THE CHALLENGES OF IMPLEMENTING REPRODUCTIVE HEALTH AND RELATED PROGRAMS: THE CASE OF MOKONISA RURAL KEBLE, WONAGO WOREDA, GEDEO ZONE, SNNPRS

A THESIS SUBMITTED TO SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN **PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN PUBLIC MANAGEMENT AND POLICY**

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLAGE OF BUSINESS AND ECONOMICS
DEPARTMENT OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT

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September 2014

Addis Ababa, Ethiopia

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the Case of Mokonisa Rural Keble, Wonago woreda, Gedeo zone, SNNPRs

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September, 2014

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Table of Content

Contents Page

LIST OF TABLE

List of Map Figure And

Map, 1 Map of the study area

ACRONYMS AND ABRIVATIONS

CBOs - Community Based Organizations

CMR- Child Mortality Rate

CSA- Central Statistics Agency

DHS- Demographic and Health Survey

FP- Family planning

HAPCO- HIV/AIDS Prevention Coordination Office

HSDP - Health Sector Development Program

ICPD - International Conference on Population and Development

IEC/BCC- Information Education Communication / Behavioral Change Communication

IMR - Infant Mortality Rate

ICPD - International Conference on Population and Development

IUD - Intra Uterial Contraceptive Device

MDGs - Millennium Development Goals

MMR - Maternal Mortality Rate

MoFED- Ministry of Finance and Economic Development

MoWA - Ministry of Women Affairs

NGOs - Non-Governmental Organizations

NPP- National Population Policy

OPM- Office of Prime Minister

PASDEP – Plan for accelerated Sustainable Development to Eradicate Poverty

RH- Reproductive Health

SLUF- Sustainable Land Use Forum

SNNPRs - Southern Nation Nationality Peoples Regional state

SPSS- Statistical Package for Social sciences

TBAs - Traditional Birth Attendants

TFR- Total Fertility Rate

TGE- Transitional Government of Ethiopia

UN/DESA- UN/ Department of Economic and Social Affairs

UNIFPA- UN Fund for Population Activity

ABSTRACTS

Ethiopia achieved promising progress in health sector after developing HSDP and health extension program. However, implementing some selected components of Reproductive Health program, specifically FP, ANC, delivery and postnatal care; and immunization, that are given emphasis in the RH strategies for the year 2006 to 2015, assumed to be challenging in densely populated rural kebele. Hence, this study was conducted with the main objective of assessing the challenges that impeded the implementation of RH and related programs. Across sectional community- based research design backed by qualitative in-depth interviews and FGDs were used. In addition, both descriptive and exploratory method was set from May 12 to July 10, 2014 at Mokonisa kebele(in Wonago wereda, Gedeo zone of SNNPR, Ethiopia).The study population consisted of all married women in reproductive age registered in the kebele administration office in the list of conventional households. To this end, 360 women samples were included in the study, pre test questionnaire was administered. The collected data were entered and analyzed by SPSS 16.0.The qualitative data was also analyzed through non- tactical bases in their thematic areas. The result of the study showed that RH services in general were under- utilized in the study area attributed to socio economy barriers and inadequate resources in health facilities; weak information channel, negligence to adolescents RH, practices of early marriage. As a result, special attention needs to be given to the most densely populated kebele, the study area, by mobilizing relevant stakeholders and deploying adequate resources so as to surmount the challenges and bring sustainable demographic transition that can enhance socio-economic change in the study area.

CHAPTER ONE

1. INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Reproductive health is defined as a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. It involves all of the reproductive processes, functions and systems at all stages of human life (WHO, 2011).

Reproductive Health is a comprehensive concept that implies a broad range of health and non-health interventions. RH undergone through series development and after the 1994 ICPD it went in to a paradigm shift to give emphasis on the quality, availability and accessibility of RH services by promoting individual women's needs and interests by standing against social injustice. The intentions of the interventions are to bring change on the odd features of poor RH services (Ibid).

Worldwide Complications associated with various maternal issues are indeed major attributes to poor reproductive health among millions of women, 2.6 billion in the category of 15 – 49 years of age, without proper health care services, are highly vulnerable to problems related to sexual intercourse, pregnancy, contraceptive side effects, etc, globally 120 to 201 million couples were with unmet need for contraceptives. It is estimated that 529,000 women die yearly from complications of pregnancy and childbirth, about one woman every minute at global level. Some 99 percent of these deaths occur in developing countries, where a woman's lifetime risk of dying from pregnancy-related complications is 45 times higher in developing countries than developed countries, remains the leading causes of death among women of reproductive age(Hanson, Kara, 2002).

Risk of death from pregnancy is very high in developing countries, while being very low in the developed world. In 2005 more than 636,000 women died each year worldwide. From that, 99% was accounted by developing countries. Of those, around 270,000 women died each year in Africa. In Ethiopia 46,000 women died each year (Samuel and Feleke, 2008).This shows that the difference is due to the availability, accessibility and quality of care provided to mothers.

Maternal mortality and morbidity can be reduced or avoided by providing and expanding resources and services that are principally targeted in achieving maternal health and safe motherhood (Samuel and Feleke, 2008).

Like several other nations did, the government of Ethiopia after adopting reproductive health strategy for the year 2006-2015 has intervened to address reproductive health problems. The strategy is in fact the component part of health policy, HSDP and health extension program that directed towards achieving both PASDEP and millennium development goals. The social and cultural determinant of women RH; fertility and FP; maternal and child health are among the six priority areas of RH strategies (MoH, 2006).

As the EDHS 2011 indicates total fertility rate is high in Ethiopia (4.8) and higher in rural than urban; and substantial difference among regions, higher in Somali (7.1) and lower in Addis Ababa (1.5). The SNNPR has TFR of 4.9 which is higher than the national average. The prevalence of modern contraceptive among married women is 27 % with 25 % unmet need for FP services, while in SNNPR its prevalence is 24.7%. With regard to ANC 34% pregnant women received the service from skilled providers and only 10% births were delivered by skilled providers. Whereas, the utilization of ANC and delivery care services in SNNPR were 27.3% and 6.2 % which was below the performance of other regions except Somali (21.5%). Nonetheless, in contrast to previous performance significance improvements were seen during the survey (CSA, EDHS, 2011).

Since several actions were undertaken to put the strategies in to effect many achievements have been secured. A few of the main achievements in implementing reproductive health program include: the reduction of maternal mortality from 871 per100, 000 lives in a year 2000 to 673 in year 2005 to 2011. Infant mortality declined from 97 deaths per 1000 live births in 2000 to59 in 2011, while under-five mortality declined from 166 deaths per 1000 lives in 2000 to 88 in 2011 (MOFED,2012). However, several challenges impeded the effort made at different intervention.

The achievement and challenges differ from state to state. Particularly, in densely populated areas, it appears to be complicated due to several factors. In SNNP, especially in Mokonisa, a densely populated rural Keble in Gedeo zone, where the crude population density is 1748 per square kilometer (CSA, 2010), serious challenges appear in implementing Reproductive Health program.

Hence, in this research attempt has been made to assess the challenges that affected the implementation of Reproductive Health related activities (Family planning, Antenatal, Delivery, postnatal care and immunization) in the study area. .

1.2 Statement of the Problem

High density of population has serious implication on socio economic situation of a certain area. It creates pressure on the utilization of land for food production, fuel wood, pure water, and other social services like education and health (Bekele, 2007).

Implementation of Reproductive Health program in densely populated areas appears to be contemplating due to complex socio-economic problems that attributed to fast growing population. In Wonago woreda, where environmental friendly agro-forestry practices support large population, as noted by Sustainable Land Use Forum (SLUF) currently the carrying capacity of the land reached at climax point, where more than 1000 person live per square kilometers (Sustainable Land Use Forum, 2006).

In particular the realization of the RH activities are not easy in Mokonisa kebele, which is found in Wonago Woreda, the most densely populated rural keble in the Wereda, where 1748 person live per square kilometers. The 2007 national census revealed that the population of Mokonisa kebele was 10463 where the ratio of females constituted slightly greater than 50% and there were 2261 households in the kebele (CSA, 2010). Based on data taken from the kebele administration office, in 2013 the kebele's population is 17962, residing on 10.27 square kilometers.

In the kebele, currently health extension service is provided by four health extension workers. But the service appears not adequately accessible to 2727 households, which seems beyond the standard that assumes one health extension worker at maximum can serve 500 households.

Moreover, the school and health center in the Kebele lack adequate manpower and sufficient logistic to provide service to the community. In spite of these facts even the available social services are barely consumed by the community. To list some, among registered students in grade one in September 2012, 66.3% of them dropped out of the school, of which 25% were girls. In Sep.2013, admission in the same grade decreased nearly by 43.5%. In the case of infant and maternal care, in 2011/2012, from 410 pregnant women 70 of them availed antenatal care

services, whereas, only 26 of them utilized delivery services in health post. On the same case, in Mokonisa health center, which provides services to three neighboring Kebeles, out of 1182 pregnant women, only 365 and 34 of them received antenatal and delivery care by skilled health workers respectively, where the proportion of the community that utilize the services under study area appear to be very small. This is a paradox and implies that a large number of the population was deprived of even the basic available services due to unknown factors.

Therefore, these facts show that realizing RH program in densely populated areas, particularly in rural kebele like Mokonisa may face unique challenges. Hence, this research seeks to assess the challenges in implementing some selected aspects of Reproductive Health programs: FP, Antenatal, Delivery, postnatal cares and immunization in Mokonisa kebele.

1.3 Research questions

Based on the statement of the problem in this research, effort is made to seek answers to the following research questions.

1. What achievements have been secured in Mokonisa Kebele in respect to reproductive health/FP, Antenatal, Delivery, Postnatal care and Immunization? Are the achievements adequate to check fast rate of population growth in Mokonisa kebele?

2. How were the achievements obtained? Does the community adequately participate to play significant role?

3. Were there any elements or factors that hindered implementing or realizing reproductive health services in the study kebele so far?

4. How is the utilization, the attitude and knowledge of the community in study area to the RH services? What are the major constraints that impeded the community not to confirm to the intervention made by different sectors?

1.4. Research objectives

1.4.1 General Objective

The overall objective of this study is to assess the challenges that deter the implementation of some selected components of Reproductive health program at grass root level.

1.4.2 Specific objectives

1. To explain the community's knowledge, attitude and service utilization on reproductive health (FP, Antenatal, Delivery, Post natal cares and Immunization).

2. To identify the achievements gained in realizing Reproductive Health program in terms of the local plan at health posts and health center,

3. To describe the means employed by the actors in providing reproductive health services to the community and the extent in which the community participate in it.

4. To explore the challenges encountered during the implementation of Reproductive Health Program (FP, Antenatal, Delivery, Postnatal cares and Immunization) both from providers institutional set up and the community's stand point; and

5. To give possible recommendations to policy makers.

1.5. SIGNIFICANCE OF THE STUDY

The findings of this study will help program designers, planers and financial institutions to think separately for special treatment and intervention in densely populated areas in general and Mokonisa Kebele in particular, to the extent that it may help sustainable population, environment and socio economic development endeavors. In addition, it is useful to the media such as community radio and the local government to strengthen ICC/Advocacy work on population. Further it will help stakeholders who work on RH, gender, culture and tradition related aspects so as to bring new insight to the community under study. Moreover, this study may help researchers as empirical point of reference for further study**.**

1.6 SCOPE OF THE STUDY

This study was delineated to reproductive health (Family planning, Antenatal, Delivery, Postnatal cares and Immunization) interventions in Mokonisa Kebele. The components of RH are so wide to be studied in a single study. Therefore, this study focused largely on the aforementioned activities. This makes the researcher to apply a deep insight in to the designed study as well.

1.7. ORGANIZATION OF THE THESIS

The study has five chapters. The first chapter includes background of the study, statement of the problem; research questions, objectives of the study, significance of the study, scope, and organization of the thesis. Next, Chapter two deals with background of the study area and methodology; and chapter three constitutes review of the related literature. Chapter four, deals with data presentation and analysis. Finally, chapter five, deals with of the summary of findings, conclusions and recommendations of the study.

CHAPTER TWO

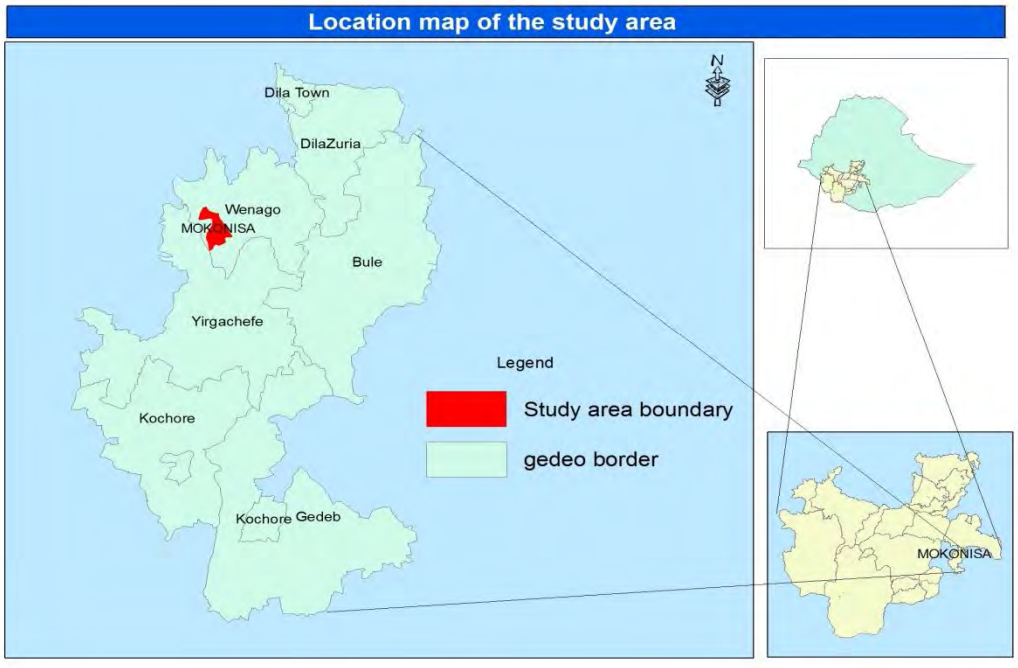
2.1 Background of the Study Area and Methodology

Location, Area and Spatial Distribution

This study was undertaken in Mokonisa kebele, which is found in SNNPRs, Gedeo zone, Wonago woreda. The kebele, the lower administrative unit, is bordered by Karasoditi and Jamjamo in the north and north east, Bankookotto and (Chelba-Yirgacheffee weredo) in the south, Dadero in the east and Dako in the west. The kebele is far away 380, 124, 20 and 8 kms from Addis Ababa, Hawasa, Dilla and Wonago town, which are federal, regional, zonal and woreda head quarters respectively. It is crossed by two roads. One is the Addis Ababa-Moyale asphalt road, which passes in the western part of the kebele and the other is all weather gravel road, which connects the asphalt road to interior rural kebeles and Yirgacheffee town.

Astronomically, Mokonisa is situated between 6^0 10'25" to 6^0 13'14" North latitude and 38^0 12' 41" to 38^0 14' 07" east longitude.

Map, 1 Map of the study area



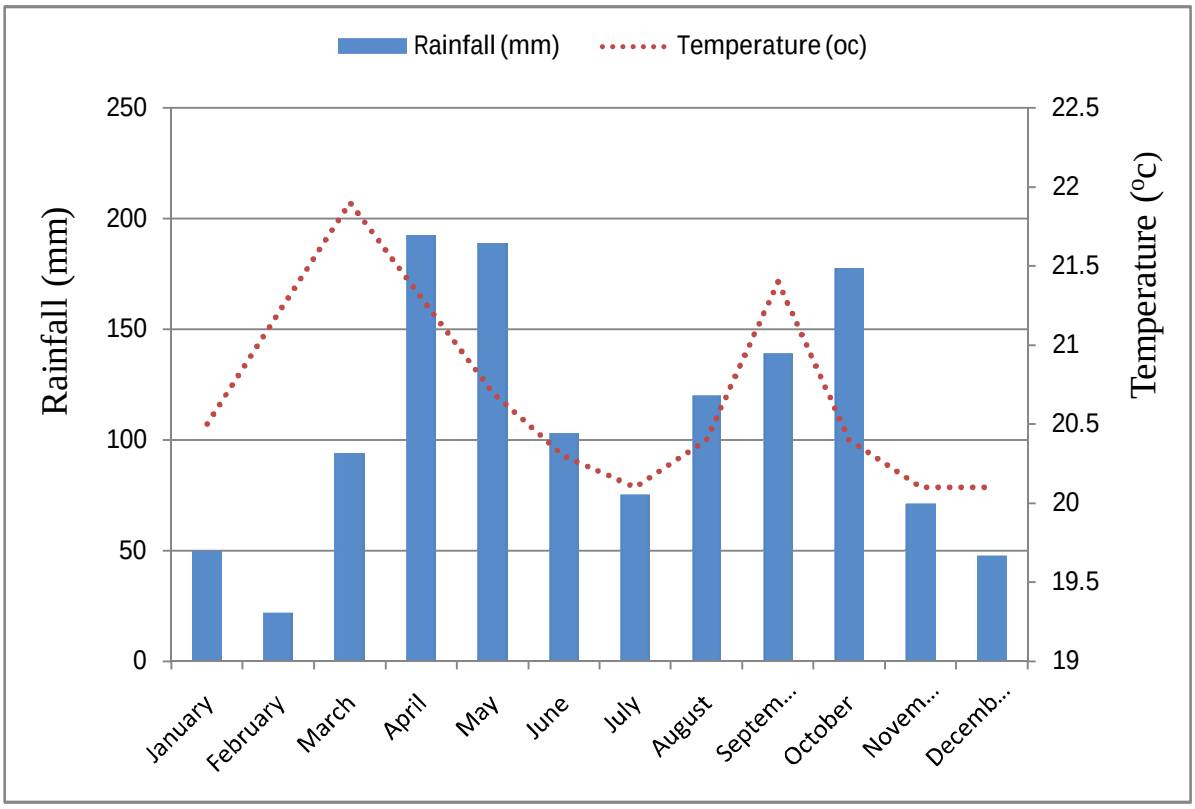
Source , Gedeo zone FEDD (2013)

The total area of Mokonisa kebele is 10.27 Km^2 or about 960 hectare of land. From this, 92.9% of the land has been covered by perennial crops and forest, 1% covered by annual crops, 4.7% occupied by settlement and social institutions, and the rest 1.4% of land has been left to other purpose (Gedeo zone FEDD,2013).

Altitude, Temperature and Rainfall

The elevation of the land of the kebele ranges from 1750m asl to 1980m asl increases west to east direction. Hence, it belongs to Woynadega agro ecological zone and agro forestry practices in the area make the temperature to be moderate. The mean monthly temperature ranges from 20^0c to 22^0c. As part parcel of Gedeo zone, Mokonisa kebele receives bimodal rainfall season, one from March to June and the next from August to October, where the former accounts 45.2% and the later 34% rainfall. Based on the information collected from the nearest meteorological center the mean annual rain fall of the study area was about 1077 mm

Figure 1: mean monthly rainfall and temperature of the study area (2002-2011)



(Source: Ethiopia Meteorological Agency, Hawasa Branch, 2014).

Population and settlement

The study area is known as densely populated rural kebele at woreda level. According to the 2007 CSA census report Mokonisa kebele had 10,463, populations settled in 10.27 square km. The 2012/2013 population data obtained from the kebele administration office also shows that the total population reached 17,962, which makes the population density to 1871 people per a square km. When the kebele population is classified in to age structure, 4049 (22.54%) of the people are from 1 to 14 age group, 12454(69.34%) people were grouped in to working age or 15-64 and 1459(8.12%) were categorized in old age or above 65 age. Therefore, the share of dependency constitutes 30.66% of the total population.

In the study kebele there are 2397 male headed and 330 female headed households of conventional type. Of these, 62(56 male headed and 6 female headed) households had TV set. With regard to housing type, 883 houses have been covered by iron sheet, as well as 1144 and 700 houses are covered by grass (hut) and dry 'Enset' leaves respectively.

Economic Activities

Like other rural kebeles in Gedeo Zone, Mokonisa kebele residents predominantly depend on agriculture where 'Enset' cultivation is practiced mainly for supporting household food consumption and coffee production for major source of earning cash, which were supplemented by other related activities too. Age old Agro-forestry practices still continued to support both human and the natural environment despite the alarming population growth in the study area.

Social and Economic Institutions

In the Mokonisa kebele many social and economic institutions render social and economic services. Among this Mokonisa primary school, Mokonisa health center together with two health posts, the kebele administration office, youth and women association, social court, agricultural extension development and a farmer training center provide different kinds of social services. In addition, 15 churches, traditional assembly or 'shango' and many civic societies play their respective roles.

Moreover, a market place, two wet coffee processing plants, small shops and soft drink selling groceries provide economic services to the community

2.2 Methodology

2.2.1. RESEARCH DESIGN

According to Tesfa and Tweeten (1994), problem-solving applied research can extend to two additional stages: applying results (conclusions) and evaluating the consequences in the real world. To attain such objectives effective research designing is imperative. To this end both institutional and community based cross sectional study design was used to assess the challenges that impended the implementation of the of core areas of national population policy i.e. Reproductive health, gender equality and information education communication/advocacy at grass root level in between May 12 to July 10, 2014.

AS Vandestoep and Johnston (2009) noted, qualitative research focuses on the constructed reality of the research participants, sees reality as constructed in the mind of the knower and situated in cultural and historical contexts, whereas quantitative research are based on objective, criteria for truth. Thus they argue to use both qualitative and quantitative or mixed approach simultaneously to take the advantages of both and, instead of depend on a single one. Hence, in this study both qualitative and quantitative research approaches were employed so as to ensure the validity of data. As the main objective of the study was to assess the challenges of implementing RH program, descriptive and exploratory research methods was preferred to describe and explore the challenges and constraints occurred when the selected components of RH under taken at Keble level.

2.2.2 SAMPLE SIZE AND SAMPLING PROCEDURE

The total population of the study area constitutes 2727 conventional households in Mokonisa Keble. Almost nearly the same size of these was women, who were in and above the reproductive age group. The number of married women who are in the reproductive age was about 1800.Using the formula for defined population ($N/1+N .e^2$) it gives 327 samples. But, in order to increase the validity of the data the sample size was increased by 2% .Then 360 married women are taken as a sample of the study. Since the eligible candidates have been homogenous in terms of sex, marital status and age category selection of the sample was made through systematic random sampling method. Before the selection of the sample, from the list of 2727 conventional households registered in the Kebele administration offices,1800 married women whose age was in reproductive category were taken as eligible candidate. In addition, four(4)

health extension workers from two(2) health posts and six(6) health personnel from Mokonisa health center (in sum 10) were selected purposively for interview. On the bases of recommendation from the Kebele manager and health extension workers in respect to their devotions on related tasks fourteen (14) informants (2 traditional administers, 2 church leaders, 2women association and 2 youth association leaders, 2 kebele health committee members and 2 volunteer health corps, 2 teachers and 2 Agricultural extension workers) were purposively selected to participated in focus group discussion. Overall 384 respondents were involved in providing data.

2.2.3 DATA SOURCE AND DATA TYPE

The researcher identified nine sub Kebles, two health posts, one health center, and one administration office as well as 360 households in Mokonisa Keble as the main data source and both primary and secondary data were used to make the analysis.

Variables:

Independent variable

- Pressure (peers, husband, parents)
- Culture
- Economic situation
- Availability and accessibility of health facility
- Traditional practices
- Availability of local infrastructure
- Lack of knowledge
- Incompatible attitude

Dependent variables

- Informed, acceptable attitudes
- Reproductive health - IEC/BCC utilization
- Reproductive health care service utilization

2.2.4. Data Collection Instruments

Vital data for this study were gathered through the use of different research instruments and their detail techniques of data collection instrument are stated below. Primary data were collected through questionnaire, interviews, focus group discussions, while secondary data were obtained from published and unpublished documents.

Questionnaire

The researcher designed questionnaire of closed ended so as to collect data from the respondents. The questionnaire was prepared in Amharic, Gedu'effa and English and administered at the convenience of respondents. Prior to the distribution of questionnaire the researcher conducted pilot-test so as to check and correct inconvenience on 25 married women. Then, three hundred sixty (360) questionnaires were distributed and filled by the support of ten trained persons for this purpose as most respondents were illiterate.

Focus group discussion (FGD)

In this study focus group discussion was used for two important cases. The first is to elicit wider information from participants through dialogue. Next, it was found to triangulate the resources of data gathered through other instruments. Thus, fourteen (14) participants that represent traditional rulers, religious leaders, teachers, agricultural extension workers, associations and committee members joined the two session's forum, each consist of seven participants.

Interviews

Primary data were also collected through unstructured interviews from ten health extension workers and health professionals purposively who provide service in Mokonisa health posts and health center, as these groups were believed to provide reliable data, and are closer to reproductive health services.

Secondary Data

The secondary data were collected from published and unpublished documents, and magazines that were available. Books, reports and internet sources were used in the process of data gathering. The National population Health policies and document, action planes, minutes, and reports were consumed for this purpose**.**

2.2.5. Data quality assurance

For internal validity and reliability of the questionnaire, the instruments were piloted on 25 married women in the nearby kebele with similar socio demographic characteristics before applying to the study subjects. The quality of the data collected was assured by checking all questionnaires at the evening of the date of collection for its completeness and unclear items were re-written in clear and easily understandable languages by the principal investigator of the study.

2.2.6. Method of Data Analysis

The data were summarized and organized thematically. Data collected through questionnaires' were analyzed quantitatively by using descriptive statistical techniques. To make analysis convenient, raw data were coded and were analyzed on question-by- question bases, and the statistical result of the questionnaire were analyzed using the Statistical Package for social science of version 16.0 (SPSS). As the research question indicated under chapter one are generally exploratory by nature, it was believed that descriptive statistical tools such as mean, and percentages were used. Moreover, results were displayed using frequency tables. On the one hand, the qualitative data obtained through interview and focus group discussions were carefully sorted and categorized based on the specific research questions. Genera themes were developed from the responses and these themes analyzed to find relationships and discrepancies among the responses based on the research questions. Finally the quantitative analysis and the qualitative results were triangulated to generate arguments and key findings.

2.2.7. Ethical consideration

Letter of permission was obtained from Addis Ababa University and was offered to the Mokonisa administrative office and Mokonisa health center where the study was conducted. Verbal consent was also taken from the study participants.

CHAPTER THREE
LITERATURE REVIEW

3.1. Theoretical Literature

3.1.1 DEFINITION OF CONCEPTS

This part of the literature begins with the presentation of some important conceptual definition of Reproductive health (RH), Family planning (FP) and Information Education Communication /Behavioural Change Communication (IEC/BCC) and Advocacy.

The 1994 International Conference on Population and Development (ICPD) came up with new approaches on reproductive health, family planning as feminists movement applauded human right issues in reproductive health and then decision on the Beijing Platform for action also made RH gender inclusive, and consequently, the definition of these terms gained wider components.

The WHO defines reproductive health as a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health involves all of the reproductive processes, functions and systems at all stages of human life (WHO, 2011).

Family planning refers to the actions couples take to have the desired number of children, when they are wanted. Family planning helps protects the woman's and children health and preserves the well being of the whole family (Institute for Curriculum Development and Research, 1998).

IEC/BCC is a process of changing social and individual attitudes and behaviors by providing relevant information, education monitoring through appropriate channels. Whereas, Advocacy is defined in many different ways and it lacks a single universal definition. HAPCO defined Advocacy as follows:

> *A process or series of organized actions applied in order to change, modify, put in place, expedite implementations or reinforce attitudes, policies, laws, programs, systems, structures, services, social norms and values, enhance resource and community mobilization through influencing or persuading individuals or institutions/organizations with authority and decision making at different levels to create enabling environment for the prevention and control of […infant, maternal and child mortality as well as high fertility…] (HAPCO, 2005, pp 18-19).*

Reproductive age is the age reproductive years of human being between 15 to 49 ages.

3.1.2 An over view of Reproductive Health

The implication RH notes 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, with the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice that are not against the law. They should have access to appropriate health care services that will enable women to go safely through pregnancy and childbirth as well as to provide couples with the best chance of having a healthy infant(WHO, 2011).

Reproductive health is a universal concern for both sexes but is of special importance for women particularly during the reproductive years. It is a fundamental component of an individual's overall health status and a central determinant of quality of life that gives healthy relationships in which there is an understanding of the balance between fulfilment and risk. It also contributes for physical and psychosocial comfort and closeness between individuals. RH as a crucial feature of healthy human development and of general health, it may be a reflection of a healthy childhood, crucial during adolescence, and sets the stage for health in adulthood and beyond the reproductive years for both men and women (WHO, 2011; Feleke and Samuel, 2008).

Numerous factors directly affect how well an individual maintains his or her reproductive health status. Some factors may be pre-determined like genetic susceptibility to a particular disorder or disease; other factors may be behavioural and involve an individual's participation in risky practices. In addition, the environment in which an individual lives, both natural and physical, may present important risk that may directly influence reproductive health. Society and culture play imperative role on the outcome of reproductive health status (WHO, 2011).

RH is a comprehensive concept that implies a broad range of health and non-health related interventions. The social and institutional contexts that influence RH are living standard, Education, the legal environment,[… culture and religion…], status of women and the health care system (MOH, 2006).

Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death. Death and illnesses from reproductive causes are the highest among poor women everywhere. In societies where women are disproportionately poor, illiterate, and politically powerless, high rates of reproductive illnesses and deaths is the norm (Henson, Kara, 2002).

Women in developing countries and economically disadvantaged women in the cities of some industrial nations suffer the highest rates of complications from pregnancy, sexually transmitted diseases, and reproductive cancers (Feleke and Samuel,2008).

Education is a key determinant of individual opportunities, attitudes, and economic and social status. Studies have consistently shown that educational attainment has a strong effect on reproductive behaviour, fertility, infant and child mortality and morbidity, and attitudes and awareness related to family health, use of family planning, and sanitation(CSA, EDHS,2011).

It is generally accepted that educating girls produces many socio-economic gains that benefit entire societies. These benefits include increased economic productivity, higher family incomes, delayed marriages, reduced fertility rates, and improved health and survival rates for infants and children (USAID, 2008).

In developing countries, however, too many children, especially those from poor families and those are living in rural or remote areas, still lack access to a safe, nearby school or other quality learning opportunities. In most developing countries, girls are less likely than boys to enrol and stay in school, or have their educational needs met through non-formal means. The best development investment available is not being fully utilized (USAID, 2008).

Lack of access to comprehensive reproductive care is the main reason that so many women suffer and die. Most illnesses and deaths from reproductive causes could be prevented or treated with strategies and technologies well within reach of even the poorest countries. Women's reproductive health is affected by complex biological, cultural and social factors (Brouvere et'al, 1998).

Reproductive health problems may be related to various issues faced by families and individuals, such as their ability to plan the number of children they have and the interval between births, to make informed decisions about their reproductive health free from discrimination, coercion or violence, and to receive education on harmful traditional practices in relation to reproductive matters.

For women, the disparity in reproductive health services [abusing their interest] violates their human rights and compromises their ability to realize their full potential. It diminishes their capacity to access education and employment, to live without fear of pain or death, to participate politically and to enjoy social interactions (Ibid)

Ethiopia has one of highest levels of child marriage but the legal age of marriage is widely ignored despite both the Federal and Regional Family codes confirm the minimum age for marriage at 18 for both males and females. SNNPR also enacted this age limit on Article 17:1 proclamation no.75/2004 (Debub Negarit Gazeta, 2004).

Complications associated with various maternal issues are indeed major contributors to poor reproductive health among millions of women worldwide. Without proper health care services half of the world's 2.6 billion women in the category of 15 – 49 years of age, are highly vulnerable to problems related to sexual intercourse, pregnancy, contraceptive side effects, etc (Hanso,Kara, 2002).

Worldwide, it is estimated that 529,000 women die yearly from complications of pregnancy and childbirth— about one woman every minute. Some 99 percent of these deaths occur in developing countries, where a woman's lifetime risk of dying from pregnancy-related complications is 45 times higher than that of her counterparts in developed countries (Ibid).

Risk of death from pregnancy is very high in developing countries, while being very low in the developed world. This shows that the difference is due to the quality of care provided to mothers.

In many developing countries, including Ethiopia, complications of pregnancy and childbirth are the leading causes of death among women of reproductive age. More than one-woman dies every

minute from such causes. In 2005 more than 636,000 women died each year worldwide. From that, 99% was accounted by developing countries. Of those, around 270,000 women died each year in Africa. Particularly being one of the less developed countries in the world, 46,000 women died each year in Ethiopia (Samuel and Feleke, 2008).

A total of 14 countries had MMR greater than 1000 of which 13 were in sub-Saharan Africa, with Sierra Leone being in the top with MMR of 2100 per 100,000 live births. Around 50 million pregnant women worldwide had morbid illness each year, of which 15% of them have disabilities like fistula, infertility, etc. Over 300 million women in the developing world currently suffer from short term and long term illness related to pregnancy and childbirth. At least 2 million women in developing countries are living with obstetric fistulas, and 50,000- 100,000 new cases occur each year. The prevalence of obstetric fistula in Ethiopia is 1 % (Samuel and Feleke, 2008).

The risk of dying from pregnancy-related complications is highest in sub-Saharan Africa and in South-Central Asia, where in some countries the maternal mortality ratios are more than 1,000 deaths per 100,000 live births. Sixty to eighty percent of maternal deaths are due to obstetric hemorrhage, obstructed labor, obstetric sepsis, hypertensive disorders of pregnancy, and complications of unsafe abortion. These direct complications are unpredictable and most occur within hours or days after delivery (Ibid).

Maternal deaths accounted for 21% of all deaths to women age 15-49; in other words, more than one in five Ethiopian women who died in the seven years preceding the survey died from pregnancy or pregnancy-related causes (DHS, 2005).

Factors that contribute to a higher risk of maternal mortality for all women can include biomedical factors, reproductive factors, health service factors, and socioeconomic and cultural factors. Adolescents have additional risk factors including not being biologically developed enough to give birth, not being psychologically prepared and having less power in the household in order to negotiate to receive health care. Adolescents are also more likely to be giving birth to their first baby which holds further risks (Ibid).

Maternal mortality and morbidity can be reduced or avoided by providing and expanding resources and services that are principally targeted in achieving maternal health and safe motherhood (Samuel and Feleke, 2008).

The three delay model identifies individual decision making, access to affordable services, and the provision of skilled personnel as the main factors which can delay access to effective interventions to prevent maternal mortality (DHS 2005).

Under the Safe Motherhood Initiative, countries have developed programs to reduce maternal mortality and morbidity. The strategies adopted to make motherhood safe vary among countries but include: Providing family planning services; Providing post abortion care; Promoting antenatal care; Ensuring skilled assistance during childbirth; Improving essential obstetric care; Addressing the reproductive health needs of adolescents(Samuel and Feleke, 2008).

3.1.2.1 REPRODUCTIVE HEALTH- COMPONENTS AND ASSOCIATED BARRIERS

Reproductive health, among others, comprises of quality family planning services, promoting safe motherhood: prenatal, safe delivery and postnatal care, including breast feeding; Information and counselling on human sexuality, responsible parenthood and sexual and reproductive health; active discouragement of harmful practices, such as female genital mutilation and violence related to sexuality and reproduction; functional and accessible referral.

Family planning

As fertility is one of the principal components of population dynamics which made the developing countries hosting large proportion of younger population, several countries adapted family planning programmes to bring birth rates down so as to improve the socio economic situation of the community. It is agreed that increased family planning expenditures are an effective long-term investment in human capital development and family welfare. Contraceptives prevent maternal deaths by reducing the number of times women go through pregnancy and childbirth (Bulatao A, 1998).

Family planning programmes raised prevalence of Contraceptive practice from less than 10% to more than 60% in developed countries where as third world remained low prevalence with high fertility , population growth and unmet need for family planning (Legese, 2011).

Contraception use and compliance is related to the range of methods available, patient choice, prevalent health and religious beliefs, perceptions of methods effectiveness, and side effects like that of women who may have less tolerance for heavy and prolonged vaginal bleeding than amenorrhea. Correct use of most user dependent methods like both male and female condom and pills requires a basic knowledge of reproduction and literacy skills to follow written instructions (Legese, 20110)..

The four cornerstones of family planning guidance are medical eligibility criteria for contraceptive use, selected practice recommendations for contraceptive use, decision-making tool for family planning clients and providers, and handbook for FP providers (WHO, Reproductive Health and Research, 2004)

Antenatal, Prenatal and Delivery care

Antenatal care refers to care given to pregnant women so that they have safe pregnancy and healthy baby. Pregnancy is a normal physiological process associated with certain risks to health of the woman and the infant she bears. These risks can be overcome through proper antenatal care. Antenatal care, the care that receives during pregnancy, helps to ensure healthy outcomes for women and newborns (WHO/UNICEF, 2003).

Antenatal care is key entry point for pregnant women to receive a broad range of health promotion and preventive health services, including nutritional support and prevention and treatment of anemia; prevention, detection and treatment of malaria, tuberculosis and sexually transmitted infections (STIs)/HIV/AIDS (particularly prevention of HIV transmission from mother to child); and tetanus toxoid immunization. Antenatal care is an opportunity promote the benefit of skilled attendance at birth and to encourage women to seek postpartum care for themselves and their new borne. It is also an ideal time to counsel women about the benefits of child pacing. Antenatal care is an essential link in the household to health care continuum- it is

an intervention that can provided at both the household and peripheral facility levels and helps assure the link to higher levels care when needed(USAID,2007).

Antenatal Care (ANC) means “care before birth”, and includes education, counselling, screening and treatment to monitor and to promote the well-being of the mother and foetus. The current challenge is to find out which type of care and in what quantity is considered sufficient to ensure good quality of care for low-risk pregnant women (WHO, 2005). The aim of Antenatal care (ANC) is to assist women to remain healthy, finding and correcting adverse conditions when present, and thus aid the health of the unborn . ANC should also provide support and guidance to the woman and her partner or family, to help them in their transition to parenthood. This implies that both health care and health education are required from health services (Ibid).

The quality of antenatal care (ANC) can be measured by the qualifications of the provider and the number and frequency of ANC visits. Antenatal care quality can also be monitored through the content of services received and the kinds of information given to women during their visits. These services raise awareness of the danger signs during pregnancy, delivery, and the postnatal period. They also improve the health-seeking behaviour of the client, orient the client to birth preparedness issues, and provide basic preventive and therapeutic care such as folate supplements, de-worming and iron tablets or syrup (Feleke and Samuel, 2008).

Prenatal Care

The objective of prenatal care is to monitor and improve the health of the pregnant mother and her baby. Getting early and regular prenatal care is necessary because it allows the health care provider the chance to find problems early so they can be treated as soon as possible (SCHS, 2005).

Delivery Care

Pregnant women should be offered information based on the current available evidence together with support to enable them to make informed decisions about their care. This information should include where they will be seen and who will undertake their care (NICE, 2008). Skilled

care during childbirth and immediately afterwards can have a significant impact on reducing maternal deaths (Population Reference Bureau, 2008).

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the newborn baby. An important component of efforts to reduce health risks to mothers and children is increasing the proportion of babies that are delivered in health facilities (Ibid).

Postnatal care

A large proportion of maternal and neonatal deaths occur during the 48 hours after delivery, and these first two days following delivery are critical for monitoring complications arising from the delivery. Thus, postnatal care is important for both the mother and the child not only to treat complications arising from the delivery, but also to provide the mother with important information on how to care for herself and her child. Safe motherhood programmes have recommending that all women receive a health check up within two days of delivery (EDHS, 2011)

The level of postnatal care coverage is extremely low in Ethiopia. The great majority of women (92 percent) with a live birth in the preceding five years did not receive a postnatal check up (Ibid).

Immunization

Immunization programme is one of the invaluable interventions directed towards curving prevalent mortality and morbidity. WHO noted its significances as one of the most powerful and cost-effective of all health interventions, prevents debilitating illness and disability, and saves millions of lives every year. It is also a key to achieve the Millennium Development Goals (MDGs) – to reduce poverty and improve human development. The contribution of immunization in achieving the goal to reduce deaths among children under five years old is critical (WHO, 2009).

Hence, MDG4 calls for a drastic reduction in deaths among children under five years of age, specifically, a two-thirds drop in the under-five mortality rate between 1990 and 2015. Most of

the effort in achieving this goal focuses on developing countries which account for over 90% of child deaths.
Consequently, immunization averts an estimated 2.5 million child deaths a year, but despite the successes, millions of children in developing countries – almost 20% of all children born every year – do not get the complete immunizations scheduled for their first year of life (WHO, 2009).

Vaccines have the power not only to save, but also to transform, lives – giving children a chance to grow up healthy, go to school, and improve their life prospects. When vaccines are combined with other health interventions – such as vitamin A supplementation, provision of de-worming medicine and bed nets to prevent malaria – immunization becomes a major force for child survival. Reaching these children will require overcoming a number of critical barriers that have slowed progress (Ibid).

A major barrier is the underlying weakness of the health system in many developing countries, difficulty in delivering vaccines through an infrastructure and logistical support system that is often overloaded. In addition, lack of understanding about the importance of vaccines – especially among the poorest populations – and a failure to actively demand access to immunization services and the threat posed by false or unsubstantiated rumours about vaccine safety is also a barrier (WHO, UNICEF and WB, 2009).
Efforts under way to overcome the barriers to expanded immunization include the use of immunization campaigns and "outreach" operations that seek out population groups not adequately covered by routine immunization programmes. In addition, special initiatives, such as the Optimize project, have been launched to help countries manage the growing complexity of immunization logistics (delivery and storage of vaccines, for example) underpinning immunization activities (Ibid).

Identifying and implementing strategies to overcome the barriers to access must be a top priority, given the right of every child to protection from preventable diseases. Many governments are demonstrating strong and effective leadership and national ownership of their immunization programmes. And the benefits of immunization are increasingly being extended to adolescents and adults – providing protection against life-threatening diseases (Ibid).

The Ethiopian immunization policy targets children of under-one year of age and women of reproductive age group (15-49 years age) for the vaccines (BCG, Measles, DPT-HepB-Hib or penta-valent vaccine, OPV and TT vaccine). The immunization schedule for the Eight EPI vaccines for children and tetanus immunization for women of reproductive age in Ethiopia strictly follows the WHO recommendations for developing countries. There are periodical supplemental doses for measles and polio. Vitamin A supplementation is integrated also both with routine EPI and SIAs in Ethiopia (FMOH, 2010).

3.1.2.2BARRIERS TO REPRODUCTIVE HEALTH CARE

Research has shown that reproductive health care services are obstructed by unavailability and inaccessibility of health facilities shortage or lack of modern contraceptives, absence of antenatal, delivery and post natal care, un availability of skilled birth provides and obstric care facilities along with water and ambulance utilities (Feleke and Samuel, 2008).

Evidence from research show that limited access to essential health related massage, majority of Ethiopians is captives of traditional health attitudes, values and practices (WHO, UNICEF and UNFPA, 2004). Consequently, this led them to hold poor health seeking behaviour, negative attitude to some RH care services (MoH and MEDAC, 2000). More specifically Modern contraceptive use in Ethiopia, as noted by Korra (1996), encountered barrier such as physical access, lack of knowledge, social and family disapproval; fear of side effects, desire for more children, lack of spouses communication about family planning, low women status and poor quality of services (Korra, 1996).

3.2. Empirical Literature

Eskezia (2012) in his study entitled ’Determinants of contraceptive use among married women in Ethiopia’ , intended to identify socio-economic, demographic and other proximate determinants of contraceptive use among married women based on Ethiopian Demographic and Health Survey (EDHS 2011) data, by employ descriptive analysis, multiple logistic regression analysis and multilevel logistic regression analysis and found out only 24.8 percent of the sample married

women were using contraceptives while 75.2 percent were not using contraceptives in descriptive analysis (Eskezia, 2012).

Women's level of education was found to be a basic determinant of contraceptive use. The results indicated that contraceptive use increase as women's educational level increased. Women who were more educated could afford to buy contraceptives, were more likely to reside in the urban areas where contraceptives are more accessible, were more informed about the available methods and were more likely to prefer small families than their less educated counterparts. Educated women are more likely to postpone marriage, and use contraceptive methods than are uneducated women (Ibid).

The study found that there is religious disparity in accepting contraceptive use. This could be due to the difference in perception of different religions concerning to marriage, reproductive behavior, and contraceptive methods as well as some religious societies assumed that a women's worth is measured in terms of her children. Even the use of contraceptive methods is not accepted by some cultures and religious societies. The result of the study showed that women who had one or more children were more likely to use contraceptives than women who had no children. Those women who had three or more children were more likely to use contraceptives than women who had no children. This could be because many women with larger number of living children were either on the limit to achieve or on achieving their preferred family size. Therefore, these women are likely to abandon pregnancy, showing interest in the adoption of contraceptive methods. In this study, age of a woman was found to be a determinant factor of contraceptive use. The likelihood of contraceptive use was lowest in the age groups 40-44 and 45-49(Ibid).

The results of the study also showed that there were significant regional differences in the use of contraceptives. The lowest likelihood of contraceptive use was observed in Somali and Afar regions. The reason for this difference might be limited access to mass Media messages such asradios, TV and newspapers on the issue of FP in these regions compared to other regions. The lowest level of contraceptive use in these regions could also be due to low availability of health facilities, health and family planning workers and become most of the women in these regions live in rural areas. In addition, women who live in Affar and Somali are predominantly Muslims which are less likely to use contraceptives than Christian women. The finding of the study

showed that women who heard family planning methods on radio, TV or in news papers one month before the survey had improved their level of contraceptive use. Women with information about family planning methods through radio, on TV or in news papers in the last month can create awareness about family planning. As a result, promoting family planning through mass media about family planning programs can be an important means of raising awareness, improving knowledge of contraceptive use. The study also showed significance variation on contraceptive use among residence of women. That is, women residing in rural areas were less likely to use contraceptives than urban women (Eskezia, 2012).

The reason could be attributed to differences in the availability of social services such as, educative information about methods and access to family planning and health care services. This also suggests that urban women may be more likely to use contraceptive particularly, modern contraceptive methods than rural women because of greater access to modern methods and medical care as well as other social facilities in urban areas. Another finding of the study was that women employed in the non-agricultural sector were more likely to use contraceptive methods than women who were not working (Ibid).

The 2011 EDHS shows in fact 29 percent of currently married women are using any contraceptives and 27 percent of these group are using modern contraception, while injectables user of currently married women constitute 21 percent, which has increased modern contraception from 6 percent in the 2000 EDHS to 27 percent in the 2011 EDHS—largely due to the sharp increase in the use of injectables, from 3 percent in 2000 to 21 percent in 2011.The survey reveal twenty-five percent of currently married women have an unmet need for family planning services; 16 percent have a need for spacing, and 9 percent have a need for limitation. But, based on their background the modern contraception share of married women in rural area are 23 percent and their unmet needs are 28 percent.

Likewise, the survey has indicted that among women age 15-49 community events are the most common source of family planning messages, at 37 percent. Radio is the second most common at 34 percent. Another common source is television, with 18 percent of women reporting exposure to family planning messages via television. Ethiopian women do not have high exposure to

written sources of family planning messages. Only 8 percent of women report seeing family planning messages in a newspaper or magazine or in a pamphlet, poster, or leaflet.

A study conducted by Ibrahim Amae(2006) entitled “Socio- Cultural Factors affecting Sexual and Reproductive Health: The Role of Traditional Institutions Among the Borena Pastoralists of Oromiya, Southern Ethiopia”.(a master’s thesis, Addis Ababa University), employed exploratory qualitative study design between January to February 2006. Of the results of the study ,RH service delivery in the study area is very poor in contrast to the regional achievement and found out the vital irreplaceable role of traditional institutions and their potential partnership in promoting SRH to the study population. Finally recommends among others enhancing utility and quality of health care services by solving problems such as acute shortage of skilled health professionals ambulance care essential medicines(Ibrahim , 2006).

The result of study made by Legesse (2011) on fertility desire and family planning utilization among HIV positive people- Seventy-five (29.3%) of the women and 56 (43.3%) of the men, totally Hundred thirty one 131(34.1%) of HIV positive people receiving care in Asella ARV treatment unit show that HIV infected women desire children than men counter parts ; PLWHAs those who have one/ no child had more desire for children in the future than those who have two and above; single individuals had less need than married counter parts. Family planning utilization of PLWHA before knowing their HIV status was 47.7% but current users were 76.5% during the study period. Current FP usage was less in those who were not in marriage than those who were in marriage at study period and those who were on ART for two years or less respectively.

As shown in the results study on prenatal care conducted by Novick (2009)**,** some women were treated respectfully and reported comprehensive, individualized care. However, some women experienced long waits and rushed visits, and perceived prenatal care as mechanistic or harsh. Women's preferences included reasonable waits, unhurried visits, continuity, flexibility, comprehensive care, meeting with other pregnant women in groups, developing meaningful relationships with professionals, and becoming more active participants in care. Some low income and minority women experienced discrimination or stereotyping as well as external barriers to care.

On a research done by Hess (2007) - Assessing Facility Readiness of Family planning Services in Ghana, overall findings indicated that 29% of facilities had the minimum requirements for all indicators, staff, infrastructure, supplies and equipment, to provide short-term methods of family planning. Of these 39 facilities, 14 (36%) were government hospitals, one (3%) was a mission hospital, and 24 (61%) were government health centers. There is an association between having the minimum equipment for FP and caseload (p=0.04). There was no association between the level of caseload in a facility and the likelihood of meeting the criteria for minimum infrastructure (p=0.74), or having adequate supplies for FP (p=0.11) (Hess, 2007).

Eskindir and others conducted assessment on quality of care in family planning services in Jimma zone, south western Ethiopia in 2003 and the result the study shows that more than 80% of unmarried clients were getting the service from non-governmental clinic. Sixty-nine (10.9%) and 14(8.1% of those who reported problem) clients expressed dissatisfaction with waiting time and solutions given by the provider respectively. Method unavailability was the reason in most service delivery points for providing methods different from clients' choices. Most clients were not told method specific and other relevant information. Provider's special training and the time of the training have shown statistically significant difference on six and two quality of care indicators respectively. Majority of the service delivery points did not have copy of guideline and mechanism to make programmatic change based on clients' feedback; all were not supervised in the last three months prior to data collection (Eskinder et'al, 2003).

A research under taken by Zergu (2003) in Gambela Region focused on women of reproductive age group residing in the urban area of Gambella woreda during the study period. Multistage sampling procedure was carried out to reach at the 936 households to be included in the survey. The finding of the study revealed that there is statistically significant difference between indigenous and non-indigenous study groups by educational status, number of co-wives, intended number of children and length of postpartum sexual abstinence. Ninety six percent of the non-indigenous women and sixty two percent of the indigenous women have heard about modern contraceptive methods. The most commonly known contraceptive methods were oral pills and injectables. More than 50.0% of the non-indigenous women were used modern contraceptive methods in their lifetime while only 20.2% of the indigenous have ever tried.

Current contraceptive prevalence was 11.5% among indigenous study women while it was 36.4% among non- indigenous group (Zergu, 2003).

Desire for more children and use of natural method like prolonged postpartum sexual abstinence were the reasons for non use among indigenous women while desire for more children and not currently engaged in wedlock were the most commonly reported reasons for non-use of modern contraceptive methods for non-indigenous women while it was found that the tradition of indigenous population enforces male partners to observe for prolonged postpartum sexual abstinence and their culture allows them to have multiple wives(Ibid).

Moreover, it was noted in the qualitative finding that once a women is engaged in wedlock it is must that she has to produce as many children as possible because children particularly daughters were assumed to be the source of family income and women cannot make any decision related to reproductive matters which consequently influenced their modern contraceptive utilization(Ibid).

A study conducted by USAID (2008) in Eucous district, East Timor has revealed good enabling environment to expand access to child spacing and family planning services to men and women of reproductive age group in East Timor. The country has the basics primary health care infrastructure through the SISCa, mobile clinics, health post and community health centers; the political will, donors and numerous child health partners willing to support her in the delivery of child spacing and family planning services to men and women in the country. In addition the men, women, religious leaders are all eager to support the government in improving access to these services to the communities and thereby improve maternal and child survival (USAID, 2008).

The findings and recommendations were focused on client/family-friendly delivery of child spacing information and family planning services that utilizes every maternal and child encounters points at the health facility and community levels of care to promote child spacing and improve access to quality family planning services. The health facilities should be better positioned and adequately prepared to accommodate the increase in the demand for child spacing information and services following community mobilization efforts in this area. With support

from partners and donor, the Ministry of Health and Oecusse district will be well positioned to produce a model of integrated maternal and child model for the effective scale of health interventions to improve the survival of mothers and children in the district (USAID, 2008).

Das,N,P et'al (2001) disclosed in their work Does Community Access Affect the Use of Health and Family Welfare Services in Rural India? India's current stage of development and demographic transition, variations in utilization of family planning and maternal and child health services are explained mainly by variations in household- and individual-level socioeconomic and demographic factors, not by variation in community access to services. Apparently family planning and maternal and child health services are available at a sufficient level in rural India so that further improvements in physical accessibility alone (e.g., decreasing the distance to a health facility) will not make a substantial difference in the propensity to use these services. The main factors affecting utilization appear to be demand factors, such as woman's education, exposure to mass media, and son preference. Quality of services may also be important, but the survey did not assess service quality (Das NP et'al, 2001).

As disclosed by the third survey of EDHS, thirty-four percent of women who gave birth in the five years preceding the survey received antenatal care from a skilled provider, that is, from a doctor, nurse, or midwife, for their most recent birth. This is a marked improvement from 28 percent in 2005. One woman in every five (19 percent) made four or more antenatal care visits during the course of her pregnancy, up from 12 percent in 2005. The median duration of pregnancy at the time of the first antenatal visit is 5.2 months. About half of mothers (48 percent) had their last live birth protected against neonatal tetanus. Only 10 percent of births in the past five years were delivered by a skilled provider. More than six women in every ten (61 percent) stated that a health facility delivery was not necessary, and three in every ten (30 percent) stated that it was not customary. Just 7 percent of women received postnatal care in the first two days after their last delivery in the two years before the survey. The most important barrier to access to health services that women mention is taking transport to a facility (71 percent), followed by lack of money (68 percent) and distance to a health facility (66 percent)(DHS, 2011).

According to the finding of 2011 EDHS, One in every 17 Ethiopian children dies before the first birthday, and one in every 11 children dies before the fifth birthday. Infant mortality declined by 39 percent over the period between the 2000 EDHS and the 2011 EDHS, from 97 deaths per 1,000 live births to 59 deaths per 1,000 live births. Under-five child mortality declined by 47 percent from 166 deaths per 1,000 live births to 88 deaths per 1,000 live births over the same period. Childhood mortality is higher in rural areas than in urban areas. These rates were highest in Benishangul-Gumuz and lowest in Addis Ababa. The neonatal mortality rate was 37 deaths per 1,000 live births, the post-neonatal mortality rate was 22 deaths per 1,000 live births, and the prenatal mortality rate was 46 per 1,000 pregnancies (CAS, EDHS 2011).

As revealed in the 2011 EDHS, with regard to immunization, one in every four children age 12-23 months (24 percent) were fully vaccinated at the time of the survey, a 19 percent increase from the level reported in the 2005 EDHS (Ibid).

According to Abreham Alano's master thesis (2003) entitled "Identified Factors Associated with the Difference Between Sidama Development Program (SDP) and Family Guidance Association of Ethiopia (FGAE) CBD Supported programs in contraceptive prevalence rate, Sidama Zone, SNNPR", significance difference was found out between in the distribution of contraceptive between the two project areas (40.7% and 51.6%) in SDP and FGAE respectively. More women in FGAE (37%) than SDP area (29.5%) discontinue contraceptive use for reason that either for desire for more children or health related problems. Moreover, the success of CBD agents associated with standardized initial training and regular subsequent refresher training with occasional incentives given to the agents showed significance variations on their success. Sustained motivation to the CBD agents with training and supervision was recommended (Abreham , 2003).

CHAPTER FOUR

4. Data Presentation and Analysis

This chapter presents and analyzes the data collected through questionnaires, interviews and FGDs. A total of 360 questionnaires were filled by respondents. As indicated in the methodology section, interviews were held with health providers and FGD with selected informants. The quantitative data were analyzed by using simple descriptive statics. Moreover, the interviews and FGD were also conducted to gather data that strengthened and triangulated the data obtained through the questionnaires.

4.1 Data presentation, Analysis

4.1.1 Socio-Economic Demographic Background of the Respondents.

The purpose of this section was to identify the socio economic demographic features of the respondents. Thus respondent's age, religion, ethnicity, educational and marital status, occupation, family size and type were assessed.

Table1 shows that the majority of respondent (62.8%) was categorized in the age group ranging from 25 to35 years, whereas 16.4%, 13.6% and 7.5% respondents belonged to 19-24, 36-49 and 13-18 age group respectively. This shows that the entire respondents belonged to reproductive age (15 to 49 years old).

With regard to religion, the vast majority respondents (88.9%) belong to protestant religion, whereas, 5.6%, 1.1and 0.8% of the respondents are followers of orthodox, catholic and Muslim religion respectively. The rest (3.6%) of the respondents belong to other religions.

As shown in the same table, with respect to the ethnic background of the respondents, the dominants were Gedeo (91.9%), whereas, Oromo (3.3), Amhara (1.9%), Gurage (1.1%), Sidama (0.8%) were identified respectively.

TABLE 1: PERSONAL CHARACTERISTICS OF RESPONDENTS

Items	Responses	Frequency	Percentage
Age	13-18	26	7.2
	19-24	59	16.4
	25-35	226	62.8
	36-49	49	13.6
	Total	360	100
Religion	Protestant	320	88.9
	Orthodox	20	5.6
	Catholic	4	1.1
	Muslim	3	0.8
	Other	13	3.6
	Total	360	100
Ethnicity	Gedeo	331	91.9
	Oromo	12	3.3
	Amhara	7	1.9
	Gurage	3	0.8
	Sidama	3	0.8
	Other	4	1.1
	Total	**360**	**100**

Source: own field survey (2014).

As shown from Table 2, with respect to educational status of the respondents, the great majority of the respondents (82.8%) are unable to read and write, whereas, 15% and 2.2% can read and write; and completed primary education respectively.

With regard to their marital status, 95.3 of the respondents were married, whereas, 3.1% and 1.7% of them were separated and widowed respectively.

TABLE 2: SOCIO- ECONOMIC CHARACTERISTICS OF RESPONDENTS

Items	Responses	Frequency	Percentage
Educational status	Illiterate	298	82.8
	Can read and write	54	15
	Complete primary education	8	2.2
Marital status	Married	343	95.3
	Widowed	6	1.7
	Separated	11	3
Occupation	House wife	291	80.8
	Own activities	49	13.6
	Daily laborer	16	4.4
	Others	4	1.1
Total		**360**	**100**

Source: own field survey (2014).

In relation to their occupation the majority respondents (80.8%) were house wives and 13.6% engaged in their own activities, whereas, 4.4% and 1.1% respondents belongs to daily laborer and other activities respectively.

As Table 3 shows those 41.7% respondents have born three to five and 27.5% respondent mothers born two and less children, whereas 25.3% respondent mothers born six to eight children. In addition, 5% & 0.6% respondent mothers bear 9 to 10 and more than 11 children respectively. On the same, with regard to children alive, 45.3% respondents have 3-5 children and 30% of them have two and less children, where as 22.5% and 1.9% respondent mothers have 6 to 8 children and 9 to 10 children respectively. These show that the number of children who died increases while the family size increases.

The table shows that 79.2% respondent husbands do not have co-wife. But 17.5% respondent husbands have a co-wife and 2.5% respondent husbands have two to three co-wives and 0.8% respondent husbands have four and more wives. This shows that a considerable number of the community practice polygamy.

With regard to the number of children alive of respondent husbands, 46.1% and 34.2% of them have 0-3 and 4-6 children alive respectively, while 17.5% and 2.2% husband have 7 to10 and more than eleven children alive respectively. This shows that significant numbers of families are characterized as extended family.

TABLE 3, DEMOGRAPHIC INFORMATION OF RESPONDENTS

Items	Responses	Frequency	Percentage
Number of children born	0-2	99	**27.5**
	3-5	150	**41.7**
	6-8	91	**25.3**
	9-10	18	**5**
	>11	2	**0.6**
	Total	360	**100**
Number of children alive	0-2	109	**30.3**
	3-5	163	**45.3**
	6-8	81	**22.5**
	9-10	7	**1.9**
	Total	360	**100**
Number co-wife	0	285	**79.2**
	1	63	**17.5**
	2-3	9	**2.5**
	>4	3	**0.8**
	Total	360	**100**
Total number children of husband	0-3	166	**46.1**
	4-6	123	**34.2**
	7-10	63	**17.5**
	>11	8	**2.2**
	Total	**360**	**100**

Source, own field survey, 2014

One of the characteristics features of respondents for questionnaire is their homogeneity in terms of sex and age category. Accordingly, 100% of the respondents are female in reproductive group (15-49 age). The next characteristic of these respondents is their ethnicity, religion, martial and educational status as well as occupation. In these respects, 91.9% & 88.9% are Gedeo in ethnic and Protestants in religion. In addition 95.3%, 82.8% and 80.8 % respondents are married, illiterate and house wives respectively. Therefore, homogeneity in ethnicity, religion, marital and educational status is the major identities of respondents for questionnaire in this study.

4.1.2 Reproductive Health Activities in Mokonisa Health institutions.

4.1.2.1 RH services utilization in Mokonisa health institutions

As Table 4 below shows, 82.8% respondents are users of reproductive health services from health institutions. 55.6% & 21.9% of the respondents obtained the services from health posts and health center in the study Kebele respectively. Moreover, 29.4% and 15.8% of the respondents received contraceptives and antenatal care services from health institutions recently. Likewise, 16.7% and 9.4% respondents received vaccination and delivery services respectively. Similarly, 2.8% of the respondents received postnatal care services from health institutions. From the above evidence, it is possible to see that both postnatal and delivery services are poorly availed to respondents which has serious implications on infant and maternal health in the study area.

Table 4, RH Services Utilization in Mokonisa Health Institutions

Items	Responses	Frequency	Percentage
Did you use RH services in the last five years?	yes	298	82.8
	No	62	17.2
	Total	**360**	**100**
From where did you get RH services	Health post	200	55.6
	Health Center	79	21.9
	Hospital	12	3.3
	Private Clinic	7	1.9
	Other	62	17.2
	Total	**360**	**100**
What RH service you obtain recently?	Contraception	106	29.4
	Antenatal care	57	15.8
	Delivery	34	9.4
	Postnatal care	10	2.8
	Vaccination	60	16.7
	Other	93	25.8
	Total	**360**	**100**

Source, own field survey, 2014

4.1.2.2 State of Respondents Contraceptive Utilization

Table 5 portrays that 61.1% of the respondents have used contraceptives, while 56.1% of them use it for spacing and only 5% for limiting to give birth. It shows unmet need of respondents, as 10.8% and 14.8% of the respondents expressed that either they didn't use contraception while

having the need or want contraception to use it in the future. In addition, 13.9% of the respondents did not have any interest of contraception.

Hence, the unmet need of contraception in the Kebele as the above data revealed appears to be 39.5%. Moreover, 38.9% of the respondents were found to be non-user of contraceptives or some of them may use traditional methods of birth control. This indicates that a considerable number of respondents in the reproductive age group still do not utilize modern birth control methods.

Table5. State of Respondents' contraception utilization

Items	Responses	Frequency	Percentage
Did you use contraception	Yes	220	61.1
	No, but I needed	39	10.8
	I Need for the future	51	14.8
	I never want to use	50	13.9
	Total	**360**	**100**
Purpose of using contraception	Spacing	202	56.1
	Limiting	18	5
	Total	220	61.1
	Missing	140	38.9
	Total	**360**	**100**

Source, own field survey, 2014

4.1.2.3 Family Planning Service in Health Institutions

As shown in Table six, 51.7% of the respondents obtain family planning services from health institution, while 28.3 of them in contrast did not utilize the service, only 20% of the respondents did not mention their position in this regard. With regard to whether respondents afford contraception use or not, 89.4% of them got the service freely, but 10% respondents had made payment for contraceptives from private dealers.

Majority of the respondents (46.1%) used injectable contraceptive of short acting (Dipo), while 4.7%, pills, 4.2% implant, 2.8% IUD, and 3.3% used other methods as well.

Table6. Family Planning Service Consumption

Items	Responses	Frequency	percentage
Obtained FP services on time and kind	Yes	186	51.7
	No	102	28.3
	Missing	72	20
	Total	**360**	**100**
Paid Fee for contraceptives	Yes	36	10
	No	322	89.4
	Missing	2	0.6
	Total	**360**	**100**
kind modern contraception used	Pills	17	4.7
	Injectable	16	46.1
	Implant	15	4.2
	IUD	10	2.8
	Other	12	3.3
	Missing	14	38.9
	Total	**360**	**100**
Attitude towards family planning	Positive	289	80.3
	Negative	20	5.6
	Complicated	21	5.8
	I don't know	30	8.3
	Total	**360**	**100**

Source: own field survey, 2014

This shows that the proportion of family planning and long acting contraception users are not very significant enough to bring about desired achievements. Great majority of the respondents (80.3%) show their positive will, whereas 5.6% of them have negative attitudes. Moreover, 5.8% of the respondents lack full understanding. Whereas, 8.3% of the respondents do not make clear their attitudes towards use of family planning services. From these evidences, it is possible to infer that 19.7% of the respondents still need support so as to change their attitudes towards intended objectives through behavioral change interventions.

4.1.2.4 State of Antenatal Care service

As shown from Table 7 below. 73.3% respondents attended antenatal care services and 44.2% , 22.5 & 8.3% of them visited health institution 3 to 4, 1 to 2 and more than five times respectively. However, 26.7 of the respondents did not visit health institutions for their antenatal care services.

This shows that a considerable number of pregnant women attended antenatal care services with reasonable follow up. But a significant number of them still did not utilize the service. Hence, this may create a gap even in the intervention made to affect other RH components such as delivery by skilled services providers, prenatal care and family planning services. With regard to voluntary counseling and blood test during pregnancy as the table portrays, 41.4% and 58.6% respondents got the services and did not get the services respectively.

Table7. State of Antenatal Care Service Consumption

Items	Responses	Frequency	Percentage
Getting antenatal care service from Health institution during pregnancy	Yes	264	73.3
	No	96	26.7
	Total	**360**	**100**
Number of visit to Health institution for antenatal care in a single pregnancy	1-2	81	22.5
	3-4	159	44.2
	More than five	30	8.3
	Not attending	90	25
	Total	**360**	**100**
Getting counseling & voluntary blood test for HIV	Yes	149	41.4
	No	211	58.6
	Total	**360**	**100**
Taking vaccination during pregnancy	Yes	236	65.6
	No	90	25
	Partially	34	9.4
	Total	**360**	**100**
Making adequate preparation before you gave birth	Yes	220	61.1
	No	140	38.9
	Total	**360**	**100**

Source: own field survey, 2014

In addition, 65.6% and 9.4% of the respondents had taken vaccination fully and partially during the time of pregnancy. In contrast, 25% of them did not take vaccines during their pregnancy period at all.

The foregoing cases show that majority of pregnant women (58.6%) did not take voluntary counseling and blood test for HIV and 25% of them also did not take vaccination during pregnancy periods which has serious effect both on maternal and infant health. Table7 shows that only 61.1% of the respondents made adequate preparation during their pregnancy, while 38.9% of them did not make adequate preparation.

4.1.2.5 Delivery Care Service in Health Institutions

Table 8 below demonstrates where respondents gave relatively their recent births 25.6%, 22.2% and 15% respondents gave birth at home with the help of parents, trained birth attendants (TBAs) and self help respectively. This constitutes 62.8% who gave births without the help of skilled providers out of health institutions. On the other hand, 18%, 11.9%, 4.5% and 2.2% respondents

gave their recent births at health posts, health center, hospital and private clinics with the help of skilled health providers respectively.

Table8. Delivery Care Service in Health institution

Items	Responses	Frequency	Percentage
Place of recent birth	Health post	65	18
	Health center	43	11.9
	Hospital	16	4.5
	Private clinic	8	2.2
	Home with the help of TBP	80	22.2
	Home with the help of parents	92	25.6
	Home with self help	54	15
	Missing	2	0.6
	Total	**360**	**100**
Time of taking examination and vaccination just after gave birth	Soon after birth	72	20
	Within 24 hours	71	19.7
	Within 2 days	11	3.1
	Within a week	64	17.8
	After confinement	105	29.2
	Never did it	37	10.3
	Total	**360**	**100**

Source: own field survey 2014

That means only 36.6% of them had got delivery services by skilled health providers in health institutions.

Likewise, respondents who took examination and vaccination just after they gave births within 48 hours constitute 47% and those who never did it were 10.3%. Together, these form 57.3%, which indicate that greater proportion of respondents did not take care of birth at proper time within two days. On the other hand, 20%, 19.7% and 3.1% respondents took the service, soon, within 24 hours and within two days after they gave births respectively.

All the foregoing evidence shows that care giving services in health institutions in the study areas did not adequately resort to avert risks on both infant and maternal health.

4.1.2.6 Postnatal Care Indicators

Table9. Postnatal Care Indicators

Items	Responses	Frequency	Percentage
Your child take vaccine	Yes	310	86.11
	No	20	5.6
	Sometime	30	8.3
	Total	**360**	**100**
Your child are feed only breast milk in the first six months	Yes	217	60.3
	No	3	0.8
	Breast milk with other	140	38.9
	Only feed cow milk	0	0
	Total	**360**	**100**

Source: own field survey 2014

As table 9 portrays 86.1 children were vaccinated. However, 8.3% of children took the service some times and 5.6% children did not take vaccination.

Similarly, the table shows that 60.3% of the respondents provided exclusively breast milk for their child in the first six months, while 38% of the respondents provided supplementary food and water in the time bound. However, 0.8% of the respondents did not provide breast milk entirely.

This implies that large number of children did not complete immunization. This information is supported by evidence obtained from qualitative parts of this study. Moreover, considerable number of children (38.9%) did not drink their mother's breast milk in the first six months exclusively.

4.1.2.7 Service Delivery level in Mokonisa Health Center

Table 10 below demonstrates the level of service delivery in respect to contraception provision, antenatal care service and delivery service by skilled health providers. Accordingly 29.4% and 11.9% of the respondents put the service as moderate and low respectively. Whereas, 8.1%, 6.7% and 4.5% respondents level the service as high, very low and very high respectively. However,

39.4% of the respondents did not utilize the service. This implies that large number of service utilizes (48%) tend to perceive the service at average and below that.

Likewise, 28.9% of the respondents perceive antenatal care service as moderate and 18.3% put the service at low as well 18.1% at high level. In addition, 6.9% and 4.2% set the level of service at very high and very low level. But 23.6% missed respond. Here it is possible to see the service in antenatal care was relatively promising. Consequently, there is a need to improve the existing service.

Table10. Service Delivery Level in the Health Center in Respect to Customer

Items Service delivery level in respect to	**Responses**	**Very low**	**Low**	**Moderate**	**High**	**Very High**	**Missing**	**Total**
contraception	Frequency	24	43	106	29	16	142	**360**
	Percentage	6.7	11.9	29.4	8.1	4.5	39.4	**100**
Antenatal care	Frequency	15	66	104	65	25	85	**360**
	Percentage	4.2	18.3	28.9	18.1	6.9	23.6	**100**
Delivery Service	Frequency	5	9	16	7	6	317	**360**
	Percentage	1.4	2.5	4.4	1.9	1.7	88.6	**100**

Source: own field survey 2014

As shown in the same table from 43 respondents who took delivery service in Mokonisa Health center 37.2% 21.9% and 16.3% respondents perceived the delivery service in the health center as moderate, low and high respectively, On the other hand, 14.0% and 11.6% put the level of the service as very high and very low respectively.

This shows that in sum 69.7% respondents' placed delivery service at average and below average level. This may brought adverse implication in utilizing delivery service by skilled health providers.

4.1.2.11. Main Sources of Information & Education for RH

Table 11 shows respondents' main source of information and education on reproductive health issues. Accordingly, 84.4% of the respondents obtain information on family planning from health providers, while 15.6% respondents did not get the information. Likewise, their main sources of information differ among respondents. Thus, 45.3% and 16.9% respondents referred neighbors or peers and community events as main source of family planning issues. In addition, 8.9%, 5%,3.3% and 3.1% respondents indicated Radio, Health providers, Television and Husband as main source of information of Fp. But 17.5% respondents mentioned either other sources or did not get information on family planning.

This show that traditional means of information was stronger than the modern type in the community. In fact, Radio programs on family planning issues also had considerable influence on the community as well. The fact that neighbors or peers influences were more pronounced due to one to five grouping system which was intact in the kebele a year before as it is indicated in the qualitative section of the study.

Likewise, 72.2% respondents had got advice from health providers on the value of nutrition on the wellbeing of children and mothers, while 22.8% respondents did not get such advice from health providers.

With regard to respondents' main source of information on the value of breast milk in the first six months of an infant and nutrition as well as RH, 36.1% and 17.2% respondents referred Health extension workers and community events as the main source of information on breast milk feeding and value of nutrition.

Health providers, neighbors/peers/ and TV are the main sources of information for the same issue at a proportion of 15.3%, 12.2% and 9.2%, respectively as well. But, 10% respondents reveal did not get information on the same issue.

Table11. Main Source of Information & Education for RH

Items	Responses	Frequency	Percentage
Getting information on FP from health providers	Yes	304	84.4
	No	56	15.6
	Total	**360**	**100**
Your main source of information for RH	Radio	32	8.9
	TV	12	3.3
	Husband	11	3.1
	Community event	61	16.9
	Health providers	18	5.0
	Neighbor /Peer/	163	45.3
	Others	63	17.5
	Total	**360**	**100**
Getting advice with value of nutrition from health providers	Yes	278	72.2
	No	82	22.8
	Total	**360**	**100**
Your main source of information to RH, value of breast feeding and nutrition	Health workers	130	36.1
	Health providers	55	15.3
	Radio/TV	33	9.2
	Community event	62	17.2
	Neighbors	44	12.2
	Didn't get information	36	10
	Total	**360**	**100**

Source: own field survey, 2014

The foregoing information shows that most respondents actually had more than one source of information on value of nutrition education and related practical training; respondents had got such skill form health extensions either in health posts, community gathering or during door to door visit of health workers. But 10% respondents who didn't get information and education on

the value of breast milk feeding and nutrition is not meant in significant in respect to infant health.

4.1.2.12 Barriers to Utilize FP & Antenatal Care Services

Table 12 depicts the kind of major barriers that inhibit respondents from FP service and antenatal care services. In fact a single person could face one or more type of barriers, but here it shows the main barriers. Accordingly, 34.2% and 21.7% of the respondents faced barrier from religion and husbands when they tend to utilize family planning service respectively. In addition, 12.8%, 10%, 8.9%, 6.9% and 5.6% respondents faced serious barriers from cultural practices, lack of adequate information, neighbors' or peers pressure, mother-in-law or parents' pressure and financial problems respectively.

This indicates that religion, husband and culture had strong adverse implication on the utilization of family planning services. Moreover, lack of information and pressure exerted from neighbors or peers also needs attention to tackle barriers. Similarly, 19.4%, 15.6% and 11.9% respondents claimed that they faced barrier from house chores, low level of financial capacity and long distance from health institutions respectively. Furthermore, 8.3% and 5% of the respondents indicated that their respective husbands and pressure from the community imposed barrier on them while they use antenatal care services. On the contrary, 39.7% of the respondents did not face barriers at all.

Table12. Barriers to utilize FP & Antenatal Care Services

Items	Responses	Frequency	Percentage
Barrier to family planning services	Husband	78	21.7
	Mather in law /parent/	25	6.9
	Neighbors/peers	32	8.9
	Culture	46	12.8
	Financial capacity	20	5.6
	Religion	123	34.2
	Lack of information	36	10
	Total	**360**	**100**
Barrier to antenatal care services	Distance	43	11.9
	Husband	30	8.3
	House chores	70	19.4
	Financial capacity	56	15.6
	Pressure from the community	18	5
	Other/no problem	143	39.7
	Total	**360**	**100**

Source: own field survey 2014

4.1.2.13 Problems Related to Pre, During and Post Delivery

Table 13 portrays what type of problems respondents faced before, during and post delivery and what factors led them to give birth at home with the help of skilled health providers.

Accordingly, 29.5% and 14.2% of the respondents raised iron and nutrition deficiency as well as complicated illness during and after delivery respectively. Moreover, 4.7%, 1.9% & 1.7% of the respondents faced infant mortality, abortion and child mortality respectively. In contrary, 48.6% of the respondents did not face any problem before, during and post delivery.

As the qualitative part of this study shows that most delivery cases that have taken place in hospitals and private clinics were the result of complicated illness and prolonged labor. As well as indicated in this section many respondent women did not well prepared before delivery and they had financial problems besides they did not obtain adequate support from husbands. Significant number of respondents faced iron and nutrition deficiency. The proportion of infant mortality, abortion and child mortality appear to be insignificant but still need serious attention to achieve the goal set at MDGs.

Table13. Problems Related to Pre, During and Post Delivery

Items	Responses	Frequency	Percentage
Problems faced during pregnancy, delivery and post delivery	Complicated illness	51	14.2
	Abortion	7	1.9
	Infant mortality	15	4.7
	Child mortality	6	1.7
	Iron & nutrition deficiency	106	29.5
	No problem	175	48.6
	Total	**360**	**100**
Major problems led to give birth at home	Swift labor and delivery	9	2.5
	Restriction imposed by mother-in-law	28	7.8
	Praying that take long time	37	10.3
	Distance	14	3.9
	lack of information & knowledge	118	32.8
	Lack of & finance	22	6.1
	Other	132	36.6
	Total	**360**	**100**

Source: own field survey 2014

Likewise, whether respondents compelled by certain problem to give birth at home, 32.8% of the respondents appealed lack of information and knowledge led them to give birth at home. In addition, 10.3%, 7.8%, 6.1%, 3.9% and 2.5% of the respondents raised long time praying at home, mother in-low or relatives pressure, lack of finance, far distance and emergent labor or delivery as main reason to give birth at home. However, nearly 36.6% of the respondents did not face such problem. This indicates that factors such as lack of information and knowledge as well as long time praying show that, efforts made to bring change in behavior did not work well in the community.

4.1.2.14 Barriers on Breast Feeding and Immunization

Table 14 shows that 30.6% and 15.6 respondents failed to provide exclusively breast milk in the first six months to their child due to lack of information and education as well as work load respectively. In addition, 12.5% of the respondents due to illness and 11.6% of them were influenced by culture failed to do so. In contrast, 29.7% of the respondents were respecting exclusive breast feeding in the first six months.

Lack of information, education and work load on women respondents made greater barrier than other factors. The table also shows that 27.7% and 19.7% of the respondents appealed house chores and lack of information mainly led them not to vaccinate their children respectively. Then, 13.3% 13.1% and 9.4% of the respondents too indicated that cultural pressure, distance and low financial capacity compelled them not did so. However nearly 16.7% respondents had fulfilled their responsibilities by vaccinate their children. Household chores and lack of information also played more adverse role in the immunization intervention too.

Table14. Barriers on Breast Feeding & Immunization

Items	Responses	Frequency	Percentage
Major problems prevent feeding child only breast milk in the first six months	Illness	45	12.5
	Lack of information and education	110	30.6
	Cultural pressure	42	11.6
	Work load	56	15.6
	Other	107	29.7
	Total	**360**	**100**
Problems prevent to vaccinate child	Distance	47	13.1
	Financial capacity	34	9.4
	House chores	100	27.8
	Cultural pressure	48	13.3
	Lack of information	71	19.7
	Missing	60	16.7
	Total	**360**	**100**

Source: own field survey 2014

4.1.2.15 Barriers to Nutrition

Table 15 portrays the reasons why respondents failed to provide adequate nutrition for children and why they failed to complete vaccinate their children. Accordingly, 47.2% respondents failed to provide adequate nutrition to children due to their low monetary capacity. Then 13.6%, 12.5% and 8.6% respondents failed to do so due to routine house chores, lack of information and cultural influence. On contrast to these, 18.1% respondents raised their children by feeding adequate nutrition. This Table 15 also shows that 30% and 18.8% respondents interrupted immunization follow up for their children due to work load and cultural medication. In addition, 14.7% respondents influenced by their neighbors and peers gave up vaccinating their children too. In fact 39.5% respondents enabled to fulfill the immunization process or did not concern them to their children.

Table15. Barriers to Nutrition

Items	Responses	Frequency	Percentage
Main problems preventing to provide nutrition for child	Economic situation	170	47.2
	Lack of information	45	12.5
	House chores	49	13.6
	Cultural Pressure	31	8.6
	Missing	65	18.1
	Total	**360**	**100**
Main problem to interrupting vaccination for Child	Cultural medication	57	18.8
	Consultant in form parents & neighbors	53	14.7
	Work load	108	30
	Other	142	39.5
	Total	**360**	**100**

Source: own field survey, 2014

This shows that inappropriate labor division between husband and wife or women respondents and their respective husbands still played adverse role even in the most important and easily under taken activity too. In addition, cultural medications which were practiced by a certain clan in the community are still highly respected than modern health care activities.

The above data revealed that low financial capacity is the major factor that led respondents not to fulfill their children's basic need. In addition, as supported by qualitative section the burden rest on respondent women such as routine house chores such as fetching water, collecting fire wood and marketing prevent them from giving care to their children even in fulfilling their basic needs. Moreover, many respondents lack information on preparing nutrient food from available resources at hand and instead due to cultural influence these respondents relied on past practices without knowing their disadvantages and hazards.

4.2 Qualitative Section

4.2.1 Results of interviews

In this part of qualitative data presentation, 8 health providers, six from Mokonisa health centre and from two health posts, responded to the interviews. Three of them are midwifery, two are

nurses, one is health officer and four of them are health extension workers. During data gathering two other health extension workers were not available in the study areas.

Reproductive health activities/plan-achievement/

With regard to the provision of services in Reproductive Health (RH) i.e. in FP, antenatal care, delivery, postnatal care and vaccination in health institution in the kebele, eight eligible practitioners responded as follows: First the head of the health centre mentioned about the plan and its consequent results as:

> *Reproductive health services have been delivered based on yearly pla .The health centre as a catchment centre for four health posts, in which each of it is connected through referral system to be assumed to serve more than 30,000 people in general and people in reproductive health in particular, but in the past four years the health centre attracted only one-six (1/6) of the target. In fact, year after year progress has been observed particularly in contraception utilization, antenatal care and vaccination, but yet it requires bringing the broader community to the services so as to meet our targeted plan and millennium development goals.*

A 26 years old health officer based on the evidence presented in the following Table 16 added the explanation on the reproductive health plan and practice in the health centre. Accordingly, Reproductive health performance in the catchment area of Mokonisa health centre was in general failed to achieve its target in the past years. With regard to family planning service in 2011/12, 2012/13 and 2013/14 the achievement was 31%, 30.8% and 17.9% respectively. So in ANC1 the achievement was 49.2%, 33.4% and 38.2%, but in ANC4 in similar year 0%, 16.3% and 25% respectively. In respect to delivery care by the help of skilled providers, 14.1%, 12.5% and 31.9% undergone respectively. Likewise, the immunization programme also underscored in the same period. Accordingly, the achievement for fully immunization was 3.5%, 3.8% and 22.1% respectively. As evidences show the performance of health and immunization intervention was below average in the past three years

Table16. Mokonisa Health Centre 2011/12-2013/14 RH Performance

Activities	2011/2012			2012/2013			2013/2014		
	Plan	Achi	%	Plan	Achi	%	Plan	Achi	%
FP total	1480	459	31	1988	613	30.8	5459	981	17.9
New	-	273	-	-	269	-	-	519	-
Repeat	-	216	-	-	354	-	-	462	-
ANC 1	1182	365	49.2	911	304	33.4	1102	421	38.2
ANC 4	320	0	0	590	96	16.3	760	190	25
Delivery by skilled providers	263	34	14.1	312	39	12.5	594	190	31.9
Dp1	350	104	29.7	470	83	17.7	1037	121	11.7
Dp3	350	48	13.7	470	35	7.4	1037	85	8.2
Pev1	-	0	-	-	82	-	1037	136	13.1
Pev3	-	0	-	-	35	-	1037	85	8.2
Measles	663	14	2.1	820	78	9.5	1037	235	22.7
Fully immunized	663	23	3.5	820	31	3.8	1037	229	22.1

Source: adopted from Mokonisa health centre reports, 2014.

However, the delivery care services undertaken by health providers in health institutions were very few in the catchment area.

The achievements secured and the involvement of the community:

Informants argue that coordinated efforts were made not only on RH, but also on other health issues and the participation of the community was somewhat good.

A 25 years old nurse who serves in the health centre for three years responded his past experiences as follows:

"Whatever the achievements were so insignificant, it was the result of joint effort of all concerned bodies that win somewhat community participation in several health programs but little for RH."

On the same issue a *27* years old health extension worker explained the matter as follows.

> *RH achievements were secured through continuous efforts of health extension worker's door to door visit and advices to a community, collective effort of the volunteer health army, kebele leaders, women and youth association, traditional*

leaders, church fathers, local civic association leader and health workers. However, the achievement by itself was not satisfactory. It needs very strong momentum to capture each and every member of the community as supporter and user of the service sustainability. That means, the participation of the community was not adequate, particularly the male members of the community, who were largely absentee in the community events and training as well this group had the power of averting our effort to un intended direction by influencing women.

As the foregoing description indicates community participation on RH activities were not all inclusive and need further expansion to win the support of all section of the community.

About family planning program, significance provision of contraception in the health institution.

A Midwifery explains about contraception as follows:

Among the modern contraception COC (combined oral contraceptive), POP (progesterone only pills), injectable (for three months, three and five years), implant and IUCD are commonly used by customers. But, the majority of the users inclined to short term contraceptives rather than on long acting contraceptives.

In general, the number of contraceptive users in terms of the population assumes to be either for spacing or limiting was very small despite the fact that annual increase has been seen as result of continuous awareness creation efforts in the catchment area. In respect to antenatal care1 and vaccination activities, promising improvement have been seen in the past three years, because relatively very large number of clients visited health institution in the catchment area. But, still further efforts are required to meet the goals.

Challenges that face the health institution in the catchment area in relation to human power, material, logistics and finance:

Human power in health centre particularly midwifery currently appear to be adequate in terms of number, but attrition of these personnel was common in the past three years which may be

attributed to inadequate facilities in the health centre. In addition, it was seldom to get short term training for these health providers. In terms of material and logistics many cases can be raised.

A *25* years old midwife nurse stated the situation as follows:

> *The health centre lacks water service and latrine room which are the most striking problems that hinder service provision for reproductive health service seekers. Moreover, absence of ambulance services, inadequate medicines, lack of some obistrect equipments and lack of residence for health providers in the vicinity have made service provision inefficient. Furthermore, inadequate financial allocation to the health centre interrupts the provision overtime services at nights as a result of duty payments were quitted and even supplies were not fulfilled. Even monthly salary payments were not fixed on time which in effect disturbs service provision in the health institution.*

Bottleneck attitudinal and gender related issues that affect the community not to use properly RH services and their reflection.

A public health nurse who serves in the health centre for four years explain the matter as follows:

> *Large numbers of women in the catchment area are subjected to serious gender inequality and cannot able to decide on their own maters particularly in contraceptive use either to space child birth or limiting birth. Women are still subjected to obey the need and decision of their respective husbands. Usually I see when a wife chooses long acting contraception, a husband enforce her to use short term contraception and many contraceptive users gave up coming to receive FP services from the health center.*

A 28 years old nurse explained the intervention under taken by the health institution on RH issues as*:*

The sector together with the other bodies attempted to enhance the communities' awareness in RH but, during community events attendants were dominantly women. When the trained women went back to home, many husbands rejected what wives decided on RH matters. Although, male residents of the catchment area had ample time, very few of them attend the meeting and short term trainings. In addition, traditional believes still played strong role on contraception use and birth giving in health institution with the help of providers. For instance, so many women believe that if mother-in-law touch the back of daughter- in- law willingly she can give up birth forever and during delivery mother-in-law has a power to make labour easy, so they belief that there is no need to go to health institution for delivery. These beliefs in fact affected both utilization of FP and delivery service adversely and due to the latter cases many expectant mothers faced a complication illness during delivery which even more exacerbated when it followed by long time praying at home.

This shows that husbands have strong influence on spouses on the utilization of contraceptives. In addition, traditional practices such as a practice that gives special power to mother-in – law adversely affected the utilization of contraceptives and assisted delivery care services. Therefore, it needs to arrange meaningful awareness creation interventions to bring change in the community.

The IEC/BCC and advocacy intervention by health providers, Medias and other mechanism, their effect on the community and barriers that hinder its effectiveness:

There are many barriers that hindered IEC/BCC and advocacy intervention basically in RH issues. To begin with, the medias the community radio, which began its function recently lacks adherent and Sustainable deliberation on RH and the chosen time to address RH issues was not favourable to the brooder community. The strong side of this broadcast is that it uses vernacular language that is easily understandable to the community. The Health institution lacks adequate finance and logistic including training material to conduct meaningful training to the community.

A 28 Years old midwife Nurse mentioned her assessment as:

> *The community in general exposed to the information channels either through broadcast media or other means and improvements has been observed both during discussion and service provision but change in behaviour to use RH services strictly still lags behind. Through the efforts made to this end we have many clients who avail RH Services in our health institutions and show determination in influencing the community in different social events and even we obtain some families who change their life styles in keeping small and healthy family size. But, absent of non- government organizations which support the case in discussion in the catchment area also have implication on slow progress of RH service utilization. In addition cultural, religious and gender related barriers have strong effect on the intervention made through IEC /BCC, Advocacy too.*

As indicated in the foregoing explanation, RH service utilization was related to the behaviour of users, which was adversely affected by traditional practices, beliefs low decision making of women on RH.

4.2.2 Results of Focus group Discussion (FGD)

1. A 62 years old representative of traditional leader mentioned about the traditional custom and the recent law that determine the minimum age to make marriage as follows.

> *Gedeo traditional custom of marriage emphasizes on making marriage at matured age for both sexes. It was an adventure to girls that confront her partner in the occasion of honeymoon. Thus Gedeo tradition supports physical endurance to conduct marriage which requires the consent of both parents of partners. When a young boy becomes matured and fulfils physical and psychological preparedness to make marriage i.e if he fulfils physical, psychological and economic criteria that enable him to lead a family life, his father takes a mission to ask the parents of the chosen girl, then after a series deliberation, marriage would be performed given that the girl also fulfil all the required criteria's such as physical strength, skill and psychological readiness.*

The girl shows this development since she has observed her first menstruation and demonstrated it through different cultural hair styles. This physical and mental development has very immense advantage not only for family life but also for the society at all, particularly during delivery and child rearing such individual would not face serious problems and be able to bear very strong child. Both traditional custom of marriage formation and the recent law that impose minimum age of 18 for marriages go hand in hand because both support physical and psychological readiness. However, both rules have faced violation especially from adolescents.

> *Nowadays adolescent marriage is common in the kebele. The youth groups using the opportunities of gathering event at churches, market places as well at schools, decide to make marriage, either due to un wanted pregnancy or simply choosing to live together without having any preparation. Consequently many complicated socio economic problems have been observed due to their short sighted decision.*

The attempts made by the school in the study area to bring back those girls under fifteen who withdrew the school and engage in marriage became impossible. These trends of adolescents would lead to a complicated social problem, which was previously assumed to be the custom of northern regions of Ethiopia.

In connection to this a 22 years old youth association representative put his idea as

> *The youth or adolescents in the kebele do not get any respect from their parents and most girls have no proper place or they encounter low respect in contrast to their brothers, In most families since females are given less value, as parents give priority to men (boys), they choose otherwise to engage in marriage at early age. As these groups lack attention in obtaining RH services in accordance with their interest, pregnancy becomes common even before wedlock. Particularly, during coffee harvest the situation appears more aggravated and large number of girls leaves school and is engaged in marriage as young men able to win them.*

2. In Gedeo society a particular clan is considered to be a provider of inherited cultural medicine for some diseases that can be cured only by them. As the society believes in such cultural

medication, when someone is exposed for such diseases, it is a common trend to divert from any modern treatment including vaccination to cultural medication.

3. With regard to contraceptive utilization barier, a 43 years old church representative speaks:

> *past religious teaching has strong implication on the use of modern contraception as some preachers cite only an article that permits unlimited right to reproduce and fill the world by ignoring the article that states ' live on limited capacity'. Therefore, many people believe that using contraception may invoke anger from God and consider it to be a source of sin. Hence, past religious preaching has still place adverse effects on family planning services.*

4. How RH issues were promoted in the kebele:

The activities of RH were carried out by health extension workers. They were backed up by kebele leadership, women and youth associations, health development army, civic society, religious leaders. Hence, the movement has been able to mobilize so many people and many awareness creation forums were undertaken, consequently, encouraging achievements were obtained. But many male members of the community and adolescents did not attain the community events that were arranged to enhance their awareness in RH. Hence, both these groups of the community should be encompassed in the program to bring a meaningful and sustainable development in the arena of RH.

Reproductive health agendas has been announced by radio, particularly by the community radio that uses local language, it is very important but, air time of the radio was not convenient and lacks continuity to the wider audiences and would require some arrangements. In addition, RH programmes disclosed in the local radio should be sustainable to bring the necessary change in behaviour of audiences. Moreover, the program needs to invite experts in the field of RH. The ICE/BCC and counselling activities undertaken by heath institution lack adequate resources and sustainability and do not attempt to include adolescents and larger male members of community as a result it appears that it missed its overall target. Furthermore, religious organization also lacks the capacity that enables to communicate RH issues to the community under their mission. An informant attempts to explain about promising achievements as:

Despite all these problems some effective results have been secured in our past experiences. These are reflected in that many people have promoted their awareness besides others in RH and they show their capability of communicating the issue to the community.

6. What are the strengths and weaknesses of health institutions in the kebele?

Concerning the strengths and weaknesses of health institution in the kebele the ex chairman of the kebele explains the matter as:

The most strong side of these institution lies on the accessibility of health extension workers in communicating their mission to the community at large. On the other hand, the health institutions in the study area lack logistic and facilities.

Several bottlenecks were found out in the health institutions. These include: lack of water service, non functional latrine, unresponsive ambulance service, and lack nearby dwelling houses for health providers in the study area. Moreover, night duty in the health centre is prone to termination due to absent of part time payment for providers; in effect many pregnant women do not receive skilled delivery services at nights. Furthermore, some health providers lack commitments to address appropriate service to the community. Beside these bottlenecks, negative attitudes of the society with respect to RH, inhibit the community not to use RH services appropriately.

To conclude, challenges that hinder the implementation of RH care services emanates, on one hand, from the short coming of health institution in the study area that were reflected in less efficient mobilization of health providers, shortage of finance and logistics. On the other hand, the knowledge gap and incompatible attitudes within the community to RH services, which are associated to traditional practices and believes basically created deterrence on RH.

CHAPTER FIVE

5. SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. SUMMARY OF THE FINDINGS

The finding of this study reveals that 17.2% of respondents did not utilize any kind of reproductive health service from health institutions. Since these respondents belong to reproductive age category, they have to be consumer of at least a single type of RH service. Therefore, efforts need to be made to attract non-users of RH services from health facilities.

In addition, only 9.4% and 2.8% respondents utilized both delivery and post-natal care services from health facilities respectively. This indicates that large number of women in reproductive age did not use both delivery and post -natal care services by skilled health providers. This data appear to be nearly consistent with demographic health survey of 2011 that identified delivery care services that the2011 EDHS found out 7%.

With regard to contraception users, 29 % clients utilized modern birth control recently relatively to other RH services. This indicate that modern contraception users were greater by 2.4% than the EDHS 2011 that reveals 27% for urban and the rural counters parts by 5.4% as the national figure was 23% (EDHS, 2011). Generally, 61.1% respondents were experienced in using modern contraceptives in their life time, where 56.1% and 5% respondents took contraceptives for spacing and limiting.

However, as revealed in this study, clients on FP services more rallied on short acting contraceptives than long acting. Hence 46.1% respondents had taken injectables of short acting (A 3 month injectable or DIP). As the qualitative section of this study shows the likelihood of suspending of contraceptive use was very high and most clients failed to use long acting contraceptives for fear of the side effect simply by listening what some users told them.

Although the majority of the respondents have positive attitude towards contraceptives, still 19.7% respondents together felt negative and unclear attitude to it. In sum, the unmet need of contraception was 39.5% in the Kebele. This is very large in contrast to the national survey that indicates the unmet need of married women for contraception was 25% (EDHS, 2011).The wide discrepancy may appear for reason that the current study conducted only in rural area.

With regard to antenatal care services consumption, 52.5% respondent clients visited health institution three and more times. But 26.7% respondents never visited for the service. In contrast to 2011 EDHS apparently the achievement made by Mokonisa health institution was promising, where the national survey reveals 19% married women received four or more antenatal visit. But, when comes to yearly plan of Mokonisa health centre, the data appears consistent to the national survey and the 2012 /2013 and 2013/2014 achievement per plan were 16.3% and 25% for ANC 4 respectively. In addition 58.6% and 25% respondents did not utilize voluntary counselling and blood testing for HIV/AIDS; and vaccination during pregnancy. Moreover, 38.9% respondents did not prepare adequately for child birth.

This study revealed the perception of respondents on Mokonisa health centre in family planning, antenatal care and delivery care service. Accordingly, 48%, 51% and 69.7% respondents labelled services at average and below average. As the qualitative section of this study, inadequate resources (human, material and financial) have seriously attributed on the side of the health institution on the service delivery. In contrast, health providers indicated false believes and pressure from husbands, parents and peers produced such effect. In this connection a research conducted by Hess in Ghana revealed that minimum requirement for staff, infrastructure, supplies and equipment has strong association to provide short term method of family planning (Hess, 2000).

With regard to information and education on RH, breast feeding and nutrition, 10 to 15.6%respondets did not get information from any source. In general, traditional sources of information channels were the main sources of information. The qualitative section of the study noted that the community radios that use the language of the community lacks continuity, suitability of time preference and adequacy on RH matters despite it won large audiences as it adopts local language .

Likewise, the 2011 EDHS has indicted that community events are the most common source of information for women in a reproductive age followed by the radio and television.(EDHS, 2011).

Reproductive health care services, as this study revealed, could not be delivered with smooth intervention. With respect to FP services, religion (34.2%) and husband (21.7%) became major barriers and followed by cultural practices (12.8%), lack of information (10%), pressure from neighbours or peers (8.9%) as well as mother-in-law or parent influence (6.9%) and financial problem (5.6%).

With regard to antenatal care services, house chores (19.4%), low level of financial capacity (15.6%) and far distance (11.9%) were the major barriers to client respondents, followed by husbands influence and pressure from the community.

On the other hand many respondent women faced problem pre, during, and post delivery. The most serious problems were iron and nutrition deficiency, and complicated illness. In addition many pregnant women gave birth at home for the reason that they lacked information and knowledge about the advantage of having the assistance of skilled provider. Further, religious followers long time praying at home during the time of labour, pressure from the relatives, lack of finance, far distance and emergent labour also compelled them to give birth at home.

Similarly, lack of information and education and work load made greater barrier on respondent women not to provide only breast milk in first six months and followed up vaccination to their child. Some also faced illness not to feed breast milk. Besides, culture had influence on many women not to respect exclusive breast milk feeding to a child.

Moreover, low financial capacity was a major barrier for 47.2% of the respondents not to fulfil nutrient food for their children, Furthermore, routine house chores, lack of information and cultural influence had also created barrier. Besides, work load and cultural medication had serious implication on respondents to interrupt immunization process for their children. Likewise, neighbours and peers influence also contributed for interruption of immunization too.

The qualitative section of this study has been discussed thematically as follows. In fact, many related issues were taken and included in the quantitative section. At micro level, planned RH activities failed to meet target. As revealed in this study. Low institutional capacity in terms of human, material and finance resource mobilization found to be the major reason for the failure. Above all, less effective awareness creation intervention also contributed adversely for underutilized RH service delivery.

Absence of conducive environment and special facilities for adolescent groups in the kebele health institution was the major challenge that this study come across. Despite the fact that, the existence of both government legal restriction that make age18 the minimum age to conclude marriage and traditional custom that encourage physical maturity and psychological readiness, adolescents violet both laws, then engage in marriage and produce children at early age, which increases the rate of population growth in the kebele. Consequently, it brought far reaching effects on the social wellbeing.

In addition, detachment of men member of the kebele from community events and short term trainings on RH, affected the achievement adversely and diminished the effort made by responsible people. Moreover, interventions that were initiated to promote economic empowerment of women lack strength and continuity to involve wider part of needy women.

Accessibility of IEC/BCC and Advocacy intervention through mass media and other concerned bodies could not be matched with the demand on the spot of the study area. The community Radio that uses the vernacular language of the study area apparently has large number of audience but it could not employ adequate and convenient time for disseminating population ICE/BCC program. Traditional information channels such as community events and short term training could not be inclusive of certain groups (husbands and adolescent). On advocacy of population the attempt could not involve wider section of women to win several individuals and groups as owner of RH issue and even that endeavor failed to show sustenance as only 360 women have benefited from saving and credit services.

5.2. CONCULUSIONS

This study was conducted to assess the challenges that impeded the implementation of the core areas of national population policy i.e. Reproductive health, gender equality and information education communication/advocacy in Mokonisa rural kebele, Wonago wereda, Gedeo zone of SNNP. Based on the findings of this study the following conclusions are drawn:

1. Use of family planning services evidently showed little progress in capturing large number of clients and it might not bring adequate check on fast rate fertility and failed to bring demographic transition in the study area.

2. Antenatal care service which also helps to inculcate other RH concepts was not adequately utilized in the Kebele health institutions.
3. Delivery and postnatal care services were underutilized in health institutions and the attempts made to block the likelihood of risk associated to birth giving were inadequate. Therefore, risk aversion efforts were not consistent enough.
4. Mother's determination on feeding breast milk for six months after child birth did not meet its target. In addition, the opportunity of many married women to provide nutrition to children and themselves definitely was insufficient.
5. The reproductive health service delivery in the health institutions was found to be inefficient not only to satisfy users' demand but also to win the attention of potential service users which was attributed to inadequate recourses in health facilities, lack of awareness, problem of attitude, having multiple responsibilities etc.
6. Insignificant participation of male partners in RH matters has led to underutilized RH services. This remained unaffected due to resource inadequacy that hindered men participation.
7. Adolescents in general were neglected from RH education and services. In effect, this led them to get into unwanted pregnancies and eventually to early marriage by violating the law that limit age for marriage and social norm that allows maturity to marriage. The practices of adolescents contributed much in scaling up fertility in the study area and hampered female's self development in education etc.
8. Information, Education and communication on population-RH did not encompass considerable section of the study population and traditional means of communication appeared the major source of information unable to fulfil RH knowledge gap in the study area.
9. Awareness creation of the family law particularly that of marriage age limit was not found effective in the study area and parents of spouses and elders were expressed to early marriage conclusion. Likewise, the advantage of traditional norms that appreciate matured age marriage was not well known to the youth.

5.3. RECOMMENDATIONS

In light of the research findings and conclusions, the following recommendations are forwarded:

1. As the study area was over crowded by dense population, RH services should be expanded by increasing the capacity of health institutions, other implementing sectors and actors. Hence, leaders, planners and programmers should to earmark enough resources and involve stakeholders on RH in the study area.
2. Awareness creation, educating and behavioural change interventions should be inclusive of adolescents, male and female members of the community and integrating Government, NGOs and CBOs in the interventions so as to play key role in population- RH knowledge creation in the study area.
3. The legislature should create conducive ground for promoting the family code, the minimum age to marriage, and reinforce the law in the study kebele. Likewise, the traditional leaders also should initiate the marriage customs that do not support early marriage.
4. Agriculture extension workers should carry out population –RH matters by integrating the case with extension development issues, collaborating with health providers particularly to address the issue to the male members of the community.
5. Confidential, separate and convenient RH service delivery should be facilitated for adolescent groups not only in health facilities but also in religious institutions, schools and youth association centers. In addition, relentless effort should be in place to retain adolescents in schools.
6. Both traditional means of information delivery system and modern broadcast such as the community radio should be strengthened to disseminate population-IEC/ECC agendas and has to work for the fulfilment of the means that help users to receive information.
7. Governmental institutions, NGOs and CBOs should be involved in women economic empowerment to provide them skill development, saving and credit services so as to transform them to self reliance. Integrating such interventions on RH population IEC/BCC and advocacy have to be designed to bring far reaching effects the study area.

8. The local government should focus on building the capacity of peoples in the kebele administrative office to play the roles of coordinating, monitoring and evaluating of population-RH matters.
9. Since this specific study does not represent wider perspectives of the region or the country, further assessment is recommended to investigate challenges of implementing RH program in extensive study areas.

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APPENDICES

Questionnaire for Respondents

Dear madam_____

I am a graduate student at Addis Ababa University and conducting a study titled "Assessment on challenges in implementing NPP in densely populated areas: The case of Mokonisa kebele,Wenago, Gedeo Zone, SNNPR." For the fulfilment of the requirements the completion of Masters Degree in public management and policy specialized in public policy. Hence, your genuine cooperation in responding to the questionnaire is very much useful. Confidentiality is kept. I thank you for your time**.**

Part I: Socio Economic Questionnaire

N^{o}	Question	Response code	
91.	How old are you?	_____ Years old.	
92.	What is your religion?	1.Protestant 2.Ortodox 3.Catolic 4.Muslim 5.Any other _____	
93.	Ethnicity	1.Gedeo 2.Oromo 3.Amhara 4.Sidama 5.Gurage 6.any other_____	
94.	Your level of Education	1. Illiterate 2. Reading and Writing 3. Completed primary education 4. Completed secondary education 5. Higher education	
95.	Marital Status	1. Married 2. Unmarried 3. Widowed 4. Divorced 5. Separated	
96.	Occupation	1. House wife 2. Personal employee 3. Daily laborer 4. Any other _____	
97.	The n^{o} of your Children	_____	
98.	Your alive Children	_____	
99.	Do your husband has other co wife	1. 0 2. 1 3. 2-3 4. More than 4	
100.	Total n^{o} of your husband's Children	1. 1-3 2. 4-6 3. 7-10 4. more than 11	

Part II Questionnaires on reproductive health, gender equality and population IEC/BCC matters.

101. Have you obtained reproductive health services from health institutions in the past 5 years?

1. Yes 2.No

102. If your answer to questions n^{o} is 'yes', from where do you obtained the service?

1. Health post 2. Health centre

3. Hospital 4. Private clinics

5. Any other _____

103. What kind of service you receive from health institution(the most recent)?

1. Contraceptive 2. Antenatal care

3. Delivery 4. Postnatal care

5. Vaccination 6. Any other_____

104. Did you ever use contraceptive?

1. yes 2. No but I had a need

3. I need for the future 4. I never need it

105. If you were contraception user, for what purpose you use?

1. spacing 2.limiting birth

106. If you are the client of Mokonisa health centre for contraception supply, How do you perceived the status of the service?

1. Very low 2. Low 3. Moderate 4. High 5. Very high

107. Did you have the service timely and according to your preference?

1. Yes 2. No

108. What type of modern contraception you were using?

1. Pills 2.injectable
3. Implant 4. IUD (lup)
5. Any other_____

109. Did you pay fee for contraception?

1. Yes 2. No

110. Who did prohibit you using Family planning?

1. Husband 2. Mother- in- law/parents 3. Neighbours/peers

4. Culture 5. Religion 6. Economic situation 7. Information & education inadequacy

111. Did you obtain information & education from health providers on family planning

1. Yes 2. No

112. From which body you obtain Family Planning information & education?

1. Radio 2. Television

3. Husband 4. Community event

5. Neighbours & friends 6. Health providers

7. If any other_____

113. What was your attitude on the Family Planning?

1. Positive 2. Negative

3. Complicated 4. Undetermined

114. Did you utilize antenatal care during your pregnancy?

1. yes 2. No

115. How many times you receive antenatal service in your last pregnancy?

1. 1-2 2. 3-4 3. above 5 times

116. What is your impression on antenatal service you obtained from Mokonisa health Center?

1. Very low 2. Low

3. Moderate 4. High

5. Very high

117. What were the obstacles you faced while you intend to obtain antenatal care?

1. Distance 2. Husband

3. House chores 4. Economic situation

5. Negative attitude from the community 6. If any other _____

118. Had you taken voluntary counselling and blood testing for HIV during antenatal care?

1. Yes 2. No

119. Had you taken vaccine before you gave birth?

1. Yes 2. No 3. Partially

120. Did you have adequate preparation before you gave birth?

1. Yes 2. No

121. Did your husband properly support you before and after you gave birth?

1. Yes 2. No

122. Where did you gave birth of the recent pregnancy?

1. Health post 2. Health center

3. Hospital 4. Private clinics

5. Home

123. In what time interval you & your child visited health providers for examination & vaccine after you gave a birth?

1. Immediately 2. Within 24 hours 3. Within two days 4. Within a week 5. After confinement 6. Never Did it.

124. What problem you encountered during pregnancy and after birth?

1. Complicated illness 2. Abortion

3. Infant mortality 4. Child mortality

5. Iron deficiency and malnutrition

125. If you gave birth at your home, what prohibit you not to visit health institutions?

1. Emergent birth 3. Elongated praying

2. Lack of permission from mother-in-law 4. Distance

5. Lack of information & education 6. Weak finance

7. If any other_____

126. If you obtained delivery service in Mokonisa health center, what is your impression of the service?

1. Very low 2. Low

3. Moderate 4. High

5. Very high 127. Did your child obtain every vaccine?

1. Yes 2. No 3. Sometimes

128. Did you feed only breast milk for your child in the first six months?

1. Yes 2. No

3. Breast milk with supplementary food 4. Only other type of milk

129. Did health providers advise you about the value of nutrition for you and your child ?

1. Yes 2. No

130. What factor inhibit you from providing breast milk exclusively for your child in the first six monthes?

1. Health problem 2. Lack of information and education

3. Cultural pressure 4. Work Burdon 5. If any other _____ 131. What barrier limits you not to visit health provider to vaccinate your child?

1. Distance 2. Economic situation 3. House chores

4. Cultural pressure 5. Lack of information

132. What factor inhibited you not to provide nutrient food for your child?

1. Poverty 2. Lack of information 3. Work load 4. Cultural pressure

133. From where you obtain adequate information on breast feeding and nutrition?

1. Health extension workers 2. Health providers

3. Radio, Television, Printed materials 4.Community events

5. Neighbors, peers, and parents 6. Never get information

134. If you quit vaccine for your child, what was the reason for interruption?

1. Inclining to the cultural medicine for the disease called " banqo"

2. Due to the advice of neighbours and parents

3. work burden 4. If any other_____

135. Did you reach on decision with your husband discusing on family planning, contraception, place of birth, child feeding and vaccination?

1. Yes 2. No 3. Partially

136. In contrast to your husband your power of control and decision making on consumption and expenses was :

1. Very low 2. Low 3. Moderate 4. Hig 5. Very high

137. Did you get benefit from any provision on saving and credit service facilitated by government or NGOs?

1. Yes 2. No

138. If your response is "yes" for question n^{o} 137, did you get any related training?

1. Yes 2. No

139. Did you play leadership role in any community based on public places in your kebele?

1. Yes 2. No

140. Do you think that your economic, social and political status in the community is improved?

1. Yes 2. No 3. I don't know

Interview guideline

1. What RH components were planned and implemented by health institution in past five year?

2. What mechanisms were employed to realize RH plan in to action? How far the community participated in RH matters?

3. What challenges encountered your health institution in providing RH services in regard to:

- Human resource
- Material/ logistic
- Finance
- Management and system of service delivery

4. What attitude and gender related bottle necks hindered the society from using RH services in the health institutions? What are the main reflections of the bottlenecks on RH services?

5. What were the result of population ICE/BCC and advocacy interventions on the community? What tangible evidences shown for? What barriers were there?

Guide line to focus group discussion

1. Did marriage formation practice in respect to the minimum age put by the law in the kebele? What similarities and differences is there between the traditional marriage custom and the government law? What implication has on the life of women, family planning, and child birth?

2. What were the indicators between husband and wife with regard to labor division, property ownership, RH such as family size?

3. What impacts were seen from husband and wife relations on FP, antenatal care, delivery, postnatal care and vaccinations service utilization within the kebele community? What was the impact of culture and religion on the same issues?

4. What outcomes are observed as the government and non- government organization facilitated a saving and credit services to promote the capacity women in the kebele (if so)? What obstacles were there to these efforts?

5. How does the coverage and effectiveness of awareness creation and educating intervention in related to RH in the kebele? What were the bottlenecks that hinder the process? What indicators exhibit the promotion of communities' awareness in the kebele?

6. What strong and weak sides were there in the health institution while they provide RH services for the kebele's community? What were the bottlenecks that hinder the community from utilizing RH services?

መጠይቅ በአማርኛ ቋንቋ

የብሔራዊ ስነህዝብ ፖሊሲ አተገባበር ላይ የሚያጋጥሙ ተግዳሮቶችን ለመዳሰስ የተዘጋጀ መጠይቅ

ክፍል አንድ

ኢኮኖያዊ ማህበራዊ ሁኔታዎችን የሚዳስሱ መጠይቆች

ተ.ቁ	ጥያቄ	መልስ ኮዶች	ይለፉ
91	ዕድሜዎ ስንት ነው?	……. ዓመት	
92	ሀይማኖትዎ ምንድ ነው	1. ፕሮቴስታንት 2. ኦቶዶክስ 3. ካቶሊክ 4. ሙስሊም 5. ሌላ ካለ ----------	
93	ብሔረሰብዎ	1. ጌዴኦ 2. ኦሮሞ 3. አማራ 4. ሲዳማ 5. ጉራጌ 6. ሌላ ካለ ……	
94	የትምህርት ደረጃዎ	1) ማንበብና መጻፍ የማይችሉ 2) ማንበብና መጻፍ የሚችሉ 3) የመጀመሪያ ደረጃ ያጠናቀቁ 4) ሁለተኛ ደረጃ ያጠናቀቁ 5) ከፍተኛ ትምህርት 6) ከፍተኛ ት/ርት	
95	የጋብቻ ሁኔታ	1. ያገቡ 2. ያላገቡ 3. ባል የሞቱ 4. የፈቱ 5. አብረው የማይኖሩ 6. አብረው የማይኖሩ	
96	የሥራ አይነት	1. የቤት እመቤት 2. የግል ተቀጣሪ 3. የቀን ሰራተኛ 4. ሌላ ካለ ----------	
97	የወለዷቸው ልጆች ብዛት	-	
98	በሕይወት ያሉ ልጆች ብዛት	-	
99	ባለቤትዎ ከእርስዎ ሌላ ስንት ሚስት አላቸው	1)0 2)1 3)2-3 4)ከ4 በላይ	
100	ባለቤትዎ ስንት ልጆች አሏቸው	1)1-3 2)4-6 3)7-10 4) ከ11 በላይ	

ክፍል ሁለት

በተዋልዶ ጤና፣ በስርዓተ ጾታና የሥነ- ሕዝብ መረጃና ትምህርት የተመለከቱ መጠይቆች

101. ባለፉት 6 ዓመታት ውስጥ የተዋልዶ ጤና አገልግሎት ከጤና ተቋማት አግኝተው ያውቃሉ?

1) አዎ 2) አይደለም

102. የተዋልዶ ጤና አገልግሎት አግኝተው ከሆነ አገልግሎቱን ያገኙት ከየት ነበር?

1) በቀበሌ ካለ ጤና ኬላ 2) በቀበሌ ካለ ጤና ጣቢያ 3) ከመንግስት ሆስፒታል

4) ከግል ጤና ተቋም 5)ሌላ ካለ ----------

103. ከጤና ተቋም ያገኙት ተዋልዶ ጤና አገልግሎት ምን ነበር?

1. የወሊድ መቆጣጠሪያ 2. የቅድመ ወሊድ አገልግሎት
3. የወሊድ አገልግሎት 4. የድህረ ወሊድ አገልግሎት
5. የክትባት 6. ሌላ ካለ ----------

104. የቤተሰብ ዕቅድ/የወሊድ መቆጣጠሪያ መድሃኒት ተጠቃሚ ሆነው ያውቁ ነበር?

1. አዎ 2. መጠቀም እየፈለኩ አልተጠቀምኩም 3. ለወደፊቱ ለመጠቀም እፈልጋለሁ
4. መቼም አልጠቀምም

105. የወሊድ መቆጣጠሪያ መድሃኒት ተጠቃሚ ከነበሩ ይጠቀሙ የነበረው

1. አራርቆ ለመውለድ 2. ወሊድን እስከ መጨረሻው ለማቆም

106. አገልግሎቱን ከቀበሌው ጤና ጣቢያ ያገኙ ከነበር የአገልግሎቱን አስጠጥ በራስዎ እይታ ሲመዝኑ

1. በጣም ዝቅተኛ 2. ዝቅተኛ 3. መካከለኛ 4. ከፍተኛ 5. በጣም ከፍተኛ

107. የቤተሰብ ዕቅድ አገልግሎቱን በሚፈለጉት ጊዜና አይነትና ከጤና ተቋሙ ያገኙ ነበር

1. አዎ 2. አይደለም

108. ይጠቀሙበት የነበረው የወሊድ መቆጣጠሪያ የቱ ነበር?

1. እንክበል/ፒልስ 2. በክንድ የሚሰጥ መርፌ/ዲፖ/ 3. ኢንፕላንት
4. ሉፕ/አዩሲዲ 5. ሌላ ካለ ----------

109. ለወሊድ መቆጣጠሪያ መድሃኒት ክፍያ ይጠየቁ ነበር?

1. አዎ 2. አይደለም

110. የቤተሰብ ዕቅድ እንዳይጠቀሙ ተዕዕኖ የሚያደርግብዎ ማን ነበር?

1. ባለቤትዎ 2. አማትዋ/ቤተዘመድ 3. ጎረቤትና ጓደኞች
4. የኢኮኖሚ አቅምዎ 5. የመረጃና ትምህርት እጦት

111. ከጤና ባለሙያዎች በቤተሰብ ዕቅድ አጠቃቀም መረጃና ትምህርት አግኝተው ያውቃሉ

1. አዎ 2. አይደለም

112. የቤተሰብ ዕቅድ አገልግሎትን በተመላከተ መረጃና ትምህርት የገኙ የነበረ ከማን ነው?

1. ሬደዮ 2. ቴሊቪዝን 3. ከባለቤትዎ 4. ከማህበረሰብ ውይይት

5. ከጤና ባለሙያዎች 6. ከጓደኞችና ከጎርቤት 7. ሌላ ካለ ----------

113. በቤተሰብ እቅድ ዙሪያ የርስዎ አመለካከት ምን ነበር?

1. በጎ 2. በጎ ያልሆነ 3. የተደበላለቀ 4. አላውቅም

114. በዕርግዝና ጊዜዎ የቅደመ ወለድ አገልግሎት ከጤና ተቋም የጋኙ ነበር

1. አዎ 2. አይደለም

115. በአንድ የእርግዝና ጊዜ ስንት ጊዜ ከመውለድዎ በፊት ክትትል ያደረጉ ነበር?

1. 1-2 2. 3-4 3. ከ 5 ጊዜ በላይ

116. ከቀበሌው ጤና ጣብያ ያገኙት የነበረው የቅድመ ወለድ አገልግሎት በርስዎ ዕይታ

1. በጣም ዝቅተኛ 2. ዝቅተኛ 3. መካከለኛ 4. ከፍተኛ 5. በጣም ከፍተኛ

117. የቅድመ ወሊድ አገልግሎት እንዳያገኙ እንቅፋት የሆነብዎት

1. የቦታ ርቀት 2 . ባለቤትዎ 3. የቤት ውስጥ ስራ ጫና 4. የኢኮኖሚ አቅም

5. ከማህበረሰቡ የሚሰነዘሩ አሉታሚ አስተያየቶች 6. ሌላ ካለ ----------

118. በቅድመ ወሊድ ወቅት በፍቃደኝነት የኤች አይቪ ምክርና ምርመራ አድረገው ያውቀሉ?

1. አዎ 2. አይደለም

119. ከወሊድ በፊት ይሰጡ የነበሩ ክትባቶችን ይወስዱ ነበር

1. አዎ 2. አይደለም 3. በከፊል

120. የመውለጃዎ ጊዜ ከመድርሱ በፊት በቂ ዝግጅት ያደርጉ ነበር?

1. አዎ 2. አይደለም

121. ባለቤትዎ በእርግዝና ጊዜና ከወሊድ በኋላ በቂ ድጋፍ ያደርጉልዎታል?

1. አዎ 2. አይደለም

122. ልጅዎን የተገላገሉ የት ነበር?

1. በጤና ኬላ በጤና ኢክስቴንሽን ሰራተኞች ድጋፍ 2. በጤና ጣቢያ በጤና ባለሙያ ድጋፍ

3. በሆስፒታል 4. በግል ጤና ተቋም 5. በቤት ውስጥ በልምድ አዋላጅ

6. በቤት ውስጥ በቤተዘመድ 7. በቤት ውስጥ ያለማንም ድጋፍ

123. የምርመራና የክትባት አገልግሎት ከወለዱ ከስንት ጊዜ በኋላ ነበር እርስዎና ልጅዎ ያገኛችሁ?

1. በእለቱ 2. በ24 ሰዓት ውስጥ 3. በ2 ቀናት ውስጥ

4. በሳምንት ውስጥ 5. ከአራስ ቤት ከወጡ በኋላ 6. ጭራሹንም አላገኘንም

124. በዕርግዝና ጊዜ በወሊድ ጊዜ ወይም ከወሊድ በኋላ ያጋጠመዎት ችግር ምን ነበር?

1. የተወሳሰበ ሕመም 2. ውርጃ 3. የጨቅላ ሕፃና ሞት

4. ከ5 ዓመት በታች የልጅ ሞት 5. የብረት ማዕድና የምግብ እጥረት

125. በቤት ውስጥ ወልደው ከሆነ ወደ ጤና ተቋም እንዳይሄዱ ያደረገዎት ችግር ምን ነበር?

1. ፋተ የማይሰጥ ሞጥና አጣዳፊ መወሊድ 2. የአማትዎ (የባለቤትዎ እናት) አለመፍቀድ
3. ረጅም ጊዜ የወሰደ የፀሎት ሥርዓት 4. የቦታ ርቀት 5. የመረጃና እውቀት ማነስ
5. የኢኮኖሚ አቅም ማነስ 6. ሌላ ካለ ----------

126. በቀበሌው ጤና ጣቢያ የወሊድ አገልግሎት አግኝተው ከሆነ የአገልግሎቱ ሁኔታ በርስዎ እይታ

1. በጣም ዝቅተኛ 2. ዝቅተኛ 3. መካከለኛ 4. ከፍተኛ 5. በጣም ከፍተኛ

127. ለሕፃናት የሚሰጡ ክትባቶችን የርስዎ ልጅ ያገኝ ነበር?

1. አዎ 2. አይደለም 3. አልፎ አልፎ

128. በመጀመሪያዎቹ ስድስት ወራት ለሕፃን ልጅዎ የጡትዎን ወተት ብቻ ነበር የሚመግቡት

1. አዎ 2. አይደለም 3. ጡትና ሌላ ተጨማሪ ምግብ 4. የላም ወተት ብቻ

129. የጤና ባለሙያዎች የተመጣጠነ ምግብ መስጠት አስፈላጊና ወሳኝ መሆኑን መክረዎታል?

1. አዎ ለ. አይደለም

130. በመጀመሪያዎቹ 6 ወራት የጡትዎን ወተት ብቻ ለልጅዎ እንዳይመግቡ ያደረገዎት

1. የጤና መጓደል 2. የመረጃና ትምህርት እጦት 3. የባህል ተፅዕኖ
4. የሥራ ጫና 5. ሌላ ካለ ----------

131. ለሕፃን ልጅዎ ክትባት በተከታታይ ክንዳያስከትቡ ተፅዕኖ የደረገበዎት

1. የቦታ ርቀት 2. የኢኮኖሚ አቅም 3. የቤት ውስጥ ሥራ
4. የባህል ተፅዕኖ 5. የመረጃ እጦት

132. ለሕፃን ልጅዎ የተመጣጠነ ምግብ እንዳይመግቡ ተፅዕኖ የሳደርብዎት

1. የኢኮኖሚ አቅም 2. የመረጃ መነስ 3. የሥራ ጫና 4. የባህል ተፅዕኖ

133. ስለ እናት ጡት ጠቀሚታ፣ የተመጣጠነ ምግብ መረጃ ሲያገኙ የነበረው ከየት ነው?

1. ከጤና ኤክስቴንሽን ሰራተኞች 2. ከጤና ጣቢያ ባለሙያዎች
3. ካሬዲዬ /ቴሊቪዥን/ ከታተሙ ፅሐፎች 4. ከማህበረሰብ ውይይት
5. ከጎረቤት /ንደኛ/ ቤተዘመድ 6. መረጃ አላገኘሁም

134. ለሕፃናት የሚሰጠውን ክትባት እንዲያቋርጡ ያደረጎት

1. በባህል ሕክምና ይድናል ተብሎ የሚታመንበት "በንቆ/ኡፉ" ልጅዎን ሲይዛው
2. ጉረቤቶች /ዘመድ እንዳያስከትቡ ሲመክረዎት 3. ስራ ሲበዛበዎት 4. ሌላ ካላ ----------

135. በቤተሰብ ምጣኔ፣ በወሊድ መቆጣጠሪያ፣ በመወለጃ ቦታ ምርጫ፣ በሕፃናት አመጋገብና ክትባት ዙሪያ ከባለቤትዎ ጋር ተወያይተው ወሳኔ ላይ ይደርሱ ነበር?

1. አዎ 2. አይደለም 3. በከፊል 4. የባለቤትዎ ውሳኔ ብቻ ይከበራል
5. በግልዎ ብቻ ይወስናሉ 6. ሌላ ካላ ----------

136. በቤት ውስጥ ፍጆታ፣ ልዩ ልዩ ወጪዎች የርስዎ የመቆጣጠርና የመወሰን ደረጃ ከባለቤትዎ ጋር ሲያነፃጽሩት

1. በጣም ዝቅተኛ 2. ዝቅተኛ 3. መካከለኛ 4. ከፍተኛ 5. በጣም ከፍተኛ

137. በመንግስትም ሆነ መያድ የርስዎን የኢኮኖሚ አቅም ለማስደግ የቁጣባና ብድር ተጠቃሚ ሁነው ያውቃሉ?

138. ለ137ኛ ጥያቂ መልስዎ "አዎ" ከሆነ ሥልጠና ተስጥቶዎት ያውቃል?

1. አዎ 2. አይደለም

139. በቀበሌ ውስጥ ባሉ የተለያዩ አደረጃጀቶች እርስዎ የአመራር ቦታ ላይ ሰርተዋል?

1. አዎ 2. አይደለም

140. በቀበሌ ውስጥ ባለዎት ተሳትፎ በማህበራዊ፣ ኢኮኖሚያዊና ፖለቲካ ውስጥ ያለዎት ስፍራ ተሻሽሏል ብለው ያምናሉ?

1. አዎ 2. አይደለም 3. አላውቅም

አመሰግናለሁ!!

Qortuma gede'uffati

Aradatowachchotixxe poolise hujete'niima hosisatixxe poolise'n gelteaaxxa raktowatatee giissemeeke qortuma

Kuta taakkaxxa

Ikkonmetike mittooumka Ieeja towatatike qortuma

	Qortuma	hiissichcho	
91	wogga atixxi me'ete	wogga	
92	Adde atixxi maachcho	1. Protestante 2. ortodokise 3. Kaatoolike 4. Isilaama 5. Wele----------	
93	Gosa yookin bogile atixxi	1. Gede'o 2. oromo 3. amaara(qawwe) 4. sidaama 5. uraage 6. wele_____	
94	Barachchcitk koobbi	1. borro borreessa yanasisabaak 2. borro borreessa dande aak 3. 1-8 koobbo muuxeek 4. 12 koobbo muuxeek 5. Kolleege	
95	Adhe huruminka jeeja	1. Heerundeexxi 2. Heerundebaaxxi 3. Aroir reyeexxi 4. Tikkeexxi 5. Welt he'nebaaxxi	
96	Hujetixxi bifa	1. Mininx ama 2. Ifixxa huje abixxiteexx 3. Barra barratik hujalle 4. Wele ----------	
97	Ildeexxe oosexxe birasan'e		
98	Ta'a lubbot hexxeexxi		
99	Aroie atik wele meelaalle me'e afe	1)0 2)1 3)2-3 4)4 iima	
100	Aroi atik me'e oose afe'e	1)1-3 2)4-6 3)7-10 4) 11 iima	

Kuta lame

Fayyunteti ila seerinke saalinna aradda towatatika tarjanna barachcho uudaaka qortumuwwa

101. saxxeexxa jaane wogguwwa giddo fayyunteti ilatixxe huje fayyuntatixxe inisituuti affe egendette?

1. eeti 2. Waawo'o

102. fayyunteti ilatixxe alffitottoolexxe kaddoole tenne huje habaa'no alfitette?

1) Loolake'n hedheeke fayyumteti keella'n
2) Loolake'n hedheeke fayyumtexeaaba'n
3) Mootummatike hospitaaliaa'n
4) Ifike fayyuntetike inistituutee'n
5) Wele----------

103. fayyuntatixe inisituutenaa'n affetteke fayyunteti ilaxxa huje maachchmma?

1) Ila qorqorraachcho (ila gaadaachcho)
2) Edise ilatixxe huje
3) Ilatixxa huje
4) Ilati udumatixxa huje
5) Kittibaatetixxa
6) Wele----------

104. mini hadixxa plane ila qorqorraachcho qors laattaatteke kaddottole egendeetta'e?

1) Eet 2. La'o fata hasaaninne 3. Edia' lao'fata 4. Haanonna la'ofatabon

105. ila qorqorati qorsa la'ofata attok, maye'a laofataatta'a?

1) bababayyise ilatee 2) ila ediaanna uurrisatee

106. huje loolinke fayyunteto la’o alifitattoke kaddotolle mikkatto wodda

1) hara heenoke 2. Heenoka 3. Oddichcha 4. Lumoka 5. Hara lumoka

107 mini hadixxa plaanexxa lao (huje) hassattatta woddanna bifa fayyuntetixx inistiituutenaan alfitaataa?

1. Eet 2. Waawwo

108 la’ofataataak ila qorqorroachcho hoonekemma’a?

1. Inkibille (pilse)
2. Hirrete’n uunaxxa liimma (diipo)
3. Inplaante
4. Luppe (iyyuusidi)
5. Wele----------

109 ila qorqorrachcho qorsaa hira lanqaammaa?

1. Eeti 2. Waawwo

110. mini hadixxa plane la’o fatabaashsha rakkisaak ayyetemma’?

1. Mininkaanna

2) Ballo atixxe (firi)

3)Ollaikinna hiriyyuwwa

4) Ikkonmetixxi hunna

5)Tarjinxanna barachchotixxi gonphe

111. Fayyuntetixxe ogeeyyuwwa mini hadixxa plaane la’ofatate tarjanna barachcho alfitee egendatte?

1. Eeti 2. Waawwo

112. minihadixxa plaanxa la’o (huje) uuddaaxxa tarjanna barachcho alfitettek ayyenaa’nitemma?

1) Raadionatenaa'n
2) Televizhinetenaa'n
3) Ardiake haasoinaa'n
4) Fayyuntetixxe ogeeyyenaa’n
5) jaalokenaa’ninna olla’akenaa'n
6) Wele----------

113. mini hadinxxe plane atixxi uushsho maachchomma?

1. eloxxe 2. Elobaaxxe 3. Karsendeexxe 4. Ege’nebo’no

114. siilinxxe yanna’n edise ilatixxa huje fayyhitetixxe inistiituuten welti afendaattaa?

1. eeti 2. Waawo'o

115. mitte siilinxa yanna’n me’ele ilati edidarre hordofaata’a?

1) 1-2 2) 3-4 3) shooleti iimma

116. loolinke fayyunteti xaabina’n alfita’n hexxetaxxi edise ilatixxa la’o (huje) batixxe uushsho

1) Hara eenoxxe 2) heenoxxe 3) oddittе 4) lumoxxe 5) hara lumoxxe

117. Edise illatixxe huje’n (la’on) gufote kaddeexxi

1) Boonchinke bayyinne

2) aroi atike

3) mini giddo hujetixxi bira sa'ne

4) ikkonoometixxi hunna

5) ardakee’n kexxaxa yanduwwa

6) Wele ----------

118. Edise illati wodda eetunteti HIV gorsatanna qore qo'nisa (qone) assitee egeudeetta'a?

1. eeti 2. Waawoo

119. edise ilati edo uunaammaxxi kittibuaatuwma adhdhinaamma'a?

1. eeti 2. Waawoo 3) gamisa

120. ilatixxi yanna geyati edi darre geltaaxxa qophpheefachcho assitaatta'a?

1. eeti 2. Waawo'o

121. Aro'i atik siilinxe yanna'ninna ilati unduma geltaaxxa kipha assaamma'a

1. eeti 2. Waawo'o

122. Belto atika ildeettek habatemma'a?

1. Fayyuntetike keellake fayyuntetixxe ekistenshinetike hujalluwwin axe kiphanni
2. Fayyuntetike xaabaa'n fayyuntetike ogeessixxe kiphanni
3. Hospitaalete'n
4. Ifixxe fayyuntetixxe inistituutenni
5. Mini giddo hobbaasanjot
6. Mini giddo firik
7. Mini giddo kiphaake hedhebaang

123. Qo'netinna kittibaatetixxa lao (huje) ildetteechchinne me'e yanna uduman belto atika alfitette?

1. Ettene barra'na
2. 24 saate giddo
3. Lame barra giddo
4. Torba giddo
5. Ilaanchummatenaan fuldettechchin uduma

6. Haranga alfebonon

124. siilinxe yanna’n ilati wodda yookin ilati uduma gelteexxe rakko maachchomma’a?

1. Wel sagerendeexxi yookin camemendeexxi dhibo
2. Gufatiyyo
3. Anno laattotixxi rewo (reyo)
4. Ondewogganni buttia’a hexxeexxa oosexxa reyo (reyo)
5. Ayirenetixxa itatixxa xe'ya

125. minenni ildettexxe kaddool fayyuntetixxe inistituutebaa meitaboxxashsha assiteexxi rakko maachchommaa?

1. Yanna uutabaaxxa ciniintonna ila
2. Ballo atixxe (miniinke annixxi ama) eeti uwwa gopha
3. Qeerraxxa yanna adhdhiteexxa mageno kadhatika seera
4. Boonnink bayyinni
5. Tarjinxxe ege'na heeno’ma
6. Ikonoometixxi hunna heeno'ma 7. Wele----------

126. loolinka fayyuntetike xaabaxa'n la’o alfiteexxexxe kaddoole hujeti (la’oti) jeeji atixxe uushshonni

1) hara heenoxxe 2. Heenoxxe 3. Oddittе 4. Lumoxxe 5. Hara lumoxxe

127. Annooletee uunaaxxa kittibaatuwwa atik belt yookin atixxi alfaamma (alfitaamma)?

1.eeti 2. Waawwoo 3. Saxxe-saxxe'a

128. Taakkeessoka jaana agenjon anno atixxae ununinxa ado callamma'a la'ofatammak (la'ofantctaammaxxi)

1. eeti 2. Waawwo'o 3.ununakanna wele hana lenbaaxxa ita 4. Lalinxxe ado calla

129. Fayyuntetixxi ogeeyyuwwa mikendeexxa ita uwwa hasissaaxxe gattabaaxxe kaddeexxa gorsiteetta'a ?

1. eeti 2. Waawwo'o

130. Edika jaana agenjuwwa unana atikixxa ado calla atixxebelto'a la'ofata baashsha assechchi

1. Fayyuutetixxi xe'ya 2. Tarjinxxenna barachchotixxe gonphe

3. aadatixxe hana fula (rakko) 4. Hujetixxe bira sa'ne 5. Wele_____

131. Anno laacco atixxee kittibaate amma-ammainni kitttibaate adhdhiyyo hoyyitaaxxi rakko ate'n gelteexxi-hexxee?

1. boonninxxe bayyuute 2. Ikkonoometixxi hunna gopha 3.minigiddixxi huje

4. Aadatixxi hanafula 5. Tarjinaxxi goophe (xe'ya)

132. Annolaatto atixxee mikendeexxi ita la'ofatatabashsha rakkotishasha gelteexxi

1. Ikkonoometixxi hunna 2. Tarjinxxa heeno'miyyo

3. Hujetixxi birasa'n 4. Aadatixxi hanafula

133. Amatike inunixxi la'o mikemeexxe itakk tarja alfitaattek habaanitemma?

1.fayuntetike ekistenshietike hujullowwii'n 2.fayyuntetike minixxe ogeeyyee'n 3.raadonete'n/televizyinet'en /maxxansendeexxe borroo'n 4. Ardi giddixxe mari'e'n 5.olo'a/ firake'n nna/ jaalokee'n 6. odonda laqebo'no

134. Annooletee uwwendaaxxa kitt bate kutatee assiteexxi

1. aadatik ciloominn ifayyeen hine additmaak baanqo (ufufuti) atika belto abiddoole

2. Olla'i giddo firi kittbaate adhdhabaashsha maloole

3. hujebira saxxoole 4. Wele_____

135. Mini hadixxi ikkonooecla qorqora iqo'nisaachcho ilaik bonchocho oosen (annoolae) laissatikinna kittibaatiti qarqaran aro'oatikinni welt haaso'oti, mitte murte'n geltinaamma'a ?

1. Eeti 2. Waawwo'o 3. Gamik 4. Aroi atikixxe murte calla ulffassendaomma'a

5.iffi'a calla mudhitaatta'a 6. Wele_____

136. Minnigiddo indaachchia gargar kaddeexxa fulchuww n atixxi qo'nena murteessetik koobbi atike aroinni welt herreggettowwodda

1.hara heenoxxe 2. Heenoxxe 3. oddítte 4. Lumoxxe 5. Hara lumoxxe

137. mootummatikenna mootummatike kaddebaaxxa organ attixxe ikkonoomexxe hunna nossaxee qusatixxinna liquffachchotixxi labki jeeja ege'nitatto?

1. eeti 2. Egenabo'no

138. 137^{xxa} qortumak hisssichchi "eeti"kaddoole, leenjo adhdhiteeta'a?

1. eeti 2. Waawwo'o

139.Looli giddo gargar- gargar hexxeexxe bakka'n hujje egendetta?

1.eeti 2.waawwo'o

140. Looli giddo affettexxe mittoominxxa ikkonooemetixxenna pooletik giddo affettexxi boonchi eleechon hite addatto?

1. eeti 2. Waawwo'o 3. Ege'nebo'non

Galateeffatannon

Declaration

I hereby declare that, the thesis entitled as " The Challenges of Implementing Reproductive Health and related programs: in the case of mokonisa rural kebele." has been carried out by me under the guidance of professor C.D Dash as part of Master Degree in Public Management and Policy specialized in Public Policy Studies.

I further declare that this thesis is my original work and has not been submitted to any other University or Institution for the award of any degree or diploma and all sources of material used for this thesis have been dully acknowledged.

Bereket Teshome _____ _____

Signature Date

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

C.D Dash (Prof .) _____ _____

Advisor Signature Date