %. HUSBANDS MADE DECISIONS IN 19 [6.2%] AND 90[29.2%] OF RESPONDENTS IN PROGRAM AND NON-PROGRAM AREAS RESPECTIVELY.

81.2% AND 14.2% OF THE WOMEN IN THE PROJECT AREAS SAID THAT DECISION-MAKING ON NUMBER OF CHILDREN AND BIRTH INTERVALS

HAD BEEN MADE JOINTLY AND BY THE WIVES ALONE, RESPECTIVELY. ON THE OTHER HAND THE CORRESPONDING PROPORTIONS FOR THE NON-PROJECT AREA WERE 69.6 % AND 5.5 %, AND 24.9% OF THE RESPONDENTS IN NONE PROJECT AREA SAID THAT DECISIONS WERE MADE BY THE HUSBANDS ALONE.

SEVENTY FOUR PERCENT OF THE WOMEN IN CBRH AREAS SAID THAT DECISION MAKING ON BUYING OR SELLING MAJOR HOUSEHOLD AND AGRICULTURAL ITEMS ARE MADE JOINTLY AND 12.9 % BY THE WIVES ALONE. THE CORRESPONDING PROPORTIONS FOR THE NCBRH RESPONDENTS WERE 36.9 % AND 4.9 % RESPECTIVELY.

REGARDING DECISION MAKING ON BUYING MAJOR HOUSEHOLD SUPPLY, 20.3% AND 4.9 % OF RESPONDENTS MADE DECISION BY THEMSELVES ON BOTH PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY.

SEVENTEEN PERCENT OF THE PROGRAM AREA RESPONDENTS REPORTED HAVING EVER TAKEN A SICK CHILD TO HEALTH INSTITUTIONS BY THEMSELVES, WITH NO PERMISSION FROM THEIR HUSBANDS, AND 9.3% OF THEM SAID THEY HAD PERMISSION TO DO SO. IN CONTRAST 4.5% OF THE NONE PROGRAM AREA RESPONDENTS TOOK THEIR CHILDREN TO THE INSTITUTIONS BY THEM SELVES, 44.3% SAID THAT THEY HAD PERMISSION FROM THEIR HUSBANDS.

SEVENTY [22.5%] AND 16 [5.2 %] OF RESPONDENTS HAD TAKEN MEDICAL CARE BY THEMSELVES; WHILE 28[9%] AND 166[53.7%] OF THE RESPONDENTS HAD EVER TAKEN MEDICAL CARE BY GETTING PERMISSION FROM THEIR SPOUSES IN BOTH PROGRAM AND NON PROGRAM AREAS RESPECTIVELY.

REGARDING SPENDING MONEY EARNED BY THE RESPONDENTS, 19.6% AND 5.5% OF WOMEN SPENT THE MONEY EARNED BY THEM, WHILE 73.0% AND 53.7 %OF THE RESPONDENTS MADE DECISIONS JOINTLY IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY. ON THE OTHER HAND CONCERNING DECISIONS MADE ON MONEY EARNED BY HUSBANDS 77.5% AND 50.2 % OF RESPONDENTS MADE DECISIONS JOINTLY WHILE 11.3% AND 45.0 %OF DECISIONS WERE MADE BY THE HUSBANDS ALONE, IN CBRHP AND NCBRHP AREAS RESPECTIVELY.

REGARDING DECISIONS MADE IN BUYING AND SELLING CATTLE, 76.2% AND 49.5 % OF THE RESPONDENTS DECIDED JOINTLY WITH THEIR HUSBANDS WHILE IN 12.5% AND 45.6 % RESPONDENTS, DECISIONS WERE MADE BY HUSBANDS ALONE IN CBRHP AND NCBRHP AREAS RESPECTIVELY.

TWO HUNDRED FORTY THREE [78.5%] AND 155 [50.2 %] OF THE RESPONDENTS HAD DECIDED IN BORROWING OR LENDING CASH OR MATERIALS JOINTLY WITH THEIR SPOUSES, WHILE 10.3% AND 45.3 % OF THE RESPONDENTS REPORTED THAT DECISIONS WERE MADE BY THEIR HUSBANDS ALONE IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY.

Table 4; Decision making status in CBRHP and non-CBRHP areas, Bassonaworana Woreda, North Shoa zone 2005/06.

Variables	CBRHP area	NCBRHP area	OR[95% CI]
	N[%]	N[%]	
	N=310[100]	N=310[100]	
In obtaining FP methods			
Woman	48(15.5)	18(5.8)	12.6(5.7,28.3)
Husband	19(6.2)	90(29.2)	1
Woman & husband	243(78.3)	202(65.0)	5.7(3.3,10.1)
Number/Interval of children			
Woman	44(14.2)	17(5.5)	14.2(5.6,34.5)
Husband	14(4.5)	77(24.9)	1
Woman & husband	252(81.2)	216(69.6)	6.5(3.4,12.3)
Buying/Selling major HH & agri.supp.			
Woman	40(12.9)	15(4.9)	12.3(5.9,26.0)
Husband	39(12.6)	180(58.3)	1
Woman & husband	231(74.4)	115(36.9)	9.31(6.1,14.4)
Buying major HH supply			
Woman	63(20.3)	15(4.9)	29.2(13.8,63.1)
Husband	25(8.1)	174(56.3)	1
Woman & husband	222(71.6)	121(38.8)	12.9(7.8,21.3)

**Spending money
for sick child**

Woman	54(17.4)	14(4.5)	18.2(8.5,39.7)
Husband	29(9.3)	137(44.3)	1
Woman & husband	227(73.3)	159(51.1)	6.8(4.2,10.9)

**Spending money
for her med. care**

Woman	70(22.5)	16(5.2)	25.9(12.5,54.2)
Husband	28(9)	166(53.7)	1
Woman & husband	212(68.5)	128(41.1)	9.9(6.1,16.1)

**Spending money
she earned**

Woman	61(19.6)	17(5.5)	19.6(9.3,42.2)
Husband	23(7.4)	126(40.8)	1
Woman & husband	226(73)	167(53.7)	7.5(4.5,12.5)

**Spending money
husband earned**

Woman	35(11.3)	15(4.9)	9.3(4.3,20.1)
Husband	35(11.3)	139(45.0)	1
Woman & husband	240(77.5)	156(50.2)	6.2(3.9,9.6)

**Buying/selling
cattle**

Woman	35(11.3)	15(4.9)	8.4(3.9,18.1)
Husband	39(12.5)	141(45.6)	1
Woman & husband	236(76.2)	154(49.5)	5.6(3.6,8.6)

**Borrowing/lending
cash/kind**

Woman	35(11.3)	14(4.5)	10.9(4.9,24.3)
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Husband	32(10.3)	140(45.3)	1
Jointly	243(78.5)	156(50.2)	6.7(4.4,10.8)

Table 4 (CONT'D)

Variables	CBRHP area N[%]	NCBRHP area N[%]	OR[95% CI]
	N=310[100]	N=310[100]	
Visiting/parents/relatives			
Woman	50(16.1)	12(3.9)	17.2(7.5,40.0)
Husband	25(8.1)	103(33.3)	1
Woman & husband	235(75.8)	195(62.8)	4.9(3.0,8.3)
Permission to greet male non-familial persons			
Yes	29(9.3)	46(14.9)	0.5(0.3,0.9)
No	281(90.7)	264(85.1)	

EIGHT PERCENT AND 33.3% OF THE RESPONDENTS REPORTED THAT THEY TOOK PERMISSION TO VISIT PARENTS WHILE 16.1% AND 3.9% SAID, DECISIONS WERE MADE TO DO SO BY THEMSELVES IN PROGRAM AND NON-PROGRAM AREAS RESPECTIVELY. ON THE OTHER HAND 9.3 AND 90.7 PERCENTS OF THE PROJECT AREA RESPONDENTS SAID THAT DECISION MAKING ON GREETING MALE NON-FAMILIAL PERSONS SHOULD BE MADE JOINTLY, AND BY THE WIVES ALONE, RESPECTIVELY. THE CORRESPONDING PROPORTIONS FOR THE NON-PROJECT AREAS WERE 14.9% AND 85.1%.

5. SOCIO-ECONOMIC AUTONOMY

REGARDING INCOME OF THE RESPONDENTS, 65.3% AND 25.6% OF THE RESPONDENTS SAID THAT THEIR INCOME COVERS MOST OF THEIR EXPENSES, WHILE 34.7% AND 74.4% OF THE RESPONDENTS SAID THAT THEY HAVE DEFICIENCY ON COVERING THEIR EXPENSES IN BOTH PROJECT AND NON-PROJECT AREAS RESPECTIVELY.

THIRTY NINE PERCENT OF THE RESPONDENTS FROM THE PROGRAM AREA MENTIONED THAT THEIR STANDARD OF LIVING IS IMPROVED WHEN COMPARED TO THAT OF FIVE YEARS BACK, WHILE ONLY 6.8% OF THE NON-PROGRAM AREA GAVE THE SAME ANSWER FOR THE CORRESPONDING QUESTION.

CONCERNING DECISION MAKING ON MONEY MATTERS, 44.1% AND 7.8% OF THE RESPONDENTS SAID THAT IT IS IMPROVED WHEN COMPARED TO THAT OF FIVE YEARS BACK AND 12.2% AND 25.6% OF THE RESPONDENTS SAID THAT IT IS DETERIORATED, IN PROJECT AND NONE PROJECT AREAS RESPECTIVELY.

FIFTY SEVEN PERCENT OF THE PROGRAM AREAS RESPONDENTS SAID THAT THAT THEIR SOCIAL ACCEPTABILITY AND PARTICIPATION WAS IMPROVED WHEN COMPARED TO THAT OF FIVE YEARS BACK. ON THE OTHER HAND ONLY 10.4 % OF THE NON- PROGRAM AREA RESPONDENTS STATED THAT THE CORRESPONDING INDICATOR WAS IMPROVED DURING THE SAME PERIOD.

REGARDING CATEGORY OF INCOME, STATISTICALLY SIGNIFICANT DIFFERENCES WERE SEEN BETWEEN THE TWO GROUPS, 68.7% AND 25.2% OF THE CBRHP AREA RESPONDENTS CATEGORIZE THEM SELVES IN TO MIDDLE INCOME AND LOWER INCOME GROUP RESPECTIVELY.

IN CONTRAST, 22.0% AND 73.5% OF THE NON-CBRHP AREA RESPONDENTS CATEGORIZE THEM SELVES IN CORRESPONDING GROUPS RESPECTIVELY [OR (95%CI) =9.2(6.2, 13.6)]

CONCERNING KNOWLEDGE ON MICRO-CREDIT PROGRAM, 74.9% OF THE PROGRAM AREAS RESPONDENTS HAVE THE KNOWLEDGE OF THE SCHEME AND 25.1% DO NOT. WHILE IN THE NON- PROGRAM AREAS 56.5% OF THE RESPONDENTS KNEW ABOUT IT AND 43.5% OF THEM DID NOT.

WITH REGARD TO SERVICE UTILIZATION FROM SUCH INSTITUTIONS, 39.1% AND 33.9% OF THE RESPONDENTS STATED THAT THEY RECEIVED THE SERVICE, IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY. CORRESPONDINGLY 60.9 % AND 66.1 % OF THE RESPONDENTS DIDN'T RECEIVE THE SERVICE FROM THE INSTITUTIONS. THE RESPONDENTS WERE ASKED WHETHER THE COMMUNITY SOUGHT THEIR OPINION ON DIFFERENT IMPORTANT SOCIO-ECONOMIC AFFAIRS, 66.9% AND 55.2% OF THE RESPONDENTS STATED THAT THEY GOT THE OPPORTUNITY TO SHARE THEIR OPINION, WHILE 33.1 % AND 44.8% OF THE RESPONDENTS DENIED THIS, IN BOTH PROGRAM AND NON PROGRAM AREAS RESPECTIVELY.

Table 5, Socio- economic situations in CBRHP and non-CBRHP areas, Bassonaworana Woreda, North Shoa Zone, 2005/06

Variables	CBRHP area	NCBRHP area	OR[95% CI]
	N[%]	N[%]	
	N=310[100]	N=310[100]	

Enough income			
Yes	203(65.3)	79(25.6)	5.4(3.8,7.7)
No	107(34.7)	231(74.4)	
Standard of living			
Improved	121(38.9)	21(6.8)	10.1(5.4,18.9)
The same	142(45.7)	207(67.0)	1.2(0.8,1.9)
Deteriorated	47(15.4)	82(26.2)	1
Decision on money			
Improved	137(44.1)	24(7.8)	12.3(6.6, 23)
The same	136(43.7)	206(66.7)	1.4(0.9,2.3)
Deteriorated	37(12.2)	80(25.6)	1
Social acceptability			
Improved	176(56.6)	32(10.4)	20.1(10.7,38.2)
The same	111(35.7)	194(62.8)	2.1(1.2,3.6)
Deteriorated	23(7.7)	84(29.6)	1
Opinion seeking			
Yes	208(66.9)	170(55.2)	1.64(1.18,2.3)
No	102(33.1)	140(44.8)	
Category of income			
Upper	19(6.1)	14(4.5)	3.97(1.8,8.8)
Middle	213(68.7)	68(22.0)	9.2(6.2,13.6)
Lower	78(25.2)	228(73.5)	1

Table 5 (CONT'D)

Variables	CBRHP area	NCBRHP area	OR [95% CI]
	N [%]	N [%]	
	N=310[100]	N=310[100]	

**Knowledge of
micro credit**

Yes	233(74.9)	174(56.5)	2.3(1.63,3.23)
No	77(25.1)	136(43.5)	

**Use of micro
credit**

Yes	91(39.1)	59(33.9)	1.8(1.23,2.63)
No	142(60.9)	115(66.1)	

**Attend Women's
meeting**

Yes	154(49.7)	137(44.0)	0.776(0.566,1.06)
No	156(50.3)	173(56.0)	

**Permission for
attendance**

Yes	60(39.0)	74(54.1)	0.712(0.48,1.04)
No	94(61.0)	63(45.9)	

**Polygamous
husband**

Yes	28(9)	50(16.2)	0.51(0.31,0.83)
No	282(91)	260(83.8)	

THE RESPONDENTS WERE ALSO ASKED ABOUT THEIR PARTICIPATION IN CIVIC ASSOCIATIONS. REGARDING THEIR PARTICIPATION IN WOMEN' ASSOCIATION, NO SIGNIFICANT DIFFERENCES WERE OBSERVED BETWEEN THE GROUPS. MAJORITY OF THE RESPONDENTS IN BOTH GROUPS, 50.3 % IN PROGRAM AREA AND 56% IN NON- PROGRAM AREA,

DIDN'T ATTEND THE ASSOCIATION'S MEETING. THOSE WHO ATTENDED THE MEETING WERE ASKED WHETHER THEY ASKED PERMISSION FOR IT FROM THEIR HUSBANDS OR ANY OTHER SENIOR FAMILY MEMBER, 39 % AND 54.1 % OF THE RESPONDENTS STATED THAT THEY WERE SUPPOSE TO ASK PERMISSION, IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY.

RESPONDENTS WERE ALSO ASKED WHETHER THEIR HUSBANDS HAVE ANY OTHER WIVES BESIDES THEM, 9% AND 16.2% OF THE RESPONDENTS WITNESSED THAT THEIR HUSBANDS PRACTICE A POLYGAMOUS WAY OF MARRIAGE IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY.

**Fig.2 Decision on buying/selling
HH & agri. items**

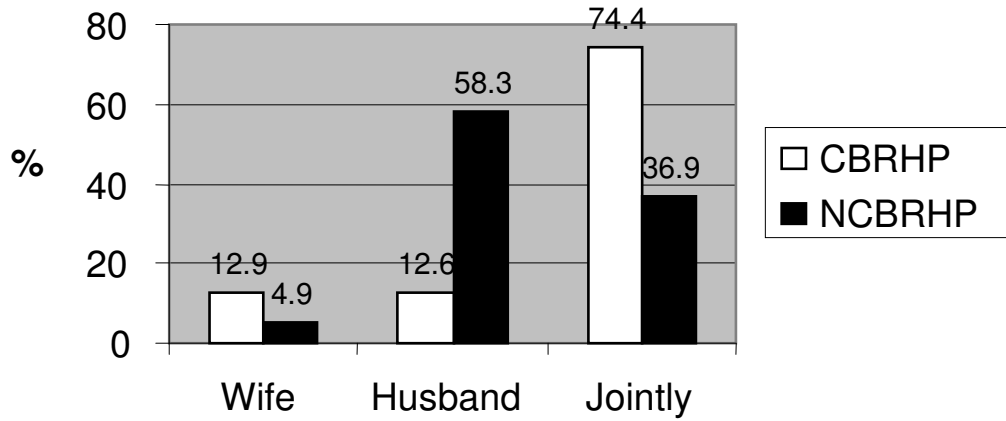
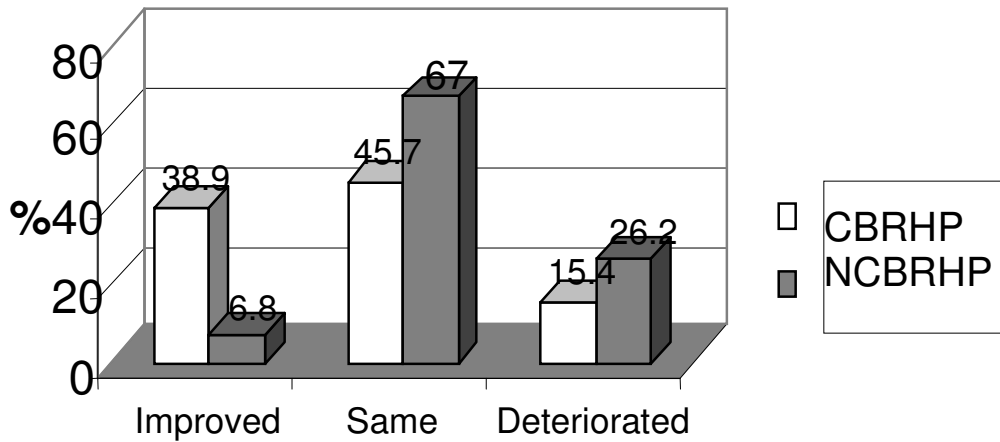


Fig.3 Perceived Standard of living



**SOCIO-DEMOGRAPHIC AND OTHER CHARACTERISTICS OF THE STUDY
POPULATION IN RELATION TO DECISION MAKING STATUS ON BUYING/SELLING
HOUSEHOLD /AGRICULTURAL ITEMS & UTILIZATION OF MCM**

SEPARATE ANALYSES WERE CARRIED OUT TO SHOW THE ASSOCIATION BETWEEN SELECTED INDEPENDENT VARIABLES AND INDICATORS OF CURRENT STATUS OF WOMEN AS OUTCOME VARIABLES.

AGE, OCCUPATION AND AVAILABILITY OF CROPLAND WERE NOT SIGNIFICANTLY ASSOCIATED WITH BOTH DECISION-MAKING ON BUYING/SELLING HOUSEHOLD/AGRICULTURAL ITEMS AND USE OF MCM.

EDUCATIONAL STATUS WAS NOT ASSOCIATED WITH DECISION-MAKING STATUS ON BUYING/SELLING HOUSEHOLD/AGRICULTURAL ITEMS. BUT IT WAS SIGNIFICANTLY ASSOCIATED WITH DECISION MAKING ON MCM USE. THOSE WHO WERE LITERATE WERE MORE LIKELY TO DECIDE ON MCM USE [AOR (95% CI) =1.7(1.2, 2.9)]

AVAILABILITY OF CASH CROP WAS SIGNIFICANTLY ASSOCIATED WITH DECISION-MAKING STATUS ON MCM [AOR (95% CI) =1.6 (1.1, 3.2)].

CBRHP SERVICE UTILIZATION WAS SIGNIFICANTLY ASSOCIATED IN ALL INDICATORS OF WOMEN STATUS; HENCE THIS PREDICTS THAT THOSE

RESPONDENTS IN THE PROGRAM AREAS HAVE BETTER STATUS THAN THE NON-PROGRAM AREAS.

TABLE 6, SOCIO-DEMOGRAPHIC AND OTHER CHARACTERISTICS OF THE STUDY POPULATION IN RELATION TO DECISION MAKING ON BUYING& SELLING HOUSEHOLD & AGRICULTURAL ITEMS.

Variables	Decision making on buying & selling		OR	(95% CI)	AOR
	Husband	Woman & husband			
Age					
≤30	97(44.3)	181(45.1)	0.9	(0.6,1.3)	1.2(0.8,1.7)
>30	122(55.7)	220(54.9)			
Educational status					
Illiterate	158(75.6)	264(69.7)	1.0		
Literate	51(24.4)	115(30.3)	1.4	(0.9,1.9)	1.2(0.8,1.9)
Occupation					
Housewife	200(91.3)	361(90)	1.2	(0.6,2.1)	0.9(0.4,1.8)
Others(Gov.employee, Student, Alcohol seller etc)	19(8.7)	40(10)			
Utilization of micro-credit scheme					
Yes	39(19.2)	111(29.3)	1.7	(1.1,2.7)	1.5(0.9,2.4)
No	164(80.8)	268(70.7)			
Study area					
CBRHP	39(17.8)	272(67.8)	9.7	(6.4,14.9)	9.5(6.1,14.8)

NCBRHP	180(82.2)	129(32.2)			
Crop land availability					
Yes	190(86.8)	325(81.0)	1.5	(0.9,2.4)	0.9(0.5,1.8)
No	29(13.2)	76(19.0)			
Cash crop availability					
Yes	30(13.7)	101(25.2)	2.1	(1.3,3.4)	0.9(0.6,1.7)
No	189(86.3)	300(74.8)			

TABLE7, SOCIO-DEMOGRAPHIC AND OTHER CHARACTERISTICS OF THE STUDY POPULATION IN RELATION TO DECISION MAKING ON MCM USE.

Variables	Decision making on MCM use		OR	(95% CI)	AOR
	Husband	Woman & husband			
Age					
≤30	78(44.6)	199(44.9)	0.98	(0.7,1.4)	0.9(0.6,1.3)
>30	97(55.4)	244(55.1)			
Educational status					
Illiterate	139(81.8)	283(68)	1.0		
Literate	31(18.2)	133(32)	2.1	(1.4,3.3)	1.7(1.2,2.9)
Occupation					
Housewife	153(87.4)	406(91.6)	0.63	(0.4,1.1)	1.1(0.9,3.7)
Others (Gov.employee, Student, Alcohol seller etc)	22(12.6)	37(8.4)			
Utilization of micro-credit scheme					
Yes	35(22)	113(26.8)	1.3	(0.8,2.1)	1.1(0.6,1.6)
No	124(78)	308(73.2)			
Study area					

CBRHP	67(38.3)	242(54.6)	1.9	(1.3,2.8)	1.7(1.2,2.5)
NCBRHP	108(61.7)	201(45.4)			
Crop land availability					
Yes	146(83.4)	367(82.8)	1.04	(0.6,1.7)	0.9(0.6,1.7)
No	29(16.6)	76(17.2)			
Cash crop availability					
Yes	22(12.6)	109(24.6)	2.3	(1.3,3.9)	1.6(1.1,3.2)
No	153(87.4)	334(75.4)			

DISCUSSION

THIS COMPARISON STUDY IN CBRHP AND NCBRHP AREAS PROVIDED IMPORTANT INFORMATION ON COMMUNITY BASED REPRODUCTIVE HEALTH SERVICES AND THEIR CORRESPONDING EFFECTS ON WOMEN STATUS. THE STUDY TRIED TO ASSES THE EFFECTS OF CBRHP ON NUMEROUS DOMAINS OF WOMEN’S LIVES, PARTICULARLY ON DOMESTIC SOCIO-ECONOMIC SPHERES.

THE STUDY REVEALED THAT THE PROGRAM AREA RESPONDENTS WHO GOT SERVICE FROM CBRHAS HAVE BETTER SOCIAL AND ECONOMIC STATUS THAN THE RESPONDENTS IN NON-PROGRAM AREAS WITH NO SERVICE FROM THE AGENTS. THIS FINDING IS ALSO CONSISTENT IN ONE OF THE BANGLADESH STUDIES WHICH SHOWED THAT THE MORE VISIT

THE WOMEN RECEIVED FROM FAMILY WELFARE ASSISTANTS, THE MORE LIKELY THEY WERE TO EXPERIENCE AN INCREASE IN STATUS. ^[17]

THERE WERE NO STATISTICALLY SIGNIFICANT DIFFERENCES BETWEEN RESPONDENTS IN CBRHP AND NONE CBRHP AREAS IN TERMS OF SOCIO-DEMOGRAPHIC CHARACTERISTICS.

THE REPRODUCTIVE CHARACTERISTICS SUCH AS AGE OF FIRST MARRIAGE AND FIRST PREGNANCY DID NOT SHOW SIGNIFICANT DIFFERENCES IN BOTH GROUPS. HOWEVER, THE AVERAGE NUMBER OF CHILDREN PER HOUSEHOLD WAS 3.11 AND 4.12 IN CBRHP AND NONE CBRHP AREAS RESPECTIVELY. THIS COULD BE EXPLAINED BY THE EXTENSIVE PROVISION OF FAMILY PLANNING SERVICES IN THE PROGRAM AREA. THIS FINDING IS CONSISTENT WITH STUDY DONE IN EAST WOLLEGA ZONE ^[20].

REGARDING DESIRE FOR MORE CHILDREN, 73.6% AND 62.5% OF THE RESPONDENTS IN THE PROGRAM AND NONE PROGRAM AREAS DID NOT WANT TO HAVE MORE CHILDREN, RESPECTIVELY. THIS DISCREPANCY COULD BE THE RESULT OF MORE FAMILY PLANNING AWARENESS IN THE PROGRAM AREAS THAN THE NON-PROGRAM AREAS.

IN THIS STUDY, HISTORY OF UNWANTED PREGNANCY WAS 24.4% IN CBRHP AND 48.7% IN NONE CBRHP AREAS AND THE DIFFERENCE WAS MARKEDLY SIGNIFICANT [OR=0.341; 95%CI=0.24, 0.48] THIS FINDING WAS HIGHER WHEN COMPARED TO SIMILAR STUDY DONE IN SOUTH GONDAR

^[31].THIS WIDE DIFFERENCE BETWEEN THE TWO AREAS COULD BE EXPLAINED BY BETTER AVAILABILITY AND UTILIZATION OF MODERN CONTRACEPTIVE METHODS IN THE PROGRAM AREA.

A SIGNIFICANTLY HIGHER PROPORTION OF WOMEN IN CBRHP AREA [90.9%] HAD KNOWLEDGE ABOUT MODERN CONTRACEPTIVE METHODS COMPARED TO THOSE RESPONDENTS IN NONE CBRHP AREAS [70.1%][OR=4.25; 95%CI=2.68,6.73].THIS FINDINGS IS COMPARABLE TO THE FINDING OF STUDY IN SOUTH GONDAR AND TIGRAY ^[31,32].AS EXPECTED ,AWARENESS TO MCM IS AN IMPORTANT FACTOR THAT AFFECTS USE OF FAMILY PLANNING METHODS. THE KNOWLEDGE ON PERMANENT METHODS OF CONTRACEPTION WAS VERY LOW [2.5%] EVEN IN THE PROGRAM AREAS, ALTHOUGH IT WAS SIGNIFICANTLY HIGHER THAN THE 0.5% REPORTED IN THE NON-PROGRAM AREAS. THIS COULD BE AS A RESULT OF LESS ATTENTION GIVEN TO THESE METHODS BY HEALTH PROFESSIONALS IN BOTH AREAS.

LIKE MANY STUDY FINDINGS BOTH IN ETHIOPIA AND OTHER DEVELOPING COUNTRIES, THE INJECTABLE CONTRACEPTIVES WERE THE MOST WIDELY KNOWN MCM FOLLOWED BY PILLS (TABLE-3). UNFORTUNETLY, ONLY 52.5% AND 29.8% OF THE RESPONDENTS IN PROGRAM AND NON- PROGRAM AREAS, RESPECTIVELY KNEW CONDOM AS A METHOD OF CONTRACEPTION. THIS LOW KNOWLEDGE ON DUAL

PROTECTION OF CONDOM COULD BE CONSIDERED AS A RISK FACTOR FOR UNWANTED PREGNANCY AND TRANSMISSION OF STI/HIV/AIDS.

THE LIKELY EVER USE OF MCM WAS SIGNIFICANTLY HIGHER IN PROGRAM AREAS THAN NONE PROGRAM AREAS, 64.8% AND 38.7% RESPECTIVELY [OR=1.93; 95%CI=1.32, 2.81]. FROM THESE FINDINGS ONE CAN EASILY UNDERSTAND THAT CBRHP NOT ONLY REDUCES SERVICE DISTANCE BUT IT ALSO INCREASES THE ACCEPTABILITY OF MCM AS A RESULT OF AVAILABLE SERVICE AND INFORMATION AT NEAR BY SITES.

CURRENT USERS OF MCM IN PROGRAM AREAS WERE 64.5% OF THE RESPONDENTS WHILE ONLY 25.5% OF THE NON-PROGRAM AREAS RESPONDENTS USED MCM CURRENTLY [OR=2.36; 95%CI=1.46, 3.82]. THIS INDICATED THAT THE CURRENT CONTRACEPTIVE PREVALENCE IN CBRHP AREAS WAS MARKEDLY HIGHER THAN THE NON-CBRHP AREAS. THIS FINDING IS CONSISTENT WITH THE STUDIES DONE IN TIGRAY AND NORTHERN ETHIOPIA ^[31, 32]. THE STUDY SHOWED THAT THE MAJORITY OF THE STUDY RESPONDENTS IN CBRHP AREAS (81.6%) RECEIVED REPRODUCTIVE HEALTH CARE FROM COMMUNITY BASED REPRODUCTIVE HEALTH AGENTS AROUND THEIR RESIDENTIAL AREA, AND AMONG THE USERS OF RH SERVICE IN NONE PROGRAM AREA, ALMOST ALL OF THEM RECEIVED THE CORRESPONDING CARE FROM PUBLIC HEALTH FACILITIES WHICH ARE LOCATED FAR DISTANT FROM THEIR RESIDENTIAL PLACES, IN MAJORITY OF CASES.

REGARDING POSSESSION OF CROPLAND, BIVARIATE ANALYSIS SHOWED NO SIGNIFICANT DIFFERENCE IN BOTH AREAS IN RELATION TO SELECTED INDICATORS OF WOMEN STATUS. ON THE OTHER HAND 32.5% OF THE PROGRAM AREA RESPONDENTS PLANTED CASH CROP AND ONLY 9.7% OF THE NONE CBRHP RESPONDENTS DID THE SAME THING [OR=4.47; 95%CI=2.86,6.98]. THIS COULD BE THE RESULT OF BETTER CPR, WHICH ALLOWED THE RESPONDENTS IN SPACING AND LIMITING CHILDREN; THIS IN TURN PROMOTED THEM TO DO ADDITIONAL ACTIVITIES FOR ADDITIONAL INCOME.

TWO HUNDRED EIGHTEEN [70.1%] AND 136[44 %] OF THE RESPONDENTS HAD RADIO IN CBRHP AND NONE CBRHP AREAS RESPECTIVELY [OR=2.98; 95%CI=2.14, 4.15].

ONE REASON FOR THIS MARKED DIFFERENCE COULD BE LIMITED FAMILY SIZE IN THE PROGRAM AREAS, WHICH DIRECTLY AND POSITIVELY INFLUENCED THE HOUSEHOLD GOODS PURCHASING CAPACITY.

IN DECISION MAKING ON BUYING AND SELLING MAJOR HOUSEHOLD AND AGRICULTURAL ITEMS, DECISIONS WERE MADE JOINTLY IN 74.4% IN CBRHP AREA WHILE ONLY 36.9% OF THE NONE CBRHP AREAS RESPONDENTS DECIDED JOINTLY WITH THEIR SPOUSES, OTHER WISE MAJORITY OF DECISIONS WERE MADE BY HUSBANDS ALONE IN NCBRHP AREAS [OR=9.31; 95%CI=6.1,14.4]. THIS FINDING IS CONSISTENT WITH THE STUDY DONE IN NORTH SHOA AND SOUTH WOLLO CBRHP AREAS, IN

WHICH THE STUDY COMPARED HIGH AND LOW PERFORMING PROGRAM AREAS ^[30].

SEVENTEEN PERCENT OF THE RESPONDENTS IN PROGRAM AREAS REPORTED HAVING EVER TAKEN A SICK CHILD TO A HEALTH FACILITY BY THEM SELVES AND 73.3% OF THE SAME AREAS RESPONDENTS TOOK THEIR CHILDREN BY MAKING DECISION JOINTLY WITH THEIR HUSBANDS. 4.5% OF THE RESPONDENTS IN NONE PROGRAM AREAS REPORTED HAVING EVER TAKEN A SICK CHILD TO A HEALTH FACILITY BY THEM SELVES AND 51.1% OF THE SAME AREAS RESPONDENTS TOOK THEIR CHILDREN BY MAKING DECISION JOINTLY WITH THEIR HUSBANDS AND THE DIFFERENCES WERE SIGNIFICANT [OR=18.2; 95%CI=8.5,39.7 AND [OR=6.8; 95% CI =4.2,10.9].

ON THE OTHER HAND DECISION FOR SEEKING MEDICAL CARE FOR THE RESPONDENTS THEM SELVES WERE MADE BY THEM SELVES IN 22.5% OF THE RESPONDENTS IN PROGRAM AREA, WHILE THE CORRESPONDING DECISION WAS MADE IN ONLY 5.2% OF THE RESPONDENTS IN NONE PROGRAM AREAS [OR=25.9; 95% CI =12.5,54.2]. THIS FINDING IS CONSISTENT WITH THE STUDY DONE IN PHILIPPINES WHERE MAJORITY OF THE DECISIONS WERE DONE BY HUSBANDS ALONE IN NONE PROGRAM AREAS ^[14].

REGARDING DECISION MAKING ON MONEY EARNED BY THE RESPONDENTS, IN MAJORITY OF CASES DECISIONS WERE MADE WITH

THEIR HUSBANDS JOINTLY IN BOTH AREAS. IN SEVEN PERCENT AND 40.8 % OF THE RESPONDENTS IN PROGRAM AND NONE PROGRAM AREAS; DECISIONS WERE MADE BY HUSBANDS ALONE RESPECTIVELY. ON THE OTHER HAND RESPONDENTS WERE ASKED ON MAKING DECISIONS ABOUT MONEY EARNED BY THEIR HUSBANDS, 11.3% AND 77.5% OF THE PROGRAM AREA RESPONDENTS SAID THAT DECISIONS WERE MADE BY HUSBANDS AND JOINTLY WITH THEIR HUSBANDS RESPECTIVELY. ONLY 50.2 % OF THE DECISIONS WERE MADE JOINTLY IN NON-PROGRAM AREAS, OTHER WISE MUCH OF THE DECISIONS WERE MADE BY HUSBANDS ALONE.

MAJORITY OF THE DECISIONS ON BUYING/SELLING CATTLE AND BORROWING/LENDING HOUSEHOLD ITEMS OR MONEY WERE MADE JOINTLY IN PROGRAM AREAS, WHILE THE CORRESPONDING DECISIONS MADE BY THE HUSBANDS WERE HIGHER IN NONE PROGRAM AREAS. ETHNOGRAPHIC STUDIES DONE IN SOUTHEAST ASIAN COUNTRIES HAVE ALSO SHOWN SIMILAR FINDINGS, IN WHICH THE STUDY SHOWED THAT FAMILY PLANNING /RH SERVICES PROMOTED INVOLVEMENT OF WOMEN IN DECISION -MAKING ^[28].

AS OTHER MEASURES OF INDICATORS FOR ASSESSING WOMEN DECISION-MAKING STATUS, DECISION MAKING ON UTILIZATION OF MCM HAD SHOWN A MARKED DIFFERENCE BETWEEN THE TWO GROUPS. FIFTEEN AND 78.3 PERCENT OF THE WOMEN IN CBRHP AREAS SAID THAT DECISION MAKING ON FAMILY PLANNING HAD BEEN MADE BY

RESPONDENTS AND JOINTLY WITH THEIR HUSBANDS, RESPECTIVELY. THE CORRESPONDING PROPORTIONS FOR THE NON- PROGRAM AREAS WERE 5.8 % AND 65% [OR=12.6; 95% CI =5.7, 28.3 AND OR=5.7; 95% CI =3.3, 10.1]. SIMILAR STUDY SHOWED SIMILAR FINDING IN BOLIVIA WHERE MAJORITY OF THE DECISIONS WERE MADE JOINTLY AFTER THE IMPLEMENTATION OF COMMUNITY BASED FAMILY PLANNING PROGRAM ^[27] . ANOTHER STUDY DONE IN TIGRAY REVEALED THAT DECISION MAKING AUTONOMY ON MCM WAS PRACTICED MORE IN CBD AREAS THAN NONE CBD AREAS [32].SIMILARLY 81.2% AND 69.6 % OF THE RESPONDENTS IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY SAID THAT, DECISION ON NUMBER OF CHILDREN AND INTERVAL BETWEEN CHILDREN HAD BEEN DECIDED BY BOTH SPOUSES. ON THE OTHER HAND 14.2% AND 5.5 % OF THE DECISIONS WERE MADE BY THE RESPONDENTS IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY [OR=6.5; 95% CI =3.4, 12.3 AND OR=14.2; 95% CI =5.6, 34.5]. MAJORITY OF THE DECISIONS FOR VISITING PARENTS OR RELATIVES WERE MADE JOINTLY IN BOTH AREAS BUT 16.1% AND 3.9% OF RESPONDENTS IN PROGRAM AND NONE PROGRAM AREAS RESPECTIVELY DECIDED BY THEM SELVES [OR=17.2; 95% CI =7.5,40.0]. RESPONDENTS IN THE PROGRAM AREAS PERCEIVED THAT THEY HAVE BETTER INCOME THAN THE NONE PROGRAM AREAS.65.3% AND 25.6% OF THE PROGRAM AND NONE PROGRAM AREA RESPONDENTS RESPECTIVELY, HAVE ENOUGH INCOME TO COVER THEIR EXPENSES [OR=5.47; 95% CI =3.87,7.73]. ONE REASON FOR THIS COULD BE, BETTER

COVERAGE OF CPR IN PROGRAM AREAS, WHICH INCREASES INCOME BY LIMITING FAMILY SIZE. THIS IS SUPPORTED BY STUDIES DONE IN PAKISTAN [29].

REGARDING STANDARD OF LIVING, DECISION MAKING POWER ON MONEY MATTERS AND SOCIAL ACCEPTABILITY, RESPONDENTS WERE ASKED TO COMPARE STATUS OF THESE INDICATORS TO THAT OF FIVE YEARS BACK. MAJORITY OF THE RESPONDENTS IN PROGRAM AREAS SAID THAT THEY HAVE IMPROVED OR REMAINED THE SAME. IN THE CONTRARY, MAJORITY OF THE NON-PROGRAM AREA RESPONDENTS SAID THAT THEY REMAINED THE SAME OR DETERIORATED AND THE DIFFERENCES WERE SIGNIFICANT.

THE RESPONDENTS WERE ASKED TO CATEGORIZE THEIR STATUS OF INCOME IN TO UPPER, MIDDLE AND LOWER INCOME GROUPS. MAJORITY OF THE PROGRAM AREAS RESPONDENTS [68.7%] CATEGORIZED THEMSELVES IN TO THE MIDDLE-INCOME GROUP. WHILE ONLY 22 % OF THE NONE- PROGRAM AREAS RESPONDENTS CATEGORIZED THEMSELVES IN TO THE SAME GROUP [OR=9.2; 95% CI =6.2, 13.6]. MAJORITY OF THE NON-PROGRAM AREAS RESPONDENTS CATEGORIZED THEMSELVES IN THE LOWER INCOME GROUP. ONE REASON FOR THIS DIFFERENCE COULD BE UTILIZATION OF REPRODUCTIVE HEALTH SERVICES AND THEIR EFFECTS IN HOUSEHOLD ECONOMY.

KNOWLEDGE AND UTILIZATION OF MICRO-CREDIT PROGRAM WERE HIGHER IN PROGRAM AREAS THAN NONE PROGRAM AREAS. THIS COULD BE AS A RESULT OF ACCESS TO INFORMATION, WHICH IS AGAIN RELATED TO IMPROVEMENT OF WOMEN STATUS SEEN IN PROGRAM AREAS. AS EXPECTED, THOSE WHO HAD KNOWLEDGE ON THE MENTIONED SCHEME WERE FOUND TO UTILIZE THE SERVICE SIGNIFICANTLY [OR=1.8; 95% CI =1.2, 2.6].

MAJORITY OF THE RESPONDENTS IN BOTH AREAS DENIED ATTENDANCE IN WOMEN'S ASSOCIATIONS. HOWEVER, AMONG THOSE ATTENDED, MAJORITY THE NON-PROGRAM AREAS RESPONDENTS OUGHT TO ASK PERMISSION FOR ATTENDANCE THAN THE PROGRAM AREAS WOMEN. NINE PERCENT OF THE PROGRAM AREAS HUSBANDS HAD MORE ADDITIONAL WIVES, WHILE 16.2% OF THE NON- PROGRAM AREAS HUSBANDS HAD THE SAME POLYGAMY TYPE OF MARRIAGE [OR=0.51; 95% CI =0.31, 0.83]. THIS FINDING COULD SHOW US THAT, THE PROGRAM ENCOURAGES MONOGAMY TYPE OF MARRIAGE.

STRENGTH AND LIMITATION OF THE STUDY

STRENGTH

COMPARISON OF PROGRAM AND NONE PROGRAM AREAS AND CONDUCTING THE STUDY IN RURAL AND REMOTE SET UP WHERE THE LARGE PROPORTION OF THE POPULATION LIVES, ARE THE MAIN

STRENGTHS OF THE STUDY. ON THE OTHER HAND THE LARGE SAMPLE SIZE AND APPROPRIATE PROCEDURES OF SAMPLING HELPED TO IMPROVE THE VALIDITY OF STUDY. UTILIZATION OF APPROPRIATE DATA COLLECTION PROCEDURES AND STATISTICAL METHODS PLAYED THE ROLE IN MINIMIZING BIAS AND CONFOUNDING FACTORS.

LIMITATIONS

SINCE THE STUDY IS A CROSS SECTIONAL STUDY, IT HAS SOME LIMITATIONS IN ESTABLISHING THE CAUSE AND EFFECT RELATIONSHIP. PRESENCE OF VERY LIMITED SIMILAR STUDIES FOR COMPARISON PURPOSE COULD BE CONSIDERED AS A CONSTRAINT FACTOR FOR THE STUDY.

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

- ✚ THE STUDY REVEALED THAT THE CPR IN THE PROGRAM AREAS IS MARKEDLY HIGHER COMPARED TO THE NON-PROGRAM AREAS. THIS IS THE RESULT OF BETTER KNOWLEDGE AND UTILIZATION OF REPRODUCTIVE HEALTH SERVICES IN THE PROGRAM AREAS.
- ✚ THE MEAN NUMBER OF CHILDREN AND FAMILY SIZE IN THE PROGRAM AREAS IS LESS WHEN COMPARED TO THE NON-PROGRAM AREAS.
- ✚ UNWANTED PREGNANCIES WERE HIGHER IN NONE CBRHP AREAS THAN THE CBRHP AREAS; THIS REVEALED THAT THERE IS HIGHER UN-MET NEED IN THE NON-PROGRAM AREAS THAN THE PROGRAM AREAS.
- ✚ IN BOTH AREAS THE KNOWLEDGE AND UTILIZATION OF CONDOM & PERMANENT METHODS OF CONTRACEPTIVES WAS BELOW THE EXPECTED LEVEL.
- ✚ WOMEN'S STATUS IN DECISION-MAKING AND AUTONOMY THAT CAN BE EXPLAINED BY VARIOUS SOCIO ECONOMIC INDICATORS WAS FOUND MARKEDLY HIGHER IN CBRHP AREAS.

- ✚ WOMEN IN THE PROGRAM AREAS HAVE BETTER DECISION-MAKING STATUS ON UTILIZATION OF MCM AND NUMBER OF CHILDREN/INTERVAL BETWEEN CHILDREN THAN THE NON-PROGRAM AREAS.
- ✚ THE STUDY ALSO REVEALED THAT WOMEN IN THE PROGRAM AREAS HAVE BETTER SOCIAL ACCEPTANCE AND PARTICIPATION, COMPARED TO THE NON-PROGRAM AREAS.
- ✚ THE PERCEIVED STANDARD OF LIVING IN CBRHP AREAS WAS FAR BETTER WHEN COMPARED TO THE NON-CBRHP AREAS.

RECOMMENDATIONS

- ✚ IEC/BCC ACTIVITIES HAVE TO BE STRENGTHENED ON KNOWLEDGE AND UTILIZATION OF CONDOM & PERMANENT METHODS OF CONTRACEPTIVES, IN BOTH AREAS.
- ✚ AS THE STUDY REVEALED, WOMEN STATUS AND REPRODUCTIVE BEHAVIORS SHOWED MARKED IMPROVEMENT IN PROGRAM AREAS. SUCH CBRH PROGRAM HAS TO BE IMPLEMENTED IN OTHER AREAS, WHERE SUCH PROGRAM IS NOT IMPLEMENTED.
- ✚ THOUGH MARKED CHANGES HAD BEEN SEEN IN PROGRAM AREAS, STILL THERE IS A PLACE FOR IMPROVEMENT OF THE PROGRAM. HENCE, STRENGTHENING THE IMPLEMENTATION OF THE RH PACKAGE IS MANDATORY TO PROVIDE BETTER HEALTH CARE FOR THE COMMUNITY.

- ✚ SECURE AND DIVERSIFY CONTRACEPTIVE METHODS MIX BOTH IN GOVERNMENT HEALTH FACILITIES AND CBRH PROGRAM AREAS
- ✚ PERSISTENT EFFORT SHOULD BE DONE TO PERSUADE WOMEN WHO HAVE THE INTENTION TO USE FERTILITY REGULATION METHODS AS EARLY AS POSSIBLE TO ATTAIN CHANGES IN FERTILITY STATUS AND TRENDS
- ✚ FURTHER STUDIES SHOULD BE DONE ON HOW CBRH PROGRAM COULD BE IMPROVED AND MADE SUSTAINABLE.
- ✚ CIVIC ASSOCIATIONS DEALING WITH GENDER AND DEVELOPMENT CAN USE CBRH PROGRAM AS AN OPTION TO IMPROVE WOMEN STATUS
- ✚ IMPLEMENTATION OF THE PROGRAM CAN ALSO CONTRIBUTE FOR THE ATTAINMENT OF THE MILLENNIUM DEVELOPMENT GOALS (MDGS), PARTICULARLY FOR GOALS 3,4,5 AND 6.HENCE, POLICY MAKERS ARE STRONGLY RECOMMENDED TO GIVE DUE ATTENTION FOR ITS IMPLEMENTATION.
- ✚ QUALITATIVE STUDY IS IMPERATIVE TO ASSES HOW AND WHY THE SIGNIFICANT DIFFERENCES BETWEEN THE TWO AREAS EXISTED

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ANNEXES

I. STRUCTURED SURVEY QUESTIONNAIRE

NAME OF THE INTERVIEWER _____

REGISTRATION NUMBER _____

1. STUDY AREA

1. CBRHP AREA 2. NON-CBRHP AREA

2. AGE IN YEARS _____

3. RELIGION

1. ORTHODOX 2. CATHOLIC 3. PROTESTANT 4. MUSLIM 5. OTHERS,
SPECIFY _____

4. ETHNICITY

1. AMHARA 2. OROMO 3. TIGRE 4. OTHERS, SPECIFY _____

5. EDUCATIONAL STATUS

1. ILLITERATE 2. READ AND WRITE ONLY ELEMENTARY AND ABOVE

6. OCCUPATION

1. HOUSEWIFE 2. FARMER 3. LOCAL ALCOHOL SELLER 4. GOVERNMENT
EMPLOYEE

5. STUDENT 6. OTHER, SPECIFY _____

7. AT WHAT AGE DID YOU GET MARRIED FOR THE FIRST TIME? AGE IN
YEARS _____

8. AT WHAT AGE DID YOU BEAR YOUR FIRST CHILD? AGE IN YEARS

9. HOW MANY CHILDREN HAVE BEEN BORN ALIVE TO YOU?

10. HOW MANY CHILDREN DO YOU HAVE NOW?

11. HOW MANY MORE CHILDREN WOULD YOU LIKE TO HAVE?

12. HAVE YOU EVER BEEN PREGNANT WHEN YOU DID NOT WANT TO BE 1. YES

2. NO

13. HAVE YOU EVER HEARD ABOUT FAMILY PLANNING METHODS? 1. YES

2. NO

14. IF YES, FOR # 13, WHAT METHODS OF MODERN CONTRACEPTIVES DO YOU KNOW?

1. PILLS 2. INJECTABLES 3. CONDOMS 4. IUCD 5. NORPLANT

6. PERMANENT

15. DO YOU USE ONE OF THE MODERN CONTRACEPTIVE METHODS 1. YES

2. NO

16. IF YES FOR #15, WHICH METHOD OF MODERN CONTRACEPTIVE DO YOU USE?

1. PILLS 2. INJECTABLES 3. CONDOMS 4. IUCD 5. NORPLANT

6. PERMANENT

17. WHICH METHOD OF CONTRACEPTION DO YOU USE CURRENTLY?

1. PILLS 2. INJECTABLES 3. CONDOMS 4. IUCD 5. NORPLANT

6 PERMANENT

18. WHERE DO YOU GET YOUR CONTRACEPTIVE SUPPLY? (IF NO USE, SKIP THIS)

1. CBRHA 2. HEALTH FACILITY 3. PHARMACY 4. SHOP OTHERS

(SPECIFY)

19. HAVE YOU EVER-GOT SERVICE BY CBRHA IN THE PAST ONE YEAR? 1. YES
2.NO

20. DOES YOUR HOUSEHOLD HAVE CROPLAND? 1. YES 2.NO

21. DOES YOUR HOUSEHOLD GROW CASH CROPS? 1. YES 2.NO

22. DOES YOUR HOUSEHOLD HAVE A RADIO? 1. YES 2.NO

23. WHO DECIDES, TO BUY OR SELL MAJOR HOUSEHOLD AND AGRICULTURAL ITEMS?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY
MEMBER

24. WHO DECIDES, IF YOU NEED TO BUY MAJOR HOUSEHOLD SUPPLY?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY
MEMBER

25.WHO DECIDES, IN SPENDING MONEY ON MEDICINE FOR A SICK CHILD?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY
MEMBER

26. WHO DECIDES, IF YOU NEED TO VISIT A HEALTH FACILITY FOR MEDICAL
PROBLEM?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY
MEMBER

27. WHO DECIDES, IN SPENDING MONEY YOU EARNED?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY
MEMBER

28. WHO DECIDES, IN SPENDING MONEY YOUR HUSBAND EARNED?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY MEMBER

29. WHO DECIDES, IN BUYING / SELLING CATTLE?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY MEMBER

30. WHO DECIDES, IN BORROWING /LENDING CASH/KIND?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY MEMBER

31. Who decides, in obtaining family planning method?

1. You 2.Husband 3.You and husband 4.Other family member

32. Who decides, on number of children and birth interval for the family?

1. You 2.Husband 3.You and husband 4.Other family member

33. WHO DECIDES FOR VISITING OF PARENTS/RELATIVES?

1. YOU 2.HUSBAND 3.YOU AND HUSBAND 4.OTHER FAMILY MEMBER

34. DO YOU ASK PERMISSION TO GREET MALE NON-FAMILIAL PERSONS?

1. YES 2.NO

35. Do your income cover your expenses 1.yes 2.NO 3.Some times yes & s/t no

36. What do you say about your standard of living of today when you compare to that of five years back?

1. Improved 2. The same 3. Deteriorated

37. What do you say about your decision making power on money matters of today, when you compare to that of five years back?

1. Improved 2.The same 3. Deteriorated

38. WHAT DO YOU SAY ABOUT YOUR SOCIAL ACCEPTABILITY AND SOCIAL PARTICIPATION OF TODAY, WHEN YOU COMPARE TO THAT OF FOUR YEARS BACK?

1. Improved 2.The same 3. Deteriorated

39. Where do you categorize yourself in terms of income?

1. Upper income 2.Middle income 3.Lower income

40. DO YOU HAVE THE KNOWLEDGE AND USE OF MICRO-CREDIT PROGRAM?

1. YES 2.NO

41. If yes for # 40, do you get any service from the institution?

1. YES 2.NO

42. Do other individuals in the community seek your opinion about important matters?

1. YES 2.NO

43. DO YOU ATTEND WOMEN'S MEETING? 1. YES 2.NO

44. IF YES FOR # 43, DO YOU NEED TO ASK PERMISSION FOR IT FROM YOUR HUSBAND OR ANY SENIOR FAMILY MEMBER?

1. YES 2.NO

45. DOES YOUR HUSBAND HAVE ANY OTHER WIFE BESIDES YOUR SELF? 1. YES 2.NO

በባሶናወራና ወረዳ በተመረጡ ቀበሌዎች ለሚደረገው የስነተዋልዶ ጤና ጥናት የተዘጋጀ መጠይቅ

የምዝገባ ቁጥር _____

1. የጥናቱ ቦታ 1.ህፃስጤፕኦ 2.ከህፃስጤፕ ወጭ
2. ዕድሜ በዓመት _____
3. ሀይማኖት
 - 1.አርቶዶክስ 2.ካቶሊክ 3.ፕሮቴስታንት 4.እስላም 5.ሌላካለ ይገለጽ _____
4. ብሔረሰብ
 - 1.አማራ 2.አሮሞ 3.ትግሬ 4. ሌላ ከሆነ ይገለጽ _____
5. የትምህርት ደረጃ
 - 1.መጻፍና ማንበብ የማይችል 2.መጻፍና ማንበብ ብቻ 3.ከ1ኛ እስከ6ኛ ክፍሮች በላይ
6. መደበኛ ስራ
 - 1.የቤት እመቤት 2.አርሶአደር 3.ጠላ/አረቄ ሽያጭ
 - 4.መንግስት ሰራተኛ 5.ተማሪ 6.ሌላ ካለ ይገለጽ _____
7. መጀመሪያ ሲያገቡ እድሜዎ ስንት ነበር ? ዕድሜ በዓመት _____
8. የመጀመሪያ ልጅዎን በስንት ዐመትዎ ፀነሱ ? ዕድሜ በዓመት _____

9. በሕይወት የተወለዱ የልጆችዎ ብዛት ስንት ነው ? _____

10. በአሁኑ ጊዜ ስንት ልጆች አሉዎት ? _____

11. ከዚህ በኋላ ስንት ልጆች እንዲኖርዎት ይፈልጋሉ ? _____

12. ሳይፈልጉ ያረገዙበት ጊዜ ነበር ?

- 1. አዎ
- 2. አይደለም

13. ስለቤተሰብ ምጣኔ ዘዴዎች ሰምተዉ ያዉቃሉ ?

- 1. አዎ
- 2. አይደለም

14. ለቁጥር 13 ጥያቄ መልስዎ አዎ ከሆነ የትኞቹን ዘዴዎች ያዉቃሉ ?

- 1. ኪኒን
- 2. በመርፌ የሚሰጠውን
- 3. ኮንዶም
- 4. በማሕፀን የሚቆየውን
- 5. በትከሻ ዉስጥ የሚቀበረውን
- 6. ቋሚ ዘዴዎችን
- 6. ሌሎች ካሉ ይገለጹ _____

15. ከላይ በተጠቀሱት ዘዴዎች ተጠቅመዉ ያዉቃሉ ?

- 1. አዎ
- 2. አይደለም

16. ተጠቅመዉ የሚያዉቁ ከሆነ የትኞቹን ዘዴዎች ይጠቀማሉ ?

- 1. ኪኒን
- 2. በመርፌ የሚሰጠውን
- 3. ኮንዶም
- 4. በማሕፀን የሚቆየውን
- 5. በትከሻ ዉስጥ የሚቀበረውን
- 5. ቋሚ ዘዴዎችን
- 6. ሌሎች ካሉ ይገለጹ _____

17. አሁን በመጠቀም ላይ ካሉ የትኞቹን ዘዴዎች ይጠቀማሉ ?

- 1. ኪኒን
- 2. በመርፌ የሚሰጠውን
- 3. ኮንዶም
- 4. በማሕፀን የሚቆየውን
- 5. በትከሻ ዉስጥ የሚቀበረውን
- 5. ቋሚ ዘዴዎችን
- 6. ሌሎች ካሉ ይገለጹ _____

18. የቤተሰብ ምጣኔ አገልግሎት የሚያገኙ ከሆነ አገልግሎቱን ከየት ያገኛሉ ?

- 1. ከሕጻን ልማት ተጠሪ
- 2. ከጤና ድርጅት
- 3. ከፋርማሲ
- 4. ከገበያ /ሱቅ
- 5. ከሌላ _____

19. በአለፈዉ አንድ ዓመት ዉስጥ ከጤና ተጠሪዉ አገልግሎት አግኝተዋል ?

- 1. አዎ
- 2. አይደለም

20. ቤተሰብዎ የእርሻ መሬት አለዉ?

- 1. አዎ
- 2. አይደለም

21. ለሽያጭ የሚወል የንግድ ተክል ያመርታሉ?
 1. አዎ 2. አይደለም
22. ቤተሰብዎ የሬድዮ አገልግሎት ያገኛል?
 1. አዎ 2. አይደለም
23. መደበኛ የሆኑ የቤትና የእርሻ እቃዎችን ለመግዛት ወይም ለመሸጥ የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎች ካሉ ይገለጹ
-
24. ለቤትዎ የሚያስፈልጉ ዋና ዋና እቃዎችን መግዛት ቢያስፈልግ ግዥዉን የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ
-
25. ሕፃን ልጅዎ ቢታመም ለህክምና የሚያስፈልገውን ወጭ ለማወጣት የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
26. ህክምና ቢያስፈልግዎ ወደ ጤና ድርጅት ለመሄድ የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
27. እርስዎ ሰርተው በሚያገኙት ገንዘብ ላይ የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
28. ባለቤትዎ ሰርተው በሚያገኙት ገንዘብ የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
29. የቤት እንሰሳዎችን ለመግዛት ወይም ለመሸጥ የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
30. ገንዘብን ወይም ንብረትን ለመበደር ወይም ለማበደር የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
31. የቤተሰብ ምጣኔ ዘዴዎችን ለመጠቀም ሲፈልጉ የሚወስነው ማነው?
 1. እርስዎ 2. ባለቤትዎ 3. እርስዎናባለቤትዎ በጋራ 4. ሌሎችካሉ ይገለጹ _____
32. ሊኖርዎት በሚፈልጉት ልጆች ብዛትና በመሀላቸው ሊኖር የሚገባውን የዕድሜ ልዩነት የሚወስነው ማነው?

- 1.እርስዎ 2.ባለቤትዎ 3.እርስዎናባለቤትዎ በጋራ 4.ሌሎችካሉ ይገለጹ _____
33. ወላጆችዎን ወይም ዘመዶችዎን ለመነብኘት ቢፈልጉ በዚህ ጉዳይ የሚወስነው ማነው?
1.እርስዎ 2.ባለቤትዎ 3.እርስዎናባለቤትዎ በጋራ 4.ሌሎችካሉ ይገለጹ _____
34. ከዘመዶችዎ ወይም ከቤተሰብዎ ውጭ ያሉ ወንዶችን ሰላምታ ለመስጠት ቢፈልጉ የባለቤትዎን ፈቃድ ይጠይቃሉ?
1.አዎ 2.አይደለም
35. የሚያገኙት የወር ወይም የዓመት ገቢ የቤተሰብዎን ዎጭ ይሸፍናል?
1.አዎ 2.አይደለም
36. የአሁኑ ጊዜ ኑሮዎን ከዛሬ አምስት ዓመቱ ጋር ሲያወዳድሩት ምን ይመስላል?
1.ተሻሽሎአል 2.ልዩነት የለውም 3.ብሶበታል
37. በአሁኑ ጊዜ ያለዎትን በገንዘብ ጉዳዮች ላይ ያለዎትን የመወሰን ስልጣን ከዛሬ አምስት ዓመቱ ጋር ሲያወዳድሩት ምን ይመስላል?
1.ተሻሽሎአል 2.ልዩነት የለውም 3.ብሶበታል
38. በአሁኑ ጊዜ ያለዎትን ማሕበራዊ ተቀባይነትና ተሳትፎ ከዛሬ አምስት ዓመቱ ጋር ሲያወዳድሩት ምን ይመስላል?
1.ተሻሽሎአል 2.ልዩነት የለውም 3.ብሶበታል
39. ከሚያገኙት ገቢ አንጻር ኑሮዎን የት ይመድቡታል?
1.ከፍተኛ ገቢ ካላቸው 2.መካከለኛ ገቢ ካላቸው 3.ዝቅተኛ ገቢ ካላቸው
40. ስለ አነስተኛ የብድር ተቋማት አገልግሎት ያወቃሉ?
1.አዎ 2.አይደለም
41. የቁጥር 40 ጥያቄ መልስዎ አዎ ከሆነ ከተቋማቱ አገልግሎት አግኝተው ያወቃሉ?
1.አዎ 2.አይደለም
42. በአካባቢዎ ያሉ ነዋሪዎች አስፈላጊ ስለሆኑ ጉዳዮች ያማክሩዎታል?
1.አዎ 2.አይደለም
43. በሴቶች ማህበር ስብሰባ ይሳተፋሉ?
1.አዎ 2.አይደለም
44. የቁጥር 43 ጥያቄ መልስዎ አዎ ከሆነ በስብሰባው ላይ ለመገኘት ከባለቤትዎ ፈቃድ ይጠይቃሉ?
1.አዎ 2.አይደለም
45. ከእርስዎ ሌላ ባለቤትዎ ሌላ ሚስት አላቸው?
1.አዎ 2.አይደለም

የጠያቂው ስም _____ ፊርማ _____ ቀን _____

FIELD INTERVIEWER MANUAL-ENGLISH VERSION [Adopted by Ayele Atlabachew]

Introduction

YOUR SUPERVISOR WILL WORK WITH YOU DURING TRAINING TO MAKE SURE YOU UNDERSTAND ALL OF THE PROCEDURES AND FORMS YOU WILL BE USING DURING THE COURSE OF THE SURVEY, AND TO MAKE SURE THAT YOU CAN PROPERLY ADMINISTER THE QUESTIONNAIRE. YOUR SUPERVISOR WILL VISIT YOU WHILE YOU ARE IN THE FIELD MAKING CALLS ON YOUR HOUSEHOLDS TO ENSURE THAT YOU ARE FOLLOWING THE CORRECT PROCEDURES. YOU WILL ALSO MEET WITH YOUR SUPERVISOR FREQUENTLY TO DISCUSS PROGRESS AND PROBLEMS, GET NEW ASSIGNMENTS AND ADDITIONAL SUPPLIES, AND TO RETURN COMPLETED WORK. WHEN REASONABLE, YOUR SUPERVISOR MAY ASK TO SEE YOUR QUESTIONNAIRES AFTER YOU HAVE COMPLETED.

In each of the selected households, for this Survey you will administer only one questionnaire, the Household Questionnaire. You will begin your administration of this questionnaire with the one person in the family who is woman and married. Obviously this person must be an adult, and it must be a person who can give reliable answers to questions about the make-up of the household

Things to be considered

A. Confidentiality

It is very important that you understand the meaning of the term “confidentiality” as it relates to the respondents in this study. You will be asking some questions about income, expenditures, and personal health, which may be sensitive to some of your respondents, and they may be reluctant to give you an answer. When you sense that this is the case, you need to be able to explain to them that the information they give you will be seen only by authorized research staff, and that these staff have made a pledge that they will not reveal this information to anyone.

B. Use of Manual

This manual is for your use before, during, and after training. Study it carefully and make sure you understand all of the instructions and procedures, which it explains. Do not hesitate to discuss anything that bothers you or that you do not understand with your Field Supervisor or Coordinator. It is very important that you feel comfortable about your work and have confidence in what you are doing. Your respondents may well sense a lack of confidence or understanding, and they will be less likely to provide you with the accurate information we need for this survey.

General Standards for Conducting Structured Interviews

- [1] Read every question exactly as it is written.
- [2] Ask all questions which are in the questionnaire in the exact order in which they are presented.
- [3] Read every question slowly so that the respondent can comprehend its meaning.
- [4] Do not explain and comment on questions in the questionnaire. If the respondent does not understand a question, repeat it again.
- [5] Do not hand the questionnaire to the respondent.
- [6] Follow the instructions about procedures contained in the questionnaire and read transition statements as provided.
- [7] Don't leave out any questions, which the respondent is supposed to answer.
- [8] Do not suggest answers to the respondent.

Special Instructions about Survey Procedures

[1] Read aloud all alternative answers if the respondent is supposed to choose one of the predetermined alternatives.

[2] Write down exactly what the respondent says in answer to a given question if he has been given an "open question".

[3] Write down in the margins of the questionnaire what the respondent says if it is impossible to choose a code that corresponds to what she says, and there is no "Other, specify" alternative.

[4] If there are special instructions in the questionnaire to do so, allow the respondent herself to read through the possible answers to the question presented to her, and then indicate the number corresponding to the answer which the respondent chose.

[5] Repeat (but do not explain) a question which the respondent did not understand or incorrectly interpreted. In this case you should indicate, in the margins of the questionnaire, that the respondent did not understand the question. No matter what the nature of the answer, it follows that you should thank the respondent for the opinions expressed and only after that, go to the next question.

Other points to consider

- Answer choices "Don't know" and "Refused" should never be read to the respondent. "Don't know" - use this answer choice only in the situation when obviously the respondent experiences difficulty or doubt in answering the question.
- "Refused" - use this answer choice when for any reason the respondent does not want to answer the question put to him. For example, if she does not want to give the amount of his income.
- You may find the instruction "GO TO..." in brackets [GO TO...]. This is a "skip" instruction, which tells you which question to ask next and is done to make your work easier. The skip instructions will allow you to skip unnecessary questions. For example, if, after the code which you indicate corresponding to the respondent's answer to Question 1, there is the instruction "[GO TO 3]" that means that it is not necessary to ask Question 2, but that you are to go directly to Question 3.

Techniques for Establishing Contact and Securing Consent for the Interview

1. Making Initial Contact

The success of the survey and the reliability of the data obtained is to a large extent dependent on the first impression which the respondent gets from you. Therefore, your job in getting acquainted with the respondent and members of the family is to create an atmosphere of good will and calmness, to persuade them of the importance and necessity of the survey, and to get participation from each person in the sample. It is necessary, therefore, to properly introduce yourself, show your cooperation paper, and explain the purpose of your visit.

2. Answering Questions

OFTEN, RESPONDENTS ASK QUESTIONS SUCH AS THE FOLLOWING: "WHY DID YOU COME TO MY HOUSE?" OR "HOW DID YOU GET MY ADDRESS?" YOU NEED TO BE SUFFICIENTLY FAMILIAR WITH THE BACKGROUND AND PURPOSE OF THE SURVEY TO ANSWER SUCH QUESTIONS. YOU ALSO NEED TO BE PREPARED TO COUNTER THE OBJECTIONS OF PERSONS WHO SEEM RELUCTANT TO PARTICIPATE. SOMETIMES SOME MEMBERS MAY TRY TO SAY THAT THEY HAVE INADEQUATE EDUCATION TO ANSWER THE QUESTIONS, OR THEY MAY COMPLAIN THAT THEY ARE TOO OLD. OTHERS WILL SUGGEST THAT YOU GO TO A NEIGHBOR OR TO A DIFFERENT MEMBER OF THE FAMILY FOR THE INTERVIEW.

Example of Introductory Script

Good morning (afternoon, evening.) My name is _____, and I am working for the _____ office. We are conducting a survey that is very important for the reproductive health service in the woreda. Your household has been selected for this survey through a statistical procedure called random sampling. For the survey to succeed, we need to get some information about you and the members of your family. Let me assure you that the information you provide will be kept in strictest confidence. No one except authorized research staff will see your answers.

Your information will be combined with answers we get from about 600 other families throughout the woreda. Your participation is completely voluntary, and you do not have to answer any of the questions you do not want to answer. Let me begin, please, by getting the ages and religion of you.

Countering Refusals

There may be some occasions where the respondent categorically refuses to participate in the survey. In such situations it will be necessary to express your regret, apologize for the inconvenience and take your leave. Your Field Supervisor will then try to assist in getting the household's participation. (You should provide your supervisor all the information necessary for visiting the household and do what you can to assist in obtaining cooperation.)

Refusals must be kept to an absolute minimum. To accomplish this, we are depending on you, the interviewer, to be able to win the respondent over. You need to be able to persuade the respondent of the scientific and practical value of the survey, the anonymity of the answers, and the importance of her participation. These are the keys to your success as an interviewer and ultimately to the success of the survey.

Conditions for Conducting the Interview

In as much as the interview takes place in the residence, a series of undesirable conditions may present themselves, which negatively affect the quality of the respondent's answers. Your task is to eliminate or minimize the effect of the following negative factors:

Influence of a third person- the ideal situation is for you to interview the respondent in an area, which is silent and bold.

Interfering activities-Frequently, you will, during your initial contact with the household, obtain agreement to participate in the survey and go ahead and begin administering the questionnaire, not having any prior agreement about the most convenient time for the interview. So, if you have interrupted some activities of the respondent, you might have to deal with interruptions, such as housekeeping tasks, tending to children, arrival of other family members or guests, etc. If the respondent is continually distracted by such interruptions, you should propose that the respondent name another time that would be better for conducting the interview without interruptions and return to complete the interview at the agreed upon time.

Other problem situations.

Occasionally you might find yourself involved in a "conflict situation" where there is a family quarrel going on, one of the respondents is intoxicated, or a family member is intoxicated. In such circumstances, you need not conduct the interview. If you cannot succeed in rescheduling the interview for some reason, and you go ahead and conduct the interview in spite of the undesirable emotional-psychological conditions, be sure to describe the circumstances and conditions in the final section of the questionnaire, "Remarks of the Interviewer."

Summary of Responsibilities

You have a very important role in the Survey of households .The goal of this research is to study various aspects of the life of the people. These aspects include obtaining data regarding the work history of households, their family situation, their housing conditions and health habits, their financial situation, and their patterns of income and expenditures.

During the data collection period, your work will largely determine the level of quality of this important research. The completeness and accuracy of our data collection effort is dependent on your taking your responsibilities seriously. Your first and foremost task as an interviewer is to follow the instructions and procedures presented in this manual very closely.

Your responsibilities include the following:

- Study these procedures and follow the instructions presented in this manual
- Understand the content of the questionnaire and the procedures for completing it. You will then be able to answer the respondents' questions during the interview
- Conduct the interviews efficiently and with high quality. Return the completed questionnaires to your supervisor within the specified time frame.
- Refrain from talking about answers or about the names and addresses of respondents. You must take personal responsibility for preserving the confidentiality of the respondents' answers.

Job description for supervisors and data collectors

Interviewer

THE INTERVIEWER IS REALLY THE "JACK-OF-ALL-TRADES" IN SURVEY RESEARCH. THE INTERVIEWER'S ROLE IS COMPLEX AND MULTIFACETED. IT INCLUDES THE FOLLOWING TASKS;

***Locate and enlist cooperation of respondents**

The interviewer has to find the respondent. In door-to-door surveys, this means being able to locate specific addresses. Often, the interviewer has to work at the least desirable times (like immediately after dinner or on weekends) because that's when respondents are most readily available.

***Motivate respondents to do good job**

If the interviewer does not take the work seriously, why would the respondent? The interviewer has to be motivated and has to be able to communicate that motivation to the respondent. Often, this means that the interviewer has to be convinced of the importance of the research.

***Clarify any confusion/concerns**

Interviewers have to be able to think broadly. Respondents may raise objections or concerns that were not anticipated. The interviewer has to be able to respond candidly and informatively.

***Observe quality of responses**

***Conduct a good interview**

The interviewer has to conduct a good interview! Every interview has a life of its own. Some respondents are motivated and attentive, others are distracted disinterested. The interviewer also has good or bad days. Assuring a consistently high-quality interview is a challenge that requires constant effort.

*Ask questions in accordance with instructions to obtain various specified information, such as person's name, address, age, religious preference, and state of residency.

- Explain survey objectives and procedures to interviewees, and interpret survey questions to help interviewees' comprehension.
- Identify and report problems in obtaining valid data.

- Review data obtained from interview for completeness and accuracy.

- Meet with supervisor daily to submit completed assignments and discuss progress.

- Performs miscellaneous job-related duties as assigned.

Supervisors

- **Team working:** works effectively with others to achieve team goals; freely contributes ideas and expresses opinions to others in the team; helps and supports others; willing to subordinate personal working goals for the overall interests of the team.
- **Time management:** plans and organizes time effectively; sets up and monitors time scales and plans; develops workable contingencies and reacts flexibly and effectively when required, balancing conflicting priorities.

- Provides regular and constructive feedback; gives a clear sense of direction to others; delegates and

- empowers team members; creates an organized and structured approach to work for their staff
- **Creativity/problem solving:** creates new and imaginative approaches to work-related issues; identifies fresh approaches and shows a willingness to question traditional assumptions; analyses issues logically and from all angles; makes systematic and rational judgments based on relevant information and generates logical, timely and workable solutions.
- **Flexibility/adaptability:** takes a flexible approach to work situations; willing and able to adjust to changing demands; receptive to new ideas.
- Interprets, and explains the documents; i.e. the questionnaire
- Updates and retains data collection and reporting systems;
- Directs work assignments and allocation of data collection priorities necessary data identification and abstraction requirements in support of on-going research and project activities
- Provides on-going evaluation, training, and development of skilled data collection staff to ensure quality of data, uniformity and appropriateness
- Reviews and monitors day-to-day data collection activities to ensure completeness and accuracy of information.
- Travels to field sites to establish new data collection resources and/or monitor current on-site data collection activity.
- Develops record keeping procedures and manages appropriate data collection tracking programs in accordance with standards.
- Implements and monitors confidentiality rules and requirements
- Performs miscellaneous job-related duties as assigned.
- Identify the clusters to be surveyed
- Supervise three to five interviewers as they perform the survey
- Ensure that the interviewers follow instructions
- Answer interviewers' questions as they arise
- Control the data quality by checking for errors during the interviewing, by checking that forms are completed fully and correctly and by checking that all the respondents are answering the questions
- Identify problems and retrain interviewers who are doing their job incorrectly

Information and consent

Dear respondent,

Hello, My name is_____. I am working in a research team of Addis Ababa University .We are interested in learning more about your knowledge and practices related to reproductive health. This questionnaire is designed for a research work which will be

approved by AAU, Medical faculty, Department of community health to be conducted in partial fulfillment of master's degree in public health. We hope you will help us by answering these questions. None of your answers will be available to any one .Do not give your name .All the information you give us will be kept private. Any one who will not be willing to participate in the study will have the right to discontinue at any time in the process. Confidentiality and privacy will be maintained by ensuring the respondents answering the questions on a separate place where no one can see them. We really need your honest response to better understand the knowledge and practices of reproductive health. The results of the study will hopefully serve as an important input to intervention programs that aim at improving reproductive health in communities in general and mothers and children in particular.

We thank you in advance for taking your time to answer our questions.

Would you be willing to participate in the study? _____ agree. _____Disagree

Consent for the respondents

I, the undersigned have been informed that the purpose of this particular research project is to find out knowledge and reproductive health practice. I have been informed that I am going to respond to these questions by answering what I know concerning the reproductive health condition. I have been informed that the information I give will be used only for the purpose

of finding out problems of reproductive health; my identity the information I give will be treated confidentially. I have also been informed that I can refuse to participate in the study or not to respond to questions I am not interested. Further more I have been informed that I can stop responding to the questions at any time in the process. Based on the above information I agree to participate in the research voluntarily with the hope of contributing to the research.

Date _____