

**Addis Ababa University**

**College of Development Studies**

**Centre for Regional and Local Development Studies**



**Inclusive Family Planning towards the Achievement of Agenda  
2030: The Case of Slum Households in Yeka Sub-City Of Addis  
Ababa**

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**Addis Ababa, Ethiopia**

**Addis Ababa University**

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## DECLARATION

I, **Selome Dereje Getahun**, declare that this thesis is my original work, prepared under the guidance of **Kumela Gudeta (PhD)**. All sources of materials used for the thesis have been duly acknowledged. I further confirm that the thesis has not been submitted either in part or in full to any other learning institution for the purpose of learning any degree.

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Signature

August, 2019

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## Contents

Acknowledgements .....	i
Contents .....	ii
List of Tables .....	iv
List of Figures .....	v
Acronyms .....	vi
Abstract .....	vii
CHAPTER ONE .....	1
INTRODUCTION .....	1
1.1 BACKGROUND OF THE STUDY .....	1
1.2 STATEMENT OF THE PROBLEM .....	4
1.3 OBJECTIVES OF THE STUDY.....	7
1.3.1 General Objective .....	7
1.3.2 Specific Objectives .....	7
1.4 RESEARCH QUESTIONS .....	7
1.5 SIGNIFICANCE OF THE STUDY.....	8
1.6 SCOPE OF THE STUDY .....	8
1.7 LIMITATIONS OF THE STUDY .....	9
CHAPTER TWO .....	10
LITERATURE REVIEW .....	10
2.1 REPRODUCTIVE HEALTH.....	10
2.2 FAMILY PLANNING .....	11
2.3 URBAN SLUMS .....	14
2.4 INCLUSIVE FAMILY PLANNING .....	16
2.5 DRIVERS OF INCLUSIVE FAMILY PLANNING .....	16
2.6 THEORETICAL FRAMEWORK.....	18
2.7 EMPIRICAL STUDIES OF FAMILY PLANNING IN ETHIOPIA .....	25
2.8 FAMILY PLANNING INTERVENTION .....	28
2.9 LEGAL AND INSTITUTIONAL FRAMEWORK OF FAMILY PLANNING IN ETHIOPIA .....	30
2.10 FAMILY PLANNING AND THE SDGs .....	36
2.11 CONCEPTUAL FRAMEWORK OF THE STUDY.....	39
CHAPTER THREE .....	46
RESEARCH METHODOLOGY .....	46
3.1 RESEARCH APPROACH .....	46
3.2 RESEARCH DESIGN .....	46
3.3 RESEARCH SITE SELECTION.....	47
3.3.1 Consultation with experts .....	47
3.3.2 Criteria for site selection.....	47
3.4 DESCRIPTION OF RESEARCH SITE.....	48
3.4.1 General overview of the sub-city.....	48
3.4.2 Description of study area .....	48
3.4.3 Sampling strategy .....	48

3.4.4 Sample size .....	49
3.4.5 Sampling method .....	50
3.5 UNITS OF ANALYSIS .....	50
3.6 DATA SOURCE .....	50
3.7 METHODS OF DATA COLLECTION .....	50
3.7.1 Household Survey .....	51
3.7.2 Direct Observation .....	51
3.7.3 Key informant interview .....	51
3.8 DATA MANAGEMENT .....	52
3.9 OPERATIONAL DEFINITION .....	52
3.10 METHODS OF DATA ANALYSIS .....	52
CHAPTER FOUR .....	54
4.1 DESCRIPTIVE ANALYSIS .....	54
4.1.1. Demographic characteristics of the sample respondents .....	54
4.1.2 Socio-economic characteristics of the sample respondents .....	56
4.1.3 Institutional characteristics of the study area .....	58
4.1.4 Contraceptive knowledge, attitude and decision practice .....	62
4.1.5 Family planning service accessibility and utilization .....	65
4.1.6 Religious and cultural beliefs .....	67
4.2 DRIVERS OF INCLUSIVE FAMILY PLANNING SERVICE .....	68
4.2.1 Macro level .....	70
4.2.2 Community level .....	70
4.2.3 Household level .....	70
4.3 DETERMINANTS OF USE OF FAMILY PLANNING SERVICE .....	73
4.3.1 Household level .....	73
4.4 FAMILY PLANNING INTERVENTION MODEL .....	79
4.4.1 Service provision .....	79
4.4.2 Policy .....	86
4.4.3 Strategy .....	91
4.4.4 FP Guideline .....	95
CHAPTER FIVE .....	99
CONCLUSION AND RECOMMENDATIONS .....	99
5.1 CONCLUSION .....	99
5.2 RECOMMENDATIONS .....	102
REFERENCES .....	104
Annexes .....	115
Annex 2- Interview guide for key informants .....	122

## List of Tables

Table 1: Family planning use by age of sample respondents .....	54
Table 2: Family planning use by marital status and main occupation of sample respondents .....	55
Table 3: FP use by level of education of sample respondents .....	56
Table 4: Family planning use by income and expenditure of sample respondents.....	58

## List of Figures

Figure 1: Conceptual framework of the study .....	39
FIGURE 2: MAP OF YEKA SUB-CITY .....	47
FIGURE 3: SAMPLING TECHNIQUES AND PROCEDURE .....	49
FIGURE 4: HOUSES IN SENGERO SUB-DISTRICT BUILT ON STEEP SLOPE .....	58
FIGURE 5: HOUSES WITHOUT ADEQUATE SHELTER.....	59
FIGURE 6: CURRENT USE OF FAMILY PLANNING METHODS .....	63
FIGURE 7: CURRENT USE OF FAMILY PLANNING METHODS BY SAMPLE RESPONDENTS .....	64
Figure 8: Influence of level of education on FP utilization as per sample respondents.....	74
Figure 9: Influence of medical barriers and fear of side effects on utilization of family planning services as per sample respondents.....	75
Figure 10: Influence of Partner's approval/disapproval on FP utilization as per sample respondents .....	75
Figure 11: Influence of decision making on FP utilization as per sample respondents.....	76
Figure 12: Influence of fertility norms on FP utilization as per sample respondents .....	77
Figure 13: Influence of service providers' bias/attitude of health workers on FP utilization as per sample respondents.....	78

## Acronyms

CSA	Central Statistical Agency
DFID	Department for International Development
DHS	Demographic and Health Survey
DTM	Demographic Transition Model
EH	Engender Health
FGA	Family Guidance Association
FP	Family Planning
GDP	Gross Domestic Product
HIV	Human Immune deficiency Virus
IUDs	Intrauterine Device
CPR	Contraceptive Prevalence Rate
FMoH	Federal Ministry of Health
GTP	Growth and Transformation Plan
HSTP	Health Sector Transformation plan
MDGs	Millennium Development Goals
MSIE	Marie Stops International Ethiopia
NGOs	Non-governmental Organizations
PMA	Performance Monitoring and Accountability
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
SSA	Sub- Saharan Africa
STI	Sexually Transmitted Infections
UHEWs	Urban Health Extension Workers
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	United States Aid for Development
WHO	World Health Organisation

## **Abstract**

*The international community has long agreed that every individual has the right to health, and that Reproductive Health including Family Planning is a fundamental right of all people. The rights-based approach of Family Planning calls on providers and programs to focus on the needs of hard-to-reach and marginalized groups, removing unnecessary eligibility requirements that exclude clients based on age, marital status, etc. and incorporating interventions at the policy, community, and individual levels. Contraceptives are available in Ethiopia. Persistently high fertility rates indicate that women fail to use effective contraceptives. Drivers for use of inclusive family planning services need to be identified in order to enable more Ethiopian women to access and utilize contraceptives. The Sustainable Development Goals Report 2018 shows that, in some areas, the progress is insufficient to meet the Agenda's goals and targets by 2030. This is especially true for the most disadvantaged and marginalized groups like urban slums. Therefore, this study has examined the level of family planning utilization and the drivers of inclusive family planning in urban slums. The study evaluated the approach and contribution of family planning intervention model in enhancing the livelihood of urban slums. The study was conducted in the slum area of woreda 4 with in Yeka sub-city of Addis Ababa. For this purpose, 287 women of reproductive age group were selected from the slum areas using multi-stage sampling technique and survey was conducted. Descriptive method was employed to analyze the level of family planning utilization and the drivers of inclusive family planning. In addition to the survey, key informant interview and direct observation were also employed to further explore and triangulate the data obtained about the drivers of inclusive family planning and to evaluate the family planning intervention model. The study revealed that the level of family planning utilization by the slum households was very low. The most important drivers of inclusive family planning were found to be Media, Availability of facilities and family planning methods, Individuals' behaviors and attitudes, Government support, donor support, non-governmental and public-private partnerships and the Health Extension Program and Youth friendly clinic (e.g. Privacy). The study revealed that there are a number of gaps and challenges observed in the family planning intervention model some of which are lack of training of service providers and Urban Health extension workers, lack of accountability by the Urban Health extension workers, the Urban Health extension Programme being not fit for purpose and doesn't capture the dynamics of social problem, absence of multiple service delivery channels, lack of peer led approach at the facility, very low policy support for community engagement in slum area, government not giving a priority to FP which implies sectorial level marginalization besides to the community level marginalization in the slum area and others. The study forwarded recommendations for the government, policy makers, service providers and different partners working on FP to consider and to work for better access and utilization of family planning and most importantly for inclusive family planning service which will hasten the progress towards the achievement of Agenda 2030.*

*Key words: Inclusive family planning, rights based approach, disadvantaged and marginalized groups, urban slums, family planning intervention model and agenda 2030.*

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the study

Urbanization has been one of the most significant driving forces of recent global development, with more than half of the world's population now living in cities. For instance, estimates indicate that about 5 billion people will live in cities by 2030; putting huge pressure on infrastructures, such as health, water, sanitation, and education (UNFPA, 2016).

The 2030 Agenda is an important political consensus document declaring the intent to work collectively towards achieving people-centered sustainable development (Darroch and Singh, 2013). Thus, at global level, SDG Goal (11) envision making cities inclusive, safe, resilient and sustainable with one of the targets giving emphasis for slums i.e to ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums by 2030 with performance indicator of proportion of urban population living in slums, informal settlements or inadequate housing to tackle urban poverty in informal settlements.

Although the proportion of the global urban population living in slums dropped from 28.4 per cent to 22.8 per cent between 2000 and 2014, the actual number of people living in slums has increased from 807 million to 883 million (UN, 2018), Consequently urban poverty concentrated in informal settlements or slums occurs at a time of rapid population growth of cities where governments fail to provide infrastructure and employment opportunities. One of the characteristic of slums is illegality especially the lack of formalized tenure by reason of lack of formal recognition in terms of registered address regularly leading to social and economic exclusion and encounter different forms of deprivation (Mrkel and Otai, 2007).

The above report states that the Sub-Saharan Africa (SSA) region ranked as third accounting (189 million) people living in slum. The trend also shows that the slum

settlements in this region doubled from 103 million to 200 million (UN-HABITAT, 2013). From spatial distribution dimension, cities are more unequal than rural areas, and are struggling to keep pace with rapid population growth in terms of necessary infrastructure. As a consequence, roughly one in three urban residents in Asia and Africa live in slums with very limited access to basic services, including health and family planning services, clean water, sanitation and education (UN-HABITAT, 2013). The drivers for the rapid urban population growth in SSA are high natural increase, which accounts for about 75 percent of the region's urban growth, while rural-to-urban migration accounts for only 25 percent (UNFPA, 2016). Besides, childbearing among the city residents living in poverty is often mistimed or unwanted leading to high rates of unintended births suggesting high unmet need for family planning or lack access to family planning methods and also services (UNFPA, 2016).

The facts and figures stated in the above paragraph implies the rapid population growth and the demographic dividend puts inclusiveness a key in making sure of taking advantage of demographic dividend in the next decades in particular for sub-Saharan Africa. The concept of inclusiveness gives emphasis on the needs of disadvantaged and marginalized people. Besides, the role of inclusiveness is important because growth and development are not evenly distributed across sectors and regions (Johnson and Anderson, 2012). Hence, legal entity is an important dimension of inclusiveness in particular for the slum residents as it has implications to accessing benefits and opportunities from public resources, particularly for the most marginalized and vulnerable communities, Consequently slums can also be characterized by overcrowding, poor environmental conditions, insecurity, and few or no basic social services (UN-HABITAT, 2013).

While reports state urban fertility has fallen in recent years, urban unmet need for modern contraception and unwanted fertility are high, and the rapid growth in the number of adolescents and other disadvantaged subgroups living in cities translates into enormous needs for targeted sexual and reproductive health services. While urban areas generally offer a wider range of health care services, including pharmacies and drug shops, than rural areas, there are still important barriers to Family Planning access in urban contexts (Ezeh, Kodzi, Emina, 2010). While inequality has been studied at the macroeconomic level, the impact of inequality on cities has been less well addressed (Stiglitz, Piketty, Kanbur, 2013). Universal access to family planning services should be an integral part of

efforts aimed at building sustainable cities and economic prosperity for all and more specifically has implications for gender equity, women's economic empowerment, and on demographic dividend. The international community has long agreed that every individual has the right to health, and that Reproductive Health including Family Planning is a fundamental right of all people. The rights-based approach of Family Planning calls on providers and programs to focus on the needs of hard-to-reach and marginalized groups, removing unnecessary eligibility requirements that exclude clients based on age, marital status, etc. and incorporating interventions at the policy, community, and individual levels.

The previous paragraphs set the overall picture about the situation of slums and family planning problems showing its nature and magnitude with facts and the envisioned goals to address them at global and SSA region. The next two paragraphs establish the situation in Ethiopia (Addis Ababa) as setting the floor to state the statement of the problem for this research.

Ethiopia comprises 80 percent of the country's urban population. The World Health Organization (WHO) estimates that more than half of the population lives more than 10 kilometers (6.2 miles) away from the nearest health facility, usually in regions with poor transportation infrastructure (UN-HABITAT, 2013). The capital, Addis Ababa, has now become one of the fastest growing cities in the world. Despite this fast growth, the city faces an enormous challenge to deliver accommodation to the urban dwellers living in poverty. Currently, 80% of housing in Addis Ababa is considered as informal; this implies that a large number of population lives in inadequate houses with several problems such as bad hygienic conditions, overcrowded spaces and lack of the basic amenities (UN-HABITAT, 2013).

Considering these pressing development problems, it is vital to highlight, the national level policy interventions that aim to address the unmet family planning and slum problems in Ethiopia. With regard to family planning, in response to the need to provide guidance for implementing National Health Sector Transformation Plan (HSTP), the National RH Strategy is developed pertaining Reproductive Health issues. This strategy stepped up the implementation of the three component strategic plans of which one is Family Planning and fertility contingent upon the implementation of the HSTP which is part of the second Growth and Transformation Plan (GTP-II) of the country. Another important milestone in the effort towards slums shows some of the slums have been transformed and the residents have moved into newly developed housing delivered under

the pro-poor condominium scheme. However, there are strong indications that this upgrading program is failing in meeting its important goal of providing houses for the poor due to inability to financially access the scheme. Despite the progress made in upgrading slum areas, there are still a number of slum areas where upgrading or re-development has never been planned.

## **1.2 Statement of the problem**

Challenges of Human capital in development arena in particular in the health sector such as reducing infant and child mortality, increasing the use of contraception, and reducing fertility rates has shown progress as of the strong investments in over the last 10 years in Ethiopia. But it is pertinent not to overlook the fertility and population growth rates that remain at 4.1 and 2.6 percent, respectively (UNFPA, 2016). The continuing efforts of lowering fertility and shifting the age structure are still important first steps towards achieving a demographic dividend and meeting the country's development goals.

The rapid progress in increasing modern Contraceptive Prevalence Rate (mCPR) which is 35% based on EDHS 2016 is impressive, but wide disparities between the richest and poorest quintiles may have adverse effects on economic opportunity among the poor. The degrees to which countries prioritize family planning equity in their national strategies varies but meeting the existing demand for family planning, particularly among a country's poorest quintile, significantly accelerate progress in increasing overall mCPR and closing the gap between the richest and poorest quintiles. Although rigorous studies on the approaches that specifically target the equity gap are limited, several important lessons are emerging (USAID, 2018).

Family Planning contributes to Building Safe, Resilient, and Sustainable Cities. It is not only rapid population growth, but rapid urbanization that is causing problems for the poorest countries (Stephenson, Newman, Mayhew, 2010). The assumption that urban dwellers have better access to family planning information and services than rural populations, in actual instances, this is not the case (Ezeh, Kodzi, Emina, 2010). Although coverage is an important indicator, meeting unmet needs and ensuring universal access to human rights-based Family Planning will not be achieved without addressing equity issues. Living up to the commitment of the international community to achieve universal access to reproductive health by 2030 will require intensified support for family planning.

Few studies were conducted in slums with different areas of focus. More than a decade ago, Mulumebet (2006) studied the contributing factors to adolescents' reproductive behavior and prevalence of contraceptive use in the slum. Adequacy of anti-natal care services was studied by Tebekaw et.al (2016) that resembles another study by Mirgissa et.al (2017) on the reasons why urban women fail to use available maternal health anti-natal care and post- natal care services in selected six urban settings in Ethiopia. Utilization of health facilities and predictors of health-seeking behavior for under-five children with acute diarrhea in slums of Addis Ababa is another study by Metadel, Bezatu, Worku, Helmut and Girmay (2017).

On one hand, these studies are important in stirring evidence and insights on the topic of reproductive health and family planning in urban slums. On the other hand as of many reasons, there are limitations in terms of focus on restricted age group, particular focus on wider aspects of reproductive health and less attention or omitting either extent, utilization, or determinants for the use of family planning, drivers for inclusive family planning at different levels starting from micro to macro level and gaps/considerations of slum areas in the national policy/strategy which this study targets to address. These limitations as a backdrop, justifications for each dimension are discussed hereunder.

Contraceptives are available in Ethiopia. Persistently high fertility rates indicate that women fail to use effective contraceptives. Drivers for use of family planning services need to be identified in order to enable more Ethiopian women to access and utilize contraceptives. The SDG Report 2018 shows that, in some areas, the progress is insufficient to meet the Agenda's goals and targets by 2030. This is especially true for the most disadvantaged and marginalized groups like urban slums. Hence it is essential to study the extent of the use and also the drivers of family planning among women of reproductive age especially in the urban slums in tackling the problem of unmet need for Family Planning. This paves the way for the improvement of the prevailing socioeconomic problems at country level and particularly, it would have a substantial contribution in the improvement of the health status of women and children (USAID, 2018).

Improving access to voluntary Family Planning services among slum dwellers play a key role in reducing the growth of slums in the country and can bring transformational benefits to the women, families, communities and to the country as a whole. Identifying the drivers

of inclusive Family Planning in urban slums at the structural, systemic and behavioral levels from both supply and demand side is very critical putting the concept of inclusiveness in the core of the situation.

As a concept, Inclusive family planning is a modest increment. However, a small step in the right direction may help to open doors for vulnerable and marginalized groups, enhancing their access to family planning, both through facilitating demand from a broader range of people and through facilitating supply from a broader range of service providers. The idea of inclusion in this study is based on the belief that all people in society are entitled to share in society's benefits and resources. It means that people who in the past have been placed at the margins of society should live as part of their communities, benefit from the facilities many of us take for granted and share the services (including health services) that all other people use.

Thus, justifications for investigating reproductive behavior at household level in terms of demographic, socioeconomic and institutional determinants for the use of FP and why inclusiveness of the FP services is so vital is presented above. However, disclosing this in isolation would trick the insight for finding durable solution as there are systemic and structural dimensions at macro level about urban slums and FP interventions.

Thus it is pertinent to examine the policy framework and logic behind approaches of the interventions in terms of the outcomes of inclusiveness; the extent and potential of enhancing wellbeing and, power and promoting sustainability as outcomes. Consequently examining rooms in the policy/strategy to adopt appropriate governance instruments; assessing the policy and practice environment for transforming towards interactive and adaptive governance and the feedback loop to incorporate best practices not only from state actors but also non state actors including the epistemic communities. This goes in line with the fact that the Ethiopia National Guideline for Family Planning services has not been revised in line with HSTP and Growth and Transformation Plan-II (GTP-II). The factors responsible for the high unmet need in particular population groups will differ by context and guidelines will need to be modified accordingly for more inclusiveness and tangible result.

## **1.3 Objectives of the Study**

### **1.3.1 General Objective**

To assess the extent and drivers of inclusive family planning service in the road towards Agenda 2030

### **1.3.2 Specific Objectives**

- 1) To assess the level of utilization of family planning service among slum households in Yeka sub-city of Addis Ababa
- 2) To identify the drivers of inclusive family planning service at different levels (households, community and national level)
- 3) To evaluate the contribution and approach of the intervention model of family planning at urban slums for enhancing livelihoods of households

## **1.4 Research questions**

1. What is the current extent of utilization of family planning service among slum households in Yeka sub-city of Addis Ababa?
2. What are the drivers that facilitate inclusive family planning service from the micro to macro level?
3. What are the strengths and drawbacks of the approach of the intervention model of family planning towards urban slums and how does it contribute to the enhancement of the slum households?

## **1.5 Significance of the study**

Decades of research and interventions on urban health and ‘healthy cities’ in the global south have tended to focus on environmental health and when they have ventured into reproductive related health services tended to focus on HIV/AIDS. Family planning research and programs have largely ignored the specificities of marginalized and vulnerable urban populations and the complexities of urban governance.

This study fills the research gap in urban slums context, by assessing the extent of utilization of family planning service. It increases the attention paid to family planning, fertility and population growth in urban development policy discussions and initiatives, with a particular focus on inclusive and sustainable cities (SDG 11 “Make cities and human settlements inclusive, safe, resilient and sustainable”). The study contributes to the evidence base needed to better meet the FP needs of the most vulnerable in urban slums.

By identifying the drivers of inclusive family planning service at different levels including the socio-cultural and policy environment and also by evaluating the national guideline for FP services, the study can generate evidence with the intention of informing not just academics but also government policy makers, “think tanks,” and other actors involved in urban policy and welfare, with the ultimate goal of improving policy and programmes.

Lastly, by evaluating the intervention model, the study adds value and clarity on the gap, identifying the strength and weakness and providing better insight on improving it.

## **1.6 Scope of the Study**

The scope of this study is from the individual up to the policy level to assess the utilization and also the drivers of family planning use at the structural, systemic and behavioral levels.

From the 10 sub-cities of Addis Ababa, the study focused on one sub-city (Yeka) as it is not possible to conduct a study at all 10 sub-cities as this requires substantial time and resource. From Yeka sub-city, the study focused on one woreda (woreda 4) where a wide

range of slum dwellers reside, and the theme of the study is limited on assessing the extent of use, drivers and on evaluation of the national guideline for family planning.

From the components of sexual and reproductive health services, the study focused on family planning only since Reproductive Health is a very wide area which includes Abortion, Maternal, neonatal and other services which need longer time and resource to cover in a study.

### **1.7 Limitations of the study**

The lack of slum/non-slum disaggregated data is the most compelling limitation of this study. Unavailability of literature on the area of inclusiveness and slum households is also another significant challenge.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

This chapter discusses the theoretical and conceptual issues used to frame the study. The chapter discusses first about the reproductive health focusing on family planning, inclusiveness of family planning, the issues in urban slums and the drivers of inclusive family planning. The benefits of FP are also covered under this section. It is then followed by discussion on different theories and approaches of family planning and review of different empirical studies of FP in Ethiopia. The family planning intervention is discussed at different levels and this is followed by the legal and institutional frameworks in Ethiopia. How FP can positively influence and advance the SDGs is also discussed under this section. Finally the conceptual framework of the study is discussed focusing on the determinant factors of family planning use at individual, couple and family, service accessibility and socio-cultural and policy environment level.

#### **2.1 Reproductive Health**

Within the framework of the World Health Organization's (WHO's) definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life (WHO, 2008).

Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant. Individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health (Hall, Moreau and Trussell, 2012).

## **2.2 Family Planning**

Family planning is defined as having the freedom and responsibility of all the couples and the individuals to decide the number of children they desire and having the knowledge, education and tools for this purpose (WHO, 2008). In other words, family planning is a preventive service that allows married couples achieving their desired number of children and deciding the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health (WHO, 2008).

Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods. Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilization, male sterilization, the intrauterine contraceptive Device (IUD), implants, injectable, the pill, male condoms, female condoms, emergency contraception, Standard Days Method (SDM), and Lactational Amenorrhea Method (LAM). Methods such as rhythm, withdrawal, and folk methods are grouped as traditional (EDHS, 2016).

### **Benefits of Family Planning**

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility (WHO, 2015). A large and growing body of literature explores the social and economic benefits of women's ability to use reliable contraception to plan whether and when to have children (Sonfield et al, 2013). Compared to other interventions, investments in family planning have been shown to be highly cost effective. It is inexpensive and the return on investment is high. Family planning interventions have powerful poverty reduction effects in addition to providing health and human rights benefits (Bongaarts and Sinding, 2011).

Cleland et al (2006) explains that the promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and prevent 32% of all maternal deaths and nearly 10% of childhood deaths. It would also substantially contribute to the empowerment of women, achievement of universal primary schooling, and long-term environmental sustainability. Over the last 40 years, family planning programmes have

played a key part in raising the prevalence of contraceptive practice from less than 10% to 60% and reducing fertility in developing countries from six to about three births per woman. However, in half of the 75 larger low-income and lower-middle income countries (mainly in Africa), contraceptive practice remains low and fertility, population growth, and unmet need for family planning are high (Cleland et al, 2006).

Investing in family planning is one of the smart investments for development as population dynamics have a fundamental influence on the pillars of Sustainable Development (Zenawi, 2012). It is a balance and check for economic development and overall population growth and increases the capability of developing countries to provide all citizens with the required services including priority health services and adequate education. If high fertility rates continue to flourish among the poor, poverty will create a vicious circle as poor women and their families lose the opportunity to move successfully through education and into productive employment among others, including contributing to a more sustainable environment and reductions in pollution of all forms.

### **Family planning in Ethiopia**

In developing countries, millions of women in the reproductive age group, who don't use contraceptives, prefer to postpone or limit giving births. This demonstrates a mismatch between contraceptive behavior and fertility preferences indicating women's inability to take the necessary decisions to prevent and avoid unwanted pregnancy (Malwenna et al, 2012). On the other hand, uptake of modern family planning services has been slowly increasing in SSA including Ethiopia. The low uptake can result in a high incidence of unintended pregnancies, rapid population growth, unsafe abortions, and maternal deaths (FP2020, 2016, Cate et al, 2015). Globally, 13% of maternal deaths occur due to unsafe abortion (WHO, 2010).

Ethiopia's population has doubled in the last 28 years, as a result of rapidly declining mortality rates and slower declining fertility rates, from around 50 million in 1991 to 102 million in 2016 (UNFPA, 2016). If the current fertility trend continues, the country's population is likely to double again in the next 30 years to reach 209 million in 2050 (UN, 2015). However, with increased investments in family planning, health, education and economic growth, Ethiopia's population growth will slow down, and the country is now

estimated to have a population of around 169 million by 2050 - 40 million less people than the scenario projected on the basis of the current trend (UN, 2015).

To benefit from the demographic dividend, Ethiopia needs to strategically invest in family planning, education and skills and economic policies. The changes in the mortality and fertility rates are changing the population age-structure in Ethiopia. The percentage of productive-age people (15-64 years of age) has risen in Ethiopia from 50% in 2000 to 55% in 2015 (the future Groups International, 2015), and is likely to increase further. Therefore, now is the time when Ethiopia could begin to benefit from the demographic transition. But full realization of this 'demographic transition' into 'demographic dividend' will largely depend on the policies that Ethiopia chooses and implements in the next 10 years.

If Ethiopia fails to respond to demographic change, it is likely to end up with a large number of young, working-age people who are either unemployed or underemployed. This, in turn, could lead to increased internal conflict, political and economic instability. Increased investments in family planning/health, education/skills and economic policies is likely to increase Ethiopia's Gross Domestic Product faster than a policy option of only investing on economic/growth sector (the future Groups International, 2015) .

Ethiopia started from a low level of family planning use. Therefore, despite progress, the country has a high unmet need for family planning. Ethiopia has around 16 million women in union in the reproductive age group. Of these, around 6 million (35%) women are using family planning methods, and over 3.5 million (22%) women have need for a family planning method but are currently not using any method because of various barriers such as fear of side-effects (21%), fatalistic attitude (8%), lack of knowledge and access (7%), religious prohibition (5%) and opposition from partner (5%) (EDHS, 2016).

The unmet need for contraceptives varies significantly by age, location, education and income. While unmet need for spacing births is highest among adolescents, unmet need for limiting births is highest among elderly women. Also, adolescents and youths represent over one-third of Ethiopia's population and are amongst the most vulnerable to early marriage, unwanted pregnancy and maternal mortality. Early marriage is closely correlated with school dropout and early pregnancy (FMoH, 2015). Sexually active

adolescents, whether married or not, face barriers related to access, quality, and cost of contraceptive services. And the ability of family planning to reduce maternal deaths can only be realized if the poorest individuals and those with unmet need are reached on a wide scale.

The current use of modern family planning methods utilization still remains low. It is, therefore, important to better understand the factors that affect modern family planning method use in all reproductive age group women in Ethiopia. Several studies have been conducted on determinants of family planning use in developing countries. In some cases, strong associations have been established between family planning use and some socio-demographic, cultural and economic characteristics of women (Yihunie et al, 2013; Bbaale et al, 2011; Malalu, 2014; Gizaw, 2011). Partner/husband discussion about family planning methods is a major factor influencing family planning use. Findings from other studies revealed that most women who have discussed with their partner/husband actually used some methods compared to those who did not (Malalu, 2014; Gizaw, 2011).

The SDGs make specific references to family planning in regard to health and well-being, gender equality and women's empowerment. Ensuring that all women and adolescent girls have access to high-quality, rights-based family planning services contributes towards achieving these goals and realizing targets related to other SDGs. Accelerated fertility decline through effective family planning programmes slows rapid population growth, contributing towards the SDGs related to the economy, environment and development (FP2020, 2016).

### **2.3 Urban slums**

Since it first appeared in the 1820s, the word slum has been used to identify the poorest quality housing, and the most unsanitary conditions; a refuge for marginal activities including crime, 'vice' and drug abuse; a likely source for many epidemics that ravaged urban areas; a place apart from all that was decent and wholesome. Today, the catchall term "slum" is loose and deprecatory (UN-HABITAT, 2015). It has many connotations and meanings and is seldom used by the more sensitive, politically correct, and academically rigorous. But in developing countries, the word lacks the pejorative and divisive original connotation, and simply refers to lower quality or informal housing. The

term “slum” is used in this study to describe a wide range of low-income settlements and poor human living conditions.

Slums in the traditional sense are housing areas that were once respectable – even desirable – but which deteriorated after the original dwellers moved on to new and better parts of the city. The condition of the old homes declined as they were progressively subdivided and rented out to lower income people. Today, slums have come to include the vast informal settlements that are quickly becoming the most visible manifestation of urban poverty in developing world cities. Such settlements are known by many different names and are characterized by a variety of tenure arrangements. In all cases, however, the buildings found there vary from the simplest shack to permanent and sometimes surprisingly well-maintained structures, but what most slums share in common is a lack of clean water, electricity, sanitation and other basic services. The growth of slums, which are characterized by overcrowding, social and economic marginalization, poor environmental conditions, insecurity, and little or no basic social services, has been linked to appreciable deterioration of key urban health and social indicators and reversals in favor of rural areas (Ezeh et.al, 2010). In particular, the new face of urban poverty has been linked to adverse Sexual and Reproductive Health (SRH) outcomes for the urban poor such as high rates of unwanted pregnancies, higher fertility, STIs, and poor maternal and child health outcomes.

As SSA becomes more and more urbanized, the fate of the urban-poor majority will increasingly define indicators and progress toward national and international development goals in the region. On average, those city residents living in poverty exhibit poorer reproductive health outcomes than their wealthier counter parts. These diminished outcomes are largely preventable by means of effective access to affordable family planning services. With high levels of unmet need for family planning and high rates of mistimed or unwanted fertility, a large demand exists for effective family planning programs among slum residents. Meeting this demand will not only improve their reproductive health but also contribute significantly to slowing the high rates of natural increase accounting for much of the growth of urban populations in SSA (UNFPA, 2016). Responding to the unmet need for family planning services among city dwellers living in poverty requires innovative strategies that build on the unique advantages of implementing

effective programs in these communities. Strengthening community-based programs and implementing new targeted interventions may be effective strategies for reaching the urban poor (UNFPA, 2016).

The point is made that many of the worst human problems, including poor health, play out together in city slums. The positive implications of effective SRH programs for maternal and child survival, morbidity and mortality outcomes have been well documented. Effective SRH programs have provided a win–win solution not only on the improved welfare of individual women and children but also on national economies and the physical environment (UNFPA, 2016).

## **2.4 Inclusive family planning**

Inclusive family planning, as a term, is an attempt to help people to think a bit more and perhaps, a bit differently, about what family planning is for, how it is delivered and who deserves to get it. Inclusive family planning seeks to build on the idea of family planning for all and to strengthen it through the rights-based approach; to stress the need for more active inclusion by recognizing those who are in need; overcome the barriers to address these needs; and to utilize a much greater range of family planning service delivery options embodied. Promoting inclusion is about helping people who have previously been excluded from mainstream society to get connected (or reconnected) with the wider community. It requires us to pay attention to all aspects of a person's life and support him or her to take part in the things that give life purpose. Closely allied to Inclusion is the need for anti-discriminatory practice. People may be discriminated out from the access to family planning service because of different factors like age, sex, socio-economic status, educational status, disability etc (World Bank, 2013).

## **2.5 Drivers of inclusive family planning**

The drivers of inclusive family planning utilization are a set of multiple factors which range from individual, community to factors at the policy level (Wulifan et al, 2016).

At the individual level, behaviors and attitudes play an important role among the choice of using family planning methods and so it effects the change of fertility status and population rate indirectly. In order to promote the usage of an effective method, attitudes

and behaviors play an important role on preference of choosing a family planning method. The identification of attitudes that affect the use of the family planning method by individuals is an important factor contributing to the scheduling of family planning services (Nazil et al, 2018).

Individuals' attitudes for family planning methods are influenced by some characteristics, such as economic factors, socio-cultural factors, environmental factors, location, age, educational, traditional beliefs, religion, family type and level of knowledge. It is known that these factors have effects on turning the attitudes into behaviors. Attitude is a notional concept and although it cannot be observed directly, the effects on behavior are well known (Nazil et al, 2018). Gender norms that justify men's control over women, partner education, fertility desire, child mortality and age at first marriage can also be a determinant factor for family planning use (Nazil et al, 2018).

Communication with husband and close family members, community wealth level, community childcare burden and exposure to mass media family planning messages can also be mentioned under the factors contributing for family planning use at the community level (Wulifan et al, 2016).

At the macro level, political will, generous donor support, nongovernmental and public-private partnerships and the Health Extension Program can play a significant role. Political will, which is initiated and sustained with evidence informed advocacy, has been the most critical factor to Family Planning policy adoption and program implementation (Wulifan et al, 2016). Political will and commitment to Family Planning leads to an enabling environment for development of Family Planning policies and guidelines, and implementation of national Family Planning programs, which are supported by implementing agencies. A key consequence of having strong political will and commitment to family planning has been increased mobilization of financial and technical resources to support the design and implementation of programs. NGOs play an instrumental role in building service delivery, behavior-change communication via mass media, and building the capacity of government. The government played a strategic leadership role in developing the family planning program, and the NGOs communicated issues through NGO platforms. A major focus of NGO work has been the procurement, management, and distribution of family planning commodities (Wulifan et al, 2016).

## 2.6 Theoretical framework

The year 2007 marked the world's transition from a primarily rural sphere to a largely urban domain. Despite its status as the world's least urbanized region, SSA currently has the fastest rate of urban growth in the world at between 3 and 4 % per annum (Rutenberg 2003; Brockerhoff). Evidence concerning the sources of urban population growth suggests that much of this increase in less developed countries is due to natural population growth, the difference between fertility and mortality rates in urban areas, rather than to migration from rural to urban areas or other determinants. The proportion of urban growth due to natural increase alone is estimated to be about 60 percent on average in developing countries (Chen et al. 1998; UNFPA 2007), but is 75 per cent in sub-Saharan Africa (migration accounts for much of the remaining 25 percent) of urban growth in sub-Saharan Africa (Brockerhoff 2000).

An important but largely neglected dimension of urban fertility dynamics is the reproductive outcomes of urban populations living in poverty. Social development in urban areas, especially expansion of infrastructure (such as roads, housing, and sanitation) and investments in health and education, have not kept pace with urban population growth in many sub-Saharan African countries. As African economies experienced decades of economic stagnation and poor governance, the unprecedented growth of urban populations created a new face of poverty characterized by significant numbers of people living in informal settlements or slums (Brockerhoff and Brennan 1998). Today, two-thirds of Africa's urban population lives in informal settlements (World Bank 2000; UN Habitat 2001 and 2003; APHRC 2002a).

The negative association between urban residence and fertility has been firmly established in the demographic literature (Brockerhoff and Brennan 1998; Kirk and Pil let 1998; Shapiro and Tambashe 2002; Demographic and Health Survey country reports). Attention to the details of the processes through which urban residence affects population and health outcomes is relatively new (Chen et al. 1998; Montgomery et al. 2003; Montgomery and Hewett 2005; White et al. 2008; Montgomery 2009). In particular, the influences of urban poverty on fertility outcomes are still poorly understood. This situation is partially attributable to the assumption that urban residence is associated with extensive exposure to ideation regarding fertility regulation, a higher cost of rearing children, and better access

to reproductive and other health services and information (Mark, 2009). Here in this study, it is argued that this is not the case for the poor in most urban areas in SSA.

Results from DHSs and several published works show that the levels of key fertility indicators among the urban people who are living in poverty are significantly worse than those of the better-off counterparts (Mark, 2009). The problem partly stems from several barriers the urban people living in poverty face in accessing high quality family planning services. Some of these barriers are examined in light of prospects for reaching the SDG target of universal access to reproductive health services in SSA (Mark, 2009). Little is known about how the poor in many urban societies are particularly disadvantaged in access to reproductive health services, because much of the literature has focused on broader rural-urban disparities. More importantly, the recent trends of stalls in aggregate fertility levels and in contraceptive prevalence in some countries make examining the fertility and contraceptive dynamics in urban SSA a matter of urgency (Mark, 2009).

#### **‘Social capillarity’**

Arsene Dumont is an exponent of the theory of 'Social Capillarity'. In his view, the works of Economists, Philosophers and Historians are not relevant in the study of Population. Various statistical data, firsthand information etc., of the universe under research are vital. He himself carried out research in latter part of the nineteenth century, and went village to village of France to collect data to find out causes of fertility. Dumont's principle of 'social capillarity' was applied to highly modern societies. This he imagines that all societies have hierarchy of social status. In his opinion inclination for change from one stratum to the other was direct cause of decrease in population. He did not agree with Spencer of that change in rate of population was result of biological changes. He did believe that his principle of social capillarity is relevant to all civilized societies, but rigid barriers of caste and status prevent upward social movement. In such societies, for example in India, rate of fertility is very high, because movement from one class to other was highly restricted. This theory was, however, criticized on the ground that it was not backed by sound statistical proof. But it is the credit of Dumont that he emphasized the need for investigating individual attitude in their social context in order to determine national population trends (Billingsley, 2019).

## **Capabilities approach**

The capabilities approach as elaborated initially by Amartya Sen represents a powerful critique of measurements of welfare based on utility. This approach draws on a liberal philosophical framework emphasizing the importance of the well-being of the individual in terms of what he or she is able to do and become and the kind of life he or she is able to lead. In this view, individual capabilities are buttressed by so-called “social arrangements” (e.g. Sen 1993) which either support or deny their capabilities. Nussbaum (2000) has further developed the capabilities framework with a particular focus on women’s capabilities in developing countries. She distinguishes between: 1) “basic capabilities” generally innate from birth; 2) “internal capabilities” which are developed states of the person; 3) 2 “combined capabilities” which require an appropriate political, economic and social environment for their exercise (Nussbaum 2000: 84-5).

The capability approach entails broadening the constituencies to which family planning services are addressed to include not only women in the childbearing age but also those adolescents. Family Planning services that have long been restricted to women should, it argues, open their doors to men. But the approach also makes a claim for inter-sectorial action to address gender inequality in social development more broadly. According to Sen’s capabilities approach, policies should be evaluated not in their ability to satisfy utility or increase income, but to the extent that they enhance the capabilities of individuals and their ability to perform socially accepted functioning. Functioning’s are the “beings and doings” of a person whereas capabilities are “the various combinations of functioning’s that a person can achieve. Capability is thus a set of vectors of functioning’s, reflecting the person’s freedom to lead one type of life or another (Sen 1992: 40). In terms of reproductive health, therefore, capabilities would embrace such concepts as the ability to have their desired number of children.

## **The Demographic Transition Model (DTM)**

The Demographic Transition Model (DTM) was developed by demographer Warren Thompson in the early 20<sup>th</sup> century (Galor, 2011). This theory helps to understand profiles of different populations and allows insight into characteristics of differing social and economic systems as they transition from pre-modern to modern societies. The DTM consists of four major stages. Summarized from studies of human population by Bongaarts

(2009), stage one is characterized by high birth and death rates; an approximate balance between these rates results in slow growth. This stage is representative of pre-industrial societies. Pre-modern countries are said to be in stage two; death rates have dropped and birth rates remain high, thus resulting in a net increase in population. Countries in stage two are experiencing a population explosion and do not become stationary in growth until stage three. A drop in birth rates characterizes stage three and population growth levels off. Finally, stage four is marked by low birth and death rates where modern countries experience contracting population structures. Most regions of the world easily identify with what stage they fall under within the DTM (Bongaarts, 2009).

With insight regarding what internal improvements may benefit a population's progress and transition into modernization, it is the moral responsibility of those populations that have experienced and learned from this transition to aid in the development of another. The whole of SSA is experiencing many detrimental effects of population pressure due to high fertility rates. High fertility rates have proven to initiate many strains that hinder the regions progress towards development. Being a world region that has access to resources and knowledge that alleviate such strains, it is important for modern regions implement change within this complex system. Effective family planning programs is one of the most important tools to lowering birth rates, which further would alleviate stressors induced by population pressure. According to Speidel (2007), "The population field needs increased commitment, appropriate policies, and adequate human and financial resources. If these conditions are fulfilled, population growth will slow, reproductive health will be improved, and the environment protected" (p. 256). Helping populations to lower fertility rates as a means to reach equilibrium with the land is a measure that can be taken to aid in SSA internal development. A drop in fertility rates is one of the most important factors observed between stages two and three of the DTM.

From the perspective of the classical demographic transition theory, a rise in life expectancy, wider use of contraceptives, industrialization and urbanization are deemed to radically change the behavior of couples with respect to family size. However, this conclusion is less compatible with what is observed in urban Ethiopia. Fertility levels in most urban areas of the country have declined drastically in spite of low levels of human development (UNDP, 2005).

Bongaarts (2002), emphasizing the crucial importance of progress in human development for the future course of fertility, has noted that on average a life expectancy of 75 years combined with literacy near 95 percent are needed for a country to approach replacement level fertility. In countries with low levels of human development, the average fertility is generally expected to be high.

### **"Multiphasic theory of demographic change"**

An explanation that might fit urban Ethiopia's fertility profile is the "multiphasic theory of demographic change". According to this theory, regulating family size is one option for households who experience economic strain as a result of the imbalance between limited economic resources and household size, which in itself is an outcome of mortality decline (Ayinmoro, 2017). Along with this, people's conviction that it is their demographic behavior which prevents them from taking advantage of emerging opportunities provides them the incentive to modify their reproductive. Similarly, the "social capillarity" explanation, advanced by Dumont, postulates that the aspirations of individuals to move up the socio-economic ladder motivate them to control their fertility (Billingsley, 2019).

When households perceive that they are falling short of their goals, they may resort to restricting their childbearing in order to reduce the gap between economic aspirations and achievements (Casterline, 2001, p. 34). Le Grand, Todd, Mondain, and Randall (2003) have also observed that reproductive goals and risks include factors other than the number of children and child mortality. Parents want successful and healthy children, which imply the need for more resources. In the absence of sufficient investments, parents may take on significant risks of undesirable child outcomes.

Persons with smaller families are in a better position to have the resources in time, finances and emotions, to achieve these positive outcomes for their children. McDonald (2002) argues that very low fertility is the product of constraint rather than of preference. For instance, there are many people who are prepared to undergo expensive and emotionally challenging infertility treatment as well as those who go through the process of adoption, in order to have children. In Ethiopia, for many people, remaining childless is the least desirable option and couples try anything within their power to have a child or children. Substantial unmet need has provoked family planning programs by governments and donors, but the impact of family planning programs on fertility and contraceptive use remains somewhat unsettled (Billingsley, 2019).

## **"Demand theory"**

"Demand theory" argues that in traditional agricultural societies, fertility rates are driven by the desire to offset high mortality, thus as society modernizes, the costs of raising children increases, reducing their economic value, and resulting in a decline in desired number of children. Under this theory, family planning programs will have a marginal impact. Using a country case study approach, both stronger and weaker family programs reduce the unmet need for contraceptives and increases use by making modern contraceptives more widely available and removing obstacles to use (Bongaarts, 2014).

At the 2012 Family Planning Summit in London, world leaders committed to providing effective family planning information and services to 120 million additional women and girls by the year 2020. Amid positive response, some expressed concern that the numeric goal could signal a retreat from the human rights-centered approach that underpinned the 1994 International Conference on Population and Development. Achieving the FP2020 goal will take concerted and coordinated efforts among diverse stakeholders and a new programmatic approach supported by the public health and human rights communities.

## **Rights based approach**

Rights based approach to family planning is an approach to developing and implementing programs that aims to fulfill the rights of all individuals to choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence. Most family planning programs are already implementing essential elements of rights-based programming—including increasing access, improving quality, expanding method options, and ensuring informed choice—though these interventions may not automatically be associated with or described in terms of rights. For decades, family planning practitioners, have worked to advance high-quality and client-focused family planning (Kumar et.al, 2017).

The international community has also long agreed that every individual has the right to health, and that reproductive health is a fundamental right of all people, such as through international conventions and conferences, including the International Conference on Population and Development (ICPD) in Cairo in 1994, the ICPD five-year review, and the Fourth World Conference on Women in Beijing in 1995. However, more is needed for an

approach to be fully considered rights-based and centered on the needs and preferences of clients (UNFPA, 2010).

Community participation, individual empowerment, and accountability need to be valued and supported as essential program elements. A rights-based approach is inclusive and seeks to empower individuals to meaningfully participate in the design, implementation, and evaluation of policies and programs. The rights-based approach calls on providers and programs to understand and address these factors by focusing on the needs of hard-to-reach and marginalized groups and by eliminating policy or programmatic barriers, including all forms of discrimination, to accessing services and information. Examples of such interventions could include considering client access to family planning and reproductive health services, including the distance the client must travel; considering cost of services, particularly for young people and other marginalized groups; addressing providers' attitudes biases towards certain clients or methods; removing unnecessary eligibility requirements that exclude clients based on age, marital status, or gender; and incorporating interventions that work outside clinics—at the policy, community, and individual levels—to address the full range of barriers that prevent and limit the ability of individual to make and act on reproductive decisions around family planning (UNFPA, 2010).

The capability approach and rights based approach share a common motivation—their direct focus on the dignity and freedom of the individual. As an approach to public policy, the capability approach highlights the critical importance of the substantive freedoms and opportunities of individuals and groups, whilst the human rights approach highlights the importance of values such as freedom, dignity and respect, equality and non-discrimination, participation and autonomy, and the arrangements that are needed to protect and promote these.

Researchers who have examined people's attitudes and views regarding family formation and size propose that people arrive at their decisions after weighing the various alternatives, including associated costs and benefits. However, the cost-benefit analysis of fertility decision making is often conducted within the framework of existing cultural values (Erfani and Beaujot, 2006).

In the past, several studies in Ethiopia explored the course and causes of fertility change (for example Hailemariam 1991, 1992; Kinfu 2000, 2001). Based on a Community and

Family Survey from the Southern Nations, Nationalities, and People's Region of Ethiopia, a study by Hogan and Berhanu (2003, p. 60) concluded that fertility differentials in this region are attributed to cultural factors particularly to social norms and preferences about appropriate age at marriage, family size or contraceptive use. In the same region, an earlier study found that women's interest in birth spacing and contraceptive use is linked to household poverty, although poor women are less likely to act on these interests (Hogan, Berhanu, & Hailmariam, 1999). Kinfu (2001, p. 224) noted that changing cultural values regarding family formation, housing shortage, unemployment, and institutional changes that followed the revolutionary experiences of the country were fundamental in bringing the dramatic fertility decline in Addis Ababa. Similarly, other researchers (Lindstrom and Woubalem, 2003; Sibanda, Woubalem, Hogan, & Lindstrom, 2003) focused their attention on the fertility decline to below replacement level recorded in Addis Ababa.

## **2.7 Empirical studies of Family Planning in Ethiopia**

Understanding why people do not use family planning is critical to address unmet needs and to increase contraceptive use. A study which was done on family planning knowledge, Attitude and practice among married couples in Jimma Zone, Ethiopia, reveals that the high knowledge on contraceptives did not match with the high contraceptive practice in the study area. The study demonstrates that mere physical access (proximity to clinics for family planning) and awareness of contraceptives are not sufficient to ensure that contraceptive needs are met. Thus, projects aiming at increasing contraceptive use should contemplate and establish better counseling about contraceptive side effects and method switch. Furthermore in all family planning activities both wives' and husbands' participation should be considered (Tizita et al, 2013).

Another study was done on Prevalence and Associated Factors of Modern Contraceptive Utilization among Married Women in Reproductive Age Group in Misha Woreda Hadiya Zone, South Ethiopia. This study reveals that the utilization of modern contraceptive method was low. Contraceptive utilization was associated with some socio-economic, socio-demographic and socio-psychological factors like age, residence, family monthly income, knowledge and spousal communication. It is also associated with different sources of information. The study recommends for one to five health development armies to be strengthened by Woreda health office, health facilities and health posts to improve modern contraceptive use to achieve development goals (Hamdalla et al, 2017).

The history of family planning in Ethiopia starts with the establishment of the Family Guidance Association of Ethiopia (FGAE) in 1966 in one clinic in Addis Ababa. Despite this long years of history, access to family planning was limited to major urban areas. The Ministry of Health (MoH) integrated family planning with a national maternal and child health (MCH) program in the early 1980s in public health facilities. Since then, the family planning service coverage increased largely as a result of a significant increase in access to health facilities (Fantahun, 2003).

Although started at a slow pace, Ethiopia has continuously experienced an increase in contraceptive prevalence in the last two decades. According to the first National Family and Fertility Survey (NFFS) in 1990, only 4% of the women in their reproductive ages were using some family planning methods, of which, only 3% were using modern contraceptive methods (CSA, 1991). The contraceptive prevalence rate has doubled between the periods 1990 and 2000 and by the year 2000 it was estimated at 8.2%. The increase has been rapid and unprecedented after 2000. The subsequent DHS surveys in 2005 recorded a twofold increase in contraceptive prevalence rate (CPR) and put the rate at 14.7%. With the trend continuing, CPR reached at 41.8% by the year 2014 (CSA, 2014). There was also an increasing trend of CPR by area of residence. In the urban areas, CPR showed an increase of 7.1% age points in 2014 from the 2011 CPR level. In rural areas, the percentage point increase in CPR was 5.6 in the three years between 2011 and 2014. Although family planning service has been showing an improvement in method mix over the years, the use of injectable contraceptives has still remained to be the dominant method (CSA, 2014).

Based on the 2016 DHS report, 36 percent of currently married women are using a method of family planning: 35 percent are using a modern method, and 1 percent is using a traditional method. Among currently married women, the most popular methods are injectable (23 percent), implants (8 percent), IUD, and the pill (2 percent each). The contraceptive prevalence rate (CPR) among married women increases with age, peaking at age 25-29 (41 percent) before declining steadily to 19 percent among women age 45-49. Urban women are much more likely than their rural counterparts to use any method of contraception (52 percent versus 33 percent). By region, contraceptive prevalence rate ranges from 2 percent in Somali to 56 percent in Addis Ababa. Contraceptive use increases with women's education and household wealth. For instance, 31 percent of

women with no education are using a contraceptive method compared with 55 percent of women with more than a secondary education. Women with no living children (30 percent) and those with five or more children (28 percent) are the least likely to use any method of contraception (DHS, 2016).

Among sexually active unmarried women, 58 percent are currently using a contraceptive method: 55 percent are using a modern method and 3 percent are using a traditional method. The most commonly used methods among sexually active unmarried women are injectable (35 percent), implants (11 percent), the male condom, and emergency contraception (4 percent each) (DHS, 2016).

Unmet need for family planning refers to fecund women who are not using contraception but who wish to postpone their next birth (spacing) or stop childbearing altogether (limiting) (Bongarts, 2014). The 2016 EDHS data shows that 22 percent of currently married women have an unmet need for family planning services, 13 percent for spacing and 9 percent for limiting. As mentioned above, 36 percent of married women are currently using a contraceptive method; that is, they have a met need for family planning. Therefore, nearly six in ten currently married women in Ethiopia (58 percent) have a demand for family planning. At present, 62 percent of the potential demand for family planning is being met, almost entirely by modern methods. Thus, if all married women who said they want to space or limit their children were to use family planning methods, the CPR would increase from the current level of 36 percent to 58 percent (DHS, 2016).

Among unmarried sexually active women, 26 percent have an unmet need for family planning, almost all for spacing. About six in ten (58 percent) are currently using a contraceptive method. The total demand for family planning among unmarried sexually active women is 85 percent. Currently, 69 percent of the potential demand for family planning is being met, almost entirely by modern methods (65 percent). If all of the unmarried sexually active women who said they want to space or limit their births were to use family planning methods, the CPR would increase from 58 percent to 85 percent (DHS, 2016).

## **2.8 Family planning intervention**

### **Country context**

Family planning intervention is affected by a country's cultural, economic, political, and social environments. An assessment of this overall context is important, as is working within it and seeking to change aspects of it to promote and implement voluntary family planning programs that respect and protect rights (Karen et al., 2014). The value of such an analysis is that the process itself, and the analysis and recommendations that it yields, can be helpful in securing an increased understanding of the need for collaboration across disciplines and sectors to identify and reduce barriers to universal access to sexual and reproductive health and rights, particularly among vulnerable groups. Aspects of the country context that are important to voluntary, human rights-based family planning include the following: country governance overall, including responsiveness of the government to wide stakeholder participation; health governance at the national and decentralized levels; finance/resources available for health and participation in decisions regarding resource allocation; the health policy environment; the sociocultural context and gender norms; government adherence to human rights agreements, including the presence and operation of national accountability mechanisms; and global accountability of donors and other Global actors to country level work (Karen et al., 2014).

### **Policy level**

Supportive policy has been identified as one of ten elements of successful family planning intervention (Richey and Salem, 2008). Policy making is a complex process that involves a range of actors having differing demands and priorities (Walt et al. 2008; Buse et al. 2010). In addition to enhancing policies that support voluntary, human rights based family planning, eliminating existing policy barriers and ensuring correct implementation of supportive policies is essential. Equally important is the implementation of policies that support family planning. National policies, laws, operational guidelines, strategic plans and other policy related instruments within the Health sector and other sectors establish the method by which countries address family planning issues and the way they do so in ways that respect, protect and fulfill rights.

The policy level includes those actions or factors that influence policies and thus the enabling environment that affect equitable access and treatment; adequate resources; good

governance; and management and accountability to ensure the availability, accessibility, acceptability, and quality of family planning information and services. Policies also address contraceptive development and method mix and human resources issues, which affect method choice and access.

### **Service level**

Programs that meet individuals' reproductive health needs and that respect, protect, and fulfill rights will appropriately focus significant attention on service delivery. The concept of quality of care reinforces the rights to self-determination, information, and education by underscoring the importance of informed choice, the quality of the interpersonal interaction between clients and providers, and the technical competence of the provider. The service level spans across issues associated with (a) quality of care; (b) contraceptive choice; (c) provider training; and (d) all modalities of service delivery, including public, private, and NGO; clinic- and community-based; and integrated with HIV/AIDS, postpartum and post abortion services, and social marketing. At this level, those actions or factors that influence the capacity of the health system to make voluntary family planning services available, accessible, acceptable, and of high quality (meeting clients' rights and providers' needs) within both facilities and communities are considered. Dual importance of trained, efficient, and respectful provider's powered clients is highlighted (Karen et al., 2014).

### **Community Level**

Emphasis on community participation in health programs declaration and is a central tenet of human rights-based approaches programs, as articulated in the UN Common Understanding; adopted Community participation can empower individuals to take development projects, increasing their degree of self-determination capable of managing their own lives (Walt et al. 2008; Buse et al. 2010). Community participation is "a strategy that provides people their problems through careful reflection and collective action." Whereas a focus on the service-delivery level is essential, be reached in communities in which socio-cultural barriers to family planning use or to autonomous decision making prevent women contraceptive information and services. Community participation program development, monitoring, accountability, or advocacy—to the acceptability of family planning programs and traction in traditionally hard-to-reach populations can be beneficial in different aspects: It enables communities to (1) participate in the development and implementation programs designed to serve them; (2) hold policymakers and transform

norms and customs; and (3) enhance community family planning to facilitate the respect, protection, and fulfillment rights to high-quality voluntary family planning information and by working toward reducing minority or marginalized population groups, including young community level also address gender and power imbalances to use through gender-sensitive and transformative approaches.

### **Individual Level**

Given the right of individuals and couples to decide freely and responsibly the number and spacing of their children, the individual is at the heart of a voluntary, human rights-based approach to family planning. With the realization that individuals can face significant challenges to the exercise of their reproductive rights, those actions and factors—including those pertaining to education, family, gender, partner, religion, and social status—that influence individual agency and the ability of individuals in a particular community to exercise their reproductive rights are considered at the individual level. While acknowledging that an individual's role and relationship within a dyadic couple and within a family structure can directly influence the realization of reproductive rights, the family level is not considered because, ultimately, rights holders are individuals who should exercise agency when making decisions regarding their reproductive health. Whereas reproductive rights tend to focus on women, the framework also acknowledges the rights and needs of men in regard to family planning intervention.

## **2.9 Legal and institutional Framework of Family Planning in Ethiopia**

Ethiopia, like many sub-Saharan African countries, experienced a big increase in population growth rates towards the end of the last century. In 1980-85, Ethiopia's population was growing at the rate of 2.92% per year, and this increased to 3.5% in 1990-95 (UN, 2015). The country has, however, managed to slow its population growth rate significantly over the past 20 years. Since 1995-2000, the population growth rate has been declining and in 2010-2015, Ethiopia's population growth rate was estimated at 2.5%. If current trends in fertility continue, Ethiopia's population growth rate will decline to 2.2% in 2025-30 and to 1.8% in 2030-35. Even though GDP growth now outpaces population growth, this is still a relatively high growth rate. To bring it down further would require acceleration in the current rate of fertility decline (UN, 2015).

In 1990, less than two-third (63%) of women of childbearing age knew of a method of family planning (CSA, 1993). In 2000, however, this increased to 82%, in 2005 to 86% and in 2011 to 97.2% (CSA and ORC Macro, 2001; 2006; CSA and ICF International, 2012). Thus, knowledge of family planning methods has increased by 54.3% between 1990 and 2011. Knowing about family planning and actually using a modern method of contraception are quite different things. In the years immediately before the National Population Policy (NPP) was launched, only a very small percentage (<4%) of currently married women of reproductive age were using family planning. In 1990 for instance, only 3.9% of all women of childbearing age were using family planning. This increased to about 6% of all women in 2000, to about 10% in 2005 to 19% in 2011. By 2014, it had further increased to 30% of childbearing age. Thus, both knowledge and use of family planning methods have increased significantly since the inception of the policy (CSA and EDHS, 2016).

### **Population Policy**

The increase in level of knowledge as well as use of family planning is directly related to the increase in the number of facilities providing family planning services and the diversification of approaches to provide services. At the time the population policy was launched, there was not a single government health facility providing family planning services in the country, and there was only one NGO, the Family Guidance Association of Ethiopia (an IPPF affiliate and the pioneer of family planning in Ethiopia), providing family planning services in the country, and that was in only one clinic in Addis Ababa. After the policy was launched, however, all government health service delivery facilities began providing family planning services (UN, 2015).

Moreover, due to the favorable environment created after the introduction of the NPPE, the number of national and international NGOs providing family planning services or supporting such efforts increased considerably. These NGOs introduced different strategies such as community based reproductive health services, social marketing, mobile clinics, and social franchising as means of increasing awareness about and access to family planning and other reproductive health services. The introduction of the Health Extension Package (HEP) has further contributed to increased knowledge about and use of family planning services. Despite these efforts, however, there is still a considerable

amount of unmet need for contraception. In 2011, it was estimated to be 25.3%, with 16.3% for spacing births and 9.0% for limiting total births (CSA and EDHS, 2016).

Until the early 1990s, due to absence of an enabling political environment, not much effort was made to expand services and use of about family planning. Recently however, mainly due to the launching of various policies, an enabling environment has been created and a considerable work is being done to improve and expand services. The revised constitution of Ethiopia recognizes broad legal and reproductive health rights of women. In particular Article 35 singles out Family Planning as follows: “Women shall have the right of access to education and information on FP and capability to benefit thereby so as to protect their good health and prevent the health hazards resulting from child birth”. Furthermore, a number of key social sector policies were formulated with the goal of improving the social sector and enhancing socio-economic development. A number of activities are geared towards the implementation of these policies. In this section policies that are directly related to the overall effort in poverty reduction and enhancing socio-economic development of the country are presented as an indication of the enabling policy environment created for expanding access and improving quality of family planning services. Recognizing the pressure rapid population growth exerts on the social and economic life of the people, the Ethiopian Government adopted the National Population Policy (NPP) in 1993 (UN, 2015).

The rationale for this policy emanated from the analyses of the interrelationship between demographic factors on one hand and developmental variables on the other. In Ethiopia, demographic factors such as rapid population growth, young age structure and the uneven spatial distribution of the population fueled by continuing high fertility regime exacerbate the severe state of poverty. Among the specific objectives of the policy are reducing the total fertility rate from 7.7 children to 4 children per woman and increasing contraceptive prevalence rate (CPR) from less than 4% in 1990 to 44% in 2015 (UN, 2015). The policy also encourages the expansion of FP programs through health institutions and community-based-programs. It also gives due emphasis to the involvement of NGOs, the private sector, and the community to complement the Government’s efforts to expand and strengthen FP services.

Following the International Conference on Population and Development (ICPD) held in Cairo in 1994, the Population Program for the implementation of the NPP was revised to incorporate the reproductive health concept and other important issues identified during the conference (UN, 2015). In the Population Program, reproductive health is one of the three core sub-programs, and FP has been identified as one of the priority components of the reproductive health subprogram. Since the ICPD, efforts have been made to integrate reproductive health services in the existing health institutions of the country. The National Health Policy (NHP) of the country focuses on expanding access to community-based primary health care services and restructuring the health delivery system as well as strengthening promotive and preventive health care services (UN, 2015). The policy not only gave priority to the democratization and decentralization of the health service system, but also gave due consideration to FP services for the optimal health of the mother, child and family. It also gave due emphasis to improving access and quality of FP services.

### **The National Policy on Ethiopian women**

The National Policy on Ethiopian Women integrates gender issues in national development efforts. It advocates mitigation of the impact of inequitable customary laws, increases access of women to economic and productive resources, and better legal back up. The policy also states that “the government shall ensure women the right to have access to basic health care facilities, information about traditional and modern FP method” as one of the strategies to empower Ethiopian women (Kassa, 2015).

The launching of these policies has created an enabling environment for the provision of family planning information and services. Although not much has been achieved so far in terms of expanding access and improving the delivery of services, the efforts being made are encouraging. Measures are being taken to amend or remove restrictive laws and regulations. For instance, the 1957 Ethiopian Penal Code (i.e. Article 805) that prohibited the widespread use and advertising of modern birth control methods was repealed in 1998 (Kassa, 2015). Also the minimum legal age at marriage increased from 15 to 18 years and affirmative actions are being taken to increase the participation of women in education, employment and decision-making. These can be considered as moderate achievements in the overall effort of strengthening FP services in the country.

## **The progress of Family Planning service provision in Ethiopia**

In pre 1980 Ethiopia, family planning services were not offered in government health facilities. There was only one NGO offering family planning information and services. The 1980 Council of Ministers directive to integrate family planning as part of the Maternal and Child Health (MCH) Program of the MOH created some favorable conditions to strengthen and expand FP services in the country. Soon after, family planning services were provided in selected health institutions integrated with MCH services. However, even then as service delivery was carried out through the network of general health facilities which are available mostly in urban or semi-urban communities, the bulk of the rural population remained without access to not only family planning but also to the basic health care services. It was estimated that only 46 per cent or less of the population of Ethiopia lived within a reasonable distance from health care facilities - reasonable distance being defined as a radius of 10 kilometers from where people live. The population/physician and population/nurse ratios were estimated at approximately 30,700 and 15,000 respectively. The figures cited above represent national averages and as such hide a considerable degree of regional disparities. Taking population/ physician ratios as examples in point, one notes that this ratio reaches as high as 285,510 for Gondar (Bizuneh et al., 2008).

The various policies mentioned above have endorsed the role of family planning in meeting the development objectives of the country and called for expansion of services. As a response to this, as of 1991, family planning services are available in all hospitals, health centers and clinics. Moreover, many NGOs not previously involved in family planning/reproductive health services have reoriented their programs and included these services as a major component of their programs. Those already in the field have expanded their coverage. Types of service delivery outlets have also increased. The current Family Planning service system in Ethiopia operates through government and NGO service outlets, including hospitals, health centers, health posts, and community based distribution and social marketing.

Initiatives like the community based contraceptive distribution programs were launched in order to expand and improve access to Family Planning services to underserved rural

communities. In late 2002, there were 30 NGOs implementing community-based services in the country (Bizuneh et al., 2008).

These services are instrumental in reaching the community through community residents who are not health professionals. These agents provide FP information, distribute condoms and oral contraceptives, and make referrals for other clinical methods. In an effort to integrate reproductive health into the health service delivery system, there is a shift from CBD to Community-Based Reproductive Health (CBRH) program. Currently, CBRH agents receive training that enables them educate the community in the prevention and management of STIs including HIV/AIDS provide maternal and child health services, and eliminate harmful practices, among other preventive measures (Bizuneh et al., 2008).

In the past, access to and use of family planning services remained limited mainly due to the absence of enabling political environment. In the post ICPD era, although a number of policies in favor of increasing access to family planning services have been formulated, access to services still remains limited and a very small proportion of the eligible population use contraception. Potential clients appear not to optimally use the available FP services at service delivery points mainly due to socio-cultural barriers towards family planning and there is a high unmet need.

The country's population is still one of the fastest growing in sub-Saharan Africa and population momentum is strong and will produce large population increases over the next 25 to 50 years. (UN, 2015). High fertility is the major contributing factor for the country's high population growth. High fertility impedes opportunities for economic development, increases health risks for women and children, and erodes the quality of life by reducing access to education, nutrition, employment, and scarce resources such as potable water. Fertility decline will by and large depend on the strength and coverage of family planning programs. The low contraceptive prevalence in the country is mainly due to some barriers such as lack of knowledge about contraceptive methods and availability, negative attitude towards family planning and rumors about side effects. By increasing access to contraception and to a wider variety of methods as well as promoting wider knowledge about proper contraceptive use and low health risks, contraceptive prevalence can be increased considerably. More users may be attracted if

the clinic environment is improved by maintaining privacy, and good hygiene, proper counseling is provided to clients and if the method mix is increased.

As the number of fixed health service delivery facilities is limited for the vast majority of the populations living in the rural areas (85%), where geographic and financial barriers to access to reproductive health care exist and where access to contraceptives is low, CBRHS approach represents a viable solution for addressing the major gaps in FP service delivery. CBRHS needs to be expanded and strengthened by introducing a more systematic and organized approach to be more effective. Moreover, establishing an effective logistic information and management system to have a sustainable distribution of contraceptives to service delivery points, and monitoring the quality of care may also attract more users.

## **2.10 Family planning and the SDGs**

Advancing FP can positively influence and advance the sustainable development goals. Women want to control their fertility, but too often lack the means, access and agency to do so. Empowering women to choose the number, timing and spacing of their pregnancies is not only a matter of human rights but touches on many issues vital to sustainable development including health, education and women's status in society. Universal access to family planning is not the only path to sustainable development, but without addressing these issues, the impact and effectiveness of other interventions will be less. In fact, almost all of the SDGs are negatively impacted by rapid population growth and the entire SDG framework could be made achievable by universal access to family planning services.

Poverty and Hunger (SDG 1, 2): When high population growth inhibits economic growth, it can have negative impact on Poverty reduction and hunger, as economic growth has historically been the main driver of poverty reduction globally. Many countries that have managed to significantly reduce rates have experienced significant economic growth and poverty reduction (UN-MDG, 2015). Health (SDG 3): Rapid population growth has a severe impact on health care. Lack of access to safe family planning methods and high fertility rates will mean hundreds of women die every day from pregnancy or child birth related complications and this number is likely to increase alongside population growth (UN-MDG, 2015). High fertility rate can also affect HIV/AIDS prevalence as the disease

is often spread from mother to child during pregnancy. Family planning thus offers an effective way of reducing the number of cases of transmission (Potts, 2007).

Education (SDG 4): According to UN, progress made in school enrolment in SSA is under threat, due to the rapid growth of the Primary school age population, as governments are struggling to provide sufficient schools and teachers (UN-MDG, 2015). UN has also identified household resources as a key determinant factor in school attendance in poor countries (UN-MDG, 2015). Thus, because of low fertility rate and smaller families, parents will have the resources to be able to send their children school. Gender Equality (SDG 5): When hundreds of millions of women world -wide lack access to contraception, it will mean that they all lack the autonomy to decide when, or whether, they have children. This in turn means that they will spend much of their lives rearing unintended children and risking death or disability through pregnancy or childbirth related complications. This limits their ability to work outside of the home, to pursue education and to participate in public life (McNay, 2005).

Water, Sanitation and Energy (SDG 6, 7): Rapid population growth forces Government to direct limited resources to continuously expanding basic services. Most of the developing countries are already struggling to provide clean water, sanitation and energy to their people and this task is almost impossible by the addition of one billion more people by 2030. Thus reducing demand for such services by slowing population growth is a more feasible approach than continuously expanding supply. Economic growth and employment (SDG 8): Marie Stops International (MSI) has found that even a 5% increase in access to contraception can boost a sub-Saharan Africa Country's GDP per capita by 35 percent (Global Impact report 2017, 2018). One of the reasons for this is that, access to family planning means that women have greater control over when or whether they have children and thus they have greater ability to participate in the workforce and the economy. High population growth can significantly limit opportunities for employment. Between now and 2050, the labour force in the developing world will increase by 33 thousand persons per day in countries where already about 80 percent of the workforce is unemployed, underemployed and are only vulnerably employed (Eradication, 2011).It would require unprecedented economic growth to provide jobs for all these people and this seems highly unlikely in a world where the number of people unemployed globally has increased by 54million since 1990 (UN-MDG, 2015). A more feasible solution for this would be to slow population growth through increased investment through family planning services.

Slum growth (SDG 11): By 2050, seven out of 10 people are expected to live in urban areas and a significant percentage of these people will be living in slums (World Urbanization Prospects, 2014). Rapid population growth means that governments that need to tackle slum growth must either continuously provide more housing or they should invest in family planning which is cost effective.

Sustainable consumption and protection of the environment (SDG 12, 14, 15): Because of population growth since 1990, global carbon emission have increased by 50%, marine fish stocks have fallen by 20%, 5.2 million hectare forest have been lost every year since 2000 and substantial proportion of animal and plant species have declined in both population numbers and distribution (UN-MDG report, 2015). It will be very difficult to change these patterns of consumption, production and waste with this rapid population growth and it is therefore reducing demand through family planning is very feasible.

Climate change (SDG 13): The collective carbon emission will be greater as the number of people on the planet increased. Slowing population growth through increased access to family planning service is important to long term reductions to carbon emission. Conflict and migration (SDG 16): Poverty, diminishing job opportunity, large youth populations and increased competition for resources have all been identified as playing key roles in conflict, extremism and political instability. These factors are believed to result from unsustainable population growth (State of the world's emergencies, 2015). Global population levels have been increasing rapidly for decades. This trend significantly limited the success of the MDGs and threatens to do the same for the SDGs (UN-MDG, 2015). Therefore, increasing access to family planning services is vital to sustainable development. Universal access to family planning services could be provided for a fraction of global aid spending and can, among other things, help to reduce mortality, improves women empowerment, boost economic growth and slow unsustainable population growth. Meeting the unmet need for family planning is not only a pragmatic approach to achieving the SDGs, it is very critical for their success.

## 2.11 Conceptual framework of the study

Barriers to contraception are the constraining factors standing between people's preferences concerning the number and timing of pregnancies and the adoption of behavior to achieve these. Barriers can inhibit women's ability to avoid unintended pregnancy (Campbell et al., 2006). Barriers to family planning occur at multiple levels in government, society and the health system (WHO, 2012). Two dominant reasons for non-use are health concerns and social disapproval. Social disapproval, expressed by women as opposition to family planning, together with lack of information, tends to be more important when contraceptive use is low. Health concerns grow in importance as contraceptive use increases. Effective and targeted actions are urgently needed to improve contraceptive choice and access for women and families globally.

The determinant factors for family planning use at the individual, couple and family, service accessibility and socio-cultural and policy environment level are captured in the framework below.

Figure 1: Conceptual framework of the study



Source: Adapted from family planning topic guide, HEART, 2014.

### Limited method choice and access

Contraceptive use depends on a person's knowledge of methods and sources of supplies. There is also usually a correlation between travel time from a woman's home to any health clinic and the likelihood that she will use a contraceptive. Evidence suggests that

increasing the number of family planning methods available in a country increases the overall practice of contraception and accelerates fertility reduction (Campbell et al., 2006; Sullivan et al., 2006). It is important to remember that women are not a homogenous group, and that different population groups such as the disabled and ethnic minorities experience different barriers to choice and access, and may face additional barriers to those experienced by other women (UNFPA, 2012).

### **Financial costs**

The prices of contraceptives vary widely in different markets and between branded and generic products. The financial cost of contraceptives may influence choice of method and adoption (Campbell et al., 2006). Evidence from South Africa shows that even when contraceptive services were offered free of charge, teenage pregnancies were not being avoided, suggesting other barriers or pressures were present (Wood & Jewkes, 2016).

### **Quality of care**

Quality of care in FP in less developed countries like Ethiopia was not given due attention in the past since it was believed that the major problem was unavailability and inaccessibility of services. However, experience shows that the mere presence of services does not imply utilization by target clients. Thus, consideration of quality of care in FP programs, particularly with respect to client acceptance and satisfaction and technical competence of service provision is found to be of paramount importance. Factors that contribute to the poor quality of services include shortage of personnel trained in family planning, lack of contraceptive supplies, and inadequacy of supervision. A study conducted in the health facilities of the Ministry of Health revealed that these problems were prevalent in all the 152 health facilities included in the study (Williamson et.al, 2009)

In order to improve the quality of care and increase client satisfaction, the method mix has been diversified through the years, and resulted in widening the clients' choice of contraceptive methods. Currently, a broad range of modern contraceptives is available to clients: more than six brands of contraceptives, injectable, condoms, IUDs, sterilization, foaming tablets, and implants. The method mix is observed to be similar in rural and urban areas.

## **Women's status and perceptions of partner's views**

The social construction of gender and women's position within society affects many aspects of family planning. Fertility preferences can be derived from the social and economic status gained by conforming to cultural expectations about motherhood rather than through personal choice, for example by having large families, sons or proving fertility by having children straight after marriage (Sills et al., 2012). Additionally, women are often financially dependent on men and may lack access to cash to purchase contraceptives and may also be coerced into making reproductive choices based on the wishes of others (Sills et al., 2012).

The dynamics and prevalence of women's exposure to intimate partner violence undermines their ability to negotiate safe sex increasing the risk of sexually transmitted infections (STIs), abortion, maternal morbidity and mortality and adverse pregnancy outcomes. As well as this, unplanned pregnancies increase the risk of intimate partner violence and violence increases the risk of unplanned pregnancies (Koenig et al., 2013).

Women's perceptions of societal views can also be a barrier. They may think that their husbands oppose family planning which can be a factor discouraging contraceptive practice in a wide variety of settings, including Egypt, Guatemala, India, the Philippines and Nepal. Data from Pakistan indicate that women's perceptions of their husbands' views are not always accurate and that they may perceive their husbands to have more negative views toward family planning than is the case (Casterline et al., 2011).

## **Medical and legal restrictions**

Practices, derived at least partly from a medical rationale, which result in a scientifically unjustifiable impediment to, or denial of, contraception. For example, women being subjected to unnecessary medical procedures as a prerequisite for gaining access to contraceptive methods may act as a barrier (Campbell et al., 2011). Even where family planning services are physically accessible and economic barriers to access are few, medical barriers to contraceptive services—such as overspecialization, demanding husbands' consent, eligibility restrictions and process hurdles—can limit women's use of services (Speizer et al., 2015). Task shifting, for instance by allowing mid-level providers

to insert IUDs and give injectable contraception, has greatly expanded access in many countries.

### **Provider bias**

Service providers sometimes deny access to a family planning method as a result of their own prejudices about the method or its delivery system or the status of the person asking for family planning (Campbell et al., 2011; Speizer et al., 2015; Sullivan et al., 2016).

Additionally, another gender dimension of service provision that should be considered is the ‘appropriateness’ of family planning services, including days and hours of operation. This is especially important for services aimed at women as they usually have the burden of care of responsibilities and may find it difficult to travel to access services during the day or may not be able to travel after dark, hence the need for mobile services and privacy with separate facilities available for women and men.

### **Misinformation**

Side effects, lack of accurate information, and misinformation commonly interact to create a disproportionate fear of fertility regulation methods (Campbell et al., 2011). For example, in Mali, young people were found to be wary of using either the pill or injectable contraceptives because they believed that these methods would make them permanently sterile (Castle, 2013).

Limited and inaccurate knowledge of reproductive anatomy and physiology are a serious concern. Medically inaccurate notions about how conception occurs and fears about the effects of contraception on fertility and menstruation, which were not taken seriously by nurses were found to be barriers to adolescents accessing contraception in South Africa. Nurses' attempts to stigmatize teenage sexuality, their scolding and harsh treatment of adolescent girls, and their unwillingness to acknowledge adolescents' experiences as contraceptive users, undermined the effective use of contraception by girls (Wood and Jewkes, 2016).

Youth need better information on reproductive physiology and sexual health, and detailed information on contraception. Tools to enhance the accuracy and availability of knowledge in the clinical setting have a role, but need to be introduced along with

initiatives to ensure that services are adolescent friendly and do not stigmatize adolescent sexual activity (Wood and Jewkes, 2016). To make progress, interventions should aim to counter negative perceptions of modern contraceptive methods and the dual role of condoms for contraception and STI prevention should be exploited (Williamson et al., 2009).

### **Strength of motivation to avoid pregnancy**

Some women who indicate a desire to avoid pregnancy are relatively unconcerned about becoming pregnant, whereas others regard it as a highly undesirable outcome and, when asked, admit to numerous concerns and worries. Women who feel ambivalent about their stated desire may be especially susceptible to other factors that act against them practicing contraception (Casterline et al., 2001). The presence or absence of barriers to fertility regulation is likely an important determinant of the pace of fertility decline or its delay in many countries. Barriers inhibit women's ability to avoid unintended pregnancy. Problems of quantifying barriers limit understanding of their importance (Campbell et al., 2011).

Effective and targeted actions are urgently needed to improve contraceptive access and for this Governments and donors need to develop and implement policies to secure access to family planning for all and in particular for vulnerable populations; funds also need to be committed to pay for it; mass and other media should be used to enhance social acceptability among men as well as women; counseling skills should be recognized as key to success in addressing concerns about adverse health effects of methods and in eliminating provider bias in services and ongoing training and supportive supervision needs to be provided for cadres of family planning providers within the health system and community.

### **Cultural, Socio-economic and policy environment**

Absence of political commitment and support, the existence of restrictive, laws, socio-cultural norms and values favoring high fertility remained major impediments to the acceptance of family planning and use of services. Status of women, the value of children as well as beliefs and religious faith of the population, among others, in

one way or the other affected the distribution and use of family planning services in Ethiopia.

**Women's Status:** Male supremacy and the subordination of women have been the characteristics of the Ethiopian society. A recent study in Southern Ethiopia in the areas of domestic violence, reproductive health and epidemiology shows that more than 50% of the 3000 Women included in the study suffered from sexual violence and about half of them from physical violence by a partner at some point in their lives (Gossay et al, 2013). The low status of Ethiopian women subjects them not only to domestic violence but also denies them economic benefits from their participation in productive work and earnings.

Moreover, their low educational level and lack of employment opportunities to participate in the labor force combined with strong social pressure that forces them to marry early and reproduce children prevent them from using family planning services and thus remained an obstacle to the expansion of family planning services in the country. Literate women, those who participate in the labor force, who marry late and who involve in household decision making are believed to have better status and therefore are likely to space or limit births. A study conducted in southern Ethiopia, for instance, show that literate women, those who participate in paid work, those who married late and those who involve in household decision making were found to be more than three times more likely to use contraception compared to the illiterate, those who married early, those not working for pay and those who do not involve in household decision making (Hogan et al, 2015).

Another important factor in relation to the status of women that affect the use of family planning is the lack of communication between spouses about family planning matters. Communication between husband and wife regarding family planning issues is an important precursor to the adoption of family planning services. In societies where the status of women is low, and traditionalism is dominant, most women do not discuss about family planning matters with their husbands and even if they do, husbands do not approve it. For example, in a study in an urban community in Ethiopia, Dilnesaw shows that 46% of the spouses do not discuss about family planning issues and that among those who discuss, 57% of the husbands do not approve the use of family planning by their wives (Bisrat, 1995). Studies in several districts of Amhara and Oromia regions also

show that most women who are actually using contraceptives do not want to be known as users because of fear of their husbands (Getaneh, 2003).

**Beliefs and religious faith:** Religion may affect the number of children one has because it may have an ideological stand for or against the use of certain contraceptives. Religion serves as a label-for such factor as "traditionalism" or family structure. For instance, the Roman Catholic ideology has a strong tendency in favor of large families. The two major religions (Orthodox Christianity and Islam) in Ethiopia also encourage large families. Followers of both religions consider children as the greatest gifts from God. For instance, when women are asked about the numbers of children they want to have during their reproductive life span, most women do not give numeric answers. Instead they say it is up to God.

# **CHAPTER THREE**

## **RESEARCH METHODOLOGY**

### **3.1 Research Approach**

The study employed a type of mixed approach i.e. both qualitative and quantitative since it depends up on both methodologies and for collecting diverse types of data which provide a more complete understanding of the research problem and to triangulate the data. The quantitative part was conducted first as the data gathered through the assessment of the extent of utilization was required to feed in to the process of evaluation of the family planning intervention model.

The level of use was addressed by the quantitative, the drivers were addressed by both the quantitative and qualitative and the evaluation of the intervention model was addressed by the qualitative. The study is a combination of descriptive and exploratory. This is because it attempted to describe about the family planning use and it explores about the drivers of inclusive family planning in slum area and as this is an area where little is known. A cross-sectional household survey was carried out since it is best suited at finding out about access and utilization and the drivers of inclusive FP service among slum households at a certain time in great depth.

### **3.2 Research design**

This section specifies how the cross-sectional study design was employed and how the study population was identified.

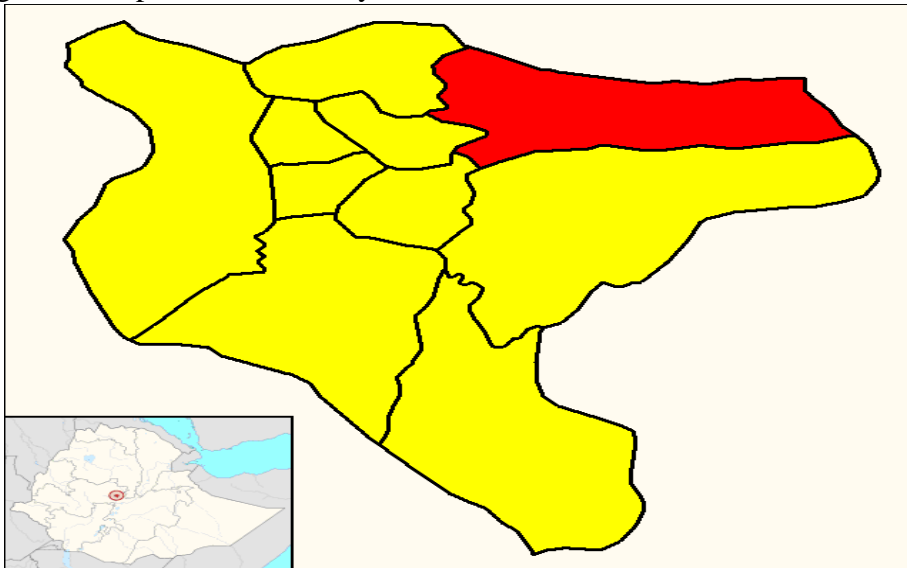
#### **Study design**

The study population constituted women of reproductive age (15–49 years) living in Addis Ababa, 3 sub-districts of slum households in Woreda 4 of the Yeka sub-city. The study population was identified in close consultation with the experts in the area and the authorities who are in a better position to suggest where slum dwellers are located. Women of the reproductive age group were identified because the study is about family planning and issues related with the utilization.

### 3.3 Research site selection

The study was conducted in slum households of Addis Ababa in Yeka sub-city. The city of Addis Ababa has 10 sub-cities namely Arada, Addis Ketema, Lideta, Kirkos, Yeka, Bole, AkakiKality, Nefas Silk, KolfeKeranio and Gulele.

Figure 2: Map of Yeka sub-city



*Source: Yeka sub-city, woreda 4 Administration office, 2019*

#### 3.3.1 Consultation with experts

The study area was in Yeka sub-city woreda 4. This site was selected in consultation with the Yeka sub-City Administration office, UN-Habitat staff, Woreda 4 Administration office Executive Head and other officials.

#### 3.3.2 Criteria for site selection

From the 10 sub-cities, Yeka sub-city was selected randomly. United Nations Human Settlement Program (UN-HABITAT) definition was employed to guide identification of the study setting. UN-HABITAT defines slum as a section of urban setting characterized by lack of basic services, relatively substandard housing, overcrowding, vulnerable to hazards, insecure tenure, and social exclusion. From the 14 woredas of Yeka sub-city, Wored 4 was selected randomly.

### **3.4 Description of Research site**

#### **3.4.1 General overview of the sub-city**

Yeka sub-city is located in the North east Part of Addis Ababa city. The total area of the sub-city is 85.98 km square and 4,284.9 people live in one kilometer square. Moreover, its entire population of the area is 368,418 people. The sub-city has 14 woredas under it and from these woredas the study was carried out in Woreda 4. Each 11 sub-districts of the woreda have one health extension worker and there is one health center in woreda 4.

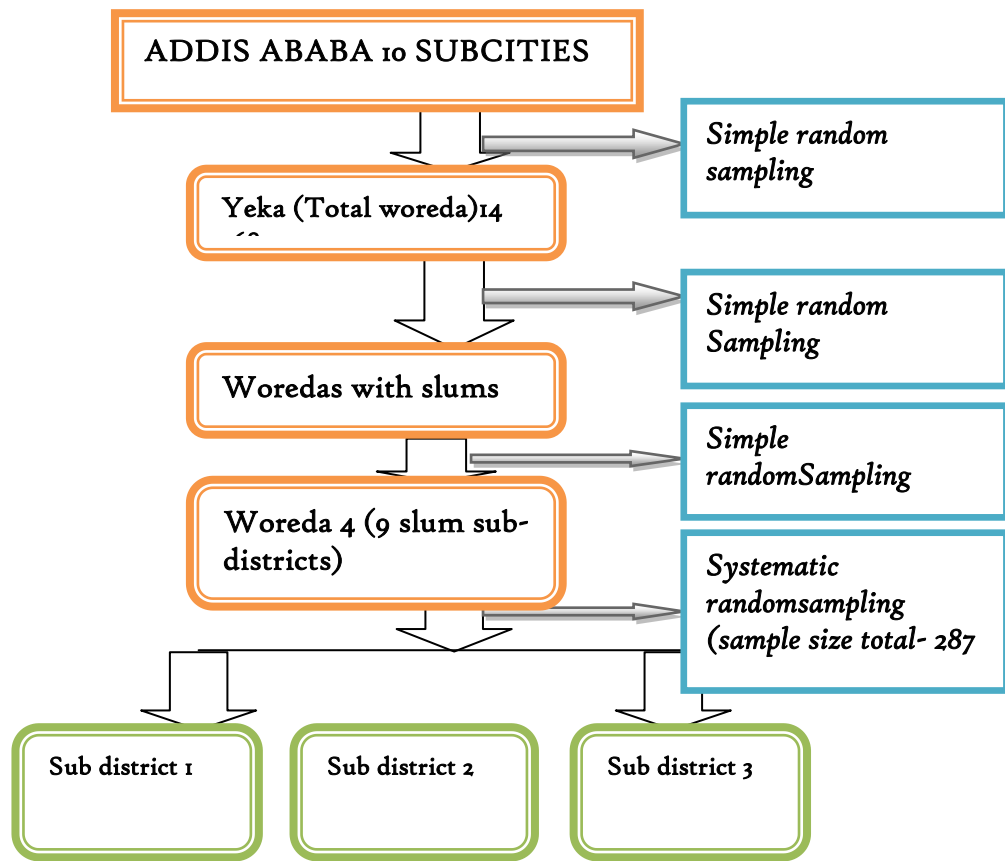
#### **3.4.2 Description of study area**

The total number of populations in Woreda 4 is 35,000 and this woreda is again sub-divided in to 11 sub-districts. From the 11 sub-districts, 9 of them are slum and this study focused on the 3 slum areas which are named as Sengeru, Shekla Meda and Cuba.

#### **3.4.3 Sampling strategy**

The study employed a multi-stage sampling procedure. First, from the 10 sub-cities of Addis Ababa, Yeka sub-city was selected and then secondly from Yeka sub-city, woreda 4 was selected. Then From woreda 4 and out of the 9 slum sub-districts, 3 sub-districts were finally selected, and finally sample was taken from this population.

Figure 3: Sampling Techniques and procedure



Source Own formulation 2019

### 3.4.4 Sample size

A sample size of 287 was derived using Slovin's formula. The assumptions made were using a 95% confidence interval and 5% margin of error. According to Slovin, for a 95% confidence level and  $p = 0.5$ , size of the sample should be

$n = \frac{N}{1 + N(e^2)}$  where, N is the population size and e, the level of precision.

$n = \frac{750}{1 + 750(0.05)^2} = 261 + \text{contingency (10\%)}$

$n = 261 + 26.1$

**$n = 287$**

### **3.4.5 Sampling method**

A total of 287 of women aged 15-49 years were recruited for the study using systematic random sampling technique. The 287 participants recruited were from households in the 3 sub-districts

Household survey: the survey was conducted using a semi-structured questionnaire on women of reproductive age (15–49 years).

### **3.5 Units of Analysis**

The unit of analysis for the first objective (i.e. assessment of the level of FP utilization) is the individual households who have/do not have the access to family planning services. These individuals are women of reproductive age (15-49). The units of analysis for the second objective (i.e. to identify the drivers of inclusive FP) are the individual households, the organizations working on family planning (Public health facility, Government, NGOs, Private clinic and Donors, the slum area and the intervention site where FP service is provided.

### **3.6 Data Source**

The source of data is from both primary and secondary. The primary data was collected using survey, key informant interview and an observation. Secondary data was collected from policy documents etc.

### **3.7 Methods of data collection**

The data were collected in April 2019 and both primary and secondary data collection techniques were employed considering the need to obtain a complete understanding of the research problem and to triangulate the data obtained from the sources.

#### **Primary data collection**

Primary data was collected using household survey, key informant interview and an observation.

### **3.7.1 Household Survey**

The survey was conducted through a semi-structured questionnaire by reviewing literatures in particular the Ethiopian Demographic Health Survey (EDHS) as a reference and modified to suit in to the local situation. The questionnaire was prepared first in English language and then translated in to Amharic language which is the local language of the study population and this Amharic version was used to collect the data. The questionnaire has both close ended and open-ended questions. Pre-test was done on 5% of the total sample size to modify the questions based on the findings. The data collection was facilitated by four nurses who were trained about the process of data collection by the principal investigator.

### **3.7.2 Direct Observation**

Non-participant observation was carried out on the study site which is a slum area and the intervention area where family planning service is provided. Direct observation was conducted not to impact the situation and to get accurate and greater objectivity. It allowed ascertaining the conditions of slums and the type of services provided by the health facility. The observation was recorded using picture/photograph, observation check-list and note.

### **3.7.3 Key informant interview**

A qualitative unstructured interview was carried out to identify the drivers of inclusive FP and the approach and contribution of family planning intervention. The interview was conducted with the participants selected from the users of family planning service, key officials at the woreda, health extension workers and family planning service providers, key officials from the Government, Donors, NGOs and private clinic. Unstructured interview was carried out for having discussion on the issues in depth.

### **Secondary data collection**

As secondary data source, policy documents and survey reports were used. Secondary data sources were used as they provide very important and reliable information which in turn provides a better understanding of the issues under review. The data sources include Demographic and Health Survey, Performance Monitoring and Accountability 2020

(PMA2020), Costed Implementation Plan, Service Availability and Readiness Assessment (SARA) report and Annual Performance Report which is published by the FMOH.

### **3.8 Data Management**

Continuous monitoring was done throughout the process of the study to ensure the various steps of the study are carried out according to protocols. To maintain quality of data, data collectors were oriented, and questionnaire guide was prepared. The collected data was checked for completeness and consistency by the principal investigator and was communicated to data collectors.

### **3.9 Operational definition**

Family planning methods are grouped into two broad categories, namely, modern methods and traditional methods. Modern family planning methods include pills, condoms, lactation amenorrhea method (LAM), diaphragms, standard day method, injectable, implants, IUD and sterilization. Traditional methods consist of periodic abstinence, withdrawal, and calendar or rhythm method and other traditional methods.

### **3.10 Methods of Data Analysis**

In this study, data analysis was made so as to put together and fit the data collected from different sources, using various data collection techniques, to the need of the research objectives. This process contains assessing the quality, accuracy and completeness of the administered data, coding of quantitative data and transcription of interviews, categorization and triangulation of the evidences. In addition to the analysis of the qualitative and quantitative data, the relevant secondary documents and photographs collected during the field work were interpreted with respect to the main issues/themes of the research question and objectives. The triangulation of the data contributed for the Data's credibility and trustworthiness.

#### **Data Analysis method for quantitative data**

For the quantitative data, descriptive statistics were employed. The descriptive data were analyzed using frequencies, percentages, mean and standard deviation using SPSS version 22 statistical packages describing data on FP use, access and utilization.

Bivariate statistical methods in particular Chi-square and t-tests were employed to investigate the difference and association of sets of discrete and continuous variables of the demographic and socio-economic data in relation to FP use/non-use.

#### **Data Analysis method for qualitative data**

The qualitative data that was collected from key informant interview, the main themes using conceptual framework was identified and then written about them, quoting extensively in verbatim format. Content analysis was done analyzing the contents of interviews and observational field notes to identify the main themes that emerge from the responses given by the respondents or the observation notes made on the field.

## CHAPTER FOUR

This chapter presents the results and discussion of the data collected from sample respondents, key informants and observation of the study site.

### 4.1 Descriptive Analysis

#### 4.1.1. Demographic characteristics of the sample respondents

##### Age, Marital status and Religion

The study employed a cross-sectional survey where 287 women of reproductive age participated. The mean age of the respondents was 28.5 years.

Table 1: Family planning use by age of sample respondents

##### Status of family planning use

	FP user (82)		FP non-user (205)		Total (287)		
	Mean	SD	Mean	SD	Mean	SD	t-statistics (pr)
Age	30.4	5.9	27.7	9.4	28.5	8.6	0.0174**

Source: Survey result, 2019 Note: \*\* indicates that the p value is statistically significant at 5%.

Different factors influence young women not to have the freedom and the right to use FP services. In slum areas, because of the cultural beliefs, the individual as well as the community's attitude, young women do not have the courage to go to the health facility and use FP. Lack of support from family members is also the other issue contributing for the low level of utilization of FP among young women.

The profile of sample respondents in table 3 below indicates majority of the respondents, 52.6%, were married and 37% of them were single. The result shows that 91.5% of the FP users were married. The chi-square test revealed a significant association between marital status and FP use. The reason for this association is married women are accepted more than the single and divorced/separated/widowed/ ones to have the freedom to go to the health facility and use FP services. In slum areas, some people even think that FP services are only for married women and for this reason the rest of the group especially the single women are afraid of what the community will say if they go to the health facility and use FP service. Service providers' bias can also be the other reason for the exclusion of single women from using FP methods. Concerning the religion, majority (87.80%) of the

respondents were followers of Orthodox Christian. There was no significant association between FP use and religion and occupation respectively.

Table 2: Family planning use by marital status and main occupation of sample respondents

<b>Status of family planning use</b>							
FP user (82)	FP non-user (205)		Total (287)		X <sup>2</sup> Statistics (Pr)		
<b>Marital status of the sample respondents</b>							
	N	%	N	%	N	%	
Single	5	6.1	101	49.3	106	37	<b>0.000***</b>
Married	75	91.5	76	37.1	151	52.6	
(Divorced, Separated & Widowed)	2	2.4	28	9.2	30	10.4	
<b>Total</b>	<b>82</b>	<b>100</b>	<b>205</b>	<b>100</b>	<b>287</b>	<b>100</b>	
<b>Main occupation of the sample respondents</b>							
Government	15	18.3	36	17.5	51	17.8	0.160(NS)
Private Employee	24	29.3	57	28.8	83	28.9	
Self-employee	2	2.4	2	4	2	0.7	
Other	41	50	110	49.7	151	52.6	
<b>Total</b>	<b>82</b>	<b>100</b>	<b>205</b>	<b>100</b>	<b>287</b>	<b>100</b>	
<b>Religion of the sample respondents</b>							
Orthodox Christian	72	87.8	178	83.8	252	87.8	0.50 (NS)
Catholic	1	1.22	2	4	1	0.35	
Protestant	5	4.54	18	8.78	25	8.71	
Muslim	2	2.44	5	2.44	7	2.44	
Other	2	4	2	0.98	2	0.7	
<b>Total</b>	<b>82</b>	<b>100</b>	<b>205</b>	<b>100</b>	<b>287</b>	<b>100</b>	

Source: Survey result, 2019 Note:\*\*\* indicates that the p value is statistically significant at 1%. NS: - Not Significant

#### 4.1.2 Socio-economic characteristics of the sample respondents

##### Educational status

Educational status was also one of the indicators employed by the study to assess the level of awareness of the sample respondents. In this regard, 42.2% of the sample respondents have studied secondary level, 31.0% elementary, 6.3% completed vocational and 14.6% joined higher education. Whereas 3.5% of the sample respondents were illiterate and 2.4% were only able to read and write. The result revealed that the number of sample respondents that have joined higher education is lower than those who have finished formal education up to secondary level. As presented below on Table4: there was no significant association between FP use and level of education.

Table 3: FP use by level of education of sample respondents

Are you currently using family planning	Educational status of the respondent							Total	Pr.
	Illiterate	only read and write	Elementary	Secondary	Technical	Higher			
No	7	5	67	83	12	31	205	0.919	
Yes	3	2	22	38	6	11	82	(NS)	
Total	10	7	89	121	18	42	287		

Source: Survey result, 2019 NS: - Not Significant

##### Main Occupation and Informality

Concerning the main occupation, 28.9% of the sample respondents reported as private employee, 17.8% were Government employee and the majority, 52.6% were engaged in informal livelihood activities and a daily laborer. As to Turkstra et al (2004) put it, cities do not offer sufficient employment opportunities for their rapidly increasing population hence as a result, many cities are characterized by high incidence of informal employment opportunities, which are unstable and yield only low income (Turkstra et al,2004). About 52.6% reported engaged in daily labor and petty selling both characterized by irregular and insufficient income to support their family. This situation prohibits from being

employed or getting fair amount of money in order to support family. Therefore, it results in economic problem as well as family problem; forcing adolescents to drop-out of school and engage in income generating activities which are more likely to be in the informal sector and this requires an immediate solution for the existing problem. There was no significant association between FP use and occupation.

In line with the quantitative, the qualitative data collected using key informant interview also confirmed that most of the slum dwellers were engaged in informal livelihood activities:

*“Majority of the people living in this area is engaged with activities like fruit or vegetable vending, street hawking, charcoal selling, local drink making and selling, Injera baking and selling, being maid, providing cleaning, washing clothes and cooking service to households in other areas etc.”* (KII,woreda 4 city administration office, 2019).

Some of the daily activities which were observed being done outdoor were making of Injera (a kind of fermented flatbread that accompanies all dishes); Drying red peppers to prepare berberè (a very spicy mixture used to prepare most of the Ethiopian dishes); Shelling dry chickpeas and coffee ceremony, which includes toasting coffee grains, grinding them, boiling them with water in a traditional pot and preparing pop-corn; grinding wheat to prepare the Ambasha (traditional wheat bread).

According to the woreda 4 administration office,

*“The administration office is supporting the youth in the slum area to get different kinds of employment opportunities at different factories and it is also helping them to be supported by safety net, generating incomes by providing service to the community like cleaning and greening the area and generating income by doing so”*(KII, woreda 4 administration office, 2019).

This is one of the areas which should be strengthened and where different stakeholders need to collaborate in improving the livelihood of the slum households.

### Income and expenditures of the sample respondents

As it is presented on the Table5 below, the average income of the respondents falls between 1,500-3,000birr.Regarding the respondents’ expenditure, the result shows that the average weekly expenditure was 553.82birr.

Table 4: Family planning use by income and expenditure of sample respondents

Status of family planning use							
	FP user (82)		FP non-user (205)				Total (287)
	Mean	SD	Mean	SD	Mean	SD	t-statistics (pr)
Income	3223	2374	2940	2595	3021	2533	0.3945 (NS)
Expenditure	603	385	534	477	554	453	0.2464 (NS)
Total	82	100	205	100	287	100	

Source: Survey result, 2019 NS: Not Significant

### 4.1.3 Institutional characteristics of the study area

#### 4.1.3.1 Access to basic services in the study area (Housing, Water, Toilet, Power)

In the slum area, inadequate and overcrowded housing, unhealthy and unsafe living condition and lack of access to clean water and sanitation were observed. Some of the houses in Sengero sub-district were built on steep slopes and river banks which are vulnerable to natural hazards. Lack of toilets causing diseases to spread like wildfire, poor ventilation (lack of windows) contributing to respiratory diseases and poor structural quality of housing were also observed. Majority of the houses have walls made of mud on a wooden structure that without proper maintenance easily deteriorate, while only few are made of concrete blocks or stone.

Figure 4: Houses in Sengero sub-district built on steep slope



Source: Picture taken during observation, 2019

The population in this area lives in a destitute living condition. Most of the households live in houses that did not have the necessary facilities like water, electricity, latrine and even without adequate shelter. Whenever there is a rain, most households suffer because they don't have adequate shelter and they don't even have a place to sleep and they can't afford to renew the roof so, they put plastics on the roof. These people were requesting the woreda administration to renew their shelters, but they didn't get any response yet.

Figure 5: Houses without adequate shelter



*Source: Picture taken during observation, 2019*

According to the key informant from woreda 4 Administration office, there was no plan of upgrading this slum area because of several reasons out of which one is because the place was not suitable to build condominiums or any other infrastructure. The key informant has also added that

*“This area is being overlooked and the government is not giving attention to this place. The community has raised lots of issues of the housing; toilet facility and the like but they haven't got a response yet” (KII, woreda 4 Administration office, 2019).*

#### **4.1.3.2 Status of the public Health facility in the study area**

Observation was also conducted at the nearest health facility which is Yekoriya Zemachoch Metasebia Health centre.

**Human capital: Skilled man power**

The catchment population of the health centre was reported as 16,000. The family planning focal point was a midwife profession. The service provider is trained on family planning (excluding post-partum family planning and training on permanent methods) and he worked in the health centre for one year.

According to the key informant from the woreda health bureau, the health centre had 10 urban health extension workers of which 2 of them were supervisors. The linkage with the urban health extension workers in referring clients for family planning service looked very weak and majority of the clients were self-referred or internally linked from other service outlets within the health centre. The key informant from the health centre confirmed that, in March 2019, only two clients came in with referrals by the health extension workers.

**Financial capital capacity and External support**

The health centre was supported by Engender Health and the family planning service outlet provided family planning, HIV testing and screening for cervical cancer services.

**FP services**

Types of family planning services provided in the HC include provision of both short acting (pills, injectable, Condom) and long acting (Intrauterine device and implants). Clients requesting permanent methods were referred to the catchment hospital.

**An overall status and general characteristics of clients of the facility**

The HMIS report shows that, the number of clients who were put on family planning in March 2019 were 65(43 on long term and 22 on short term types). In the same month (March) majority of clients' age ranged from 25-29. In line with this the key informant interview from the health centre mentioned that the most /regular/frequent clients who come to the health facility for family planning are women of above 25 years.

**Physical capital Status of Inputs and referrals**

According to the key informant from the health centre, there was no family planning commodity stock out in the last one year. It was observed that the Health Centre had family planning guideline and job aids including the latest WHO medical eligibility criteria. The family planning service was well integrated with other service outlets in the health centre including with vaccination, under 5 clinic and HIV treatment (ART). The key informant from the health centre mentioned that, *"They use internal referrals to send*

*clients between service outlets. In the family planning clinic, clients which are at high risk for HIV are screened for HIV. In the last one month there was one confirmed case that was linked to ART clinic to initiate treatment” (KII, Yekoriya Zemachoch Metasebia Health Centre, 2019).*

The key informant from the health centre has also mentioned that, the other service outlets also provided short acting methods with in their clinic and if clients prefer long acting they link them to the family planning clinic. Clients who come for comprehensive abortion care services are also counselled on family planning and linked to the family planning room internally to access the service.

According to the key informant from the woreda health bureau, the health centre had 10 urban health extension workers of which 2 of them were supervisors. The linkage with the urban health extension workers in referring clients for family planning service looked very weak because of lack of accountability of the UHEWs and majority of the clients were self-referred or internally linked from other service outlets with in the health centre. The key informant from the health centre confirmed that, in March 2019, only two clients came in with referrals by the health extension workers.

#### **4.1.3.3 Current challenges in the service provision as perceived by the experts**

The service provider at the health centre responded that reporting is done using the HMIS including new and repeat clients based on the guidance from FMOH. The challenges raised by the service provider include:

- a. No trained staffs on post-partum IUD and it have increased a chance of missing mothers to immediately start a long acting method post-delivery.
- b. Limited awareness on family planning among community members especially on IUDs people think that it will migrate with in their body and harm them.
- c. limited partner/husband involvement there are still clients who take family planning hiding from their partners
- d. Having three health centres which are very near each other and clients preferring to go to JanMeda or Bella health centres instead of this one due to better proximity.

#### **4.1.4 Contraceptive knowledge, attitude and decision practice**

##### **Utilization and discontinuation rate of contraceptive use**

The information that individuals have about family planning methods would determine the type they would prefer to use (UNFPA, 2016). Cognizant of the fact that this would also affect the utilization and discontinuation rate of contraceptive use. The respondents were asked if they have ever heard of family planning and majority of the respondents (98.3%) responded that they have heard of family planning and out of these 39.7% of them have ranked television as the first source of information. From the 98.3%, 89.9% of the respondents didn't choose Health extension as a source of information for family planning and this shows that there is a gap in this area.

##### **Awareness about the family planning methods**

Concerning their awareness about the family planning methods, only 4.4% of the respondents were aware about implant, 6.1% were aware about permanent method (female tubal ligation), 15.2% were aware about pills, 14.3% were aware about IUD and again 14.3% were aware about injectable.

##### **Family planning methods Used**

From the family planning methods listed (Standard days method, Injectables, Condom, Pills, Lactational Amenorrhea, Implant, IUD and female tubal ligation) 48.1% of the respondents have never used any of the methods and the rest 51.9% of them have used one of the FP methods from the list. From these 51.9%, the majority of the respondents, 32.2% have used injectables. Thus, the study revealed that pills, injectable and IUD are the most known family planning methods and injectable was the most commonly used family planning method in the past. This was also confirmed by the service provider and the couples interviewed at the intervention area. The women interviewed mentioned that

*“The most popular choices of family planning methods in this area have been Injectable. The reason that women choose injection is because it's simple to use and women can have children immediately after discontinuation”* (KII with FP user in the intervention area).

According to the service provider, most of the women are not willing not only to use the long-term methods but to even learn about those kinds of methods. This shows that there

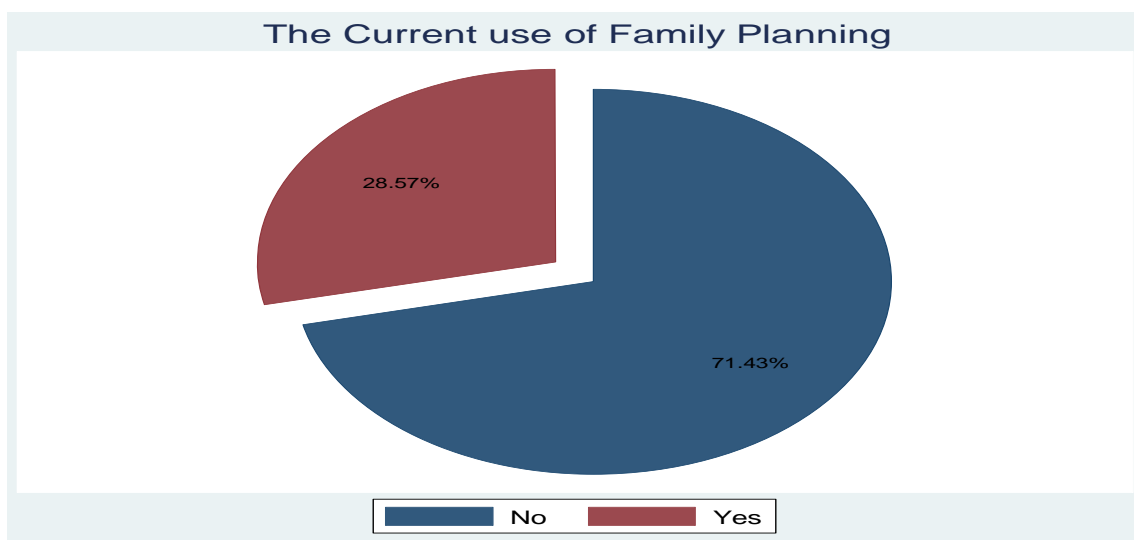
was a gap in the family planning method mix and low utilization of the long-term family planning methods in the past but this looks different considering the current use of family planning methods as described below on figure 6.

### Use and type of FP method

As the figure 6 below indicates, 71.43% of the respondents are not using FP method currently.

When asked the level of FP need is in the woreda, both the service provider and the woreda health bureau head mentioned that it is moderate. Regardless of the need, the current use of family planning is very low and this is one of the important areas where emphasis should be given by all partners who have a stake on it.

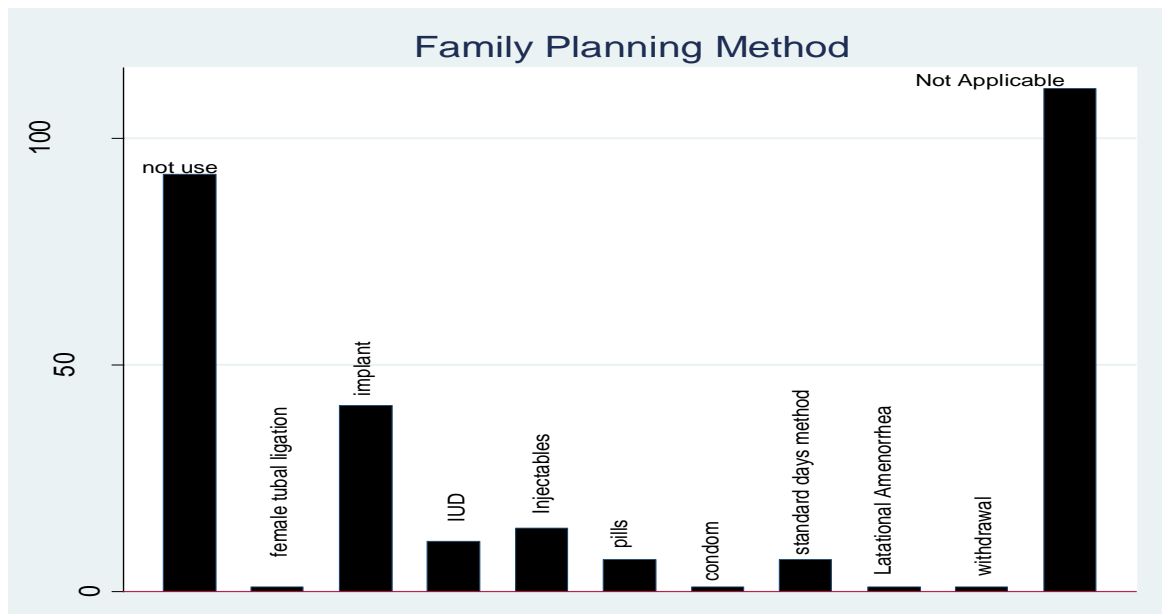
Figure6: Current use of family planning methods



Source: Survey result, 2019

From 28.57% who are currently using FP method, 14.3% reported using implant and 4.9% using injectable. This shows that there is a huge shift in the use of family planning methods from short acting like injectable to long acting family planning method like implant. The result also shows that the permanent method for female (Tubal ligation) and IUD were poorly utilized. This indicates that there is still more work to be done on family planning method mix.

Figure 7: Current use of Family planning methods by sample respondents



Source: Survey result, 2019

In line with this quantitative data, the key informant at the FMOH made a strong remark on how putting more effort in promoting LARC would pay off hence requires attention. It was highlighted that

*“IUD uptake is low even among those who are informed”* (KII,FMOH, 2019). The poor utilization of IUD which was revealed by the quantitative data, were also confirmed by the service provider interviewed at the health center. He mentioned that *“From the long-term methods, the use of IUD is very low and this may be because of the high misconception towards using IUD. Some clients think that it would be relocated from uterus to other organs and create problem”* (KII, service provider at the health center, 2019).

*The service provider has also added that, “in three months’ time, clients who used IUD are only 6 and the reason for not using this method that much is because of the mis-conception”*(KII, service provider at the health center).

### **Quality and status of counseling and provision of information**

These findings pointed out the importance of proper counseling and providing appropriate information to all clients, so that they can make an informed choice. Service providers also need a tool kit that help them to scientifically respond to common myths, misconception and frequently asked questions.

The key informants from the health center, woreda health bureau and NGOs in their response shared the importance of improving the quality of FP counseling and service and training of FP providers on how to be mindful while counseling clients was emphasized by the key informants. Some providers used to put pressure on their clients to use LARC in order to meet the given target but this shouldn't be the case as clients need to have the freedom to choose which ever method they want to use.

### **Benefits of FP**

Concerning the benefits of FP, 28.2% reported that FP is used to avoid unwanted pregnancy and 26.1% reported that FP is used to space child birth. 24.9% reported that FP is used to limit family size and the rest 20.8% reported that the benefit of FP is for mother and child health. In contrary to this majority of the respondents (54.3%) reported that it is delightful to have large family if one has enough money. This shows the need to work on creating awareness about the importance of limiting family size regardless of the economic capability one might have, and this was stressed by the key informants from NGOs and donors.

### **4.1.5 Family planning service accessibility and utilization**

#### **Accessibility of the FP methods**

Regarding the accessibility of the FP methods, Likert scale was applied using a statement 'Family planning/contraceptive methods are accessible' and asking the respondents to choose from the 5 scales. Hence 35.9% have agreed and 44.6% have strongly agreed that FP methods are accessible. 7.3% and 2% of the respondents have disagreed and strongly disagreed (respectively) that FP methods are accessible. This result shows that some of the community members do not have the access to FP methods.

#### **Information where to get FP**

The respondents were asked if they know of a place where they can obtain FP method and 97.9% knew where to obtain and the rest 2.1% didn't know where to obtain them. This shows that majority of the respondents have the information where to get FP methods. However, the result from the qualitative study shows that the slum households do not know where to get FP service. As evidence, the key informant interview with EH is said:

*“There should be dedicated service to the special need including those who are marginalized; unsafe sex is common in slum areas and the consequence of this is pregnancy, abortion and the like; the level of awareness is very low, and they don’t easily access FP service. The literacy level is also the other contributing factor hence they don’t know where to get the service”*(KII, EH, 2019). He also added that health seeking behavior is another factor for this. There is a discrepancy between the result from quantitative and qualitative study and this needs further study on the level of awareness of the slum households.

### **Fees for family planning services**

The respondents were also asked if they have paid any fees for family planning services in the last 12 months. 67.13% of the respondents have not paid any fees for FP services in the last 12 months and 3.15% have replied that they have paid. Those who have paid, were asked how much they paid and what would they say about the fee. Based on their response, what they have paid is within the range of 4-35birr and majority of them replied that the cost is fair and cheap. The reason for this difference is because of the source where they get family planning service. Some respondents directly purchased family planning commodities from pharmacies and some received the service from the nearby health center.

In line with this, the data collected from the key informant interview with the service provider at the health center shows that family planning service at the HC is provided for free.

The fees for FP methods was also assessed at private clinics and the key informant from a private clinic mentioned that,

*“The fee for FP service at the clinic is fair, it’s from 50 birr up to 250 birr depending on the type of FP method”*(KII, Private clinic, 2019).

The service providers at the private clinic believe that clients prefer private clinics to avoid the waiting time at the Health Center and to get privacy. They also think that counseling at most Health Center is very poor and no detail information is provided about the FP methods.

### **Visit by a health extension worker**

The respondents were asked if they were visited by a health extension worker in the last 12 months. 85.37% of the respondents replied that they were not visited by a health extension worker. This shows the gap in the health extension programme and how this has impacted the utilization of family planning services.

### **Transport access to reach the health facility**

The respondents were also asked if they have paid any fee for transport to the health facility and 98.61% of the respondents replied that they haven't paid anything for the transport.

### **4.1.6 Religious and cultural beliefs**

The influence of religious and cultural beliefs can be different from place to place considering the heterogeneity of the population. In the study area, 50.87% of the respondents reported that their religion does not support the use of family planning service and 43.90% responded that their religion supports the use of family planning service. This shows that there is a difference from religion to religion and even there is also a difference in people's interpretation of their religious beliefs towards family planning use and having more children. Some Orthodox religion followers believe that using family planning service is forbidden by the bible and others like some Muslim religion followers believe the opposite. This may require the engagement of religious leaders as part of the work being done to improve community engagement and they can play a huge role towards increasing utilization of family planning methods.

In relation to culture, 72.1% of the respondents believe that their culture supports the use of FP service but 23.7% believe that their culture do not support the use of family planning. When checking if gender issues affect family planning use in the slum area, 56.4% of the respondents replied that it doesn't affect but 41.8% responded that it affects the use of family planning. This implies that there is a need to work on gender empowerment, cultural sensitization and educating the community to change their attitude towards the use of family planning service.

## **4.2 Drivers of inclusive family planning service**

Inclusive family planning seeks to build on the idea of family planning for all and to strengthen it through the rights-based approach; to stress the need for more active inclusion by recognizing those who are in need; overcome the barriers to address these needs; and to utilize a much greater range of family planning service delivery options embodied. The drivers of inclusive family planning utilization are a set of multiple factors which range from individual, community to factors at the policy level (Wulifan et al, 2016).

### **Understanding of the concept inclusiveness**

The understanding of the study participants towards the concept inclusiveness was different. Even though all the key informants at different levels (government offices, private, health facility including the FP users at the intervention area, donors and NGOs) have had a clear understanding of what inclusiveness mean, majority of the slum households (54.3%) didn't really understand what it means. This took a considerable time for data collectors to explain the term to the respondents and ensure that they finally understand before they proceed with the questions on the drivers of inclusive family planning service. This may be due to the concept being recently developed and not widely communicated especially in terms of the use of family planning service.

### **Reason for lack of inclusiveness**

The result obtained from the key informants implies that family planning is not inclusive and as evidence some of the interviews from the FP users and donors are stated below:

The interviewed client at the health center mentioned that the family planning service which is provided in this area is not inclusive as Adolescents are mostly excluded from using this service because of mainly cultural barriers and attitudes of the society as they are young and not married. She also mentioned that

*“Most people think that the adolescents should not use family planning as it's only allowed to married couple. Since the health center is located very close to the households the Adolescents do not have the courage to be seen by the neighborhoods while using family planning service at the health center”*(KII, FP user at the HC, 2019). She also added that more efforts should be done by the

Health Extension Workers in awareness rising. She also mentioned that the other reason why family planning services is not inclusive is because of the low involvement of men. She said she believes that there is some improvement towards male involvement in family planning service provision but still there is a lot to be done to improve this significantly and media can play a big role in this regard.

The other client has also said that

*“Family planning service is not inclusive as most adolescents do not use because of different barriers like socio-cultural and lack of family support. They should have the access to FP methods as they are very much vulnerable than the other age group and teaching at schools can be a better option to increase the adolescent’s awareness about FP”* (KII, FP user at the HC, 2019). She also mentioned that awareness creation at school; mothers teaching their children who reached the adolescent age group and changing the attitude can be the areas that should be worked on to make FP service more inclusive.

The key informant from DFID mentioned that,

*“it is difficult to say that FP is inclusive at this stage because there are groups whose FP needs are not addressed because of different reasons in relation to Age, Educational level, socio-economic status etc. e.g. most adolescents do not have the knowledge about family planning. When they have unsafe sex, they only take emergency contraceptive and the consultation they get is very poor”* (KII, DFID, 2019). She also mentioned that the other group who may not have access to FP is the poor. She said, *“The poor are mostly uneducated and may not have the awareness about FP methods. Even though the service is free, because of the socio-cultural factors they may not access it. They lack not only the knowledge and awareness, but the decision-making power too”*(KII, DFID, 2019). She mentioned that religious beliefs and gender issues are also the other issues which are determining the inclusiveness of FP service. Most clients, who do not use FP because of religion, don’t even have the awareness about natural family planning methods like standard days, etc.

According to the key informant at the woreda administration office, there is an issue of marginalization/exclusion in the slum area because of the problems they are facing in

relation to housing and being ignored by the government and not getting any response to the problems they are facing. Most of the households in this area are children and grandchildren of the people who were battalions during the war between North Korea and China in 1951. The children of those people are suffering from a number of social problems and the government is doing nothing about this.

The households were asked if they feel excluded or not. Majority of them (51.9%) responded that they feel excluded from the FP service since the UHEWs are not visiting them and not providing any service. They have a huge dissatisfaction with the service provision also.

### **Potential drivers of inclusive family planning service as perceived by the respondents**

Factors that determine the use of family planning service can be seen from the micro to macro level.

#### **4.2.1 Macro level**

In relation to the factors at the macro level, 3.1% of the sample respondents indicated Government's Political will and commitment to Family Planning as the most important driver of inclusive family planning service and 8% of the sample respondents indicated Government support as the most important driver of inclusive family planning service.

#### **4.2.2 Community level**

10.5% of the sample respondents indicated community literacy level and attitudes as the most important driver of inclusive family planning service and 4.9% indicated health extension programme as the most important driver of inclusive family planning service.

#### **4.2.3 Household level**

The household respondents were asked to rank the possible drivers of inclusive family planning service from 1-13. 1 for the most important driver to 13 being the least important. The majority, 30.3% of the respondents indicated Media as the most important driver of inclusive family planning service and 12.9% ranked Availability of facilities and family planning methods 1<sup>st</sup> and 12.5% ranked Individuals' behaviors and attitudes as the most important.

The factors that were expected to be the drivers of inclusive family planning service were media, individual's behaviors and attitudes, community's literacy level and attitudes, Government support, donor support, NGO and PPP, Health extension programme and Government's political will and commitment to family planning. On the result, there were also other factors which were considered as drivers of inclusive family planning service in addition to those listed above. These are: Availability of facilities and family planning methods, service provider's attitude, youth friendly clinic, confidentiality, staffing at the district and sub-district levels, communication with husband and close family member and client access (e.g. hours, wait times). These factors were ranked by the respondents in their order of importance.

In line with this quantitative data, key informants from donors and NGOs also mentioned media and health extension programme as the most important drivers of inclusive family planning service. As evidence, the key informants from woreda 4 health bureau and EH are stated below:

The key informant from the woreda health bureau mentioned that,

*“To make family planning service more inclusive, the health center needs to create integration with the Urban Health Extension Workers to enable them to work more on the awareness creation about family planning service, work on counseling and refer clients to the health center”*(KII, woreda health bureau, 2019).

According to the key informant from Engender Health, to make family planning service more inclusive, more work should be done on media. Media can improve the male involvement towards family planning service utilization. He mentioned that we do have the Reproductive Health strategy which includes FP and we even have strategy specific for Adolescents, but the gap is on implementation. There is a huge gap in terms of demand creation. The government policy is pro-poor and the issue of vulnerable groups is addressed 50% but there is a gap in the Adolescent age group, street girls and boys and women and girls in the humanitarian settings. He said,

*“More work needs to be done in social inclusiveness making services more inclusive to the youth, street girls and boys, people with disability, pregnant girls, males”*(KII, EH, 2019). He mentioned that most of the services at the facility are not male friendly. Previously the strategy has been tailored to the majority which is

female which has been addressed but now we have to move to the others specialized services. He also stressed that media can play a big role and more work should be done on improving the service providers' inter-personal skills to a range of services and to a range of users including male users. He recommended for Service providers to be equipped with different special skills.

As a means of working towards inclusive family planning, there is also a mechanism which was suggested by the key informant from MSIE mentioned that

*“To make FP services more inclusive to different population groups, we need to take in to account varieties of service delivery modalities. Marie Stops Ethiopia as one key partner for FMoH and being a key actor on service delivery, it has been using diversified kind of service modalities to reach all population groups that includes outreach/mobile service modality, static service modality, franchising private sectors and working with industrial parks, flower farms and textile under its workplace programs. Moreover, Marie Stopes Ethiopia has also designed a voucher/waiver program to address the potential financial barriers for service uptake and the organization is planning to reach this marginalized groups in the future”*(KII, MSIE, 2019).

The key informant has also added,

*“PSI Ethiopia had a program at the slum areas with emphasis on HIV/AIDS and MSIE was partnering with PSI to address the FP need of the specific population groups located in the slum areas. Though the scale is limited, and focus was given for HIV/AIDS, there are also other community-based organizations which are working on FP at slum areas. Most of that community-based organization did refer FP clients to the nearby facilities once they created the awareness. MSIE with one of its project portfolios has planned to test a new model that fits in to these groups in the next few months. The model is called “Marie stops ladies” who will be nurses in profession and are responsible to go to slum areas and create awareness to those groups”*(KII, MSIE, 2019).

The key informant mentioned that

*“What we can do to make FP service inclusive is internally we can work on raising FP issue on different outlets- OPD, Vaccination outlet etc. using these*

*opportunities. Service providers usually miss the opportunity of addressing unmet need immediately when women come; to deliver; when she comes for vaccination”.*

She stressed on the need for continuous follow-up and more work on service integration before we work on demand creation and working on demand creation- those who have knowledge but lack decision making power including working on male involvement. She also pointed out that inclusiveness in terms of geographic location is also poor. Slum areas and pastoralist regions are facing this issue because of their geographic location.

### **4.3 Determinants of use of family planning service**

Factors that determine the FP use can be seen at demographic, socio-economic, behavioral and Institutional levels.

#### **4.3.1 Household level**

The factors that were expected to determine the use of family planning service, before the study was conducted, were knowledge/awareness, motivation, health concerns, partner’s approval/dis-approval, communication, decision making, distance and transportation, quality of care, costs, medical barrier, service provider’s bias, abortion laws, religion, fertility norms and women’s status. But as the result shows even though most of the listed factors were also selected by the households as a determinant of use of FP service, some of them like communication, distance and transportation, religion and abortion laws were not selected by them as a determinant factor.

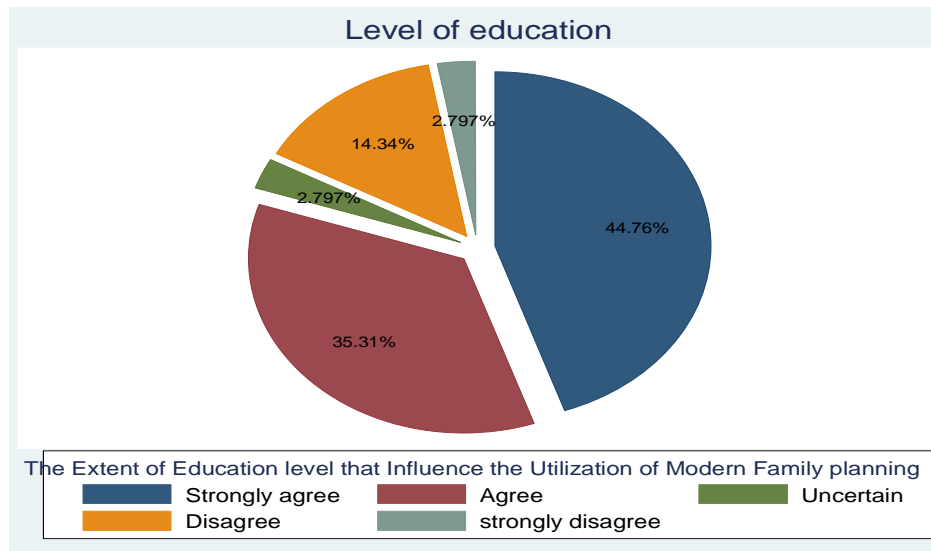
The result on abortion and other FP related laws are not considered as a determining factor for FP use in Ethiopia and this was confirmed by the key informants. As an evidence the response provided by the key informant from DFID is stated as below:

*“In Ethiopia, the FP related laws are very progressive, and the laws do not place unnecessary medical restrictions on contraceptive use/provision. It is very open and unlike some African countries, it doesn’t need approval from partners for women and from parents for adolescents to use FP service. They all have the right to use the service” (KII, DFID, 2019).*

As it is presented on the figure 8, 44.76% of the respondents strongly agreed and 35.31% agreed that the level of education can influence the utilization of family planning service.

22.6% of the respondents reported as strongly agreed and 31.0% agreed that women’s status can also influence family planning service utilization.

Figure 8: Influence of level of education on FP utilization as per sample respondents

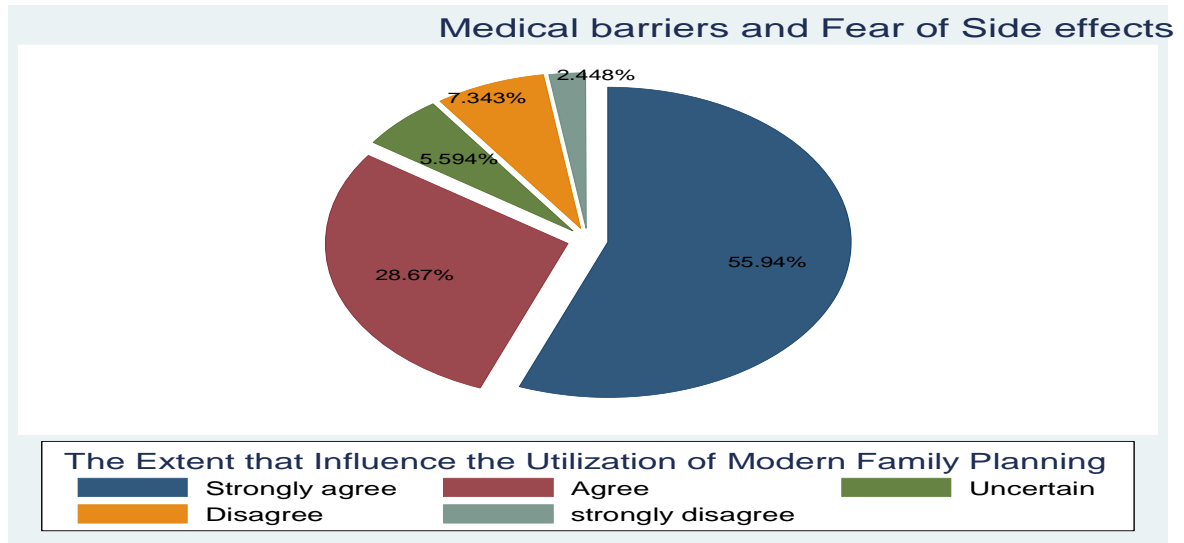


Source: Survey result, 2019

As it is presented on the figure 9 below, the majority (55.94%) strongly agreed that the medical barriers and fear of side effects influence the utilization of modern family planning service. In line with this quantitative data, the qualitative data collected using key informant interview has also confirmed that fear of side effects is one of the most important factors in determining the FP use:

*“Family planning service is not accessed by all because of lack of awareness and some of the methods like IUD are not often chosen by the users. Sometimes IUD may not be available at the clinic and there are also times when FP methods including implant may not be available. Most clients do not want to use family planning method because of fear of side effect such as procedure and hormonal effects” (KII, Private clinic, 2019).*

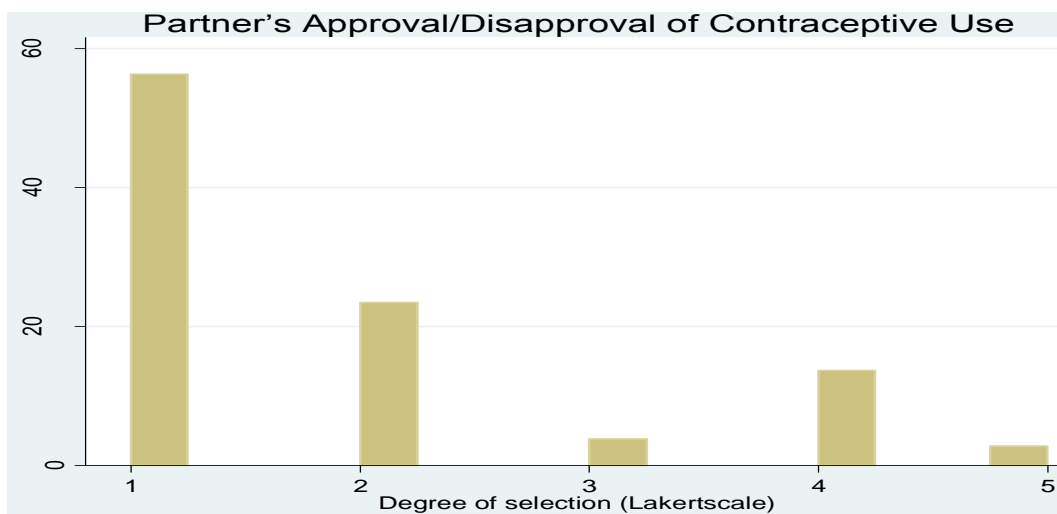
Figure 9: Influence of medical barriers and fear of side effects on utilization of family planning services as per sample respondents



Source: Survey result, 2019

Using the Likert scale 1-5, 1 for strongly agree and 5 for strongly disagree, the respondents were asked to what extent Partner’s approval/disapproval of contraceptive use can influence the utilization of family planning and majority (56.1%) of the respondents strongly agreed that it can influence the utilization as it is presented on the figure 10 below.

Figure 10: Influence of Partner’s approval/disapproval on FP utilization as per sample respondents



Source: Survey result, 2019

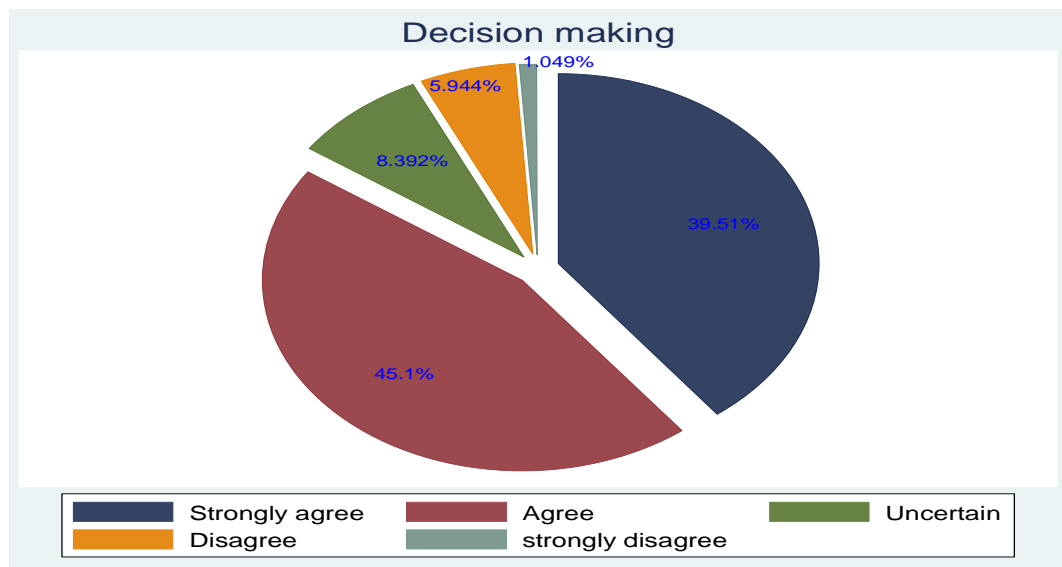
The qualitative data also confirmed that partner’s approval/dis-approval is one of the most important factors that influence FP service utilization. As evidence, the interview with the service provider at the health center is stated as below:

*“some women come to the HC by hiding from their husband since they don’t allow them to use family planning methods since they want to have more children”* (KII, Service provider at HC, 2019).

This has a huge impact on the women’s decision-making ability to use FP and will impose a challenge on the well-being of the family.

Decision making is also another indicator employed to identify the determinants of FP utilization. 39.51% of the respondents strongly agreed and 45.1% agreed that decision making influences FP utilization as it is presented on figure 11 below.

Figure 11: Influence of decision making on FP utilization as per sample respondents



Source: Survey result, 2019

In line with this, the result from the qualitative also confirmed that decision making power/ability is a very important factor for using family planning service. As evidence the key informant interview conducted with MSIE and FGA are stated below:

*“Ethiopia is a predominantly patriarchal society. Thus, usually husbands tend to decide on behalf of their wives on the number of children they should have. Socio-culturally, children are assets in many parts of the country. All these factors affecting the decision power of women to determine her sexually and reproductive*

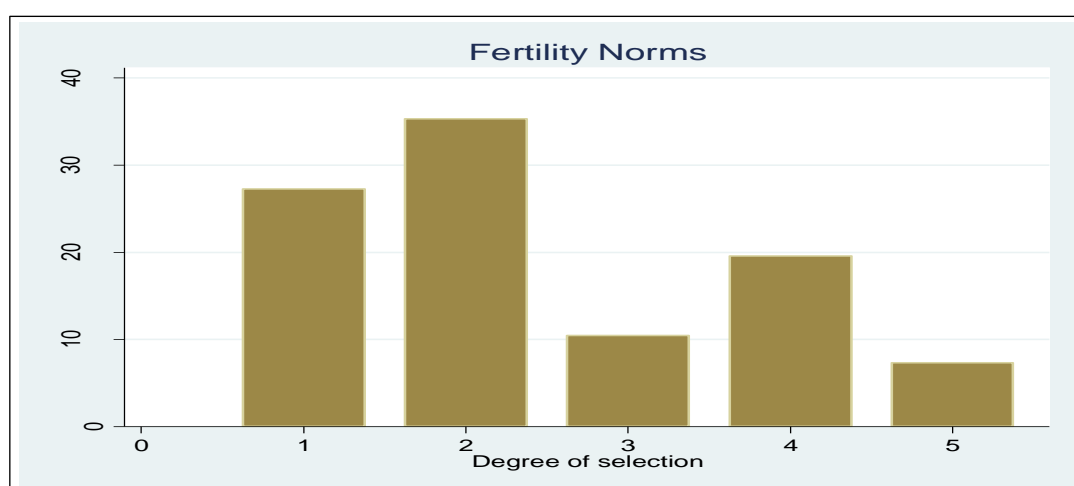
*health rights: Education, advocacy and awareness raising are key in addressing the socio-cultural and gender barriers of FP services” (KII, MSIE, 2019).*

In relation to gender imbalance, the key informant from FGA mentioned that

*“Women’s decision-making ability is a key factor in the utilization of family planning. This decision- making ability may be influenced by partner’s approval/dis-approval. If a women is educated and empowered, she will be able to make a decision on family planning use and she will then be able to limit her children will be able to support her children to get quality education, and she will also be able to have time to work and generate income. Because of gender empowerment and education, a woman will be able to use FP which will enable her to improve her livelihood moving out of the vicious circle of poverty” (KII, FGA, 2019).*

The majority of the respondents have put level of awareness/knowledge, motivation, accessibility, quality of care/service and cost of family planning methods as the most determinant factors of utilization of family planning service. In addition to this, as it is presented below on Figure 12, 27.2% of the respondents strongly agreed and 35.2% agreed that fertility norms influence the use of family planning service.

Figure 12: Influence of fertility norms on FP utilization as per sample respondents



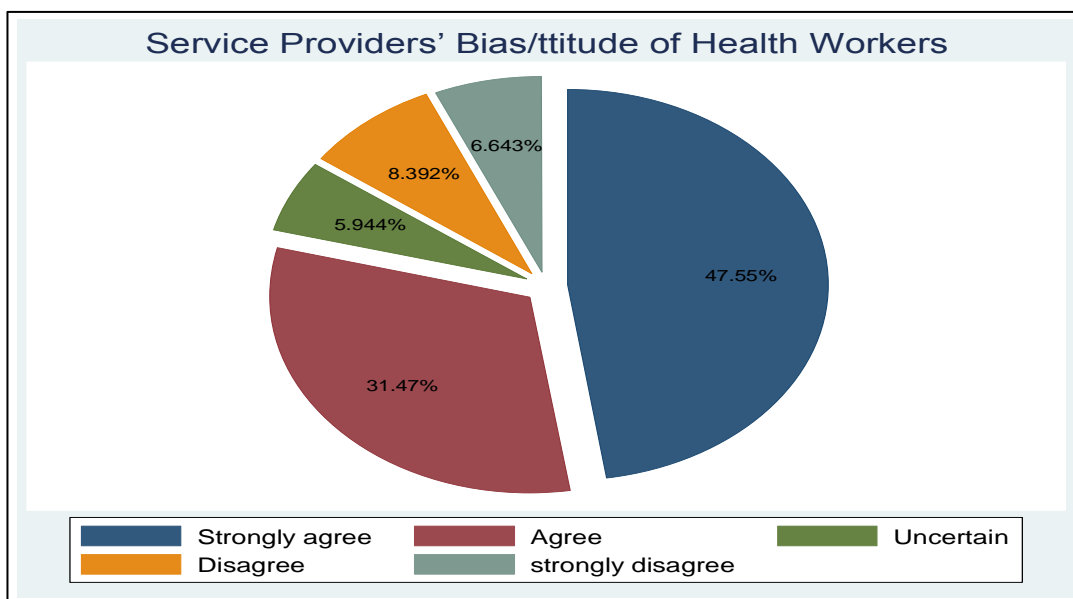
Source: Survey result, 2019

47.0% of the respondents strongly agreed and 31.4% agreed that service providers' bias influences the utilisation of family planning in slum areas as presented below on figure 13.

In line with this the qualitative data also confirmed that service provider's bias as the most important influencing factor in the use of family planning service in slum areas. As evidence, the key informant interview with a UNFPA is stated below:

*“the challenges with the provision of family planning service in slum areas are mobilizing the society, service provider's bias- not only in terms of skill but also value clarification or mindset about FP's contribution and role for countries like Ethiopia” (KII, UNFPA, 2019).*

Figure 13: Influence of service providers' bias/attitude of health workers on FP utilization as per sample respondents



Source: Survey result, 2019

### Challenges and solutions

The participants were asked what challenges they have faced when seeking for modern family planning services and the majority, 69.7%, faced fear of side effects, 10.6% of them faced challenge with partner's support and 9.8% of them faced poor services at the health facilities. When they were asked, what solutions they think could solve the challenges they mentioned, 32.1% responded that more awareness and education on issues of modern family planning can be a solution. 22.3% reported that increased number of health facilities in slum areas can be a solution to the challenges they faced.

## **4.4 Family Planning intervention model**

In this study, the FP intervention model has been evaluated in terms of its approach, identifying the gap, its strength and weakness and its contribution for enhancing livelihoods of slum households. The evaluation was done using expert's opinion, interviewing key informants and reviewing relevant literatures and the model was from the service provision up to the policy level.

### **4.4.1 Service provision**

#### **Affordability and accessibility of FP services**

Assessment was done on the range of affordable methods at the health facility and it is confirmed that there is no fee at all in relation to family planning service provision. It is good that clients can access the FP methods of their choice without any barriers in relation to cost. However, according to the key informants from HC, NGOs and private, access has always been a challenge in the FP program particularly availing range of method mix. For instance, the service provider at the health facility was trained in short acting and long acting but not being able to provide post-partum IUD and permanent methods has compromised the method mix so is the quality and access.

The Malawi experience supported the decision in the shift in policy and human resource deployment which has made dramatic improvement in access to a full range of FP methods. All female sterilizations are performed by clinical officers, not by doctors. This emphasized the need to do task shifting from highly skilled workforce to low level workers to improve access and choice of FP services. Hence, this can reinforce our recent move towards having Level 4 HEW to provide LARC and training of mid-level health workers particularly health officers for the provision of permanent methods.

The key informant from the woreda health bureau mentioned

*“one of the reasons why urban slum dwellers may not want to use family planning services can be their knowledge and attitude towards FP. She thinks that providing family planning services to slum dwellers should be a priority as this is one of the mechanisms to improve their economy and to improve their livelihoods”* (KII, woreda 4 HB, 2019).

### **Counseling and awareness raising activity on FP methods**

The key informant from Addis Ababa Health Bureau also stressed that

*“The major gap in family planning service provision is counseling both at the facility and at the community level (outreach). We need to work on mobilizing the society, teaching the community about the benefits of family planning, we have to do sensitization and awareness raising at least once in three months’ time since there is a huge mis-conception by the community about the FP methods”*(KII, Addis Ababa Health Bureau, 2019). She also added that *“The women may prefer to listen to their neighbor rather than the service provider. I have seen a woman who came to the facility for FP service talked to the other woman sitting next to her in the waiting area and changed her mind about having implant insertion. This is just because the other women shared her experience with the implant she has, which is not related with the method it- self”* (KII, Addis Ababa Health Bureau, 2019).

She stressed on the need to teach the community about FP and how it contributes in enhancing their livelihood. The other area she mentioned is the integration of FP with other services. She said they initiate the activities but the service providers in place lack the commitment and ownership in the continuity of the initiative of best integration. There is an issue of sustainability at the health facilities. She also suggested to improve the reporting system.

### **FP service delivery channels and approach used in the provision of FP service**

According to the key informant from the health center, there are two delivery channels in the health center. One is through direct service provision to the clients who come to the health center and the other one is through the UHEWS to the households. The health center uses facility led approach in the provision of family planning service, but the interviewed clients recommended that it would be good to consider peer led for the new clients who wants to use FP method and for clients who may not feel comfortable being treated by male service provider.

According to the key informant from FGA, most FP partners including FGA use both mainstream effort and targeting specific group as well. It is good that partners are using a

twin-track approach, but the second approach lacks targeting slum areas which need to be seen and addressed. The key informant from Addis Ababa Health Bureau mentioned that

*“There is a concept we use in PMC which is ‘spot area’ which helps us to target a specific group but there is no such practice in family planning, which is a huge gap. We have to specifically target slum areas in the FP intervention”* (KII, FGA, 2019).

According to the key informant from a private clinic, clients always come to the clinic for FP intervention and the service providers have never gone to the clients.

Unlike the private clinics, some NGOs like FGA and MSIE provide outreach services to the clients by going directly to their area. They provide these kinds of services using different criteria like socio-economic status, people with disability, marginalized and underserved community, and commercial sex workers and so on. But this approach hasn't included slum households yet. This can be the best approach to apply on slum areas as these people also priorities their socio-economic issues and problems and family planning for them is the least priority, so they prefer to go out and work hard to bring some money for their survival. These people need to get the FP service at their places and more work needs to be done on educating them how FP can contribute to improve their livelihood by limiting the family size, better health and education of the children and the mother, more time get a job rather than spending time taking care of children and improving their quality of life.

Most of the key informants of this assessment agreed that the FP intervention which is provided currently does not specifically target slum areas. There is a plan to address this area, but the plan hasn't progressed very well.

### **Urban Health Extension Program**

According to the key informants at the health center and woreda 4 health bureaus, the family planning service provision which is provided by the UHEWs is limited with health education and distribution of condoms. The UHEWs will only refer those clients who want to use FP since they don't have the skills to provide the service at their home. There is also a gap on whether the UHEWs do visit the households at their home because 85.37% of the sample respondents who have been asked about the home visit responded

that the UHEWS have never visited them. On the other side the UHEWS responded that they do the home visit every day. The internal referral system is good but the external is very weak and needs to be improved. There is a huge gap observed between the HEWs and the households during the study and this needs to be addressed in consultation with the Woreda Health bureau and the HC.

The interviewed UHEWs mentioned that

*“They cannot provide FP services other than distributing condoms for the slum households at their home just because they are not trained to do so”* (KII, UHEWs, 2019).

The HEWs reported that most of the household women want to get the service at their home and they prefer this instead of going to the HC. The limited skill and capacity of the UHEWs is one of the reasons for the low utilization of family planning in the study area. According to the key informant from the health facility, there is no any systematic clinical coaching and tracking individual provider competence at the health facility and the UHEWs are not motivated enough to improve their skills through on job trainings.

According to the key informant from the woreda health bureau, in woreda 4 there are a total of 104 Women Development Army /WDA/ and each sub-district has on average 9 to 10 WDAs. The WDAs work with the HEWs. She said that

*“one of the barriers to people in slum areas not to use family planning service is their economic status. Most of the slum dwellers are daily laborers and they are busy doing these kinds of activities to survive and they don’t have time to spend at home. Due to this the HEWs do not get the opportunity to talk to them during their home visit”* (KII, Woreda Health Bureau, 2019). She also added *“The second barrier is the attitude of women. Those women who are staying at home are mostly not willing to discuss about family planning”*. The third barrier the key informant mentioned is their geographic location. The location of the slum area is very complex that the HEWs find it very difficult to do their home visit on a daily basis.

The key informant from the Woreda health bureau mentioned that

*“The fact that HEWs are coming from other places is becoming one of the barriers to people in slum areas not to use family planning services as the households do not accept them since they don’t belong to the community in woreda 4”* (KII,

woreda health bureau, 2019). She said that *“Previously HEWs have been assigned to the area where they have grown-up, and this made it successful but now since the HEWs are assigned randomly and since the residents don’t know who they are, they are not willing to let them in to their homes and listen to what they teach them”* (KII, woreda health bureau, 2019).

### **Training and capacity building of FP service providers**

In relation to training and capacity building, the key informant from Addis Ababa Health Bureau mentioned that

*“There is high turn-over of trained health providers and there is also an issue of mis-use of the trained staff. Some-times clients are treated by service providers who are not trained even in the presence of the trained one”* (KII, Addis Ababa health bureau, 2019).

The key informant at the HC mentioned that,

*“There is only one trained provider on staff and there is no enough staff to handle daily client flow and needs. The provider has been trained with FP basics only. The frequency and scope of trainings are not adequate”* (KII, HC, 2019). He also stressed that the providers need trainings in method provision, referral, individual and couple counseling, client screening, infection prevention, Gender sensitivity, youth friendly services and integration.

The key informant from the FMoH mentioned the contribution of pre-service education in mounting FP providers. Thus, it can be included as one strategy in enhancing access in relatively cost-effective way. It is a better alternative to the huge investment in in-service training. It was also highlighted the importance of investing on adolescent RH particularly married adolescent through employing evidence-based approach. For instance, a key informant from the FMoH mentioned

*“Strengthening the pre-service education is the right solution to have many skilled health workers who can provide FP service. With the current high turnover of providers, we cannot guarantee to have a skilled provider at a given facility all the time”* (KII, FMoH, 2019).

It was also suggested that the modality of in-service training to be short with a focus on planned mentorship.

In-terms of training systems, pre-service training in FP needs large investment. The key informant from EH mentioned that

*“Pre-service training that is provided at the Universities is only theoretical which lacks clinical skills. Universities are expected to provide basic skills but the gap here is a lack of continuous professional development in terms of in-service training”* (KII, EH, 2019). The respondent from DFID said *“The pre-service training is very poor as it is not detail and lacks practical session. There is in-service training at different levels but there is lack of refresher training and high turn-over of the staff who have taken the training”*(KII, DFID, 2019).

Countries like Tanzania have already recognized the importance of pre-service education in enhancing access for FP service. Their national FP guideline indicates that an institution’s pre-service curricula for all health service providers should include FP, in order to provide full integration of FP and RH services in the national health care delivery system. Tutors in all medical/nursing institutions (public, private, and faith-based) need to be equipped with FP information, technology, and skills to enable them to teach their trainees according to updated curriculum.

A key informant from EH stressed that the communication skill of health professionals need to be considered during the pre-service training which is key for FP counseling. They agreed that FMOH needs to give more focus on creating Companionate, Respectful and Caring health professionals (CRC), which is one of the transformation agenda of HSTP, to make our health facilities user-friendly to attract more FP method users and have the users continue using. The key informants also stressed the need to conduct regular client satisfaction survey linking to the essence of CRC to improve the counseling and service quality.

### **Male involvement in FP service provision**

The respondent from MSIE stressed male involvement in FP should be strengthened; FP, from its very design, is considered as the female program, and there is a need to consult and properly counsel husbands. The key informant from the intervention area responded

that “*Male involvement in FP service provision is very low and most men think that FP is only women’s responsibility, and this is the area which needs improvement*” (KII, MSIE, 2019).

Advocacy against FP, politicization and challenges in relation to the service provision

There is a resistance towards FP service (low acceptance among the community) in the country and the reasons include the current mis-conception, myths and advocacy against FP. There is a growing politicization of family planning that might affect the delivery of FP service if the mis-conception increases. Groups that portray population control are being created and this is a growing concern at this time.

FP program is facing a challenge from different directions, from the community, providers, community leaders and political activists. Key informants proposed to conduct extensive study and for development of effective FP communication strategy and how to reposition FP agenda. Besides, there is lack of clarity on quality definition, as to the key informant from the FMoH, “*what most people know about quality FP service is employing effective counseling and availability of method mix*” (KII, FMoH, 2019). However, the concept of quality in FP service is beyond that. Hence, the quality directorate at the ministry is working on developing standard and measurement for quality FP service. Besides, there are no adequate evidences that explain the minimal gain in CPR as compared to the huge investment that require further investigation. This is emphasized that investment on FP is huge; however, looking at the return measured in terms of method acceptance, there is a need to do much; hence further investigation is required to identify reasons and possible solutions for improving achievement.

When asked what the existing barriers are in promoting FP service, most of the key informants mentioned that the FP program got politicized in some areas that it has made the intervention very complex putting lots of women vulnerable for unwanted and unplanned pregnancies.

Up until 1995, India used target approach to guide, monitor and evaluate their FP program, however, in 1996, the Indian government took the radical decision of abolishing method-specific contraceptive targets replacing it with what was initially called the Target-free Approach, where health workers’ caseloads would be determined by needs identified at the community level, rather than centrally-assigned. ICPD 1994 program

action recommend that governments should secure conformity to human rights and to ethical and professional standards in the delivery of FP and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and regarding service provision.

#### **4.4.2 Policy**

Ethiopia like many other countries do not have a standalone FP policy, however FP is addressed in the 1993 national health policy, more over the national health policy currently under revision underscores access to health and FP as a human right issue and emphasize the role of other sectors and multi-sectoral collaboration in health. The draft national health policy also takes FP in to account as part of maternal health component. The policy strongly emphasized women health and provides direction to increase the number of female health professionals and strengthen women role in decision making for their own and family health.

#### **Assessment on the need for a standalone policy for FP**

The study tried to explore if separate FP policy is needed for Ethiopia. The policy makers at FMOH stressed that, evidence and further discussion should be done that strongly justifies the importance of developing FP policy. Furthermore, the key informants stressed that it is more appropriate to enforce FP component in the current draft national health policy, population policy and other relevant policies rather than formulating separate FP policy. The National Planning commission is also planning to revise the outdated population policy and during the revision it is recommended that it include demographic dividend and the role of FP. Besides, the women policy can include the importance of FP to address the women right and women empowerment issues, and the role of women development army on the FP services while revision. The key informants also expressed that FP is well addressed in the Health Sector Transformation Plan (2015/16-2019/20). The FP programme implementers reflect the importance of having separate FP policy. Though they see the importance of having FP policy, it also resonates their concern on lack of evidence to show the need for FP policy.

## **Health Sector Transformation Plan (2015-2020)**

The Health Sector Transformation Plan (HSTP) underlined Reproductive Maternal, Neonatal, Child and Adolescent Health (RMNCAH) to be a priority and has set ambitious goals (example CPR 55%) to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels. It emphasized the country will give more focus for high impact interventions related to RMNCAH, and the targets set in the HSTP are in line with the global aspirations, such as the sustainable development goals.

Most of the key informants of this study agreed that HSTP is comprehensive and gave the required focus to maternal and child health, including RH/FP. However, the concern is most leaders at different level may not be well aware about the existing policies and strategies, given the on-going frequent change of leadership and problems associated with distribution/dissemination.

As the key informant from FMoH mentioned,

*“I am not sure how many of the leaders at different level in the health care system are familiar with those strategies. The only way to monitor it ever been implemented is through supervision.... not sure if it is enough to learn strategies are put in place” (KII, FMoH, 2019),*

The respondents from NGOs also mentioned that policy, strategic and other documents prepared by FMoH are not properly distributed and reached to them on time. Even though one of the HSTP transformation agenda is equity in the health service delivery, and FP is one of the key HSTP indicators, yet the performance is very low.

When asked about any policy gap in terms of promoting adolescent RH service, the respondent from NGO said

*“I don't think there is a policy gap rather the problem is alignment between different sector ministries. For example, there is no proper alignment between the Ministry of Education and FMoH” (KII, NGO, 2019).* It is identified that there is no consensus on the Sexual and Reproductive Health (SRH) package in terms of understanding issues around adolescent SRH. Most of the key informants agreed

on the challenge related to weak harmonization among stakeholders and stressed the need to reinforce intersectoral collaboration.

### **Population Policy and Women Policy**

Other related policies analysed in this study included the Population Policy and Women policy. The Population Policy (1993) stressed harmonization of the population growth rate with the economic capacity of the nation. The policy is good at presenting the linkage between population and development (education, maternal health, housing, agricultural productivity, etc). Strategies are also embedded within the policy and one of its strategies is to reduce the Total Fertility Rate (TFR) from 7.7 to 4 in 2015. The document also defined the responsibilities of various relevant stakeholders including Ministry of Education, FMOH, Ministry of Labour and Social Affair, Ministry of Finance and Economic Development, Ministry of Agriculture and FGAE. However, the Population Policy (1993) was designed with specific target until 2015, thus it is overdue and needs immediate revision.

The National Women Policy (1993) stated Ethiopia as one of the top countries with high fertility rate and significant number of women lack access to FP knowledge about the spacing of children. Key informant from Ministry of Women, Children and Youth Affair (MoWCYA) stated

*“The women policy is well-prepared, and it mentions about women participation and empowerment and relevant RH issues. However, it has been developed long time ago (more than 25 years), and does not reflect the current needs of women, especially for the youths and adolescents; besides, technology is missing”*(KII, MoWCYA, 2019).

The MoWCYA has developed the Ethiopian Women Development and Transformation Strategy and Package in 2017, which are comprehensive and consist of up to date information. These documents emphasized gender mainstreaming, multisectoral collaboration, and put clearly the role and responsibility of each sector at all level. These documents are prepared in Amharic, and not well enacted. The study participant at the MoWCYA mentioned as they need support for translating these documents in to English and other local languages and make familiar to all to facilitate their implementation.

## **Social inclusiveness in the policy documents**

The key informant from EH mentioned that

*“Social inclusiveness is not seen in its totality rather in to min and pieces. It would be good if social inclusiveness can be seen across policies and strategies. The FP guideline should consider how to handle special clients. The guideline is more focused on the technical rights-based FP” (KII, EH, 2019).*

He also mentioned that family planning is one of the components of the population policy. Social inclusion is a new concept and most of the policy documents lack comprehensive social inclusion. The health policy (the old one) indicates about the social inclusiveness and the previous plan (Health Sector Development Plan) also articulates about inclusiveness but none of them are comprehensive.

## **FP programming gaps as perceived by the experts**

According to the key informant from DFID, the main programming gaps which limit the progress or achievement of national policy goals and objectives are:

- 1) The leaders not giving a priority to FP. Even though there is a commitment made, FP is not seen as a priority by the Government.
- 2) There is no problem in terms of planning the programme but in terms of increasing accessibility and in relation to demand creation, there is a huge challenge.
- 3) The other challenge is in the quality of family planning service
- 4) In relation to socio-cultural factors, gender imbalance is affecting the utilization of family planning service.
- 5) The other challenge is in relation to financing which is highly donor dependent. She added that this is becoming a huge concern from the sustainability point of view.

She also mentioned that the level of policy support for community engagement in slum area is very low and there is no mechanism where community-level champions are involved in these efforts. This can also be strengthened by engaging UHEWs, community leaders and religious leaders by advocating about the use of FP to enhance the livelihood of the slum households.

The interviewed UHEWS mentioned that a group discussion has never happened with in the community and community meetings have been conducted long time ago. As the

supervisor of the UHEWs said, this is because the community members are daily laborers and do not have time for these kinds of community gatherings.

The key informant from a private clinic mentioned that

*“The government does not support private sector participation but since it supports the NGOs, private sectors get support from NGOs in turn. There is a huge gap in terms of HR training, Infrastructure and skills development in the private sector”* (KII, Private sector, 2019).

### **FP and its contribution to achieve Agenda 2030 as perceived by the government and development partners**

Key informants from the government, NGOs and Donors believe that family planning can play a big role in helping to achieve Agenda 2030. They also believe that FP a short cut and a very good means of tackling poverty for countries like Ethiopia which is suffering from a high population growth. The key informant from the FMOH mentioned that,

*“FMOH, in collaboration with FPbC team and secondees, prepared two important platforms to address this emerging barrier on family planning program. The first event was organized to engage parliament social standing committee on the current health service status of the country, including family planning. The FMOH-MCH-N Directorate organized a meeting to orient members of the Social Standing Committees on the health status with a focus on family planning in Ethiopia. The meeting was the platform for the review of country intervention on FP and maternal and child health. A total of 70 members of the social standing committee of the Ethiopian parliament were in attendance. The meeting provided constructive discussions between members of the Social Standing Committees of the House of People Representatives to deliberate on priority policy interventions, build and sustain the momentum for political will for FP within the existing situation”* (KII, FMOH, 2019).

She also mentioned the following commitments which were made by the social standing committee to address the problem on FP:

- Advocate for inclusion of family planning as a key component of all relevant development programs, including poverty reduction strategy and action plans and sector-wide approaches, and health-related programs aimed at achieving the Sustainable Development Goals;
- Enlist the support of FMOH in promoting family planning. Pass legislation supportive of family planning expansion and improvement;
- Establish and support parliamentary subcommittees on Health and FP; and
- Commitment towards monitoring and evaluation of FP services at country level.

#### **4.4.3 Strategy**

The strategies addressed in this study included the National RH strategy (2016-2020), Costed Implementation Plan (CIP) for FP in Ethiopia (2015/16-2020), Health Extension Program (HEP) strategy and National Adolescent and Youth Health Strategy (2016-2020). The main points raised by the key informants included what more should these strategies encompass and how effective are these strategies and the gaps in terms of implementation of these strategies.

#### **The National Reproductive Health (RH) Strategy**

The national RH strategy (2016-2020) states the goal of FP is to reduce unwanted pregnancies and enable individuals to achieve their desired family size. To achieve this, the strategy sets the following action points: decentralizing the provision of all FP services including long acting and permanent methods to the lowest possible service delivery level. The RH strategy also incorporated: increase access to and utilization of quality FP services, particularly for married and unmarried young people and those who have reached the desired family size and create acceptance and demand for FP, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth.

The strategies set out by them are still relevant. The implementation of some of the strategies did not happen at the expected time; such as allowing the lower health service outlets to provide long term contraceptives. This is not happening now at the study area since HEWs are not providing not only LARC but short-term contraceptives also.

The National RH strategy also highlights putting more effort to increase the CPR and reduce the unmet need with focus on LARC and permanent contraceptive methods.

Despite the country's track record in consistently increasing FP uptake, the growth has not been uniform across the various methods, and especially on use of long-acting reversible and permanent methods is extremely low. To increase FP uptake through a rights-based approach, it is essential to improve the quality of FP counseling and services and bring about a well-informed decision-making process on method choice.

To make CPR 55 by 2020 from the current 37, there is a plan to have 3 million more new users. As key informants put it

*“We are off-track, 2 years left; we are long way to go to achieve the target”*. The strategy is getting into the community through the Primary Health Care Units – strengthen HEP (training and mentorship of level 4 HEW) through creating a hub of 3500 health centers that are linked with health posts.

According to the key informant from DFID, the Contraceptive Prevalence Rate (CPR) in Ethiopia in general and in Addis Ababa in particular was high at first but now it stagnates so this needs to be seen. The population number is increasing at an alarming rate and the FP uptake needs to be proportional with this rate. She also added that leadership on FP is poor and needs to be improved. Practically to tackle population growth nothing is being done. A strategy needs to be developed to tackle this. More work needs to be done on how to use the decentralized system, how to champion the women (praise the champions), revitalizing the health extension programme. One to one communication, stories/case studies on how FP contributed in improving their quality of life and strengthening media can be beneficial in this regard.

### **Costed Implementation Plan (CIP) for Family Planning**

Costed Implementation Plan for FP, 2015/16–2020 is expected to help meet the goal of increasing modern contraceptive prevalence rate to 55 percent amongst married women by 2020 and reducing the total fertility rate to 3.0. The five strategic priorities in the CIP represent key areas for financial resource allocation and implementation performance. It includes demand creation especially on long term method, enhancing service delivery and access through availing skilled providers, outreach and mobile clinics services. The CIP included addressing the AYH, improving the distribution of FP commodities and consumables from the central level to service delivery points by increasing the capacity of healthcare workers to manage the logistics system and the Ethiopian Pharmaceuticals and

Supply Agency (EPSA). Moreover, improving multi-sectoral coordination in the planning, implementation, and monitoring of FP program at all levels, increasing the budget allocation for FP both at the federal and regional levels to ensure RH commodity security.

The cost of the total plan is projected to be 6.2 billion Ethiopian Birr (ETB) or US\$285 million between 2015 and 2020, which will increase the number of women in Ethiopia currently using modern contraception from approximately 6.2 million users in 2014 to 10 million users in 2020. Though the CIP clearly stipulated the budget required to achieve the target for the FP 2020 commitment, as most of the key informants put it, the budget allocated to FP by the government is very low or non-existent at all level.

The key informant from DFID mentioned

*“The majority of the budget is donor dependent. Compared with the other services, the budgeting for Family Planning is highly dependent on donor’s support and the allocation from the government is very low”*(KII, DFID, 2019)

The key informant from EH said that

*“There is no specific/dedicated budget for FP. There is high level ownership issue not prioritizing FP as a standing agenda. The population growth in Ethiopia is increasing at an alarming rate and FP is one aspect of population but it is not considered as high-level leadership issue”*(KII, EH, 2019). He added that FP programmes are highly donor dependent and the fund allocated nationally and to the regions is not sufficient.

According to the key informant at the FMoH, the CIP describes FP quality, equity and access including how to overcome geographical barrier. According to the key informant from EH, the Health Extension programme was first developed with the intention of supporting the rural community and this doesn’t fit for the urban community as the set-up is completely different. He stressed that

*“An alternative mechanism should be developed for the urban community or the UHEP should be modified taking the socio-economic conditions in to account. This may need a different strategy which may shift to the school health or work place. Using media can also play a big role in this regard and more work needs to be done in interpersonal communication”* (KII, EH, 2019).

Most key informants raised their concern if the leadership is aware of the existing strategies thus implementation has remained as a challenge.

### **The National Adolescent and Youth Health (AYH) Strategy**

The national Adolescent and Youth Health strategy clearly articulate the goals, the service delivery mechanisms, the roles of institutions including schools and how to reach those adolescents who are out of school. Instead of treating RH separately, it makes it an integral part of the adolescent and youth health package. The goals are to increase CPR among all female youth aged 15-24 years from 18.30% to 30%, reduce unmet need for modern contraception among adolescent aged 15-19 years 32.80% to 10%, reduce unmet need for modern contraception among youth aged 20-24years from 21.80% to 10%. The health services are provided in community based and healthcare facility-based service delivery mechanisms. AYH becomes an integral part of the health extension package, with the priority of scaling-up community-based AYH interventions through HEW.

The national AYH strategy stated schools and Higher Education Institutions (HEIs) to be widely utilized for comprehensive sexuality and life skills education, counseling, treatment and referral services. Out- of school platforms such as youth centers, peer clubs and associations provide spaces for education on adolescent and youth health and development and for information provision through health workers, e-health, and helplines. Hence, stakeholders working on AYH need to re-design a mechanism for best integration in the comprehensive health service package.

When asked about any strategy or guideline recommendation to bring FP services inclusive of adolescents, a respondent from NGO, suggested the strategy should articulate clearly on how to bring all sectors that are serving and working for/with youth together and reach on the consensus on how the provision of RH service should be like to overcome all potential barriers. The key informants from donors also pointed out absence of clear strategy on how to make the FP service integration with other reproductive, maternal, neonatal, child and adolescent health services. They also stressed integration of the FP with public health interventions and service outlets, such as immunization and antenatal clinic. They prioritized the following strategies to be developed in the next two years:

Besides, the key informants stressed that strategies and guidelines are not distributed and used by the intended users. Hence, there is a need to further explore the reasons for suboptimal implementation of existing policies and strategies and build a system to disseminate and monitor the implementation of policies and strategies at all level of the health systems. On Service Availability and Readiness Assessment survey report, guideline availability is one of the criteria for FP readiness and this is very low. They also added that the policies and guidelines need updating to reflect current evidence or best practices.

#### **4.4.4 FP Guideline**

The FP guideline referred to the constitution on Article 35 which states

*“to prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to FP information, education, and capacity.”* It also cited the National Health Policy that states maternal health and child health deserve due consideration and emphasizes on intersectoral collaboration. It states the rationale for FP, defines the strategies for access to service, the range of services provided by facilities and professionals, the role of partners and private sectors, FP service for clients with special needs like adolescents and people with HIV, advocacy and communication, quality of service, contraceptive commodities supply chain management, and HMIS.

#### **The gaps identified in the FP guideline**

The communication part of the FP guideline mostly dealt with what the content of the message and the channel should be. Because FP is becoming very sensitive agenda, persuasive communication to get new couples accept methods is not going to be easy. Hence, a well thought of communication strategy should be designed. This can help to avoid the misconception and to address the current confusions regarding FP. The key informants proposed the need to design target specific messages, using different media, and technology, such as mobile apps, brochures, CDs to provide information to patients and clients at the health facilities waiting areas. Therefore, it is high time to develop a strong FP communication guideline particularly to regions where there is misconception regarding to FP programs. As to the key informant from Addis Ababa Health Bureau, the mis-conception on FP is not a problem in Addis Ababa. Most Clients know the importance

of contraceptive service, and there are more users of LARC than short acting contraceptives. This finding emphasized the need of developing context specific strategies and guidelines.

The section that outlines quality on the FP guideline is limited to describing the clients and providers' right. But, with our ambitions meeting the goals set, we would remain a way behind from our target unless we work on quality FP which has much to do with quality of counseling (implement right based approach).

The key informant from the FMoH mentioned that

*“one of the gaps identified in the FP guideline is it doesn't put age cut off point when it comes to who should not use FP. Access to FP service though seem to address those in reproductive age group, no lower age limit is set. This allows flexibility to even target those girls 13 and 14 years of age”* (KII, FMoH, 2019).

This is an opportunity since any sexually active adolescent can access contraception whenever they need it. This point was also acknowledged by the key informant from the FGA. However, some respondents claim that there has to be age cut off point, raising their concern what lower age they should consider giving the FP service. The key informants added that there is discussion going on to make the service accessible to young girls of age less than 15.

According to the key informant from NGO, there is no guideline that dictates requirements or service standard to start or provide permanent methods. Thus, it was suggested to include standards on provision of permanent method in the guideline.

Right based approach is not very well articulated in the document, according to the remark given by key informant from FMoH.

*“I suggest the FP guideline narrates the approach clearly with the means of achieving it. The FP program indicators are CPR and acceptance rate. I recommend there should be indicators of quality like how many women have used them by their choice that emphasized the right based approach”* (KII, FMoH, 2019).

## **Revision of the FP guideline**

The national family planning guideline is under revision now. The reasons were increasing quality of service through availing method mix by training HEWs on LARC; to accommodate the new medical eligibility criteria recommended by WHO.

According to the key informant from UNFPA, the FP guideline doesn't include slum areas as communities with special needs. The key informant from DFID has also mentioned that

*“it is good to have national policies, strategies and guidelines related to FP. This shows how the Government is committed but the weakness is on the implementation. There is a huge gap in the planning, resource mobilization and ensuring that those with unmet need have the access to FP. The service is also very poor. Driving these policies and guidelines from parliament to the lower level of leadership and commitment is poor. The FP guideline is under revision, but it doesn't focus more on adolescents, slum areas and people with disability”* (KII, DFID, 2019). She also added that the FMoH and Technical Working Groups need to work on this so that due attention can be given to these and got improved. There is a specific strategy on RH for adolescents and by working with the Ministry of Education, comprehensive sexual education is provided, and this strategy includes mental health also for those adolescents who are drug abuse. Other African countries use this strategy as a model. When we come to the implementation, there have been lots of gaps because of the change of officials at the FMoH.

## **Guidelines that indirectly support the promotion of FP**

There are also other related guidelines that indirectly support the promotion of FP. The Health National Adaptation Plan for Climate Change (HNAP 2017) clearly outlined the effect of population pressure for land degradation and aggravating the negative effect of climate change. It puts FP as one of the major strategic approaches to prevent or mitigate climate change. This idea needs to be considered while developing/revision of FP guideline, manuals, training material and so on.

The Health Sector Gender Mainstreaming Guideline (2014) provides guidance on integrating gender into all health programs, including FP and SAC; to develop and implement gender transformative planning, implementation, monitoring and evaluation

that help to reduce gender inequalities. However, as pointed out by the key informant from FMOH, the guideline was developed about five years ago, and it requires revision based on up dated data (evidence), and new innovations, (technologically advanced interventions).

The equity plan of action stressed to improve equity and bridge the big health outcome indicators gap, including FP and SAC, of developing regions, and some selected hard to reach zones within other regions in the country. However, the equity plan of action doesn't properly address other equity dimensions, such as gender, economy and educational status that need to be considered in Addis Ababa also.

# CHAPTER FIVE

## CONCLUSION AND RECOMMENDATIONS

### 5.1 Conclusion

This chapter briefly summarizes the major findings of the study and draws conclusion from the findings and then provides some recommendation for further considerations.

The major findings of the study highlighted that the level of family planning utilization in slum households of Yeka sub-city specifically in Woreda 4 is very low. The overall factors for the utilization of FP service are knowledge/awareness of the individual and the community, motivation, partner's approval/dis-approval, communication, decision making, distance and transportation, quality of care, costs, fear of side effects, service provider's bias, religion, fertility norms and women's status. Demographic, socio-economic, behavioral and institutional level factors govern the utilization of FP in slum area.

It is difficult to say that FP is inclusive at this stage because there are groups whose FP needs are not addressed because of different reasons in relation to age, sex, educational level, socio-economic status, geographic location etc. e.g. most adolescents do not have the knowledge about family planning and they even don't have the freedom to use FP methods because of lack of family support, service provider's bias, lack of proper consultation and information. The other group who may not have the access to FP service is the poor. Even though the service is free, because of the socio-cultural factors the poor are not accessing it. They lack not only the knowledge and awareness, but they lack the decision-making power too. Religious beliefs and gender issues are also the other factors which are determining the inclusiveness of FP service. Most clients, who do not use FP because of religion, don't even have the awareness about natural methods.

Lack of male involvement is also the other issue which needs to be addressed to make FP service more inclusive. Most of the FP services at the facility are not male friendly and service providers need to be equipped with different special interpersonal skills on how to treat those special groups mentioned above. In relation to geographic location, slum

households and pastoralist regions are mentioned as an example of those who have limited access to FP because of their location. The slum area in woreda 4 is very complex which even made the HEWs not comfortable to do their home visit and teach the households about FP service.

In order to make FP more inclusive, the most important drivers of inclusive family planning are Media, Availability of facilities and family planning methods, Individuals' behaviors and attitudes, Community's literacy level and attitudes, Government support, donor support, nongovernmental and public–private partnerships and the Health Extension Program and Youth friendly clinic (e.g. Privacy) target specific approach of FP.

The key role of media in driving inclusive family planning service is vital. The health facilities, health providers can work on raising FP issue on different outlets and using the opportunity of addressing the unmet need and the need to work on service integration, male involvement, mobilizing the society and the service providers not only in terms of skill but also value clarification or mindset about FP's contribution towards improving the livelihood of the community and its role to achieve SDGs for countries like Ethiopia.

Social inclusiveness is not seen in its totality rather it's seen in to min and pieces and if social inclusiveness can be seen across policies and strategies. The FP guideline should consider how to handle special clients. The guideline is more focused on the technical rights-based FP. Social inclusion is a new concept and most of the policy documents lack comprehensive social inclusion.

The health policy, population policy and women policy, as well as, the reviewed strategic documents and guidelines emphasized the importance of FP service and ensuring informed choice of a range of quality, safe and effective contraceptive methods for empowering women to decide whether and when they wish to become pregnant. However, it is commendable amending of these policy and strategic documents, and other tools used by decision makers and service providers through time by including timely and innovative information. It is also crucial to aware decision makers and health professionals on the existing policies, strategies, and other tools as appropriate. Besides, it is essential to involve end user on the design and development of materials and provide continuous advocacy and training to facilitate the implementation.

The factors identified at all levels (from micro to macro) by the sample respondents at household level and the key informants (experts) are important in driving inclusive family planning in slum areas. During the data collection process, each respondent (the household and key informant) emphasized on the issues that they would like to see addressed as an individual and as an organization respectively and even within the key informants themselves at some point. This implied that there is a variation in the motive which needs a continuous negotiation and this issue requires further study/investigation.

The study evaluated the approach and contribution of the FP intervention model to improve the livelihood of slum households. A number of gaps and challenges have been identified in the intervention model. Some of them are lack of training of service providers and UHEWs, Limited awareness on family planning methods among community member and a challenge in demand creation, lack of accountability by the UHEWs, the UHE programme not fit for purpose and doesn't capture the dynamics of social problem, limited partner involvement, inability to make services widely accessible through multiple service delivery channels, lack of decision-making power by women, socio-cultural factors including gender imbalance, lack of peer led approach at the facility, level of policy support for community engagement in slum area being very low and lack of institutional linkage through monitoring and evaluation, government not giving a priority to FP which implies sectoral level marginalization besides to the community level marginalization in the slum area, lack of support to public-private partnership, lack of proper dissemination of policies, strategies and guidelines, FP guideline not focusing on/targeting adolescents, slum areas and people with disability, the scale of operation of FP service being limited at the HC level and lack outreach service to the slum households and this resulting lack of client satisfaction, the financing for FP service being highly donor dependent and a huge concern from the sustainability point of view.

This study examined both the determining of FP use and the drivers of inclusive FP at different levels which makes it unique and different from the other studies which are limited in terms of focus on restricted age group or intervention area.

## 5.2 Recommendations

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

- At the health center which is near by the slum area, there is no trained staff on post-partum IUD and this has increased a chance of missing mothers to immediately start a long acting method post-delivery. Hence the center should have a pool of service providers trained on post-partum IUD
- There is limited awareness and utilization of family planning methods among the slum households and there should be continued engagement with the community via urban health extension workers to improve awareness and increase referrals for family planning services.
- To make FP service inclusive, more work needs to be done at different levels from the individual up to the policy level by working on service integration, male involvement, working on media, expanding the outreach services and targeting slum areas and making the services closer to them, revising the FP guideline to consider how to handle special clients including slums and adolescents, considering peer lead approach and providing outreach services to slum households by providing training to UHEWs, working on gender imbalance, Government giving a priority to FP and to slum households who are suffering from a number of social problems, increase the level of policy support to community engagement.
- The financing for FP is highly donor dependent and this is becoming a huge concern from the sustainability point of view. There is a need to work on domestic Financing, revenue generation etc.
- Health Extension programme was first developed to reach the rural households and this approach is being applied in the urban area also. However, this urban health extension programme is not fit for its purpose. The slum households are mostly engaged with informal livelihood activities and they spend most of their time outside of their home generating income. This approach succeeded in the rural area because the women usually spend their time at home doing domestic chores, but the context is different in urban area. There is a need to conduct further study on how to make this approach fit for its purpose.
- There is a practice of targeting a specific group in the provision of different kinds of health services including FP service but this approach has never been practiced

targeting slum areas. Service providers and different partners working on FP should consider this approach by addressing the issues of slum households.

- The policies, strategies and guidelines related with FP need updating to reflect current evidence or best practices including consideration of target variation. The number and types of FP related guidelines and policies that the country has are appreciated, but there is a huge gap on following the implementation of these guidelines, strategies and policies and there is a limitation on the timely updating of the existing guidelines and policies. The Health National Adaptation Plan for Climate Change (HNAP 2017) clearly outlined the effect of population pressure for land degradation and aggravating the negative effect of climate change. It puts FP as one of the major strategic approaches to prevent or mitigate climate change. This idea needs to be considered while developing/revision of FP guideline, manuals, training material and so on. The government should also develop a mechanism to monitor and closely follow-up the proper dissemination of policies, strategies and guidelines and ensuring that they are in use by health providers.
- The biggest challenge with the provision of family planning service in slum areas are mobilizing the society and service provider's bias not only in terms of skill but also value clarification or mindset about FP's contribution and role towards the achievement of agenda 2030 for countries like Ethiopia. Hence there is a need to work on value clarification and attitude transformation.
- Considering the growing resistance, misconception and politicization of FP across the country, there is a need to work on advocacy for inclusion of family planning as a key component of all relevant development programmes aimed at achieving the Sustainable Development Goals.
- This slum area has been ignored for long periods by the local administrations, being completely abandoned to their fate. The community is being excluded not only from getting urban health extension service because of the complexity of the area but also from getting other basic services also like water, sanitation, electricity, lack of proper shelter, overcrowding of houses, not able to get any ambulance or fire alarm services during emergency since the complexity of the topography of the slum area doesn't allow the trucks to enter in to the villages. If the government can look in to this area and plan for upgrading or at least re-developing the slum area.

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## Annexes

### Annex 1- Questionnaire designed to collect data from women of reproductive age group

Addis Ababa University  
College of Development studies  
Centre for Regional and Local development studies

**Topic: Inclusive family planning towards the achievement of Agenda 2030: the case of slum households in Yeka sub-city of Addis Ababa**

#### Introduction

Dear respondent,

My name is ..... We are conducting a research on the above topic. You have been randomly selected to take part in the study for being part of the resident of Woreda 4 in Yeka sub-city. You are kindly requested to take part in this study by completing this questionnaire. Your participation is purely voluntary and you reserve the right to withdraw anytime without any explanation. You are free to refuse to answer any questions which you may not be comfortable with.

The purpose of this study is to assess the extent and drivers of inclusive family planning services in the road towards Agenda 2030. The information we collect will help the government to plan family planning services. The questions usually take about 20 to 30 minutes on average. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team and produced reports of the study will not identify the individual respondent.

Are you willing to respond to the questions? Yes  No

Do you have any questions?

May I begin the interview now?

*(First of all, I would like to thank you for your willingness and for taking time to respond to the following questions)*

*A questionnaire for women of reproductive age (15-49)*

*Code no \_\_\_\_\_*

## I. SOCIO- DEMOGRAPHIC CHARACTERISTICS

1. Location (name of sub-district) \_\_\_\_\_
2. Age \_\_\_\_\_
3. Religion
  - a. Orthodox
  - b. Catholic
  - c. Protestant
  - d. Muslim
  - e. Other, specify \_\_\_\_\_
4. Marital Status
  - a. Single
  - b. Married
  - c. Divorced
  - d. Separated
  - e. Widow
5. What is your educational level
  - a. Illiterate
  - b. Only read and write
  - c. Elementary- please specify completed grade \_\_\_\_\_
  - d. Secondary- please specify completed grade \_\_\_\_\_
  - e. Technical/Vocational \_\_\_\_\_
  - f. Higher- please specify completed grade \_\_\_\_\_
  - g. Other, specify \_\_\_\_\_
6. What is your main occupation?
  - a. Government employee
  - b. Private employee
  - c. Self-employee
  - d. other, specify \_\_\_\_\_
7. How many children do you have?  
\_\_\_\_\_
8. What total number of children would you like to have?  
\_\_\_\_\_
9. Why do you want to have this number of children?  
\_\_\_\_\_
10. What is the average weekly expenditure of the household? (If you are single, what is your weekly expenditure?)  
\_\_\_\_\_
11. What is the average monthly income of the household? (If you are single, what is your monthly income?)  
\_\_\_\_\_

## II. Contraceptive knowledge, attitude and decision practice

12. Have you ever heard of family planning?
  - a. Yes
  - b. No
13. If your answer to q. no 12 is yes, please select and rank the sources where you have got the information about family planning.
  - a. Radio
  - b. Television
  - c. Newspaper/Magazine
  - d. Community event
  - e. Neighbour
  - f. Female friend

- g. Family (mother, sister etc) h. Poster/leaflet/billboard i. antenatal visit j. prenatal visit k. During labour and delivery l. postnatal visit m. Vaccination of children n. Other health appointments o. Other specify \_\_\_\_\_
14. Please indicate the family planning methods that you are aware about. Please circle all that apply  
 a. Standard day's method b. Injectable c. condom d. pills e. Locational Amenorrhea f. Implant g. IUD h. female tubal ligation i. Vasectomy j. Other, specify \_\_\_\_\_
15. Have you ever used one of (more than one) the family planning methods listed above?  
 a. Yes b. No
16. If your answer to q. no 15 is yes, please list the method/s you have ever used?  
 \_\_\_\_\_
17. As an individual, do you think that having many children is good?  
 a. Yes b. No
18. Do you think that having many children is good for the community?  
 a. Yes b. No
19. If you are married, when did you get married?  
 \_\_\_\_\_
20. Are you currently using family planning?  
 a. Yes b. No
21. If your answer to q. no 20 is yes, when did you start using family planning?  
 \_\_\_\_\_
22. If your answer to q. no 20 is yes, from the methods listed below which one are you using?  
 a. Standard days method b. Injectable c. condom d. pills e. Implant f. IUD g. female tubal ligation  
 I. Rhythm method j. withdrawal k. Vasectomy l. other, specify
23. For how long have you been using (CURRENT METHOD) now without stopping?  
 \_\_\_\_\_
24. What do you think are the benefits of family planning?  
 a. Limiting family size b. To avoid unwanted pregnancy c. Spacing child birth  
 d. For mother and child health e. other, specify
25. If your answer to q. no 20 is no, why are you not using family planning/modern contraceptive method?  
 a. To have many children b. Health concerns about the methods c. Spouse opposes d. my religion prohibits family planning use d. can't access the method e. other, specify \_\_\_\_\_
26. If you don't use modern contraceptive, do you intend to use any modern method sometime in the future?  
 a. Yes b. No
27. Family planning/contraceptive methods are accessible.  
 Strongly agree  Agree  Uncertain  Disagree  strongly disagree
28. Who is the breadwinner of your household?  
 a. Husband b. Wife c. Husband and wife d. Other, specify \_\_\_\_\_
29. Do you communicate with your husband and close family members about family planning issues?  
 a. Yes b. No



**IV. Religious and cultural beliefs**

46. Religious beliefs influence the utilisation of family planning services.  
 Strongly agree       Agree       Uncertain    Disagree    strongly disagree
47. Does your religion support the use of family planning service?  
 a. Yes    b. No
48. Cultural expectations influence the utilisation of family planning services.  
 Strongly agree       Agree       Uncertain    Disagree    strongly disagree
49. Have you ever talked with your mother, female friend etc, about family planning?  
 a. Yes   b. No
50. Does your culture support the use of family planning service?  
 a. Yes    b. No
51. Do gender issues affect family planning use in your area?  
 a. Yes    b. No
52. Do Adolescents can freely access family planning service at the nearest health facility and not excluded from this service?  
 a. Yes    b. No
53. If your answer to q. no 52 is no, why do you think they are excluded?  
 \_\_\_\_\_

**VI. Drivers of inclusive family planning services**

54. What does inclusiveness mean to you?  
 \_\_\_\_\_  
 \_\_\_\_\_
55. Do you feel that you are marginalised /excluded from using family planning service?  
 a. Yes   b. No
56. If your answer to q. no. 55 is yes, why did you say so? (when and how)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
57. Do you think family planning service is inclusive?
58. Why do think so?  
 \_\_\_\_\_  
 \_\_\_\_\_
59. Can you please rank the below drivers of inclusive family planning service from 1-13, 1 for the most important driver and 13 for less important.

<b>Drivers of inclusive family planning service</b>	<b>Rank</b>
Individuals' behaviours and attitudes	
Government's Political will and commitment to Family Planning	
donor support, nongovernmental and public-private partnerships and the Health Extension Program	
Media	

Availability of facilities and family planning methods	
Service providers' attitude	
Community's literacy level and attitudes	
Staffing at district and sub-districts levels	
Government support	
Communication with husband and close family members	
Youth friendly clinic (e.g. Privacy)	
Confidentiality	
Client access (e.g., hours, wait times)	

#### VI. Determinants of family planning service

60. To what extent do you think the following are key factors that influence the utilisation of modern family planning services in health facilities?

Variable	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Level of income					
Cultural beliefs					
Level of education					
Level of awareness/Knowledge					
Women's status					
Medical barriers and fear of side effects					
Communication					
Decision making					
Motivation					
Accessibility					
Partner's approval/disapproval of contraceptive use					
Distance and transportation					
Quality of care/service					
Religion					
Abortion laws					
Costs of family planning methods, consultation and other family planning service					
Fertility norms					
Service providers' bias/attitude of health workers					

## **VII. Challenges and solutions**

61. What challenges do you normally face when seeking for modern family planning services
- a. Transport issues
  - b. partner support
  - c. poor services at the health facilities
  - d. lack of money to pay for services
  - e. fear of side effects.
  - other, specify
62. What solutions do you think would solve the above challenges? Please rank your responses.
- a. Free provision of modern family planning by the government
  - b. Subsidized family planning services at health facilities
  - c. More awareness and education on issues of modern family planning
  - d. Increased number of health facilities in slum areas
  - e. Other, specify
-

## Annex 2- Interview guide for key informants

### For Addis Ababa Health Bureau

- 1) Identification:
  - (A) Name of respondent
  - (B) Designation of the respondent
- 2) Demographic Questions:

Gender: M      F

Age:
- 3) What is/are the main source(s) of funding for FP (e.g., government/internal, donor/external)? How diversified are they?
- 4) Is there any initiative that work on the inclusiveness of slum areas in Addis Ababa towards health service provision in general and family planning service in particular?
- 5) How are the urban health extension workers influencing access to family planning services in slum areas?
- 6) What are the challenges in the provision of family planning services in slum areas
- 7) What do you think the role of the government should be in supporting family planning?

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- a. Setting legal and policy frameworks
  - b. Creating service standards/protocols
  - c. Providing services through government facilities
  - d. Providing special adolescent focused services
  - e. Providing contraceptives and other FP commodities
  - f. Supporting information, education, and communication (behaviour change communication) programs
  - g. Other\_\_\_\_\_
- 

- 8) How, if at all, does the FP program give particular emphasis to special populations, for example?

- 
- a. Youth (married and unmarried)
    - Are youth-friendly FP services widely available and accessible?
    - Is there FP education in schools?
  - b. Couples (married and unmarried)
  - c. Men (individually and as part of a couple)
  - d. Low-income groups
    - Is FP included in national health insurance policies/plans?
    - Are there voucher and/or sliding scale arrangements for low-income clients?
    - Are services free to those who cannot afford them?
  - e. Slum residents
    - Is the program working to expand the availability of FP services through various sectors/sites (e.g., fixed facilities, mobile services, community-based health workers, employment-based h. Marginalized or vulnerable population groups
-

### **For Donor**

- 1) Could you tell us a bit about the FP activities your organisation support?
- 2) Which technical areas do you support? Prompts, if needed:

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  - a) Health care planning, management, financing
  - b) Infrastructure
  - c) Aspects of training
  - d) Supervision
  - e) Quality assurance
  - f) Logistics management information system or other information systems
  - g) Commodities
  - h) Community outreach
  - i) Social and behaviour change communication
  - j) Primary health care
  - k) Maternal and child health (MCH)
  - l) Social marketing
  - m) Franchising

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- 3) Do you focus on specific geographic areas?
- 4) Are specific demographic groups targeted?
- 5) Have government and other leaders' positions been analysed? If so, how broad is support for FP (or is it targeted to certain groups or focused on particular methods)? What is it informed by (e.g., evidence vs. beliefs/politics)?
- 6) Does the program target vulnerable groups? Who/what/how?

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### **For NGO**

- 1) Do you have any plan to work on the provision of family planning service on slum areas?
- 2) What do you think should be done to make family planning service more inclusive and what is your organisation's contribution towards this?
- 3) If you are already working on family planning service provision in slum areas, what was the reason for this?
- 4) What are the challenges with the provision of family planning service in slum areas and what can be done to resolve this?
- 5) Is there a family planning project implemented in slum areas of the country?
- 6) What is the general focus of your involvement in family planning (FP) (e.g., financial support; aspects of service delivery (supply); aspects of the enabling environment; demand)?
- 7) What is the scale and time- period of operation of the family planning service that you provide?
- 8) Do you go to clients/do clients come to you for intervention?
- 9) What geographic areas do you target?
- 10) What is the source of your funding for FP?

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- 11) Do you target specific demographic groups (e.g., youth, men, postpartum women, low-income groups)?  
Are the services you offer subsidized?
- 12) In your view, what are the main strengths and weaknesses of existing national policies, strategies, and guidelines related to FP?
- 13) To what extent are these policies, strategies, and guidelines disseminated and in use?
- 14) How is this monitored and supported?
- 15) Do any policies or guidelines need updating to reflect current evidence or best practices?
- 16) How would you describe overall support for the FP program in terms of:

- 
- Budgeting processes
  - Funding allocations
  - Training systems (preserve and in-service)
  - Logistics systems
  - Supervision and management systems
- 

- 17) What are the main programming gaps that limit or constrain progress or achievement of national policy goals and objectives?
- 18) Thinking about the social, cultural, and gender norms that influence FP use/uptake, what are the main barriers that are being faced by FP partners, and how are they being addressed?
- 19) What level of policy support is there for community engagement in this area? To what extent are community-level champions being involved in these efforts?
- 20) What do you think are the main areas in which programming in this area could be strengthened?
- 21) To what extent are family planning services decentralised?
- 22) As an NGO do you have the freedom to collaborate on family planning issues?
- 23) To what extent are family planning commodities subsidised? What efforts are there?

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24) To what extent the community is engaged in the planning and implementation of family planning intervention?

25) Have FP service delivery procedures and guidelines been disseminated?

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- a. Are they considered up-to-date and evidence-based?
  - b. How can they be improved upon?
  - c. How well do providers understand them?
  - d. Do you know if their use is monitored during site visits? Are they consistently applied throughout all levels of the health care system?
  - e. Are you aware of any current FP-related laws that place unnecessary medical restrictions on contraceptive use and/or provision?
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**For Private clinic**

- 1) Does the government encourage private-sector participation? If so, how (e.g., tax breaks, incentives)?
- 2) Are private FP services subsidized? If so by whom?
- 3) In your opinion, what are the biggest constraints that the FP program faces?  
Prompts, if needed:

- a) Infrastructure
- b) Government support (e.g., budget, regulations, infrastructure)
- c) Staffing at national, regional, and district levels
- d) Staff training, motivation, oversight/supervision
- e) Education and outreach (at all levels)
- f) References and resources (e.g., protocols, guidelines, job aids)
- g) Client access (e.g., costs/fees, hours; waiting times; provider availability/attitudes)
- h) Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- i) Sociocultural issues (e.g., myths/misconceptions, biases; spouse/family opposition; gender inequalities)
- j) Political or religious factors/opposition
- k) Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
  - l) Population segments that are more difficult to reach (e.g., urban vs. rural)
- 4) What do you think should be done to improve the FP program and make it more inclusive?
- 5) To what extent are family planning services decentralised?
- 6) As a private clinic, do you have the freedom to collaborate on family planning issues?
- 7) What is the scale and time- period of operation of the family planning service that you provide?
- 8) Do you go to clients or do clients come to you for intervention?
- 9) To what extent family planning commodities are subsidized? What efforts are there?

**For Selected couples and single from the intervention area:**

- 1) Identification:
  - (A) Name of respondent
  - (B) Designation of the respondent
- 2) Demographic Questions:
 

Gender:            M            F

Age:
- 3) Why did you visit the health facility and/or see a service provider today?
  - 1 = to learn about family planning methods
  - 2 = to adopt a family planning method
  - 3 = Other: \_\_\_\_\_
- 4) What is your opinion of the family planning services provided at your health facility?
 

(Probe for how they like the services, the health workers attitudes, costs)
- 5) What are the most popular modern methods of contraception that are used by individuals and couples in this community?
- 6) Are you currently using any method to delay or avoid getting pregnant?

- 7) What method(s) of contraception are you using?  
(Probe for reasons for choice of those methods, if this was the first method used)
- 8) For how long have you used this (these) method(s)? (probe for when, at what age they started using FP, any discontinuations in between, any change of methods)
- 9) How do you like the family planning method(s) that you are using?  
(probe for the good and bad, side effects)
- 10) How do you cope with the challenges in using modern family planning methods?
- 11) Are the people in your life supportive about using these method(s) of family planning?  
(probe for significant others support or discouragements, who is supportive and non-supportive, how she feels about these people and their views)
- 12) Have you used any modern methods in the past but have since stopped using them? IF No why. IF YES, tell me about those method(s)? (Probes: what were they, where did you obtain them from, how did you obtain them, who recommended them)
- 13) For how long did you use the methods?  
(Probe for period of use and when they stopped using the method)
- 14) Under what circumstances did you to discontinue the use of the method(s)?  
(Probe for access issues; costs of methods; side effects; who influenced decision:- providers, peers, significant others)
- 15) What would you want to tell other women/ men who have not started using contraception or those who have discontinued but are sexually active?
- 16) Do you think family planning service is inclusive in your area? Why?
- 17) What in your view can be done to improve the utilisation of family planning in slum areas?
- 18) What do you think are the factors that determine family planning use in slum areas?
- 19) What do you think can be done to make family planning more inclusive?
- 20) How do you feel about male involvement in family planning service provision?
- 21) Is there a mechanism where clients can provide feedback on the family planning service provision?

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- 22) How do you see the quality of family planning service provision at the nearest health facility?
- 23) Are you satisfied with the service you received today?
- 24) Was there a fee for the services you had? How much was it?
- 25) How long did you have to wait before someone saw you?
- 26) When you visited the health facility, was any one available to attend to you immediately?
- 27) Were you treated with respect when you approached the nurse, doctor, pharmacist, health worker?
- 28) Would you recommend the service provider your saw today to a friend/relative?
- 29) Do you believe the service provider you attended today:
  - a. Is competent to provide family planning services
  - b. Would not give you anything harmful
  - c. Could be trusted with a secret
- 30) What kind of approach does the health facility uses in the provision of family planning service? (Peer led or facility led or other?)

- 31) Have you ever received home visits by community health workers that include discussion of family planning?
- 32) Do you have anything else you would like to share with us about modern family planning methods?

**For Service providers at a health facility**

- 1) Identification:
- (A) Name of respondent
- (B) Designation of the respondent
- 2) Demographic Questions:
- Gender: M      F
- Age:
- 3) What is the FP need level in your woreda? Probe: High need, moderate, low.
- 4) Who are your most/regular/frequent clients for family planning? Or, who mostly comes to you for FP?
- 5) What are the most popular choices of FP methods in your Woreda?
- 6) Do you know why they choose these methods (instead of the other methods you mentioned to them)?
- 7) What services are available at this facility?
- Family planning (FP) [ ]
  - Male reproductive health (RH) [ ]
  - Prevention of mother-to-child transmission (PMTCT) of HIV [ ]
  - Maternal and child health (MCH) [ ]
  - Youth RH [ ]
  - HIV and AIDS services [ ]
  - Other [ ]
- 8) What FP methods are available at this facility?
- ❖ Male condom [ ]
  - ❖ Female condom [ ]
  - ❖ Oral contraceptive [ ]
  - ❖ Injectable [ ]
  - ❖ Implant [ ]
  - ❖ Intrauterine device (IUD) [ ]
  - ❖ Male sterilization [ ]
  - ❖ Female sterilization [ ]
  - ❖ Fertility awareness/standard days method (SDM) [ ]
  - ❖ Education on the lactational amenorrhea method (LAM) [ ]
- 9) What method is most commonly selected for use?
- 10) How many affordable methods are there at the facility?
- 11) How many delivery channels are there? Is there any effort made to make the services widely accessible through multiple service delivery channels?

- 12) Why is that method so commonly chosen (e.g., myths/misperceptions regarding other methods, provider bias, social norms, recommendation from friends/family, cost, availability)?
- 13) What kinds of (and how many) trained providers are on staff?
- a. Are there enough staff to handle daily client flow and needs?
  - b. Have (some/most/all) providers been trained in the following areas? Yes/No
    - FP basics
    - Method provision
    - Referral
    - Individual and couples counselling
    - Client screening
    - Infection prevention
    - Gender sensitivity
    - Youth-friendly services
    - Integration
    - Logistics/commodity management
  - c. How frequent are refresher/in-service FP trainings? What do these trainings cover?
  - d. Are the quality, scope, and frequency of FP trainings adequate? If not, how could they be improved? In what areas do providers need additional training?
- 
- 14) Who is served/targeted by the facility?
- a. Is it accessible to (some/most/all of) the catchment area?
  - b. Does it provide special FP services for men? If so, what are the challenges? What works well? Do you have specific service hours for men?
  - c. Does it provide special FP services for youth? If so, what are the challenges? What works well? Do you have specific service hours for youth?
- 15) Are there fee(s) associated with certain methods? Are clients asked to cover other costs (e.g., medical supplies)?
- a. If so, for which methods and/or supplies?
  - b. Do you think that fees affect clients' interest in choosing a particular method?
  - c. Is there a national insurance/voucher scheme for FP?
  - d. Is there a sliding scale or fee waiver for those who cannot afford services?
- 16) Do adolescents come to the facility to get family planning service?
- 17) Do men and women come together to ask for family planning service?
- 18) What efforts does your health centre do to encourage men and adolescents involvement in family planning?
- 19) Does the health facility provide integrated family planning services?
- 20) What kind of approach do you use to provide family planning service? Do you make the services available to couples in their villages and home?

- 21) Is there any systematic clinical coaching and tracking individual provider competence at the health facility?
- 22) How does the referral system work within the health facility?
- 23) Do you have referral linkages with other local community-based FP agents/NGOs/other for FP activities?
- 24) How is your relationship with them?
  
- 25) What are the strengths of the current referral system?
- 26) What are the weaknesses of the current referral system?
- 27) What can you suggest to improve the current referral system?
- 28) What can you suggest to improve FP services in your woreda?
- 29) What efforts does your health centre do to make family planning service more inclusive?
- 30) What are the challenges of providing family planning services to the slum residents?

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**For the Federal Ministry of Health:**

- 1) Identification:
  - (A) Name of respondent
  - (B) Designation of the respondent
- 2) Demographic Questions:
 

Gender:            M            F

Age:
- 3) How are national goals communicated to relevant actors and stakeholders? What coordination mechanisms are used to harmonize efforts of various partners?
- 4) Are there any important policy gaps related to FP? What efforts are under way to address these gaps?
- 5) How do current laws and policies affect the importation of and provision of contraceptive commodities? Are there any legal barriers that need to be addressed?
- 6) Are there any important policy gaps or changes that are needed to support FP programming? What efforts are under way to address these policy gaps or make these changes? What else needs to be done?
- 7) What is the level of unmet need for family planning in Addis Ababa– is it high/low, and why? What can be done about this? Are there specific groups that have bigger need than others? Or that have less access than others?
- 8) Is the Government in favour of improving FP services or not? Explain. Are there aspects of the Government FP policy and programme that limit/hinder clients to access FP services? What can be improved at policy level?
- 9) What is current status of integration of family planning and other services e.g. .Mat Health, HIV/STI, GBV, adolescent health etc.? Do you see this as good or bad?
- 10) How recently have the national FP guidelines been updated? Are there any gaps in these guidelines, in your view?
- 11) Do these guidelines consider the marginalised and vulnerable communities including slum households?

- 12) How are these guidelines disseminated? How is their use monitored?
  - 13) Do heads of government and other officials speak publicly and favorably about FP? If yes, how frequently (at least once or twice a year)? What form has this taken (e.g., public speeches, radio/TV broadcasts)?
  - 14) To what extent are family planning services decentralised?
  - 15) What are the efforts made towards inclusiveness of the slum areas in the provision of family planning service?
  - 16) What has been made in considering target variation in the national guideline of family planning service?
  - 17) What are the benefits of addressing the family planning needs of women in slum areas of Addis Ababa?
  - 18) What are the challenges of the provision of family planning service in slum areas of Addis Ababa?
  - 19) To what extent are family planning commodities subsidized?
  - 20) Does the family planning service provision target specific or is it provided to all?
  - 21) How do you feel about the level of funding for family planning that is provided by the government? Is it too little, enough, too much?
  - 22) Is there a dedicated line item for FP in the national budget? In the Ministry of Health (MoH) budget?
  - 23) Are you involved in supporting public-private partnerships or social marketing? If so, how (e.g., subsidizing private services)?
  - 24) Is there any alternative implementation approach for family planning?
  
  - 25) What has been made to increase the demand for family planning?
  - 26) What are the efforts made towards increasing contraceptive method choice?
  - 27) To what extent the community is engaged in the planning and implementation of family planning intervention?
- 
- 28) What are the efforts made towards improved quality of care and equity of access?
  - 29) What are the efforts made to improve supply of quality contraceptives?
- 
- 30) Do you think family planning could play a role in helping to achieve Agenda 2030? How?
  - 31) Do you think family planning could play a role to achieve the following Sustainable Development Goals? (Yes, No, Don't know)

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Goal 1: No Poverty

Goal 2: Zero Hunger

Goal 3: Good Health and Well-Being

Goal 4: Quality Education

Goal 5: Gender Equality

Goal 6: Clean Water and Sanitation

Goal 7: Affordable and Clean Energy

Goal 8: Decent Work and Economic Growth

Goal 9: Industry, Innovation and Infrastructure

Goal 10: Reduced Inequalities

- Goal 11: Sustainable Cities and Communities
- Goal 12: Responsible Consumption and Protection
- Goal 13: Climate Action
- Goal 14: Life below Water
- Goal 15: Life on Land
- Goal 16: Peace, Justice, and Strong Institutions
- Goal 17: Partnerships for the Goals

**For Yeka sub-city Woreda 4 Administration office**

- 1) Identification:
    - (A) Name of respondent
    - (B) Designation of the respondent
  - 2) Demographic Questions:
    - Gender:    M            F
    - Age:
  - 3) Can you describe the socio-economic status of the woreda and the 9 sub-districts which are slum
  - 4) What is the main challenge that the slum residents are facing currently?
  - 5) Is there any plan of slum upgrading or re-development in Woreda 4 that you are aware of? If no, what do you think is the reason?
  - 6) What does the administration do to improve the livelihood of the slum residents?
  - 7) How many health facilities are there in the woreda?
  - 8) How many health extension workers are there in the woreda?
  - 9) Is there an issue of marginalisation/exclusion in the woreda? If yes, do you think this marginalisation is at the sectoral level/community level?
- 

**For Woreda 4 health bureau**

- 1) Identification:
    - (A) Name of respondent
    - (B) Designation of the respondent
  - 2) Demographic Questions:
    - Gender:    M            F
    - Age:
  - 3) How do you set your plans regarding contraceptive coverage?
  - 4) In your own view, what are the barriers to people in slum areas not to use family planning services?
  - 5) Do you know of any reason why urban slum dwellers may not want to use family planning services?
  - 6) In your own view, do you think providing family planning services to urban slum dwellers should be a priority?
- 
- Yes .....    No.....
-

Why?

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- 7) In your opinion, what are the biggest constraints that the FP program faces?
  - 8) Do you know of people living in slum of Woreda 4 that are using any form of modern contraceptive?  
Yes No
  - 9) From what you know or have heard, are there couples who would like to use modern method of family planning, but are not currently using any method? Yes No Don't know
  - 10) Would you say that the percentage of women who would like to use a method of family planning, but are not using any method is: < 5%, between 5%-10%, between 10%-20%, >20% (best guess)
-